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Original Article

Primary Health Care Evaluation: the view of clients and professionals about the Family Health Strategy[1]

Simone Albino da Silva[2]
Tamara Cristina Baitelo[3]
Lislaine Aparecida Fracolli[4]

Objective: to evaluate the attributes of primary health care as for access; longitudinality; comprehensiveness; coordination; family counseling and community counseling in the Family Health Strategy, triangulating and comparing the views of stakeholders involved in the care process. Method: evaluative research with a quantitative approach and cross-sectional design. Data collected using the Primary Care Assessment Tool for interviews with 527 adult clients, 34 health professionals, and 330 parents of children up to two years old, related to 33 family health teams, in eleven municipalities. Analysis conducted in the Statistical Package for Social Sciences software, with a confidence interval of 95% and error of 0.1. Results: the three groups assessed the first contact access - accessibility with low scores. Professionals evaluated with a high score the other attributes. Clients assigned low score evaluations for the attributes: community counseling; family counseling; comprehensiveness - services rendered; comprehensiveness - available services. Conclusions: the quality of performance self-reported by the professionals of the Family Health Strategy is not perceived or valued by clients, and the actions and services may have been developed inappropriately or insufficiently to be apprehended by the experience of clients.

Descriptors: Primary Health Care; Health Service Evaluation; Family Health Strategy.

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[2] PhD, Adjunct Professor, Escola de Enfermagem, Universidade Federal de Alfenas, Alfenas, MG, Brazil.
[3] RN, Escola de Enfermagem, Universidade Federal de Alfenas, Alfenas, MG, Brazil.
[4] PhD, Associate Professor, Escola de Enfermagem, Universidade de São Paulo, São Paulo, SP, Brazil.

Corresponding Author:
Simone Albino da Silva
Universidade Federal de Alfenas. Escola de Enfermagem
Rua Gabriel Monteiro da Silva, 700
Centro
CEP: 37130-000, Alfenas, MG, Brasil
E-mail: simonealbino76@hotmail.com

Introduction

In all countries of the world, there are changes that require a redesign of health care to respond more effectively to new and more complex needs such as demographic transition, epidemiological transition, the evolution of technology and the increase in social expectations regarding health and vital well-being. These and many other changes require health responses, particularly demanding an organized and strong PHC[1].

In Brazil, PHC is organized in different ways, and from the mid-1990s it was carried out predominantly in the form of the Family Health Strategy (FHS). This strategy was designed incorporating the knowledge generated in international experiences of health systems based on primary health care and on the proposals defined in the Alma Ata Conference, with the principles of universal access, continuous, comprehensive and coordinated care aimed at the communities and their social context[2]. Its main objectives were to structure and consolidate the principles of the Brazilian Unified Health System - SUS, reorient the centrality of care practice towards the family in its physical and social environment and expand the network of services of that level of care.

With the implementation, expansion and strengthening of PHC in the Americas and, particularly, in Brazil, the production of knowledge that allows assessing the quality of primary care provided to the population – especially with regard to characteristics of the structure, care process, and health outcomes – is essential[2]. There are concepts, instruments, and measures to assess the quality of the services[1].

In this study, we used the concept of primary health according to Starfield[3], which is based mainly on the technological dimension, listing the particular qualities of PHC, the so-called essential and derivative attributes. According to this author, the essential attributes of PHC are the individual's first contact access to the health care system that is the accessibility and use of the health service as a source of care in every new problem or a new episode of the same health problem; longitudinality, i.e., the existence of a continuous source of care, as well as its use over time; comprehensiveness, service range considering the biopsychosocial character of the health-disease process, such as promotion, prevention, cure and rehabilitation actions, available and appropriate to the context of PHC, including referrals; the coordination of care, which presupposes some form of continuity, either by the same professional or through medical records, or both, in addition to recognition of problems addressed in other services and the integration of this care into the global care of the patient.

Three other characteristics, called derivative attributes, also qualify the actions of PHC services[3]: family counseling in assessing individual needs should consider family background and potential for care and also as health threat; community counseling, recognition of community health needs through epidemiological data and direct contact with the community, as well as collaborative planning and evaluation of services; cultural competence, adaptation of provider to the special cultural characteristics of the population to facilitate the relationship and communication with this population.

The objective of this study was to evaluate the attributes of primary health care concerning: access; longitudinality; comprehensiveness; coordination; family counseling and community counseling in the Family Health Strategy, triangulating and comparing the views of stakeholders involved in the care process.

Methodology

This was an evaluation research[4], with a quantitative approach, with cross-sectional design[5] coming from the doctoral thesis "Evaluation of Attributes of Primary Health Care in the Family Health Strategy in municipalities of southern Minas Gerais", approved by the ethics committee of the School of Nursing of the University of São Paulo - EEUSP, evaluation 30699 of June 1st, 2012.

The research area was the health micro region of Alfenas, Minas Gerais, Brazil. The municipalities of this area were submitted to the criterion of having population coverage by FHS higher than 50% and their FHS units should be located in the urban area and be in continuous operation for at least five years. In total, 11 municipalities and 33 FHS units met these requirements. Concerning health professionals, inclusion criteria included working in the FHS unit for over a year and being a physician or nurse, totaling 44 professionals.

The sample size calculation for FHS clients had as reference the total population of the selected municipalities, with estimated standard deviation of 1.2, error of 0.1, resulting in a total of 546 adults and 549 adults responsible for children aged from zero to two years[6]. This number was divided proportionally among the participating cities and FHS units.

Inclusion criteria for adult clients were being over 18 years old, living in the area served, and being registered for more than one year in the FHS. The child client was represented by a caregiver/responsible and was subjected to the same criteria. The child should be a registered client in the FHS unit.

Data collection occurred from June to July 2012, and was conducted by undergraduate and graduate students of the School of Nursing, Federal University of Alfenas, trained for this purpose. The approach of the professionals was made at the health unit during working hours, by appointment. Sampling of clients was made intentionally, in which community health agents informed the research team which residents from their micro areas met the inclusion criteria for adults and children. The interviews with clients were conducted at their houses, with one adult per housing unit, with no presence of family health team members.

All participants were informed of the research objectives through the Informed Consent in accordance with current legislation. The interview consisted of two parts: the social characterization questionnaire and the Primary Care Assessment Tool – PCATool – questionnaire, which assesses the attributes of PHC based on the principles of structure, process, and results.

The Professional PCATool has 77 questions; the Adult PCATool has 88 questions, and the Child PCATool has 53 questions, distributed among the attributes of PHC. The possible answers for each item are: "certainly yes" (value=4); "probably yes" (value=3); "probably not" (value=2); "certainly not" (value=1), and "do not know/cannot remember" (value=9). The scores for each attribute are calculated by the simple arithmetic mean of the values of the answer for each question.

As general result of evaluation by the PCATool, we have the Essential Score, which is found by the mean of the scores of the attributes First Contact Access – use; First Contact Access – Accessibility; Longitudinality; Coordination – Integration of Care; Coordination – Information Systems; Comprehensiveness – Services Rendered; and Comprehensiveness – Available Services. To obtain the value of the General Score, this mean is added with the scores of the attributes Family Counseling and Community Counseling. The Essential and General Scores characterize the degree of orientation of the service or health system toward the attributes of the primary health care.

The answers were organized in the Microsoft Excel software for Windows and analyzed using the Statistical Package for Social Sciences software - SPSS 14.0, with a confidence interval of 95%, and the reference value of 6.66, as limit between high and low score. For comparison by groups, we used the ANOVA model with post hoc by Tukey's method.

Results

The demographic, social, and economic characteristics of the eleven municipalities participating in the research are shown in Table 1.

Table 1 - Demographic, social and economic characteristics of the municipalities in the health region participating in the FHS evaluation, Alfenas-MG, Brazil, 2012

Municipality	Population	Urban	Rural	Female	Male	<1/2 Minimum wage (monthly)	Education	Unemployment	MHDI*	Per capita income
		%	%	%	%	%	%	%		
1	73,774	93.77	6.23	51.09	48.91	21.35	87.74	6.87	0.761	BRL 467.90
2	38,688	82.89	17.1	50.01	49.99	26.8	85.19	4.79	0.715	BRL 475.00
3	27,600	69.41	30.6	49.05	50.96	34.77	83.09	2.44	0.682	BRL 401.25
4	20,426	70.31	29.7	48.68	51.32	27.58	85.32	3.86	0.733	BRL 442.50
5	20,245	82.39	17.6	49.73	50.27	24.84	86.58	3.7	0.715	BRL 500.00
6	13,731	83.93	16.1	49.57	50.43	24.15	86.68	4.37	0.727	BRL 456.66
7	13,717	72.92	27.1	49.1	50.89	38.11	83.82	3.83	0.668	BRL 417.50
8	11,476	87.65	12.4	49.21	50.79	34.69	84.31	6.07	0.683	BRL 383.66
9	9,820	63.13	36.9	49	51	28.66	84.5	3.89	0.691	BRL 446.25
10	7,542	87.19	12.8	49.58	50.41	38.17	80.03	1.99	0.677	BRL 366.66
11	5,763	80.84	19.2	48.26	51.74	30.96	79.66	2.83	0.67	BRL 478.47
Total/mean	242,782	79.49	20.51	49.39	50.61	30.01	84.27	4.06	0.702	BRL 439.62

* MHDI: Municipal Human Development Index
Source: Authors, based on data from the Brazilian Institute of Geography and Statistics – IBGE.

The municipalities in the micro region of Alfenas have as demographic characteristics being small, with important population group living in the rural area, with a balance between the percentage of men and women in the population, with prevalence of adults (56.39%), followed by children/adolescents (30.46%), and seniors (13.15%). In the socioeconomic indicators, the low unemployment rate stands out positively; however, the other indicators, when compared to official data from the State of Minas Gerais and Brazil[7], show a region with low Municipal Human Development Index - MHDI, low per capita income, low percentage of literate adults, and high percentage of people living with less than half the monthly minimum wage. In these 11 municipalities, PHC is organized predominantly by the FHS, with four municipalities with population coverage between 50 to 75% and seven municipalities, between 75 and 100%. In the most populated cities, there are still some traditional basic health units that are part of the PHC.

In the population described above, the following subjects were sought: professionals, adult clients, and adult clients responsible for children aged from 0 to 2 years.

A total of 34 health professionals answered the PCATool, of which 19 were nurses and 15 were physicians. The characterization of this group showed that 76.5% have training time higher than five years; 64.7% are between 20 and 39 years old; 55.9% have the PHC service as the only employment, in which they have a weekly workload of 40 hours; and that 55.9% have between one and five years of time working in the unit. A total of 89.48% of nurses and 13.33% of physicians have specialization in the PHC area.

Adult clients and those responsible for children had a noteworthy number variation. Although sampling was conducted in a delimited and intentional way, many clients did not answer about the FHS unit that served their area, but about other health services to which they felt bound. Among the adult clients, 59 (10.07%) answered about hospital/emergency department/emergency room. Those responsible for children up to two years old pointed the specialized clinic (25.26%), the BHU (9.39%), and the Emergency Room (9.04%) as regular sources of child health care to the teams from the FHS. Use of other services by population ascribed to a unit of the FHS is an important fact that needs further studies to identify the failures that lead to this behavior.

To compose the results of this evaluation study, we used only the questionnaires from clients who referred to the FHS as the preferred health service, totaling 527 (89.93%) adult clients and 330 (56.31%) adult clients responsible for children.

Participating adult clients had as characteristics being female (86.15%); married (59.96%); white (62.81%); with up to three children (50.10%), and average age of 53.36 for women and 58.23 for men.

Adult clients, responsible for children aged 0–2 years, evaluating the FHS, were, mostly female (98.79%); white (56.13%); mothers (85.45%); in the age group of 20–39 years (79.09%); married/cohabiting (76.92%), and having 1 or 2 children (63.47%).

Result of comparisons of scores between the three groups of study participants is shown in Table 2.

Table 2 - Comparison between mean scores obtained in the evaluation of the attributes of Primary Health Care according to the type of participants, in the micro region of Alfenas - MG, Brazil, 2012

Attribute of PHC*	Group	N	Mean	SD†	P Value	Grouping
First Contact Access – Use	Adult	527	8.59	1.97	<0.001	A
	0 to 2 years	330	7.99	2.45		B
First Contact Access – Accessibility	Adult	524	3.21	1.49	<0.001	A
	0 to 2 years	330	4.87	2.45		B
	Professional	33	4.13	1.27		C
Longitudinality	Adult	527	7.26	1.96	<0.001	A
	0 to 2 years	329	6.66	1.98		B
	Professional	33	7.86	1.12		C
Coordination – Integration of Care	Adult	259	6.10	2.67	0.014	A

(continue...)

Table 2 - (continuation)

Attribute of PHC*	Group	N	Mean	SD†	P Value	Grouping
Coordination – Integration of Care	0 to 2 years	47	6.88	3.24	0.014	Ab
	Professional	33	6.91	1.47		B
Coordination – Information Systems	Adult	510	6.41	2.16	<0.001	A
	0 to 2 years	316	6.98	1.95		B
	Professional	33	8.95	1.33		C
Comprehensiveness – Available Services	Adult	460	5.22	1.56	<0.001	A
	0 to 2 years	288	5.18	1.88		A
	Professional	32	6.80	1.24		B
Comprehensiveness – Services Rendered	Adult	508	4.92	2.50	<0.001	A
	0 to 2 years	321	6.50	3.42		B
	Professional	33	8.01	1.25		C
Family Counseling	Adult	511	5.69	2.93	<0.001	A
	0 to 2 years	323	5.10	2.97		B
	Professional	33	8.82	1.40		C
Community Counseling	Adult	464	5.88	2.48	<0.001	A
	0 to 2 years	294	5.69	2.24		A
	Professional	33	7.68	1.46		B
Essential score	Adult	527	5.96	1.09	<0.001	A
	0 to 2 years	330	6.44	1.18		B
	Professional	33	7.12	0.74		C
General score	Adult	527	5.92	1.20	<0.001	A
	0 to 2 years	330	6.21	1.20		A
	Professional	33	7.40	0.77		B

*PHC: Primary Health Care; †SD: Standard Deviation
Source: Authors. Notes: Means followed by the same letter in the column are statistically equal to 5%.

Comparison between the three groups of participants showed that there was agreement in the low rating for the First Contact Access - Accessibility and high rating for longitudinality. Note the predominance of the high values given in the evaluation of the professional group for all attributes, with statistical significance compared to the other groups, with the difference being more evident in the attributes of Family Counseling, Community Counseling, and Comprehensiveness - Services Rendered.

Between the two groups of clients there was agreement for high rating scores for First Contact Access - Use and longitudinality and for low score ratings for attributes of Family Counseling, Community Counseling, Comprehensiveness - Services Rendered, Comprehensiveness - Available Services, First Contact Access - Accessibility, Essential Score, and General Score.

Discussion

In the cities where the survey was conducted, FHS prevails as a form of organization of primary health care. Considering the social and economic conditions in the region, the political decision of strengthening the PHC meets the need for financial sustainability and the principles of universal access and equity.

Nevertheless, in some municipalities, implementation of the FHS was not effectively integrated into the existing traditional primary care structure. In the data collection period, we observed concomitance PHC models and their dysfunctions. In municipality 1, most of the FHS units had no vaccine area, a part of the FHS teams had weekly pediatrician care and, the other part, had in its territory traditional BHUs linked to a medical school, which provided the population with

daily service. In municipalities 4, 6, and 7 there was weekly pediatric service in the so-called "polyclinics", places in which there were also the only vaccine rooms in the municipality, thus directing the opportunities of approach to child and family out of the FHS unit. In municipality 8, the only basic unit with FHS had no medical professional, and the emergency room was the other option of service in the city, the one that was indicated by most participants.

The authors believe that these arrangements described contribute to the high percentage of clients residing in areas of FHS that indicated other services, especially in child health care. In assessments that used the same methodology, the percentage of responsible adults indicating the FHS as the main source of care for children aged 0–2 years was above 75%[8,9].

Regarding this concurrence, we consider that although the superior quality of care given by the FHS compared to traditional primary care is proven[10], this coexistence of models occurs, making the services sometimes complementary, sometimes competitors, certainly hampering the overcoming of the individualistic and curative model and the achievement of comprehensiveness. In this context, further studies that point ways to overcome these challenges are indicated.

For evaluation of the PCATool, the first attribute evaluated is Access, which is subdivided into two categories: First Contact Access – Use and First Contact Access – Accessibility. The first measures to what extent the client prioritizes the use of a particular PHC health unit, while the second measures the availability of this service to the client, its capacity for routine care, spontaneous demand, for an acute illness, or aggravation of a chronic disease[3].

First Contact Access - Use achieved high scores for the two client groups. Similar results of surveys carried out in different regions of the country reinforce that the population interviewed have in the FHS a regular source of health care, seeing it as a gateway to the health system, due to chronic problems, by preventive actions, or for new health needs[10–12].

The three groups interviewed gave low mean values for First Contact Access - Accessibility, which also occurred in other studies[10–12]. This result is highlighted, because this means not just dissatisfaction of the clients with the service, since the professionals also gave a low rating; it means that the introduction of family health did not necessarily result in an improvement of access, making the FHS stray from the health care model reorientation recommended in the official discourse[12]. Analysis of the items that compose this attribute showed that, in the micro region of Alfenas, despite the high population coverage, there are several barriers to access to care in the FHS, particularly with respect to ways of communication and opening hours. The structure and the work process in the FHS units favor only the routine care, during weekdays, for which the person's presence is essential for information and scheduling.

High-score assessments of the three groups surveyed converged on the attribute Longitudinality, emphasizing that the values given by the professionals were higher than those of clients. Positive results for this attribute in assessments by FHS professionals and clients were also obtained in other studies[10]. It is evidenced, then, that there is continuity in the relationship between the client and the health service, with construction of bond and accountability between professionals and clients over time and permanently, following the effects of interventions in health and of other elements in the client's life[13]. Despite the positive result, the study of the components of this attribute indicated that professionals have little knowledge of the health history and living conditions of FHS clients and their families.

The attribute Coordination was divided into two dimensions, Integration of Care and Information Systems. Coordination - Integration of Care was assessed by all professionals; however, only clients who stated having received referral to specialized services could assess it. Those responsible for children aged from zero to two years and the professionals evaluated it with a high score, indicating that according to these groups coordination of care is adequate. The evaluation of adults was classified as of low score, although, statistically, it is the same as that of another group of clients. The items questioning about counter-referral had the worst ratings in the three groups. From the perspective of the professional that refers, there is no feedback that promotes continuity of care, while, from the client's perspective, primary care professionals have no interest about the results and quality of care provided in the other health care levels.

Coordination requires both a means of information transfer – the structural component – and the recognition of such information – the procedural component[3]. Regarding the structural component, in the study location, the supply of specialized services was planned and executed under the model of regionalization; however, communication between the services did not follow the same logic, and there is no electronic

medical record system to gather information and share it between municipalities.

The dimension Coordination – Information Systems, which concerned mainly the existence and availability of medical records had highscore assessments by professionals and adults responsible for children aged 0–2 years. The evaluation revealed that, although the professional makes the records available, clients report more often that they cannot peruse it, in accordance with a result known in another study[14]. It is inferred that the understanding of the rights of clients of health services in this micro region needs development based on health education, creating conditions for the individual's autonomy.

The attribute Comprehensiveness was also addressed in two segments, namely Available Services and Services Rendered. In the first segment, there was agreement between the two groups of clients with lowscore evaluation. The three groups of participants attributed insufficient assessments for minor surgery actions; orthopedic suture; counseling/treatment for the use of licit and illicit drugs, consumption of alcohol, and smoking; counseling/treatment of mental health, as also occurred in other studies[9,14–17]. PHC professionals have the responsibility to deal with clients having a variety of sufferings, currently having – in the Unified Health System – insufficient structure to offer responses to situations that permeate the health-disease process[16].

In Comprehensiveness - Services Rendered, once again low scores were given by clients and high scores were given by professionals. Here, it was evident that the units participating in the study have no counseling on prevention of falls and household accidents, of accidents with firearms and intoxicating substances, and on prevention of burns.

The understanding of comprehensiveness should occur from different aspects, not mutually exclusive, focusing primarily on prevention and health promotion activities, with no compromise of assistance services[15]. In the studied region, educational and counseling actions, aimed at disease prevention and health promotion, are still incipient, revealing the maintenance of the care model centered on curative practices[16].

For the attributes Family Counseling and Community Counseling, the mean scores of clients were below the reference values, while those of the professionals were above the reference values. Evaluation of managers and professionals regarding the services is always higher and better than that of the client and, specifically, the family focus and community counseling achieve high ratings by professionals and the greatest divergences in relation to the clients' opinions[10–12,18]. Results for the attribute Community Counseling indicate that the participation and social control are not incorporated into FHS actions in the area under study.

The difference in values conferred to the attributes by clients and professionals reveals that this high performance of mean scores given by professionals – specifically in relation to family focus and community counseling – suggests the capacity to construct a sense of belonging to a health care ideology, constituting a kind of ethos for the professionals. Hardly, these attributes would receive low scores from their own managers and professionals, as they are tasked with deploying them in the services[10].

Regarding the attribute Family Counseling, criticism is due to the PCATool instrument, which assessed in a reductionist manner, oriented to disease and curative practices, since its approach does not address the fundamental features that confer identity to the FHS. Importantly, we emphasize the importance of permanent education strategies that lead the professionals to identify the importance of sensitization and learning about the family approach and the comprehensive care in their daily work, given the assessments of this attribute and its importance in the FHS.

Conclusion

The evaluation of the presence and extent of the attributes of the PHC, from the perspective of three groups studied, identified limits and possibilities of the work of the FHS in the health region of Alfenas - MG. The quality of the work in the PHC as self-reported by the professionals is not perceived or valued by clients, leading the authors to infer that the actions and services may have been developed inappropriately or insufficiently to be apprehended by the client's experience.

The high percentage of clients of the FHS who reported having other facilities in the health care network as a reference for care, particularly in child care, seems to be due to the non-integration of the two current models of PHC. About the attributes Community Counseling and Family Counseling, it was clear the confrontation of perspectives between professionals and clients, in which the knowledge and the recognition that the professional has on the subject do not translate into practices perceived in the experience of the client, who does not feel recognized as part of a family and as a member of a

community who needs to express oneself, participate, and evaluate.

The barriers to access were congruently identified by the three groups that evaluated the FHS despite the high coverage of FHS services in the micro region of Alfenas; it does not constitute a comprehensive gateway to the National Health System. Longitudinality is in a good level of development, in the opinion of all three groups, constituting as one of the strengthened points of PHC in the studied area. In coordination, it was clear that the FHS is recognized as a filter for care levels of greater complexity and as a basis for a regionalized health system, and the need to develop mechanisms to ensure counter-referral was indicated, because if the client who accesses the FHS and the respective professional are unable to continue the therapeutic project in other care levels, solvability is compromised and discredited, breaking up the connection between caregiver and care.

Regarding the Comprehensiveness, in the view of the three groups, health practices in the FHS of the Alfenas region do not include a broad spectrum of PHC operation, nor constitute a favorable convergence point for the intersectoral character of public policies that interfere with social problems and determinants, which are not exactly diseases. The prevention and promotion actions were subjugated to traditional practices of treatment and rehabilitation, thus the comprehensiveness and expanded clinic were not affected.

Obviously, it is not possible that the PHC respond to all the health demands of the population of a region that is characteristic of a developing country; however, the technical aspect of the PHC requires constant improvement.

Limitations of this study include: the regional boundaries, which makes generalizations about the results impossible; however, it still contributes to the characterization and evaluation of the FHS in Brazil; the sample being predominantly composed of older women, which occurred mainly due to the data collection period, which coincided with the coffee crop in southern Minas Gerais; and the small number of professionals who met the inclusion criteria, which compromised the result of statistical tests seeking associations between the variables of this group and the mean scores of the PHC attributes.

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