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POTENTIALITIES AND LIMITATIONS OF PMAQ AB: HEALTH PROFESSIONALS' PERSPECTIVE

POTENCIALIDADES E LIMITAÇÕES DO PMAQ AB: PERSPECTIVA DOS PROFISSIONAIS DE SAÚDE

POTENCIALES Y LIMITACIONES DE PMAQ AB: PERSPECTIVA DE LOS PROFESIONALES DE LA SALUD

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ABSTRACT

Objective: to identify the potentialities and limitations provided by *PMAQ-AB* from the perspective of health professionals ***Method:*** this is a study with a qualitative approach carried out with 17 health professionals in a city in the central region of Rio Grande do Sul. ***Results:*** Signs of potentialities and limitations in relation to the National Program for Improvement of Primary Care Access and Quality were evidenced. It was perceived that there are advantages in having the program implemented in their health unit and, despite this, the study also revealed the dissatisfaction of health professionals, as they expressed the great difficulty in relation to public management. ***Conclusion:*** the development of this study made a broader view of the Unified Health System possible, as well as a broader view of the program, which stands out as a systematized source for the evaluation of health systems.

Descriptors: Health Evaluation; Primary Health Care; Practice Management; Health Policies.

RESUMO

Objetivo: identificar as potencialidades e as limitações proporcionadas pelo PMAQ-AB na perspectiva dos profissionais de saúde ***Método:*** trata-se de um estudo com abordagem qualitativa realizado com 17 profissionais da saúde em uma cidade na região central do Rio Grande do Sul. ***Resultados:*** Evidenciaram-se sinais de potencialidades e de limitações em relação ao Programa Nacional de Melhoria do Acesso e da Qualidade da Atenção Básica. Percebeu-se que há vantagens em se ter o programa implementado em sua unidade de saúde e, apesar disso, o estudo revelou também a insatisfação dos profissionais da área da saúde, ao passo que esses expressaram a grande dificuldade em relação à gestão pública. ***Conclusão:*** possibilitou-se, pelo desenvolvimento deste

estudo, uma visão mais ampliada ao Sistema Único de Saúde e a respeito do programa, que se destaca como fonte sistematizada de avaliação dos sistemas de saúde.

Descritores: Avaliação de Saúde; Atenção Básica à Saúde; Gestão da Prática Profissional; Políticas de Saúde.

RESUMEN

Objetivo: identificar las fortalezas y limitaciones que brinda el PMAQ-AB desde la perspectiva de los profesionales de la salud. ***Método:*** se trata de un estudio con abordaje cualitativo realizado con 17 profesionales de la salud en una ciudad de la región central de Rio Grande do Sul. ***Resultados:*** se evidenciaron señales de potencialidades y limitaciones en relación al Programa Nacional de Mejoramiento del Acceso y la Calidad de la Atención Primaria. Se percibió que existen ventajas en tener el programa implementado en su unidad de salud y, a pesar de ello, el estudio también reveló el descontento de los profesionales de la salud, mientras que expresaron la gran dificultad en relación con la gestión pública. ***Conclusión:*** el desarrollo de este estudio permitió una visión más amplia del Sistema Único de Salud y del programa, que se destaca como una fuente sistemática de evaluación de los sistemas de salud.

Descriptores: Evaluación de la salud; Primeros auxilios; Gestión de la práctica profesional; Políticas de salud.

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INTRODUCTION

It is known that the concept of Primary Health Care (PHC) emerged in 1920, in the United Kingdom, in the Dawson Report, which configured the system of health assessment at various levels, characterizing the Health Care Network (HCN) and describing the functions of each one. It is detailed that, consequently, in 1978, the International Conference on Primary Health Care took

place in Alma-Ata, where PHC was defined as the place where practical, scientifically and socially acceptable, accessible and socially participative essential care is performed, developing an autonomous and self-determination spirit.[1]

It is pointed out that, in Brazil, the standard term used is Primary Care (PC), elaborated in the highest degree of decentralization, and should guarantee, to all users, the integrality of care, through the union of the three spheres of government, being the first contact of health with the population and the main communication with the HCN. It was created, as in any other sphere of the Unified Health System (UHS), to be offered free of charge and integrally to the entire population, considering its singularity and sociocultural level, aiming at planning public actions for the protection and promotion of health.[2]

The National Primary Care Policy (NPCP) was approved by Ordinance No. 2,436, of September 21, 2017, establishing the guidelines for its organization in the HCN. Primary Care is defined as the set of individual, family, and collective health actions involving promotion, prevention, protection, diagnosis, treatment, rehabilitation, harm reduction, palliative care, and health surveillance, developed through integrated care practices and qualified management, performed with a multidisciplinary team and directed to the population in a defined territory where the teams assume sanitary responsibility.[2]

From this perspective, with the purpose of expanding management capacity, aiming to improve access and quality of health actions in primary care in the three spheres of government, the Ministry of Health (MH) published Ordinance No. 1. 645, of July 19, 2011, establishing the National Program for Improvement of Access and Quality of Primary Care (*PMAQ-AB*), whose main objective is to induce the expansion of access to health services and the improvement of the quality of Primary Care, with the guarantee of a comparable standard of quality nationally, regionally and locally, in order to allow greater transparency and effectiveness of governmental actions directed to Primary Care.[3]

The *PMAQ-AB* is an important tool in the management of health resources, which helps in the use of health services and contributes to improvements in access and quality. The program is structured in seven main guidelines, as follows: 1. To have a quality parameter for comparison at the national level among the teams; 2. to stimulate a continuous and progressive process of improving the standards and indicators of access and quality; 3. to be transparent in all its stages, allowing the permanent monitoring of society about its actions and results; 4. to involve, mobilize and hold the managers accountable; 5. to negotiate and contract the management of resources according to the commitments and results agreed upon and achieved; 6. to stimulate an effective

change in the model of care; 7. to be voluntary for the adhesion of both the teams and the managers.[4]

This investigation is justified in order to profile the *PMAQ-AB* as a tool to enhance the work processes of health teams, which may foster the knowledge of the various actors involved in its implementation.

This study is guided, in this perspective, by the guiding research question: "What are the potentialities and limitations provided by *PMAQ-AB* from the perspective of health professionals?"

OBJECTIVE

To identify the potentialities and limitations provided by *PMAQ-AB* from the perspective of health professionals.

METHOD

This is a qualitative, descriptive and exploratory study conducted in a city in the central region of Rio Grande do Sul (RS).5 The city has a total of 33 Health Care Units and, among them, seven District Units (Rural Area), five of which are Basic Health Units (BHUs) and two Family Health Strategies (FHSs).

This research was developed in two FHSs of the city because they participated in the planning process of the PC. Physicians, nurses, nursing technicians, community health agents, dentists, and oral health assistants were selected as participants of this study. Of the 31 professionals eligible for the study, four were on leave, four refused to be interviewed and six claimed not to be part of the *PMAQ-AB* process, therefore, the total number of interviewees in this research was 17 professionals.

The inclusion criteria were: the participants had participated in the Planning Process, in the six Workshops of PC Planning and the professionals were inserted in the PMAQ-AB process. Professionals who were on leave of any kind during the data collection period were excluded.

It was used as a technique for the production and recording of data obtained the semi-structured interview composed of closed and open questions. The data was recorded in a digital audio recorder, transcribed for analysis and interpretation by the researcher, and then analyzed through thematic analysis, performed in three stages: pre-analysis, material exploration and treatment of the results obtained and interpretation.[5]

Participants were informed about the research and signed the Free and Informed Consent Term (FICT). The study participants were identified, in order to preserve their anonymity, by means of coding, using the letter P and numbers (example: P1, P2, P3, and so on). The research was

approved by the Ethics and Research Committee (REC) of the Federal University of Santa Maria (UFSM) under CAEE number 94320218.0.0000.5346 and Opinion number 2.844.19.

RESULTS AND DISCUSSION

The research was composed of 17 participants: two nurses, two nursing technicians, 11 Community Health Agents (CHAs), one oral health assistant and one dentist. Table 1 shows that the average length of service of the professionals is 11.8 years.

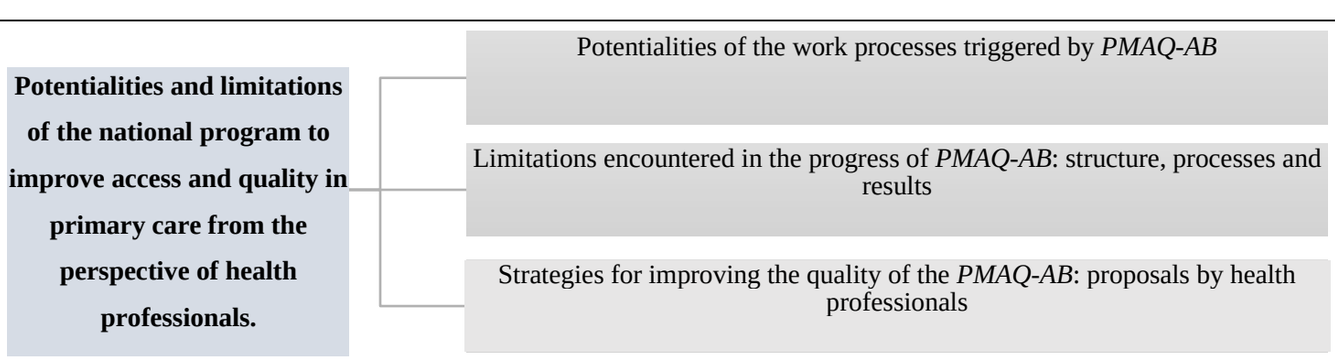
Table 1. Characterization of the research subjects and years of professional activity.

PROFESSION	TIME OF SERVICE
Nurse	7 years
Nurse	11 years
Nurse Technician	18 years
Nurse Technician	13 years
Community Health Agent	15 years
Community Health Agent	13 years
Community Health Agent	16 years
Community Health Agent	20 years
Community Health Agent	8 years
Community Health Agent	10 years
Community Health Agent	19 years
Community Health Agent	20 years
Community Health Agent	6 years
Community Health Agent	8 years
Community Health Agent	10 years
Dental Surgeon	3 years
Oral Health Assistant	4 years
Average Length of Service	11.8 years

Source: the authors.

After exploring the material resulting from the research, the following categories emerged: Potentialities of the work processes triggered by *PMAQ-AB*; Limitations encountered in the progress of PMAQ-AB: structure, processes and results; and Strategies for improving the quality of *PMAQ-AB*: proposed by health professionals, as shown in figure 1.

Figure 1. Category and subcategories emerged from the research with the professionals. Municipality in the central region of Rio Grande do Sul. 2020.



Source: the authors.

Potentialities of the work processes triggered by *PMAQ-AB*

It is revealed that the participants understand the evaluation of *PMAQ-AB* as a fundamental axis of professional learning, with common problems being essential for the development of collective learning, according to the speech below.[6]

> *It is a program to qualify the work and in which everyone is part, everyone works together for growth, to achieve the goals and qualify our unit. [...] Service, actions, planning, I think it is very important. It was a good process of growth and that led to more union, because we really learned that we have to work together. [...] everyone has to know the whole health process, [...] I have to know the reception, the nurse, the doctor, everyone has to know their service to make the unit work well.* (P8)

It is also pointed out in this excerpt that the professional characterizes the *PMAQ-AB* and portrays the importance of teamwork as fundamental in health services so that the tasks are performed in their entirety. It is also noteworthy that the work process in health services does not occur individually; therefore, a team must be integrated in a multi-professional way so that the operation of care occurs in a comprehensive way.

It is understood that one way to manage health actions and work processes is the adoption of technologies at work. In this sense, Merhy classified these technologies as soft, soft-hard, and hard, and these are portrayed in a broad way, analyzing from the production process to its results. It is understood that soft technologies are those of relationships such as bonding, welcoming, and autonomy; soft-hard technologies are those of structured knowledge that operate in the health work process; and hard technologies are those of material resources such as equipment, devices, norms, and organizational structure.[6]

It is known that soft technologies, because they deal with the technology of relationships and welcoming, are, in advance, the ones that human beings need the most, since man is composed of a biopsychosocial being and this is the technology capable of providing the necessary well-being for both the professional and the user.[6] In this context, the professionals express themselves regarding the contributions that the program has provided to the health service, as observed below.

> *The improvement of the service, the staff has improved in dealing with patients, the information is more explicit [...]. (P12)*
>
> *I think the team has improved in the quality of care, attending the user with more quality, with goals [...]. (P9)*
>
> *We took more training courses, we are always trying to keep up to date [...].* (P8)

The professionals' recognition is perceived in relation to the reception, improvement of the quality of service and Continuing Education (CE). It is believed that CE is a necessary condition for professional development, promoting an institutional change, besides the strengthening of the team's actions and updates of technical and theoretical practices known by them, also seeking to improve personal, professional and social competence so that actions and health services are more effective in relation to the health needs of the population.[7]

Soft-hard technology is understood as structured knowledge, i.e., knowledge that does not require high-tech resources for its implementation, and is composed of the theoretical and practical knowledge of health professionals for a better organization of the work process.[8] In this sense, the participants are satisfied, as highlighted in the statements below.

> *The PMAQ comes to show that, that we have a lot to do and everything on paper [...]have a record of the things you do [...]. (P3)*
>
> *It contributed to many things, [...]we have to do things we didn't do before [...]we have to have everything put away to show that we do [...]have a record of activities.* (P2)
>
> *Organizations, minutes, documentation [...].* (P4)
>
> *Action Planning [...].* (P17)

A survey conducted with municipal health managers showed that the main changes brought about by the *PMAQ-AB* were improvements in the organization of work and in health action records. These changes, according to the authors, indicate the achievement of the quality standard proposed by the program, demonstrating the effectiveness of the program's implementation .[7,9,10]

It is observed that the registration and organization of health actions is one of the proposals of the *PMAQ-AB* that is well evaluated and adhered to in general. These have the essential purpose of providing information about the assistance provided to maintain the standard of quality and continuity of care.

Limitations encountered in the progress of *PMAQ-AB*: structure, processes and results

Teamwork is considered a potential generator of change in the work process proposed by PMAQ-AB, especially when performed in a multidisciplinary way, aiming at resoluteness of care, being one of the biggest challenges of the PC. It is necessary, however, that the work occurs in a joint manner, generating union of diverse knowledge and practices to achieve the same goals and health care.[11]

However, the great difficulty of teamwork is related to different perspectives on the definition of team, ways of acting and thinking. It is essential, in this case, that health professionals have the same goal, aiming to achieve it together. In FHSs, teamwork is characterized as an action that should be present in the professionals' work routine, in which they articulate their technical and managerial actions through communication.[12] This statement is expressed in the following speech fragments.

> *The teams are separated, so one ends up advancing more than the other, we need to unite and talk more [...] the PMAQ, in fact, is for everyone to work together, there are some who work more in favor of it and others who work less, I think the difficulty I see is this.* (P7)

This communication can contribute to overcome the biomedical model of health, so that professionals know the competencies of the team and encourage the structuring, organization, and valorization of their abilities. In the professional routine, communication contributes to teamwork, since it is an important factor for the transmission of information, causing the team to develop professionally, and leading to a more integral and effective work.[12]

> *[...] the biggest problem with the PMAQ in the teams is the conflict between the people in the team [...]the controversy that one works more, the other works less [...].* (P5)
>
> *[...] here there are two teams, one team has now won a higher grade than the other, so it has created a little bit of conflict [...].* (P15)
>
> *[...] lack of involvement of some professionals [...].* (P13)

In order to enable a broader and more collective view of the work processes, the interaction of FHS professionals becomes essential so that a divided, inhumane, and individual-centered practice does not occur. Communication is also fundamental for a good development of teamwork, since it causes the interaction between people to reach harmony in interpersonal relationships.[13]

The *PMAQ-AB* was formulated with the goal of encouraging improvement in various aspects of the PC, such as infrastructure. It can be seen, therefore, in the external evaluation phase, when assessments are made of the infrastructure, which includes supplies, equipment and materials, and of the work process among the primary care teams, that the certification is done through pre-established quality standards and the results achieved by the teams.[14]

One of the five central efforts presented by the program to put Primary Care at the center of the proposals of the managers of the three spheres of government is an important investment in the infrastructure, computerization, and modernization of the information systems,[15] an investment that, according to the reports of the professionals, exists in theory, but does not occur in practice.

> *[...]what upsets me about the PMAQ is, for example, the amount that comes is to be divided by the team and there is (a percentage) that is to be used in the unit, for*

> *the purchase of materials [...] it's the most difficult thing to get [...] that doesn't depend on us, it depends on the management.* (P9)
>
> *[...]there is a percentage that is for the supporters and another part for the projects, but we have never seen this [...] we have never been able to use this part and neither have the supporters, as far as I know [...].* (P15)

According to the new NPCP, it is the non-transferable responsibility of all levels of government to ensure adequate infrastructure and good operating conditions for health services, ensuring space, furniture, and equipment. It is added, in this vein, that it is the function of the manager of the PC to organize and manage issues of infrastructure and inputs of the BHUs, ensuring the proper use of resources and avoiding shortages.[2]

It is revealed, in this perspective, that the difficulty found in the health services is the precarious physical and material infrastructure of the units.[15] It is observed that, despite the advances achieved in the field of collective health, these problems still persist, going against the rights of users and professionals[16,17], as it is observed that there is no distance to follow.

> *When they (PMAQ-AB) start charging for medications in the unit, [...] identification signs, [...] handrails on the ramp, it doesn't depend on us, these are things that depend on the management, and I don't think it's fair that we receive a low score for things that are not our responsibility.* (P9)

According to the data obtained through the First Cycle of *PMAQ-AB*, only 13.5% of the FHS teams had excellent infrastructure conditions, which leads us to reflect on a proposal to overcome the challenges of the PC. Thus, universalization and commitment should be the basis of proposals to improve health services and fundamental to expand the FHS, aiming to improve care and the commitment among the three spheres of government.[17] In the following statements, the participants mentioned the difficulty caused by the bureaucracy of the services as a hindrance to the acquisition of materials.

> *[...]the difficulty we have to use the money that comes for consumables [...] so, it is very bureaucratic, there is no one to help us in the secretary's office regarding this.* (P1)
>
> *[...]difficulties in relation to resources, that, sometimes, we don't get the material to develop a work [...] we end up doing it with our own resources.* (P14)

It is observed that the infrastructure of the UHS, especially in the PC, will not be achieved without the guarantee of quality and a team with full and resolute dedication to the FHS. It is known that there are other investments in improving the conditions of the PC proposed by the MH and, despite them, there are still precarious conditions of infrastructure, especially in facilities, supplies, IT, and qualified professionals.[18,19]

The infrastructure of a FHS, including sufficient equipment, materials and supplies, must be adapted to the population and its needs, as well as the work processes for comprehensive health care of users.

> *We need more professionals [...] there is no pediatrician, no gynecologist, rooms are a struggle, sometimes, to find.* (P2)

> *[...] we always run into a lack of material [...] we lack more professionals to perform the service [...] due to this increased demand [...].* (P8)

The structural deficiencies of the units are reflected in the dissatisfaction of FHS professionals due to the model proposed by the MH that the FHS should provide comprehensive care to the population. It is noted that there are flaws in this issue and this reveals the need to invest in the organizational improvement of the unit so that there is more quality in the service provided. The author exposed, in a study, that what is most expected of health managers is that they seek better planning of actions and adequacy of the units.[20]

For the PMAQ to be effective in the municipalities, quality and effective public management is necessary. This is defined as a process that creates policies and elects programs to put them into practice, in addition to promoting resources, monitoring, and evaluating such health programs. The municipal health management, for an effective performance, has the obligation to plan, monitor, and evaluate actions within this context with the objective of qualifying the care provided by the municipalities.[15]

A study conducted in the state of RS highlighted the importance of health managers due to their role in the adherence and development of the *PMAQ-AB*. It is essential that managers develop a plan to improve the actions of the program in order to generate a more efficient work in the search for the quality of the PC.[9]

It is believed that public management is the main mentor of the institutional support recommended by the *PMAQ-AB* to health teams, but many of them are unassisted, consequently jeopardizing the effectiveness of the program. It is detailed that, when asked about the main difficulties seen in relation to the *PMAQ-AB*, the interviewee clarified as can be seen in the following excerpts

> *Basically, it's the support, right, there are still things that we have a lot of doubts about and we don't have the support of those who should support us, in this case, the management [...],but one researches and ends up knowing a lot more than they do [...].* (P6)

> *[...]the support is something you say once and the person is willing to help you, it is not something you have to keep fighting for months or more than years, this is not support [...].* (P9)

The *PMAQ-AB* Instructional Manual established that the institutional support is a commitment from the three spheres of government and aims to enhance the actions aimed at qualifying the PC, planning actions, training, and continuing education, among several others. This support is essential for a horizontal management, considering the health professionals and the population demand.[10]

It is necessary that the public management be present in the development processes of the program, since its participation is questioned by health professionals and they feel this absence.[12] They encourage, through their participation, changes in the health teams, aiming at a better quality of health care. This lack of action is characterized in the following statements.

> *[...]lack of information [...] lack of clarification of many things, there are supporters that don't show up [...] and we have to manage on our own, we have to search on the internet [...].* (P3)

> *There is still a lot of ignorance among professionals [...] management also did not know (about PMAQ-AB) [...] We lack someone who understands [...] someone who works with PMAQ [...] we lack knowledge, understanding.* (P13)

With the adhesion to PMAQ-AB, a horizontal management is sought, excluding the verticalized biomedical model, aiming that the actions are carried out by both managers and health professionals, because both influence the quality of care. It is clear that, in this sense, management is responsible for the management, development, and implementation of these health actions in the PC, together with the professionals who work there. It is perceived, however, that there are weaknesses, requiring interventions in work processes and also in the management of public resources in order for the PC to be equalized throughout the Brazilian territory.[9]

It is observed that the PMAQ-AB came to assist in this issue, bringing new standards and guidelines for the PC, aiming, among them, to achieve goals and results through quality indicators. There are flaws in the management in the view of health professionals, being unresolved in relation to the monitoring of these indicators, as observed below.

> *[...]of management, we need more resoluteness [...].* (P10)

> *[...]it is not something that we can achieve because of the excessive workload, that is why we lack a supporter to be together and present [...].* (P13)

The fragility of the evaluation of some managers is corroborated by their lack of knowledge about the program. It is pointed out that one of the factors for this to happen is poor communication, which generates conflicts and makes it impossible to fully develop the PMAQ-AB. It is important that management and professionals seek strategies to communicate more effectively and efficiently. It is also essential that professionals contribute to the management, seeking theoretical and practical professional development, in order to minimize the weaknesses found.[9]

Strategies for improving the quality of the *PMAQ-AB*: proposals by health professionals

According to the *PMAQ*, self-assessment should be carried out in the work processes not only to identify problems, but also with a view to interventions and actions to overcome them. It is detected that establishing priority investments and action strategies is essential to overcome the existing weaknesses in each health service. These self-assessment processes recommended by the *PMAQ-AB* are committed to quality improvement, and are intended to strengthen them, since they contribute to the identification of these needs, in this case, institutional support and the physical and material structure.[21]

The interviewees express strategies to improve even more the quality of the PC, since, even with the program's recommendations; there are still weaknesses in the system. It can be seen this in the excerpts below.

> *[...]we have to improve the internal evaluations, action plan [...].* (P1)
>
> *One more doctor could come to attend children, women, [...] some more equipped rooms, [...] but these are things that don't depend on us, right.* (P2)
>
> *I think the physical part and the materials [...] and also the access to the unit.* (P11)

This scenario shows a fragility in structural issues and the need for adjustments in the health care model, especially bureaucratic and managerial actions, so that this does not compromise the quality of the PCU, aiming at greater resoluteness in meeting the population's demands.[17]

The planning of these actions must be built equally among managers, coordinators, teams, and users, making them more effective. It should also provide greater communication between these actors, increasing the managerial capacity of each and improving collective and responsible decision making.[21]

One of the reasons why difficulties occur is the concern of health professionals regarding the lack of investment in infrastructure and material resources, as well as in working conditions, transportation, and equipment. There are also weaknesses in the interaction between professionals and managers, which generates an organizational gap that compromises the coordination and continuity of care.[18]

> *The management lacks political good will [...].* (P9)
>
> *I think that what can improve is this institutional support, greater agility for these funds and for consumption materials, I think it would help a lot [...].* (P1)
>
> *The question of supporters and these inputs that should come [...].* (P7)

It is believed that, in the speeches, it is clear the need for greater institutional support to strengthen the integrated work processes, because it is the management that invests in the quality of this service, generating a more effective teamwork. In addition, the public management must, among several actions, adopt measures to rescue the interpersonal relationship between

professionals, managers and users, managing their remuneration, professional qualification and training, among them, of health professionals and municipal managers regarding the achievement of goals and quality indicators.[22]

Interpersonal relationship between boss, colleagues and team [...]. (P16)

The *PMAQ-AB* commitment to quality improvement should be permanent and should also be periodically reinforced among the FHS teams. It is trusted that strengthening the development and improvement of initiatives appropriate to the challenges posed by professionals in their health realities should be indispensable and, due to their complexity, these should be increasing, given their socio-political-cultural context.[10]

It becomes essential to go through these difficulties during the organization of the work process so that the actions are effective, being necessary to seek changes for the qualified care of users and management. *PMAQ- AB* has been an important agent of transformation for changes, both in the work processes and in the care and management of planning and resource management.

Regarding the work process of the teams that are part of *PMAQ-AB*, it is complemented that there may be an incentive for competitiveness among the teams in the search for recognition and merits, especially in the quantification of the improvement of outcome indicators in some health specificities, failing to have a broad look at the health-disease process, which may lead to the weakening of the UHS principles of universality, integrality and equity.[23]

CONCLUSION

The potentialities provided by the PMAQ-AB implemented in their health unit were evidenced in this research, through the professionals' perception, highlighting: improvement of work processes; greater effectiveness of teamwork; management of health actions by all professionals; improvement of information systems; continuing education; and, especially, in the quality of care, this being its main objective.

Despite this, the study revealed limitations, such as the dissatisfaction of health professionals, while they expressed the great difficulty in relation to public management, referring to it as unsatisfactory and absent, and also in relation to resources for structural and material funding, which are insufficient in relation to the demands found in their place of work. In addition to this weakness, many professionals also perceived deficiencies in interpersonal relationships and reported the need to trigger continuing education in health regarding the *PMAQ-AB*.

One of the limitations of this study is its local-regional nature, which highlights the need for other studies on the subject with a national scope.

It is hoped that this study can contribute to the understanding of the *PMAQ-AB* as a potential to qualify the work processes in the PC and trigger reflections that can help in the operational aspects of other evaluative processes in health in places with similar characteristics.

CONTRIBUTIONS

All authors contributed equally in the conception, analysis and interpretation of the research, in the writing and critical review, with intellectual contribution, and in the approval of the final version.

CONFLICT OF INTERESTS

Nothing to declare.

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