



PMAQ-AB: THE LOCAL EXPERIENCE FOR THE QUALIFICATION OF THE NATIONAL PROGRAM

PMAQ-AB: A EXPERIÊNCIA LOCAL PARA A QUALIFICAÇÃO DO PROGRAMA NACIONAL PMAQ-AB: LA EXPERIENCIA LOCAL PARA LA CALIFICACIÓN DEL PROGRAMA NACIONAL

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ABSTRACT

Objective: to evaluate the process of implementation of the PMAQ in the State of Paraíba from the experience of the external evaluation team. **Method:** it is a descriptive and analytical study, of documentary type, from the field diaries of the teams that participated in the External Evaluation of the PMAQ in Paraíba. All of the journals were submitted to Content Analysis proposed by Bardin, including pre-analysis, exploration and treatment. The interpretation of the journals was based on the experience of the PMAQ stages, with the following thematic categories: adhesion and contracting, development, external evaluation and re-contracting. **Results:** there was identified the lack of knowledge by the part of managers and health professionals about the program and the vision of external evaluation as an instrument of punishment. **Conclusion:** there is still a long way for the PMAQ guidelines to be implemented in practice and to become an incentive for guarantee of the access to and the quality of health care for the Brazilian population. **Descriptors:** Health Evaluation; Primary Health Care; Family Health; Quality of Health Care.

RESUMO

Objetivo: avaliar o processo de implantação do PMAQ no Estado da Paraíba a partir da experiência da equipe de avaliação externa. **Método:** estudo descritivo e analítico, tipo documental dos diários de campo das equipes que participaram da Avaliação Externa do PMAQ na PB. Todos dos diários foram submetidos à Análise de Conteúdo proposta por Bardin, passando por pré-análise, exploração e tratamento. A interpretação dos diários teve base na vivência das etapas do PMAQ, tendo como categorias temáticas: adesão e contratualização, desenvolvimento, avaliação externa e recontratualização. **Resultados:** foi identificado desconhecimento por parte dos gestores e profissionais de saúde quanto o programa e a visão da avaliação externa como um instrumento de punição. **Conclusão:** ainda há um longo caminho para que as diretrizes do PMAQ sejam efetivadas na prática e que se torne um incentivo para a garantia do acesso e qualidade da atenção à saúde para a população brasileira. **Descritores:** Avaliação em Saúde; Atenção Primária à Saúde; Saúde da Família; Qualidade da Assistência à Saúde.

RESUMEN

Objetivo: evaluar el proceso de implementación del PMAQ en el Estado de la Paraíba, de la experiencia del equipo de evaluación externa. **Método:** este es un estudio descriptivo y analítico, del tipo documental de diarios de campo de los equipos que participaron en la Evaluación Externa del PMAQ en Paraíba. Todos los diarios fueron sometidos al Análisis de Contenido propuesto por Bardin, a través de pre-análisis, exploración y tratamiento. La interpretación de los diarios se basaron en la experiencia de las etapas del PMAQ, con las siguientes categorías temáticas: la pertenencia y la contratación, el desarrollo, la evaluación externa y la recontractación. **Resultados:** se identificó la falta de gerentes y profesionales de la salud acerca del programa y la visión de la evaluación externa como instrumento de punición. **Conclusión:** hay un largo camino para que las directrices del PMAQ tengan efecto en la práctica y que se conviertan en un incentivo para garantizar el acceso y la calidad de la atención sanitaria a la población. **Descriptores:** Evaluación de la Salud; Atención Primaria de Salud; Salud de la Familia; La Calidad de la Asistencia de Salud.

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INTRODUCTION

Basic Care (AB) in Brazil has been the mark of several evaluation processes, including those financed by the Ministry of Health (MS) since its implementation in the 1970s. Among the efforts made in the last three decades, with a greater focus, the “Evaluation for Quality Improvement of the Family Health Strategy” (PAMQ-FHS), developed in 2005, to analyze the Brazilian work process at this level of attention; and the SUS Performance Index (IDSUS) between the years 2008 and 2010, in order to identify the service conditions and serviceability of the various levels of complexity, including AB.

In the same course, instituted on July 19th, 2011, by means of Ordinance N 1,654 GM/MS, the new MS proposal, the National Program for Improving Access and Quality of Primary Care (PMAQ-AB), presents a Differential of the previously established proposals, inasmuch as it intends, in addition to recognizing, to stimulate the improvement of quality and access to Primary Care. In this sense, the evaluation of AB units constitutes only one of the stages of the program, carried out after initial stages of development for the improvement of the services.^{1,2}

According to the Ministry of Health, PMAQ-AB was implemented with the purpose of encouraging federal, state and municipal managers, as well as the Primary Care Teams, to offer services provided in access and quality. The proposal is to meet the real needs of the population, so as to create a national quality standard regarding the actions directed to AB.^{1,2}

To this end, the program was organized in four stages. The first consists of joining the program, through contractualization of commitments and indicators between the Primary Care teams, municipal managers and the Ministry of Health. The second is based on the production of local changes through self-assessment, monitoring, permanent education and support Institution. The third stage comprises the external evaluation, in which the improvements in the conditions of access and quality achieved are verified. And the fourth is a re-contractualization to establish new standards and quality indicators, stimulating the implementation of a constant process of evaluation and re-evaluation.^{1,2}

In Paraíba, as proposed by decree N 1654 of the Ministry of Health, the first and second stage were under the responsibility of municipal and state managers, as well as the Primary Care teams.³ The third was conducted by the State’s external evaluation team,

linked to the Federal University of Paraíba, which, in partnership with the Federal University of Campina Grande, is a collaborative network coordinated by the Federal University of Rio Grande do Sul, where teaching and research institutions of the States: Mato Grosso, Mato Grosso do Sul, Pará, Paraíba, Rio Grande do Sul and São Paulo.

The external evaluation team in Paraíba was composed of a state coordinator, three local coordinators, three technical supporters, nine supervisors and 36 quality assessors, who evaluated the physical structure of all 1220 Basic Health Units and Interviewed workers and users of the 625 teams that joined the PMAQ.

Considering the extent of the PMAQ proposal and the importance of the initial results to subsidize subsequent steps, it is intended to analyze the peculiarities, weaknesses and potentialities in its implementation in Paraíba, with a view to the four stages that make up the program, in order to understand the complexity of each of them.

In this sense, it is required to evaluate the process of PMAQ implementation in the State of Paraíba from the experience of the external evaluation team.

METHOD

It is a descriptive and analytical study, based on the documental research of the field journals constructed by the supervisors and evaluators of the PMAQ External Evaluation team in Paraíba. Thus, the study based on the experience of this team, from which it is possible to highlight aspects of the development of PMAQ-AB in this State in all its stages. It is also worth mentioning that this team, besides being directly involved in the third phase of the program, can also follow it indirectly from its first stage of the first cycle that begun in 2012, to the first stage of the second cycle, held in 2013. In addition, the researchers selected to conduct the external evaluation had already had different insertions in the Basic Attention of the municipalities of Paraíba, either in the scope of the academy or as workers and/or managers in the different scenarios of the Unified Health System (SUS).

Thus, previous experience allowed them to become subjects involved in the process and imbricated in the object of study, which instrumented them with tools of analysis resulting from the insertion in the process itself that was intended to be analyzed. The

protagonist of these subjects is a positive element, since their implication in the process of implementation of the PMAQ in the State of Paraíba provides them with analysis items that external looks would not capture, precisely because the insertion in the research scenario provides certain conditions of construction of concept and analysis only to those who are involved in it.⁴

The instrument used in this research, the field diary, allowed descriptive recording of the impressions, concerns and worries during the course of the field work.^{5,6} The commitment to documentary research of these field journals was intended to capture the maximum of situations considering their capacity to provide the reactions, characteristics and peculiarities imbricated in the PMAQ implementation process in Paraíba.

Field journals were produced daily by researchers and supervisors and sent weekly to local coordination. The data collection period ran from May to October 2012. At the end of this period, 1500 pages of field diaries were compressed.

These data sources were analyzed based on the Thematic Content Analysis proposed by Bardin,⁷ based on the definitions that standardized the Program for Improving Access and Quality of Primary Care.⁸ Following this author, this analysis has three fundamental stages: Pre-analysis, in which an organization of the work scheme to be used is carried out; The exploitation of the material in which the data is coded, fulfilling the scheme elaborated in the previous phase; and The Treatment of results, where the researcher seeks to make the results found in valid and meaningful data.⁷ From these stages, the contents of the journals were organized into four thematic categories, following the four phases of the PMAQ: adhesion and contracting, development, external evaluation and re-contractualization. Following this categorization, the contents were organized and interpreted in the light of the regulations of the Ministry of Health for the said Program.

RESULTS AND DISCUSSION

PMAQ-AB, as a strategy to stimulate the improvement of services provided in Primary Care, aims to improve and facilitate the access and quality of health services, in order to solve the health needs of users.

To achieve this goal, the PMAQ design was guided by seven guidelines: 1. To have a parameter of comparison between the AB Teams in different realities; 2. To be incremental; 3. To be transparent in all

stages, allowing its monitoring by society; 4. To mobilize, involve and hold investors in a process of change; 5. To develop the practice of negotiation and contracting; 6. To encourage changes in the model of care, development of workers and orientation of services and 7. To be voluntary.⁹

In the present discussion, these guidelines are relevant for the analysis of the different stages of PMAQ implementation in Paraíba. In turn, this analysis is structured based on the experience of the stages of the program, from which the following topics of reflection are defined: adhesion and contractualization, development, external evaluation and re-contractualization.

♦ Adhesion and Contractualization to PMAQ

This first stage consists of joining the program through contracting the indicators, through commitments agreed, firstly, between Primary Care teams and municipal managers, and then with the Ministry of Health⁸.

Adhesion is voluntary and based on the premise that the achievement of goals depends on motivated and proactive actors that engage from the agreement of the indicators to the implementation of actions.⁹ Thus, the process requires the effective participation of the various professionals from the Primary Care teams, municipal managers, municipal councils and inter-agency committees, operating from guidelines 4 and 5 of the program, mentioned above.

Each actor in this process has a structuring role. Initially, the manager signals the municipality's participation in the PMAQ, and then the AB teams visualize the indicators to be contractualized and sign the Term of Commitment (TC).⁹

Once the adhesion is approved with the Ministry of Health, the municipality must inform the Municipal Health Council (CMS), the Regional Interactive Commission and the Bipartite Interactive Commission (CIB). To formalize the contracting process, in addition to the compromise term between the AB teams and the municipal management, the CIB needs to sign a CT or a resolution confirming the commitment between the municipal and state management.⁹ The formal regularization of the commitments between the different actors was a strategy to ensure the expression between the regional administrations.

Therefore, the PMAQ encourages participatory management in the improvement of Primary Care. However, its

implementation presupposes active and deliberative advice, as well as discussions among those involved with an emphasis on local priorities. For that, political subjects with self-recognition, representativeness and legitimacy are necessary, capable of recognizing realities and from them proposing and managing changes.¹⁰

Thus, it is essential that the actors involved in the PMAQ implementation process integrate into the essence of the proposal,¹¹ in order to be able to deliberate changes, producing horizontal planning based on their actuality.

This integrated way of managing has been stimulated by the Federal Government, including through decrees,¹² which provides for the organization of the SUS, health planning, health care and interfederative articulation.

Based on the observations made, the inclusion of municipal managers in the PMAQ implementation process has been fragile since the external evaluation in the municipalities. At this stage, there were frequent reports of managers who claimed to have doubts about the program or even to ignore it, to the point where a municipality agreed to a unit of AB that did not exist. This demonstrates, above all, the fragility in the involvement and ignorance of the proposal at the moment of adhesion and contractualization.

In the course of the external evaluation, in several situations, the managers positioned themselves with insecurity, anxiety and fear. And, in some cases, there was an effort to interfere in the application of the evaluation instruments. There was a request for rescheduling of the visit, with the justification of needing more time to improve health units, which corroborates the lack of preparation of the municipal administrations to carry out the stages of the program, according to the proposal.

At the time of the evaluation, the coordinator of Primary Care was present and very uneasy, so much so that when the professional said that there was no equipment, she answered that it had been sent to the unit (Supervisor 21).

It is important to highlight that, once again, the Secretary of Health, stayed on top of our evaluation, always interfering with his concern. He was asked to withdraw from the evaluation, but did not take it into account (Evaluator 23).

The fragility shown by the managers was also identified in the professionals. It was found that some Primary Care teams did not feel involved in the process, especially because they did not participate effectively in

the moment of contracting. It is believed; therefore, that such fragilities should be interrelated, since the interaction of process actors needed to start from the dialogue between the municipal manager and the health professionals, from the moment of the discussion of the indicators for the formalization of adhesion and contractualization.

Among the reports recorded in the field journals, the non-involvement of health professionals in the first moment of the program is highlighted due to lack of opportunity and / or convocation to participate in it. In some cases, the professionals reported not being invited by the managers, or even for the discussion about the municipality's adhesion to the PMAQ.

The professional (doctor) reported not recognizing the Program of Improvement of Access and Quality. According to her, the management has not passed any information on the external evaluation. She said she was informed the day the unit was visited by the team. The doctor said there was little interest of management in providing quality support to them (Evaluator 26).

This circumstance observed in some municipalities of Paraíba seems to show a de-characterization of the PMAQ-AB principles, especially regarding the mobilization, involvement and accountability of the actors for the change process.

On the other hand, in the municipalities in which the AB teams demonstrated to work in partnership with the management, the capacity of the PMAQ to stimulate changes was evidenced:

The Secretary had already stated that the unit was in chaos, about to happen some accident and that he decided to put it in the PMAQ just to be able to improve it and he did. He presented to our team the photos of the before the unit, which really proved the structural disorder (Evaluator 26).

Therefore, it was possible to observe in the first stage of the 1st Cycle of the PMAQ in Paraíba difficulty in the concretization of the proposed contractual agreement, with the involvement of the different actors in the municipal and regional space, which implied in the construction of a fragile foundation with potential repercussion in the development of the next stages of the program in the various municipalities of the State.

◆ Development

The second stage of the program consists on the development, being structured in four

dimensions: self-evaluation, monitoring, permanent education and institutional support. According to the principles of the Program, the starting point of this stage is self-evaluation, since the identification of problems and their strategies to overcome them are determinant to define the priorities of changes in the work process, investments in infrastructure, besides guiding the processes of permanent education and institutional support. In view of these aspects, it is understood that this stage is essential for achieving the changes proposed by the program.^{1,2}

To this dimension, the Ministry of Health proposes a self-assessment tool - Self-Assessment for the Improvement of Access and Quality in Primary Care (AMAQ) - that can be adapted by the management or teams, according to their realities and needs. It should be emphasized that, in order to become a critical-reflexive action, self-assessment must be performed with the various actors who produce basic attention.

The instrument seeks to support the implementation of the program's guidelines and objectives and to promote reflections on the responsibilities between staff and management, in the commitment to improve access and quality. It has been organized into dimensions that encompass what is expected in terms of quality in basic care and with the principle that any primary care service can use it.¹³

The AMAQ enables a moment of health planning, promoting the institutional culture of thinking strategically in basic care, taking into account the needs and possibilities of attending them, through reflection on their work process.

In the experience lived in Paraíba, it was possible to identify professionals who recognized in the PMAQ-AB implementation process an opportunity to perform self-evaluation and identify weaknesses in their work processes.

We always have to try to improve people's assistance, and often we do not know where to start... and PMAQ came to help us. - Speech of the professional of the evaluated team (Supervisor 01).

The program envisages that the development phase should run for six months, until the external evaluation visit, so that obstacles can be identified and strategic actions developed with monitoring, ongoing education and institutional support.

However, in dialogues held during the external evaluation, situations were identified that reflected a distancing from the above-

mentioned proposal, with fragile uses of the AMAQ instrument.

The interview with the professional was carried out in a short period of time and in a tense atmosphere, and it was not satisfactory, where she informed that she knew nothing about the program and that the secretary of health had delivered the AMAQ book Last Friday (Evaluator 30).

It is essential the effort of the management and the teams in the self-evaluating moments to drive the processes of change, in which the tools and the investments guaranteed by the program result in more concrete changes in the health services are essential.

When applied very close to the visit of the external evaluation team, the AMAQ seems to be used only as a preparation for the visit of the evaluators and not as a self-evaluation process and trigger of improvements in Primary Care, a problem that affects the whole development of the program.

Nurse interviewed showed dissatisfaction throughout the interview, reporting that some items addressed by the questionnaire were not implanted in the unit and had to be put into practice in a short time (eg school activities) in order to receive the PMAQ team (Supervisor 23).

In these contexts, the PMAQ seems to favor situations of institutional coercion, with strong tension of the professionals of the basic attention teams, to their adaptation to the criteria to be observed in the external evaluation, in a short interval of time, besides favoring the low involvement of the professionals in the objectives and indicators and in the management of financial resources.

An interesting fact that occurred in the Unit was the nurse reporting her relief with the end of the evaluation, since the period that preceded it was permeated by much pressure from the management. In a very short time, the team had to meet several management requests to adapt some aspects of the work process, according to the standard suggested in the PMAQ (Supervisor 15).

This process feeds the misunderstanding of evaluative processes as devices of criticism and punishment, and not, as the program expects in its guidelines of being incremental; and mobilizing, involving and empowering actors in the change process. Thus, it is understood that the dimensions (self-evaluation, monitoring, permanent education and institutional support) of this stage should be interlinked and integrated, with monitoring being a factor for achieving good results in quality standards indicators.

The Family Health Strategy and the PMAQ aim to contribute to transforming the health care model. In this context, the monitoring and use of information is an essential element in the management of care. Authors highlight the undervaluation of the health information system.¹⁴ This fragile use reflects how the work with the data obtained from the registries, services and activities carried out are designed only to generate statistics, resulting in an absence of diagnosis of the needs of the service, and consequently weakening their planning and evaluation.⁹

The monitoring of indicators should be one of the elements to be considered in identifying priorities for continuing education, institutional support, and improvements in the work process.⁹ The indicators agreed in the PMAQ aim to induce changes in strategic actions for basic care, prioritized By the Ministry of Health.

The selected indicators refer to some of the main strategic focuses of basic care (prenatal, prevention of cervical cancer, child health, control of systemic arterial hypertension and Diabetes Mellitus, oral health, mental health and communicable diseases); as well as strategic initiatives and programs of the Ministry of Health (stork network, psychosocial care network, urgency and emergency network), seeking synergy between the PMAQ and the priorities agreed upon by the three spheres of government (BRAZIL, 2012a, p.25).

At the same time, the Permanent Education (EP) considers that the work process is emancipatory and that it transforms reality and Institutional Support (IA) should promote a managerial function that seeks to reformulate the traditional way of doing health supervision.⁹

The linking of the EP to Institutional Support strengthens the development of management and care competences. It also reveals the complexity and articulation of the problems experienced by the workers in their daily life, and thus amplifies the alternatives for their confrontation.^{8,13}

In the dimension of Permanent Education, the highlight is the advancement of new technologies and the relevance of Distance Learning (EAD). When used properly, the proposal is an instrument that facilitates the training and matrix support processes for the SUS.¹ In this sense, although in the implementation phase, Telehealth was highlighted in field journals as a national action that seeks to improve the quality of care and basic care in the Unified Health System (SUS). It integrates teaching and service through information technology tools,

which offer conditions to promote Teleassistance and Tele-education.¹⁵

When asked about the existence of permanent education actions in the municipality, the interviewee mentioned that there was and mentioned among them telehealth, noting that some professionals underwent training but had not been implemented (Evaluator 14).

The PMAQ provides institutional support that seeks institutional democracy, broadening the levels of autonomy of the subjects and the defense of SUS guidelines, focused on empowering teams, avoiding culpability and lack of accountability. In this sense, it is the responsibility of the Ministry of Health to support the state coordination of basic health care, the Councils of Health Secretaries (COSEMS) and the municipalities for the implementation of this management device. The state coordinates of basic care, in turn, should support the management of basic care in the municipalities and these to the health teams.

The program therefore aims at the implementation of collaborative networks that foster the culture of evaluation and monitoring as tools for managing work processes, with a view to qualifying basic care.

◆ External evaluation

The third stage of the PMAQ, called the external evaluation, aims to investigate the access and quality conditions of the municipalities and the Basic Attention Teams (EAB) participating in the program, with the support of Teaching and Research Institutions.²

The importance of evaluating health services lies on the possibility of identifying the guidelines that guide the care model, not only with the purpose of making technical or administrative changes, but to highlight the factors that induce changes in health actions.¹⁶

It should be emphasized that the instrument used in the external evaluation is similar to the AMAQ, and is composed of a series of quality standards, which represent the level of quality expected. It covers elements related to the structure, equipment and working conditions in the health units; the quality of the work tie and investment of management in permanent education of the workers; the support offered by management to the primary care teams; the access to and the quality of health care provided to citizens; And to the satisfaction and participation of the user in front of the services that are dedicated to him.²

The key difference between the instrument of external evaluation and that of self-assessment lies in the fact that in the first the certification is carried out based on the direct observation of the evaluator and, above all, through evidences evidenced through specific documentation, such as minutes, reports or AMAQ, which is based only on the answers of the professionals evaluated.

In this way, it is imperative that the professional that will be interviewed knows the structure, equipment, materials, supplies and the work process of the Family Health Unit in which it is inserted.

With regard to this stage, it was identified that most of the professionals interviewed were nurses, corroborating the idea that nursing is one of the professions most involved in the management of health units, as well as performing their care activities.¹⁶

Regarding the placing of the professionals in front of the interview, it was verified that there were professionals who presented difficulties in responding to the external evaluation, either because they had little time in the FHS, or because they were not aware of the actions and thematic areas worked by the Basic Attention and the structure itself of the assistance network of the municipality. On the other hand, it was possible to identify professionals who had apparently prepared in advance and who were more confident about what the external evaluation team would ask.

At the beginning, he was asked about which actions the team participated in last year and because it was recently, he did not know how to respond (Evaluator 16).

A sum of factors made the interview very strenuous, because, in addition to the professional, at various times, have persisted in the search for some documents considered inadequate to what was requested; also, during the interview, over and over again, it was necessary to bring it to the center of the questions (Evaluator 12).

The interview with the nurse of the unit was quiet, because the professional answered all the questions with determination and safety and, whenever he asked for a document that proved this affirmation, he was always there at the hands, because he had previously separated all the necessary documentation, which facilitated and much the progress of the interview (Supervisor 04).

The lack of understanding and accepting of the professionals in relation to the questions made it difficult for the interviews to progress, making the evaluation even more

time consuming. In addition, according to the field journals, those professionals who showed greater receptivity and collaboration with the external evaluation were the same ones who had already provided the necessary supporting documents, demonstrating their proximity to the external evaluation stages.

It is possible to assure that this difficulty in responding to the questioning of the evaluation is possibly related to the weaknesses in the application of the AMAQ, since the realization of the self-assessment, as recommended, would serve as another tool for reflection on the assistance provided, resulting in a fewer doubts and a lack of supporting documents, since teams would be more empowered about the evaluation standards adopted in the Program.

This weakness is confirmed by the fact that, during the third stage, many managers asked the institutions responsible for the external evaluation, in this case the UFPB and UFCG, a list with the documents that would be required by the instrument, demonstrating ignorance by the instructional manual of the program that lists such documentation.

The professionals presented different reactions and behaviors during the application of the instrument. With regard to positive reactions, such as receptivity, satisfaction, objectivity and collaboration, sections of the field diaries show good acceptance of the external evaluation of PMAQ by some professionals, since this program caused not only changes in the service, as it gave more visibility to it.

We were well attended by the receptionist and also by the Nursing Technique, including facilitating us the entire time in which we resorted to lead us in our activities. We were also welcomed by the Physician who was present, together with the Nurse, in the answers to the questionnaire and facilitating the presentation of the documents (Supervisor 05).

Concerning negative reactions, feelings such as nervousness, anxiety, tension, restlessness, worry, fear, resistance, fear, self-doubt, disinterest and hostility were identified. Such feelings often appeared during the interview, especially when there were no supporting documents of production or by cogitation that managers would be aware of the answers provided.

Concerning the professional interviewed (nurse) she was apprehensive about the interview, and sometimes she was afraid to answer questions for fear that the secretary would take notice of them (Supervisor 06).

We were welcomed by the nursing technique that received us rudely and was extremely

uneducated, stating that she was not aware of our research and that the professionals (Doctor and Nurse) had already been absent from the unit (Supervisor 24).

Authors discuss the diversity and disagreements in the conception of the evaluation in health service, demonstrating the existence of a current that defends the process of evaluating how to make value judgments on certain aspects, and another aspect that includes the evaluation as an opportunity to reflect on the various interests and representations, with a view to transforming processes under evaluation.¹⁷

It was noticed that some professionals of the evaluated teams seized the external evaluation of the PMAQ based on the theoretical line of the value judgment, seeing the program as another inspection that could produce punishments, generating negative postures to the process.

Among other causes, this type of behavior may be related to the lack of knowledge about the purpose and importance of the program, alluding to possible flaws in relation to previous phases, especially in the development phase, since self-assessment would be the best tool to identify and discuss problems, With the purpose of reorganizing the strategies through a joint action between teams and managers.⁹

In addition to the lack of knowledge about PMAQ, another possible motivation for the fear of professionals would be the way the program is implemented in practice, since, despite the Ministry of Health treating it as an inductive policy, it is observed that there is a risk of the same to be used as another form of punishment of the workers by the local managers, using the result of the team as parameter for the continuity or not of the professional's employment, for example. Thus, when managers and workers recognize the PMAQ as a punitive policy, increases the probability of the emergence of only superficial changes in services.

The way of doing evaluation, based on the risk of punishment, seems to still show ways of organizing the services and functioning of management, in which workers are seen as mere implementers of actions, defined by actors with greater organizational power. At the same time, the fragility of the employment relationship produces labor relations permeated by fear, which exposes workers to asymmetrical power relations and even bullying at work.

In order to obtain a better result in the evaluation, some municipalities have used an artifice called PMAQuiagem, which refers to

several attempts to manipulate and modify reality for the researchers. Such positions were found in both the speeches and postures of managers, professionals and even users.

We assume the term PMAQuiagem in this article, from its socialization by other researchers involved in the external evaluation of PMAQ at the national level. The same was copied in the perception of changes made solely for the external evaluation of PMAQ-AB.

After a few moments the coordinator of basic attention appeared at the unit with rudeness and brought with her various materials for the unit as identification plate, room indication plates, pressure device, nebulizer, all printed material, among others (Evaluator 22).

However, the changes provided by the program can be considered positive when they bring lasting and effective benefits to the units, improving the working conditions of the teams and the assistance provided to the population.

At the time of our evaluation had some workers performing small repairs on the unit, such as repairing toilets, electrical installations and other small repairs (Supervisor 02).

Such changes corroborate one of the seven guidelines that guide the organization and development of the PMAQ, which refers to the stimulus and effective change of the model of attention developed by the workers, orienting the services according to the needs and satisfaction of the users;² however, there were also only superficial changes, on time, that had no lasting impact on the work process of the professionals, nor did they bring benefits to the community, with the possible intention of just "makeup" reality.

The professional brought custom folders to each protocol request, when opening the first folder was actually identified that there was a leprosy and TB protocol. When I went to look at the other folders, the professional collected all of them and said that I had seen one, I could see. But I asked to see the other folders, because it would only mark what I had actually seen. Then she handed over the folders and when I opened it I could observe that instead of protocols there were pamphlets of real estate, newspapers and some informative from the ministry that did not fit the requested protocol. The nurse was very ashamed, for the farce had been discovered, she apologized and said: I am doing my part, they have shown and I am fulfilling (Evaluator 16).

A close relationship between the LDCs and the managers 'and professionals' vision of the

PMAQ is seen as punitive, since if the teams effectively suffer reprisals due to their performance in the program, that is, if the fear of the professionals materializes, The policy itself will be put in check because of a possible increase in the LDCs in the next assessments.

◆ Re-contractualization

Finally, the fourth phase of the program, called re-contractualization, occurs after the certification of the Primary Care teams evaluated. At this stage, managers and professionals must contract indicators and commitments based on the performance achieved by each team, completing the quality cycle provided by the program.⁹

It is during this phase that the municipal manager should indicate which teams will participate in the next cycle of the program, and then conduct the contracting of the same. In the second cycle of PMAQ, started in 2013, all family health teams were able to join, as well as teams from the Family Health Support Center (NASF), which are fundamental for reorienting health care practices in the territory of the Basic Attention.¹⁸

Throughout the recontracting, some difficulties could also be identified. One of them concerns divergences regarding the financial transfer of the program.

The complement of the Ministry of Health to subsidize the municipal administrations in the accomplishment of the commitments signed with a view to the improvement of Primary Care is based on the transfer of financial resources.⁹

At the moment of joining the PMAQ-AB, made by the municipal managers as a sign of interest in participating in the program, the Ministry of Health provides an initial financial incentive of 20% of the full value of the Quality Component of the Basic Variable Attention Floor, being this is the first stimulus for the development of improvement actions at the local level.⁸ From this, the performance analysis of the teams conducts the list of resources transfers.⁹

In order to carry out the transfer of financial resources, the MS uses the Basic Attention Information System (SIAB) as a way of monitoring the teams contracted in the first stage of the cycle. In this way, financing is expected to occur through the implementation of the proposed actions and the achievement of goals.

While ordinance N 1654/2011 clearly establishes the obligation to define and

achieve the indicators established in the accession as a condition for receiving the financial resource, it does not establish criteria for the application of this financing.³

The absence of such guidance allowed managers to define locally the destination of resources. On the one hand, this is considered positive, if funding is applied to meet the greatest needs. Conversely, this opening provoked a negative reaction on the part of the professionals of the AB teams who complained about the appeal because it was not used to increase the remuneration of the workers.

The management of financial resources, in the first cycle of the PMAQ, proved to be a difficulty for some of the municipal managers. For this reason, it has become one of the main topics of discussion at the moment of re-contractualization, in an attempt to subsidize the governability of the resources coming from the program in later cycles.

Another difficulty identified was the managers' dissatisfaction with the result obtained in the external evaluation. In some municipalities, the management argued that the external evaluation was not in keeping with the local reality.

In order to clarify possible doubts about the program and the external evaluation, and to discuss the process, meetings were organized between the managers, the external evaluation coordination team of Paraíba, representatives of the Ministry of Health, the State of Paraíba Department of Health and COSEMS. At these meetings, the difficulties experienced by the different actors throughout the process were listed and new strategies were agreed for a better development of PMAQ's subsequent cycles in Paraíba.

CONCLUSION

The present article sought to describe the main characteristics and constituent elements of the PMAQ, evaluating how it is being implemented in practice. In this way, the four stages that organize the logistics of the program, with emphasis on its dynamic movement, the strategies used to "make it happen" and the application of the norms that structure the design of each an.

It is observed that the state of Paraíba presented a significant adhesion to the PMAQ, which is quite positive for a new program of voluntary adherence and that requires a series of pre-tasks and assumption of several commitments for adhesion, however note There is also a fragile participation of the

performers (professionals, managers and users) in all phases of the program, which produces a perception of it as another way of financing or monitoring.

With the identification of these difficulties and potentialities experienced in the implementation of the program, it is hoped to offer subsidies for its strengthening, in order to consolidate it in its role of inducing processes of monitoring, evaluation and implementation of changes aimed at expanding access and the improvement of the quality of primary care in Brazil.

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