



Evaluation of the Responsiveness Index of the Family Health Strategy in rural areas

Avaliação do Índice de Responsividade da Estratégia Saúde da Família da zona rural
Evaluación del Índice de Responsividad de la Estrategia Salud de la Familia de la zona rural

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ABSTRACT

Objective: To evaluate the responsiveness of Family Health Strategy units in the rural area of the Federal District registered in the National Program for Improvement of Access and Quality of Basic Care. **Method:** Descriptive study, which used a questionnaire to evaluate the following dimensions: a) respect for people: dignity, confidentiality of information, autonomy, communication; b) customer orientation: facilities, choice of the professional, agile service and social support. **Results:** The users' assessment of responsiveness was 0.755. The dimensions related to respect for people received an index of 0.814 and customer orientation was 0.599. **Conclusion:** Care is given that shows respect for human dignity, but progress needs to be made in building confidentiality and the autonomy of users. Infrastructure is poor and care is not agile, highlighting the need for greater investments in rural areas.

DESCRIPTORS

Family Health Strategy; Rural Population; Health Evaluation; Primary Health Care; Primary Care Nursing; Quality of Health Care.

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INTRODUCTION

The growth of the Family Health Strategy (FHS) has been the leading factor behind the improvement of Primary Health Care (PHC) in Brazil. This strategy is understood as a tactic for reorienting the healthcare system, in order to change the care model and operationalize it through the implementation of multiprofessional teams⁽¹⁾. Various investments have been made to enhance the FHS, especially to organize the work process in terms of improving the resolution of health issues and to have a greater impact on the health situation of people and the community.

There is no question that the growth in the number of FHS teams has improved the access to health services for most of the Brazilian population⁽²⁻⁴⁾. However, it is still quite poor in various regions of the country⁽⁵⁾. Recurrent problems have been reported in relation to lack of coordination in integrated networks, high demand, the medical-centered model, lack of training and few opportunities to participate in the democratization of the work process in health⁽⁶⁻⁷⁾. These weaknesses have prompted reflections on the need for other strategies in order to improve it.

In rural areas, despite the expansion of FHS units, population dispersion and vast territorial areas have been hindrances to the strategy's coverage, which has been insufficient for effective PHC. Another complicating factor for the progress of the FHS in rural zones of small and medium-sized cities is scant resources, including qualified professionals^(1,8-9), particularly a shortage of physicians willing to work in the countryside.

Studies indicate that the health conditions in rural areas are more precarious than in urban areas, where there is usually greater access to other types of health services⁽⁸⁻⁹⁾, besides PHC. Ensuring equal and quality access for the whole population continues to be a major challenge of the Brazilian Unified Health System (SUS, in Portuguese). In this regard, the National Program for Improving Access and Quality of Primary Care (PMAQ, in Portuguese)⁽¹⁰⁾ has sought to assess PHC performance. There are still few studies that analyze in greater depth how the health system affects the rural population.

Furthermore, in rural settings, the situation of families is more complex, since they face other difficulties that are not noticed in urban areas, such as insufficient public transportation, lack of health services and, in many regions, lack of infrastructure, like electricity and means of communication⁽¹¹⁻¹²⁾. These deficiencies create greater obstacles for the work of rural FHS teams.

Therefore, it is necessary to evaluate the quality of care provided by FHS in rural areas, especially to identify the shortcomings, in order to improve the health system. Some studies point out the difficulties accessing health services, but there are still few that verify how rights – individual and collective – are considered in the analysis of access to and use of services and health systems⁽¹³⁾.

According to health assessment studies conducted by the World Health Organization (WHO), the concept of responsiveness of health systems refers to the way in which the system meets the expectations and demands of users in

aspects not directly linked to medical care⁽¹⁴⁾, based on the premise that users are entitled to adequate, timely care.

Studies on responsiveness seek to analyze the interaction between how the health system operates and user satisfaction⁽³⁾. They also avoid subjective aspects, common in satisfaction surveys, since they assess concrete individual perceptions, i.e., based on experiences legitimized by users regarding aspects of the health system⁽¹⁴⁻¹⁵⁾.

Therefore, the objective of the present study was to examine the Responsiveness Index of Family Health Strategy units in rural areas of the Federal District, participating in the PMAQ, with respect to dimensions involving respect for people and customer orientation.

METHOD

This was a descriptive exploratory study, conducted among FHS teams located in the rural area of the Federal District, participating in the PMAQ-AB.

The Federal District, unlike the other states of Brazil, does not have cities, since it is organized politically and administratively into 31 Administrative Regions. It is located in the Center-West region of the country and has a population estimated by the Brazilian Institute of Geography and Statistics (IBGE – *Instituto Brasileiro de Geografia e Estatística*) to be 2,917,830.

There were 55,681 users registered in the PMAQ-AB from the FHS of the Federal District. Of these, 42,462 were urban residents and 13,219 lived in rural areas. The determination of sample size was based on a proportional division of users from rural and urban areas, on the premise that there were more users in urban than rural zones. This proportion totaled 382 users, 92 of whom were from the rural area. A sampling error of 5% and a confidence level of 95% were adopted. The units were chosen by convenience. Participation in the study depended on the users' agreement.

The inclusion criteria for users were: have regularly visited the FHS unit for more than 3 months and be 18 years of age or older. Users suffering from physical or mental conditions were excluded.

The data was collected from May to July 2016, on alternate days and shifts (morning/afternoon). A questionnaire was used which had been validated in another type of service⁽¹³⁾ and adapted for the present study. It contained 28 questions divided into three major blocks: i) characterization of the profile of users; ii) the dimension of responsiveness in relation to respect for people, and; iii) the dimension of responsiveness for customer/user orientation. The dimension of respect for people included issues related to the ethical dimension in people's interaction with the health system, comprised of the following variables: dignity, confidentiality, autonomy, and communication. The dimension of customer/user orientation, in turn, includes components that influence user satisfaction, but are not directly linked to health, encompassing variables such as agility, social support, facilities and choice of the professional.

The data analysis was performed in accordance with the validated model⁽¹⁶⁾, which defined the closed variation between 0 and 1, where the maximum positive value for the service dimension was 1, considered the ideal standard to be achieved. The scale for interpreting the values from the index used was the following: excellent (0.901 and 1); very good (0.801 to 0.900); good (0.701 to 0.800); average (0.601 to 0.700); bad (0.401 to 0.600); very bad (0.201 to 0.400); and terrible (0.000 to 0.200). The questionnaire was adapted for application in PHC, since the original had focused on outpatient services.

The calculation of the scores for the questions was done through transforming the categorical data, obtained through the responses to the questionnaires, into numerical data. The ordinal scale of four items (always, almost always, rarely and never) used in the questionnaire had the following values: the item “always” corresponded to a value of 10; the item “almost always”, to a value of 7; the item “rarely”, to a value of 3; and the item “never” was assigned a value of 0. For the dichotomous questions of the questionnaire (answered with yes or no), the values 10 and 0 were assigned, with a

value of 10 denoting a positive evaluation, and a value of 0 a negative one. Then, the mean of the values was calculated and divided by 10, resulting in the score for the answer. This score represented the assessment of users in relation to that indicator after conversion into an index varying from 0 to 1. Finally, the mean of the indexes within each of the dimensions was calculated. Equal weights were assigned to the questions from each dimension for calculating the index.

The study was approved by the Research Ethics Committee of the Teaching and Research Foundation for Health Sciences under opinion No. 569/2011, and free and informed consent forms were signed by all the participants.

RESULTS

With respect to the profile of the interviewees (Table 1), most were women (78.2%), with ages varying from 20 to 49 years (75%) and had completed secondary education (34.8%). In terms of income, it varied between one (36.9%) and four minimum wages (54.3%). Most had been visiting the unit for a good length of time.

Table 1 – Characterization of rural FHS users, by Administrative Regions of the Federal District, Brazil, 2016.

	Sobradinho	Gama	Itapoã	Brazlândia	São Sebastião
Sex					
Male	25.00	23.33	20.00	16.67	15.38
Female	75.00	76.67	80.00	83.33	84.62
Total	100	100	100	100	100
Age					
18 to 29 years	28.13	26.67	60.00	25.00	7.69
30 to 49 years	59.38	60.00	20.00	41.67	61.54
50 to 69 years	6.25	13.33	20.00	33.33	23.08
Over 70 years	6.25	-	-	-	7.69
Total	100	100	100	100	100
Education					
Incomplete Elementary	18.75	26.67	20.00	25.00	7.69
Complete Elementary	12.50	16.67	-	8.33	7.69
Incomplete Secondary	25.00	20.00	20.00	25.00	46.15
Complete Secondary	34.38	30.00	60.00	33.33	38.46
Incomplete Higher	-	3.33	-	8.33	-
Complete Higher	3.13	-	-	-	-
No education	6.25	3.33	-	-	-
Total	100	100	100	100	100
Income					
Up to 1 minimum wage	28.13	43.33	20.00	50.00	38.46
2 to 4 minimum wages	68.75	40.00	80.00	41.67	53.85
Over 5 minimum wages	3.13	16.67	-	8.33	7.69
Total	100	100	100	100	100
Length of time visiting the unit					
1 to 3 months	-	3.33	-	-	-
3 to 11 months	37.50	30.00	20.00	41.67	30.77
1 to 4 years	50.00	43.33	20.00	41.67	-
5 to 10 years	9.38	16.67	40.00	-	53.85
Over 10 years	3.13	6.67	20.00	16.67	15.38
Total	100	100	100	100	100

As for responsiveness, the results demonstrate that the dimensions concerning respect for people had better indexes than the customer/user orientation dimension (0.814 and 0.599 respectively), as shown in Table 2.

In the dimension focusing on respect for people, the “communication” category obtained an index of 0.790, considered good. This category referred to the frequency with which users sought information in FHS units, how easily the desired information was obtained, and if the physicians and nurses paid attention to their problems, providing explanations about the illness and treatment. “Dignity”, which obtained an index of 0.897, considered very good, was related to how users were treated by FHS professionals, especially during physical examinations, i.e., with respect, privacy and without discrimination. The

“confidentiality” category, which obtained a score of 0.695, considered average, involved the trust users had in the servers to preserve the secrecy of the information in their medical records. “Respect for autonomy” was also classified as average (0.664) and assessed whether users were informed about treatment options by physicians/nurses, and if they were allowed to ask questions and decide on the type of treatment.

Another dimension analyzed in Table 2 was customer/user orientation, which obtained an index of 0.599. In this dimension, the “social support” category achieved an index of 0.805, considered very good. The questions were related to the social support received by users in the family health team, which involved the participation of relatives, friends and members of the community in the treatment.

Table 2 – Service Responsiveness Index values from rural FHS units, according to dimensions, Federal District, Brazil, 2016.

Dimensions	Responsiveness Index (CI 95%)
Respect for people	0.814 (0.801-0.827)
Dignity	0.897 (0.882-0.912)
Confidentiality	0.695 (0.599-0.791)
Autonomy	0.664 (0.629-0.698)
Communication	0.790 (0.767-0.813)
User orientation	0.599 (0.577-0.621)
Agility	0.609 (0.563-0.654)
Social support	0.805 (0.731-0.879)
Facilities	0.653 (0.633-0.674)
Choice of the professional	0.051 (0.008-0.093)
Responsiveness Index	0.755 (0.743-0.767)

The other category in this second dimension, which referred to facilities, had questions about the cleanliness and comfort of the waiting area, medical offices, meeting rooms and restrooms, and received a score of 0.653, ranking it as average. In terms of agility in consultations, the questions were related to the number of days needed to schedule an appointment, waiting time before being seen on the day of the appointment, and the time it took for users to receive lab test results. The index for this dimension was 0.609, characterizing it as average. The last block

assessed was the possibility of choosing the professional, which obtained 0.051, i.e., terrible.

Table 3 shows the service Responsiveness Index of rural FHS, according to the Administrative Regions of the Federal District. The Itapoã Administrative Region was given the best assessment in most of the dimensions, whereas the Sobradinho Administrative Region received the worst assessments in most of the dimensions.

There were also considerable differences in the assessments of the dimensions among the different Administrative Regions.

Table 3 – Service Responsiveness Index of rural FHS units, by dimensions, according to the Administrative Regions of the Federal District, Brazil, 2016.

Dimensions	Sobradinho	Gama	Itapoã	Brazlândia	São Sebastião
Dignity	0.887 (0.860-0.914)	0.901 (0.875-0.928)	0.925 (0.864-0.986)	0.892 (0.849-0.936)	0.906 (0.869-0.943)
Confidentiality	0.562 (0.380-0.744)	0.700 (0.525-0.874)	1	0.833 (0.586-1)	0.769 (0.504-1)
Autonomy	0.619 (0.558-0.680)	0.668 (0.609-0.728)	0.860 (0.753-0.966)	0.727 (0.643-0.812)	0.630 (0.525-0.736)
Communication	0.697 (0.653-0.740)	0.795 (0.753-0.838)	0.975 (0.936-1)	0.885 (0.840-0.930)	0.849 (0.793-0.904)
Agility	0.482 (0.399-0.566)	0.655 (0.577-0.732)	0.478 (0.273-0.684)	0.661 (0.642-0.781)	0.804 (0.707-0.901)
Social support	0.815 (0.683-0.948)	0.783 (0.643-0.922)	0.800 (0.244-1)	0.675 (0.403-0.946)	0.953 (0.885-1)
Choice of the professional	0	0.010 (-0.010-0.030)	0.244 (-0.280-1)	0.058 (-0.070-0.186)	0.130 (-0.065-0.327)
Facilities	0.655 (0.631-0.678)	0.652 (0.608-0.697)	0.651 (0.556-0.747)	0.490 (0.420-0.559)	0.770 (0.731-0.808)
Total	0.712 (0.691-0.732)	0.761 (0.741-0.782)	0.832 (0.788-0.876)	0.768 (0.737-0.799)	0.805 (0.77-0.833)

DISCUSSION

With respect to FHS responsiveness, the dimensions that received the best assessments by FHS users were related to respect for people (0.814), which could be considered a reflection of the investments made in the policy to humanize the Brazilian public health system⁽⁶⁾, especially through actions to strengthen PHC. The dimensions related to user orientation, involving aspects pertaining to the infrastructure of the health system, were graded the worst (0.599). These results demonstrate the shortcomings in health services that rural residents must endure, i.e., difficulty accessing basic health services^(8-9,11-12).

Among the dimensions related to respect for people, being treated with dignity received the highest index (0.897). This dimension particularly reveals the care that FHS professionals manifest at the time of performing clinical examinations: with respect and without discrimination – which are fundamental competencies for ensuring a bond between users and the service, strongly reinforced in the technology referred to as reception⁽¹⁷⁾.

However, “confidentiality”, which is part of being treated with respect, was assessed as average (0.695). Confidentiality refers to respect for privacy, which is a traditional moral concept in health services, which involves storing data/information and protecting it from third parties, who have access to it as a result of their professional activities⁽¹⁸⁾.

It is also argued that secrecy is associated with the bioethical principle of autonomy⁽¹⁹⁾, because personal data belongs solely and exclusively to the patient, who is the only one who can decide with whom this information may be shared. In this sense, health professionals, who are familiar with the data and information of users, should not disclose it, unless authorized by the user or in exceptional situations, as indicated by ethics or the law, such as cases of required reporting stipulated by law and regulations, where professionals may break secrecy covenants due to epidemiological criteria related to public health^(18,20).

Communication, the second best assessed dimension by users, had an index of good (0.790). This dimension refers to communication between professionals and users, which is crucial for forming a relationship of trust in the service. Health professionals should know how to guide and dialogue with patients for building health care in a joint and comprehensive way. Communication should break the barrier of asymmetry of information and create new possibilities for the understanding of cases and proposals for solving problems detected⁽²¹⁾.

The possibility of users having autonomy, however, was assessed as average (0.664). The concept of autonomy is associated with the progressive consolidation of human rights. It was incorporated into the doctor-patient relationship more precisely in the 1960s, based on empirical studies that showed an association between greater support for the autonomy of patients and better health outcomes⁽¹⁹⁾. However, the democratization of the relationship between health professionals and patients, the importance of the autonomy of patients in therapy choices and procedures to be followed, and models in which patients and physicians are seen as jointly responsible in this process, are practices still in the early stages⁽²²⁾. In order to transform hegemonic and vertical health practices,

it is necessary to address the power/knowledge relationships established between health professionals and users, as well as reflect on the basic assumptions underlying this reasoning⁽²²⁾.

Reasoning based only on the biomedical care model, centralized in individual clinical treatment, which is still adopted in the field of health – more specifically in PHC – can prevent communities from taking care of themselves and also from using folk knowledge. This model reinforces professional practices based on dictates as to how people should live, and typically involves using various drugs⁽²²⁾. In this context, when communities are presented with the same dictates, they can become increasingly passive in their capacity for self-care, which can reinforce seeking out health services only in situations of illness⁽²²⁾. Furthermore, within this logic, communities can contribute to increased medicalization which, in turn, helps reinforcing discursive mechanisms based on the hegemonic model⁽²²⁾.

In the customer/user orientation dimension, it was noted that agility is lacking in the provision of care (0.609), i.e., users report lack of access to health services, since there are difficulties scheduling appointments, long waiting times on the day of the appointment and delays in receiving lab test results.

It should be emphasized that FHS is usually the only health service available in rural areas, and the distances for accessing it may be great, due to the sparse geographic distribution of the units. Therefore, access to health services needs to be improved so that it is available any time users require care, such as the measures established by the British government: PHC services must provide medical care within 48 hours, and for any other professional from the team, such as nurses, within 24 hours⁽⁵⁾. This requires reviewing the modes of organization of the services, to enable a better balance between emergency service schedules (easy and quick access) and schedules for other health program actions.

The fewer the barriers in relation to access, whether geographical, institutional, cultural or social; the greater the possibility of drawing users closer to the services, which helps preserve or improve their health status. However, especially in rural settings, creating this closeness is still a major challenge in PHC and requires concrete strategies⁽²³⁻²⁴⁾.

The facilities of the FHS units were considered average (0.653), especially because rural units have not yet been built in the Federal District. The existing facilities are normal houses that have been leased to host the health service and are, therefore, improvised and uncomfortable. It is necessary to provide an adequate environment to better receive users.

Another aspect assessed negatively was being able to choose the professional (0.051), since the FHS units only had professionals from the minimum team. It is important for users to be able to choose the professional that will care for them, since this affects the relationship of trust that will be established. Effective bonds between professionals and users are conducive not only to adherence to treatment, but also lead to more autonomous decision making by users⁽¹⁷⁾. However, Brazilian PHC still does not foster this type of flexibility whether due to insufficient coverage or the rigidity of the mode of organization of the work and local health system.

It was also noted that the “social support” dimension was graded as very good (0.805). This dimension involves the community, which is necessary for strengthening social bonds, especially in rural areas, where the population is quite scarce and, consequently, more prone to social isolation. This demonstrated that it is a challenge to transform practices centered on community production for the rural population.

Finally, there were considerable differences in assessments of the same dimensions (respect for people and customer orientation) among the different FHS units in the regional administrations and among units from the same regional administration. These results suggest that there are inequalities in healthcare processes within the PHC context, more specifically in the rural FHS of the Federal District. The Itapoã regional administration, a training field for health courses from the Universidade de Brasília, obtained better indexes, possibly due to the academic investments in health practices. The results also indicate the need to strengthen the field of health services management, in order to restructure care networks and ensure access, accessibility and addressing of the demands and needs of the population for professionals trained to operate effectively in rural communities.

The population in rural areas is more vulnerable and exposed. Apart from problems allocating health professionals to remote areas, they are also subject to inequities in the distribution of health actions and services, since there is a tendency to concentrate these in large urban centers⁽²⁵⁻²⁶⁾. It was also noted that there is a lack of care models for the rural population in Brazil.

A study that assessed primary care and mother and child health in a rural *quilombola* (slave-originated) community⁽²⁷⁾ found that the health service perpetuated the curative and

medical-centered approach in the health-disease process, indicating the need for improved responsiveness in terms of singularized care.

Residents from rural areas have long required the attention of public policies, particularly from the Brazilian Public Health System, due to inequalities in health care, and in order to develop a care model that respects their specific needs.

As for the limitations of the study, the first was the possible presence of bias, common in cross-sectional studies. Another was related to the fact that the study did not include populations totally excluded from the system, or even forgotten since they live in remote and difficult to access rural areas. Last, it can also be argued that gratitude bias may have hindered obtaining a more critical vision of the care.

CONCLUSION

FHS responsiveness in rural areas had more satisfactory indexes in the dimension related to respect for people, which indicates that care is given with respect for human dignity and, in this area, nursing teams make essential contributions. Progress still needs to be made in building confidentiality and fomenting the autonomy of users. The indexes for the customer/user orientation dimension were less satisfactory, especially due to poor infrastructure and lack of agility in providing care. This indicates that FHS/PHC in rural areas needs greater investments from the SUS-DF. In short, more in-depth discussions are needed, with the participation of nursing teams, in regard to infrastructure and fundamental work processes to improve PHC as the main gateway to the health system.

RESUMO

Objetivo: Avaliar o índice de responsividade das unidades Estratégia Saúde da Família da zona rural do Distrito Federal cadastradas no Programa Nacional de Melhoria do Acesso e da Qualidade da Atenção Básica. **Método:** Estudo descritivo, com utilização de questionário para avaliar as seguintes dimensões: a) respeito pelas pessoas: dignidade, confidencialidade da informação, autonomia, comunicação; b) orientação para o cliente: instalações, escolha do profissional, agilidade no atendimento e apoio social. **Resultados:** A avaliação dos usuários quanto à responsividade foi de 0,755, sendo que as dimensões relativas ao respeito pelas pessoas alcançaram índice igual a 0,814, e à orientação para o cliente, de 0,599. **Conclusão:** Os cuidados são realizados com respeito à dignidade humana, todavia, há que se avançar na construção da confidencialidade e da autonomia dos usuários. A infraestrutura é precária e falta agilidade no atendimento, o que revela necessidade de maiores investimentos nas unidades da zona rural.

DESCRITORES

Estratégia Saúde da Família; População Rural; Avaliação em Saúde; Atenção Primária à Saúde; Enfermagem de Atenção Primária; Qualidade da Assistência à Saúde.

RESUMEN

Objetivo: Evaluar el índice de responsividad de las unidades Estrategia Salud de la Familia de la zona rural del Distrito Federal registradas en el Programa Nacional de Mejoría del Acceso y la Calidad de la Atención Básica. **Método:** Estudio descriptivo, con utilización de cuestionario para evaluar las siguientes dimensiones: a) respeto por las personas: dignidad, confidencialidad de la información, autonomía, comunicación; b) orientación para el cliente: instalaciones, elección del profesional, agilidad en la atención y apoyo social. **Resultados:** La evaluación de los usuarios en cuanto a la responsividad fue de 0,755, siendo que las dimensiones relativas al respeto por las personas alcanzaron índice igual a 0,814, y la orientación al cliente, de 0,599. **Conclusión:** Los cuidados se llevan a cabo con respeto a la dignidad humana; sin embargo, hay que avanzarse en la construcción de la confidencialidad y la autonomía de los usuarios. La infraestructura es precaria y falta agilidad en la atención, lo que desvela la necesidad de mayores inversiones en las unidades de la zona rural.

DESCRIPTORES

Estrategia de Salud Familiar; Población Rural; Evaluación en Salud; Atención Primaria de Salud; Enfermería de Atención Primaria; Calidad de la Atención de Salud.

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