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Evaluation of users' satisfaction regarding mental health care in the Family Health Strategy*

AVALIAÇÃO DA SATISFAÇÃO DOS USUÁRIOS COM O CUIDADO DA SAÚDE MENTAL NA ESTRATÉGIA SAÚDE DA FAMÍLIA

EVALUACIÓN DE SATISFACCIÓN DE PACIENTES CON EL CUIDADO DE SALUD MENTAL EN LA ESTRATEGIA SALUD DE LA FAMILIA

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ABSTRACT

The objective of this study is to evaluate the satisfaction of patients with mental suffering regarding the comprehensiveness of the treatment they received from the Family Health Strategy. This case study was developed based on an evaluation study with a qualitative approach at a family health care unit in Chapecó, Santa Catarina. Subjects were 13 users with some kind of mental disorder. The following seven domains were used to evaluate satisfaction: autonomy, confidentiality, communication, respectful treatment, immediate treatment, basic facility conditions, and accessibility to social support networks. It was found that users perceived the strengths and weaknesses of service organization and of the care that was provided: the attachment, the relationship between the team and the community, care with the family, home visits, and the health professionals comprehensive view in the physical exam were reported to be reasons for the users' satisfaction.

DESCRIPTORS

Mental disorders
Family Health Program
Comprehensive Health Care
Mental health
Patient satisfaction

RESUMO

Esta pesquisa objetiva avaliar a satisfação de usuários portadores de sofrimento psíquico acompanhados pela Estratégia Saúde da Família, com vistas à integralidade. Foi um estudo de caso desenvolvido a partir de uma pesquisa de avaliação com abordagem qualitativa em uma unidade de saúde da família no município de Chapecó/SC. Os sujeitos do estudo foram 13 usuários com algum tipo de transtorno mental. Para avaliação da satisfação foram utilizados sete domínios: autonomia, confidencialidade, comunicação, tratamento respeitoso, pronto atendimento, condições das instalações básicas e acesso a redes de apoio social. Ao final do estudo identificou-se que os usuários percebem os pontos fortes e os fracos da organização do serviço e do cuidado prestado: o vínculo, a relação entre a equipe e a comunidade, o cuidado com a família, as visitas domiciliares e o olhar integral do profissional de saúde no exame físico foram relatados como motivos de satisfação dos usuários.

DESCRIPTORES

Transtornos mentais
Programa Saúde da Família
Assistência Integral à Saúde
Saúde mental
Satisfação do paciente

RESUMEN

Investigación que objetiva evaluar la satisfacción de usuarios portadores de sufrimiento psíquico seguidos por la Estrategia Salud de la Familia, apuntando a la integralidad. Estudio de caso desarrollado a partir de investigación de evaluación cualitativa, en unidad de salud de la familia del municipio de Chapecó-SC. Los sujetos del estudio fueron 13 usuarios con algún tipo de trastorno mental. Se utilizaron siete dominios para evaluar la satisfacción: autonomía, confidencialidad, comunicación, tratamiento respetuoso, rápida atención, condiciones de instalaciones básicas y acceso a redes de apoyo social. Al final del estudio se identificó que los usuarios perciben los puntos fuertes y débiles en la organización del servicio y del cuidado brindado. El vínculo; la relación entre equipo y comunidad; el cuidado a la familia; las visitas domiciliarias; la visión integral del profesional de salud en el examen físico, fueron resaltados como motivos de satisfacción de los usuarios.

DESCRIPTORES

Trastornos mentales
Programa de Salud Familiar
Atención Integral de Salud
Salud mental
Satisfacción del paciente

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INTRODUCTION

In order to consolidate the principles of the Single Health System (SUS), the Family Health Strategy (FHS) is presented as a proposition for care that values the following principles: establishment of bonds with the population; integral health care delivery; teamwork with a multi-disciplinary focus; emphasis on the inseparability of clinical care and health promotion; strengthening inter-sector actions; territorial actions; and encouraging the community's participation, among others.

This strategy proposes switching the health care model from one traditionally centered on healing practices, to a care model that focus on the family within its ascribed territory. There is a need to include mental health issues within FHS dynamics—and such a need is evidenced daily in health practices—due to the frequent arrival of users at FHS units with psychological suffering with varied complaints. Hence, the health team needs to be prepared and improve its problem-solving capacity to solve the problems of these users.

In this context, assessing mental care health provided at FHS units from the perspective of users is essential to developing more integral care delivery. Assessing is a process that involves the judgment of many actors (professionals, managers and, mainly, users) concerning the characteristics of the service and care delivery⁽¹⁻³⁾.

The first studies addressing assessments of the quality of health services emerged in the 1970s and focused on user satisfaction as the main object of study⁽⁴⁾. The user is the individual best situated to judge his/her own wellbeing and care received⁽⁵⁾. Therefore, listening to what s/he thinks about the health services is appropriate. The user understands quality of service to mean attaining expected benefits in the face of demands, expectations and health needs, and quality is an objective pursued by managers, health providers, and users in many countries in the world, including Brazil. In the field of quality in health, we work with the assumption that good work processes lead to good outcomes⁽⁶⁾.

Knowledge and logic related to assessment belong to different domains of knowledge, so that the experience accumulated by users enables them to establish their assessment indicators⁽⁴⁾. Users can collaborate to great effect with service organizations if they are allowed to have a voice, that is, new strategies may be adopted or those existing may be improved to qualify care results through the evaluation of user satisfaction. As is known, users played an important role in Brazilian Psychiatric Reform, thus, the perception of users with some mental disorder concerning care delivery could not be left aside. Asking users who need mental health care to evaluate such care is a

challenge because it produces and reinforces the exercise of their citizenship⁽⁷⁾.

The concept of user satisfaction in this study refers to the subjective perception of the individual concerning care received. Satisfaction, as a dimension of quality of care, is linked to the user's expectations. In other words, satisfaction occurs in the relationship between health care delivery and the individual's health condition. There is a greater chance such expectations are met when both converge⁽⁸⁾.

An assessment of care delivery and how the user benefits from the service's organization when solving his/her needs can be obtained through user perceptions.

OBJECTIVE

To evaluate the satisfaction of users with psychological suffering cared for by the Family Health Strategy aiming to meet the concept of integrality.

METHOD

This is a case study based on assessment research with a qualitative approach. The qualitative assessment performed by users in this study refers to the dimension *Outcome* of Donabedian's assessment method⁽⁵⁾. An outcome is the product of interaction between users and health services in the conditions of the presented context; it is the final product of care delivery, considering health, satisfaction of standards and expectations⁽⁵⁾. For this reason, it is assessed

through satisfaction determined through interviews with users.

This study is part of a qualitative research project of the Baseline Studies of the Project for the Expansion and Consolidation of the Family Health Strategy (PROESF), financially supported by the Brazilian Ministry of Health and the World Bank and carried out by the Federal University of Pelotas, School of Nursing and Obstetrics and Medical School, Department of Social Medicine. This study was conducted in cities in the South and Northeast of Brazil. Primary and secondary data were collected through an epidemiological study⁽⁹⁾.

The qualitative part of the larger project was conducted in two cities: one in the northeast (Recife, PE) and the other in the south (Chapecó, SC). These cities were chosen based on criteria and data obtained during the epidemiological study, which showed a successful experience concerning integrality within the FHS. Only data related to the city of Chapecó, SC, Brazil are presented in this study, focusing on integrality of mental health care provided within the FHS.

The chosen FHS unit presented indicators concerning integrality that suggest it is a consolidated experience such as: time of implementation of FHS in the city (since 1995); among the FHS units selected for the PROESF epidemiological study, this unit was the oldest (since 2000); time period of the system's full management (since 1998); initiative of continuing education; indications of field supervisors as having successful experiences; and the development of the project *Acolher Chapecó* [Welcome Chapecó], which received the David Capistrano award from the Ministry of Health in 2004.

This study was approved by the Ethics Research Committee at the Federal University of Pelotas, Medical School (Protocol 083-05).

The study's participants consisted of 13 users with some type of mental disorder. Two criteria were used to select participants: the FHS unit's professionals were asked to identify users with a mental disorder or problems related to mental disorders; and users identified as having mental disorders through observation (consultations and home visits) were also selected. Hence, three users were selected after observation and 10 were indicated by the team.

All the interviewees had already attended appointments in the FHS unit, agreed to participate in the study and were interviewed at home. To ensure confidentiality of the participants' identities, these are identified as U.1, U.2, U.3, successively, throughout the text. We observed that most of the users indicated by the team used alcohol and experienced depression. No individuals with severe disorders were discovered, which leads us to infer that individuals with severe disorders are not acknowledged as users of the FHS unit.

The interviewed users were 29 to 89 years old; their educational level ranged from illiterate to the 8th grade out of primary school; time of residence in the neighborhood varied from five months to 33 years (since birth); eight were women and five were men. Data were collected through interviews. The fieldwork was carried out in Chapecó, SC, Brazil in October 2005.

Assessment criteria, selected based on the users' reports, converged with domains selected by WHO experts and which were used in a study conducted in Mexico⁽¹⁰⁾. The seven domains used to facilitate the measurement of satisfaction were: autonomy, confidentiality, communication, respectful treatment, prompt service, conditions of basic infrastructure, and access to social support networks⁽¹⁰⁾. These domains emerged or failed to emerge as a result of analyzing the collected data.

RESULTS

User's satisfaction (individual perception) is complex because there are various factors influencing a user's per-

ception. Among them the following stand out: previous experiences with medical care, conditions under which such experiences occurred, and the individual's current health condition. These factors should be taken into account when assessing health services, thus it is the subjective perception of users concerning care delivery that is investigated as demonstrated in the following reports:

I guess they have helped me [...] they are doing everything that can be done. They are my "salvation". [...] because I feel I'm supported when I need, I know I have someone to talk there, I have someone to help me [...] I'm alone in the world. So, I feel like I have some family. I'm very well cared for, I cannot complain (U.11).

This physician examines me. It is half an hour inside her office [...] she sees everything daily, everything she prescribed, to take notes. She's great. And I had exams for everything. [...] I took a heart exam and I have nothing. [...] I took an exam that showed an intestinal infection and now it is affecting my nerves (U.3).

The reports show that users construct their own assessment criteria, that is, they associate care with positive value judgments. The bonds and relationships established between the team and the community, the dynamics of laboratorial exams, care provided to families, medication supplied, home visits, the integral care provided by physicians during physical assessment, and even the number of users waiting for their consultation were reported as reasons to be satisfied.

We are well cared for there. If, like, we can't make the appointment for any reason, we go there the same [...] my medication is there, safe (U.4).

[...] there is no complaint. They've always treated me well. Any exam I may need is always very fast, I don't know if it's because of my disease [...] I have no complaints (U.12).

[...] the physician and nurse come here and are welcomed, I go to the unit and am welcomed, as well [...] (U.7).

From what I see, I think it's always crowded. Now, if they've treated us badly, people wouldn't go there (U.13).

All this criteria construction is very important for analysis, especially if we consider that many users of health services in Brazil still are unaware of their rights as citizens.

Dissatisfaction is linked to users having difficulty accessing a service when they do not attend any of the promoted programs such as childcare, pregnancy, hypertension and diabetes); they view the situation as one where there are few waiting tickets, many lines, and demand is disorganized. They report that in addition to being required to arrive at the service early in the morning and wait for a long period of time to get a consultation, the number of physicians is insufficient and the physical area is inappropriate.

That unit is very small; it needs more space. It needs a larger room [...] it should be different. Those people waiting for an exam should go to one wing and those waiting a consultation should go to another [...] I don't think people should stay all together (U.6).

I guess there are things that could be improved, they needed a place of their own, not pay rent. It is so small; people almost have no place to stay when it's raining. It'd improve for the workers too, not only for us. They also could benefit from that improvement (U.10).

User dissatisfaction was linked to the difficulty to get a waiting ticket to apply for a consultation and waiting time. After obtained a token, people wait up to four hours to get a consultation.

None of the interviewees participated in the Local health Council (LHC). Eight of the 13 participated in the hypertension group promoted by the family health team, two participated in groups promoted within the community, and three attended another health service (Psychosocial Health Center). Hence, this domain is partially covered because there are users who would like to participate in groups and engage in other activities not promoted by the FHS unit or by the community.

[...] I'd like to participate in an elderly group if there was a course for us to learn crocheting or knitting [...]. After I left the group [...] because there was a participant who said that we had to talk, that people went there only to eat, I didn't go only to eat; I went there to have some company [...] (U.2).

The domain of autonomy still has to overcome the culture of patronage, that in which health providers have to do everything for the users and they do not become responsible for their own health. The users should use the LHC to make suggestions and give their opinions concerning the activities developed within and outside of the FHS unit.

The second domain refers to confidentiality, which assumes users have control over who has access to his/her health information. Users have full power over their medical files and can take them to any referral service when they have a consultation.

There are problems related to access to medical files because only FHS team physicians and nurses can take notes on the files of users. The community health agents (CHA) do not have permission to handle the users' files, which is a restriction believed by many to be unnecessary since these workers are members of the health team and are sufficiently ethical and professional to access the users' files without disseminating information contained in it.

The third domain is communication and refers to the fact that users are entitled to receive full information regarding their health condition and treatment. The forth domain refers to respectful treatment, implying that users receive humanized treatment, that they are entitled

to their full rights and are not harmed in their dignity. The third and forth domains are interconnected in this study, thus they were analyzed together.

These two domains refer to the relationship established between the user and health care provider, that is, careful treatment, interest for the user's health condition, and clarification of doubts (signs, symptoms, exams), among others. This is some of the information pertinent to the users for them to become satisfied with the service. Moreover, from these domains, bonds can be established and integral care can be constructed.

[...] yeah, the physician instructed me. They explain how you are supposed to take it. We already know. They explain as we get the medication at the unit. Whether there is a physician or not [...] they tell you everything. The day there is a physician, the day a physician is not available, the day you have to schedule an appointment. They explain everything, everything (U.3).

The CHA always visits me [...] everybody who works in the unit has already visited me, many times, always concerned about how I was [...] I feel I have support, when I need, I know that I have someone there to talk, I have someone to help me [...] (U.11).

The fifth domain refers to emergency care, that is, the time elapsed since the user sought out care and when care was actually delivered should not generate risk or harm the patient so that a new search is required. The sixth domain refers to the conditions of basic infrastructure and requires that the physical characteristics of the service such as cleaning, ample space and light are appropriate.

The fifth and sixth domains were already addressed in relation to lines and waiting time in addition to inappropriate physical area, all of which generate dissatisfaction in the FHS unit users. The users' assessment concerning these domains indicates these are negative aspects identified in the teamwork process.

The seventh and last domain refers to access to social support networks, meaning the user receives hospital care but does not lose contact with his/her social milieu. Users reported satisfaction with some aspects of the care network because most referrals were prompt as opposed to others that took up to two years.

They also reported being satisfied with the FHS team's follow up throughout the entire referral process (the unit schedules the specialist and then informs the CHA of the date of the appointment for those patients requiring referrals) as already mentioned in the assessment of the process.

[...] Everything happened within eight days [...] when I left the hospital, on the day after, I went, I went to the unit and got prompt service, was sent to psychosocial care center and they scheduled the consultation there, then it didn't take eight days and I had an appointment [...] I got everything within eight days (U.11).

Respectful treatment may reflect results that are dialectical because there is a group satisfied with the relationship but not satisfied with the physical and organizational areas. Thus, we infer that users positively evaluated some actions and negatively evaluated others that also depend on the relationship between the team and management or between the team and users.

From this a big question emerges: what characteristics does health care delivery possess when the service is organized in such a way that users have to arrive early at the unit to obtain a waiting ticket and then wait additional hours in a small place to get an appointment or even schedule an appointment on another day or in another month?

Some interviewees reported they liked the project *Acolher Chapecó* because they could obtain prompt service any time during the FHS office hours. They would be received by a nurse, physician, or nursing auxiliary and leave with exams or medications as the following report shows:

I guess that the previous project should be implemented again, you know. Because, at the time of the project, if you had something and it was not something grave, the nurse herself would take a look. Now, it's only the physician. So, it's more difficult now. And you go there and it's always crowded, always crowded, sometimes you're really sick, go there and there is no way to get an appointment. So, you go to an ER (U.12).

The project was terminated in the FHS units without users being consulted and then, after the project ended, the users learned that consultations (medicine prescriptions and exams) would be only performed by physicians, hindering access because the project had created a demand that became compressed and had to wait for medical consultations.

DISCUSSION

Users are constantly assessing and diagnosing problems in the service, even if such an assessment is a result of their personal opinion and experience. They discuss and assess the supply of health care services and judge whether it is good or bad. This fact is observed in some reports when the user assesses a service and indicates its strengths and also some potential "solutions" for the problem.

The services should listen to users at the time of decision-making because their opinion may play an important role in the organizations' future and also strengthen the involvement of users with social participation.

Mental health needs are complex and require complementing on the part of other health services. All this set of actions should benefit and satisfy users. Users should leave the service certain that everything was done to

solve their problems and that the health team is interested in their recovery⁽¹¹⁾.

Many people and institutions responsible for providing health care waste opportunities to collect valuable information from those they serve to provide feedback to the services⁽¹²⁾.

Bonds established with the team, humanized care, the dynamics of laboratorial exams, family care, home visits, integral care when the professional is performing physical assessments and medication supplies are indicated as elements that lead to satisfaction.

On the other hand, the high number of users waiting for a consultation, the insufficient number of wait tickets, long lines, disorganized demand within the FHS, the need to arrive early in the morning to get a ticket, waiting time, the requirement to be cared for only by a physician or specialist, and the inadequate physical area are pointed out as elements that lead to dissatisfaction.

Many problems have been observed in Brazil in relation to access and reception. In the case of the FHS, the physical area is not suitable to accommodate people waiting for consultations and lines, which were presented as some of the unit's limitations.

Based on that, the users construct assessment criteria associated with value judgments they express as either positive or negative. Such criteria defining satisfaction or dissatisfaction were identified based on users' reports.

The difficulty in getting wait tickets (users have to arrive early to get in the line) could be solved if the system of distribution of tickets was abolished. For that, more appointments, not necessarily medical appointments, need to be available. These could be nursing consultations, which is a solution reported by the users who ask for the return of the *Acolher Chapecó* project⁽¹³⁾.

Even though the FHS unit adopts two types of organization (scheduling and wait tickets), easy access is ensured only to specific groups, which refers to a *pseudo* alteration of the exclusive model of emergent care. When users are not able to get a ticket, they leave the unit without having their problem addressed. Hence, the unit stills works within the traditional organizational model focused on medical consultations through the distribution of tickets⁽¹⁴⁾. Nonetheless, users report satisfaction concerning the way they are treated at reception and during consultations.

The studied FHS was organized through the *Acolher Chapecó* project until 2004. According to the project, nurses and nursing auxiliaries actively listened to the users and ensured them access. The project received the David Capistrano award in 2004 but in 2005, when the city's management was replaced, the project was terminated.

The project was part of a context of changes that represented a proposition to reorganize the work process based on teamwork, discussion of the therapeutic project

of each user, and giving priority to the user's needs as the axis of the care model organization.

The implementation of the project gave priority to individual, confidential and active listening, which was performed by nurses, nursing auxiliaries and the physician. According to reports, the FHS unit's nurses and nursing auxiliaries were those who received the users, a situation also observed in other FHS units.

The problem relating to a lack of time is only partly related to the way health care delivery is organized. Based on data collected, the work with groups and health education was not intensified, not in the sense that this would be the axis of the service organization.

According to the users, the project was good because there were no lines and they could attend a consultation any time they needed (specifically for obtaining medication or taking exams). However, we understand that the goal was to improve access to health care, that is, people should have access not only to medication and exams, but demand should also be organized.

The project basically transformed the reception/welcoming point into a clinical consultation according to the traditional model, reinforcing a model centered on the disease and consultation, against FHS guidelines. Such guidelines recommend the model be centered on the user and health promotion, to promote integral care. However, the project specifically solved clinical demand, unlike the enlarged clinic we plan to construct, though it was more welcoming and solved the immediate problems of users.

Ending the project without discussing that action with the community and the City Health Department reveals different interests implicated in a process of change that is full of contradictions. Hence, the greatest criterion of user autonomy would be their participation in Local and City Health Councils and their ability to demand their rights. We also add their participation in the FHS organization toward the construction of integral care. Autonomy should not be confused with independent individuals; it rather refers to an individual who has established bonds with the service and helps to construct health care delivery through the exchange of information.

The services should work to improve the ability of users to deal with difficulties, encouraging through teamwork, self-care and an understanding of their own body, disease, and relationships with their social milieu, enabling users to survive with quality of life⁽¹⁵⁾.

Access and reception/welcoming are elements essential to care, so that one can effectively influence the health conditions of users and that of the collective, and are elements that favor the reorganization of services and qualification of care delivery⁽¹³⁾.

Health promotion is also implemented through self-care, through sharing responsibility with users concerning their own health, through mutual help, and also social, economic and cultural conditions⁽¹⁶⁾.

Users can no longer be considered mere spectators in a system that offers services it considers necessary. Users need to be acknowledged as individuals who have rights and autonomy and are capable of making decisions and assuming responsibility for their choices⁽¹⁷⁾.

CONCLUSION

Users perceive and identify the strengths and weaknesses in the organization of service and care delivery. Bonds, the relationship between the team and the community, the dynamics of laboratory exams, family care, medication supply, home visits, integral care provided by professionals at the time of physical assessment, the number of users waiting for consultations were considered elements that lead to satisfaction.

Users should be listened to and also be invited to participate in the decision making process, but there is a long way to go in the health field in the quest for integral care. Therefore, it is important that users and families know their rights, acknowledge their duties and effectively participate in the construction of practices through Local Health Councils and the City Health Department because their satisfaction or dissatisfaction should be valued and understood as a process toward the qualification of health care delivery.

Through the assessment of users, fragility in three domains was evident: emergency care, conditions of basic infrastructure and autonomy. Users continually assess the services and discuss the conditions of health care delivery, judging what is good and bad, indicating both potentiality and limitations, and also suggesting potential "solutions" for problems. On the other hand, we still need to improve the ability of services to listen to users and take their voice into account in the decision-making process and consider it a positive element for a model intended to offer better service in the future comprehending, as best as possible, the range of users' needs and achieving more efficacious care delivery.

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