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Artigo Original

Suelen Bernardo Guckert[1]
Carolina Rogel de Souza[1]
Aline Megumi Arakawa-Belaunde[1]

The role of speech-language therapists in primary healthcare from the perspective of professionals in family health support centers

Atuação fonoaudiológica na atenção básica na perspectiva de profissionais dos núcleos de apoio à saúde da família

Keywords

Health Promotion
Speech-Language Sciences
Primary Health Care
Family Health
Health Personnel

ABSTRACT

Purpose: To analyze the perception of professionals constituting Family Health Support Centers (FHSC) of a capital in the South Region of Brazil regarding the role of speech-language therapy professionals in primary care (PC). **Method:** This is a qualitative, observational cross-sectional study. All professionals constituting the FHSC who voluntarily agreed to collaborate with the research participated in this study. A semi-structured questionnaire was applied containing information about the professional profile and activities developed in PC. **Results:** Health professionals perform actions that would allow for the joint participation of speech-language therapy professionals, since this category is not contemplated in the staff members that constitute the municipality team analyzed. According to the questionnaire, referrals to speech-language therapy professionals are mainly related children issues with speech and language. Little knowledge on the contribution of speech-language sciences regarding interdisciplinary actions was found. **Conclusion:** The participants of this study demonstrated a reductionist perception regarding speech-language sciences in PC. In addition, the actions performed by the professionals of this study are directed towards what the speech-language professional could contribute instead. Further studies could demonstrate the benefits that speech-language professionals can provide to the activities performed.

Descritores

Promoção da saúde
Fonoaudiologia
Atenção Básica
Saúde da Família
Pessoal de Saúde

RESUMO

Objetivo: Analisar a percepção dos profissionais que compõem os Núcleos de Apoio à Saúde da Família (NASF) de uma capital da região sul do País, sobre a atuação do fonoaudiólogo na atenção básica (AB). **Método:** Trata-se de um estudo qualitativo, observacional transversal. Participaram da presente pesquisa todos os profissionais do quadro do NASF que aceitaram voluntariamente colaborar com a pesquisa. Aplicou-se um questionário semiestruturado contendo informações sobre o perfil profissional e suas atividades desenvolvidas na AB. **Resultados:** Os profissionais de saúde realizam ações que possibilitariam a participação conjunta do fonoaudiólogo, porém, essa especialidade não está contemplada no quadro de profissionais que integram as equipes do município estudado. De acordo com o questionário, os encaminhamentos para a fonoaudiologia acontecem principalmente em assuntos relacionados à fala e linguagem infantil. Percebe-se pouco conhecimento acerca da contribuição fonoaudiológica no que diz respeito às ações interdisciplinares. **Conclusão:** Os participantes deste estudo demonstraram uma percepção reducionista no que diz respeito à atuação fonoaudiológica na AB. Além disso, as ações realizadas por estes profissionais direcionam-se àquelas que o fonoaudiólogo poderia contribuir. Sugere-se que próximos estudos possam demonstrar os benefícios que o fonoaudiólogo pode levar para as atividades realizadas.

Corresponding Address:
Aline Megumi Arakawa-Belaunde
Centro de Ciências da Saúde, Coordenadoria Especial de Fonoaudiologia, Campus Universitário, Trindade-Florianópolis (SC), Brasil.
E-mail: arakawa.aline@ufsc.br

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[1] Universidade Federal de Santa Catarina – UFSC – Florianópolis (SC), Brasil.

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INTRODUCTION

The Brazilian Unified Healthcare System (UHS) was created to offer the population with recognition of health as a social right contemplated by public policies in a universal and integrated manner, leading to reflection on the perception of health care[1]. In 1994, to strengthen this new model of health care, the Family Health Program (FHS) was created, later called Family Health Strategy (FHS) and, in 2008, the Family Health Support Center (FHSC)[2].

In 2017, there were some modifications to the model adopted by FHSC. Its main modification concerned the supported teams, as the FHSC currently also assists traditional Primary Care teams (PC), changing their naming to Extended Center for Family Health and Primary Care (FHSC-PC). The FHSC-PC team constitution has not changed, remaining with different professions and specializations of the Health field acting in an integrated manner[3].

Speech-language therapists (SLT) were part of this program since the implementation of UHS, gaining space as they joined the PC[4]. Along with the multi-disciplinary team, this professional can perform activities such as situational and institutional diagnosis, welcoming, home visits, individual or group consultations, in health education within waiting rooms and/or near health units (physical activity groups, health and conviviality care, mental health care, arts therapy, matrix-related work, work in campaigns for healthcare, permanent education of support teams, as well as conduct and disseminate research)[2]. It should be noted that, when included in the team of the FHSC, the SLT should prioritize activities of collective nature, collaborating for the strengthening of social support and community approximation[5].

There are demands exclusive to the SLT in terms of clinical and collective care in order to act as to provide rehabilitation as well as prevent and promote health[6].

The focus on health promotion is one of the main goals of PC Professionals, providing a support network with appropriate health promotion strategies the community in which the whole network is addressed, taking into account the needs of the population[7]. According to the Brazilian National Health Promotion Policy, the participation of other sectors and institutions is essential to provide health and care[8].

Health-promoting measures contribute to a better quality of life of the population[8]. In addition, collective services promote an environment favorable to the exchange of experiences between participants, as well as the adoption of healthy living habits, which result in the well-being of these individuals[6].

In this case, it is important to follow the principles of PC, which involves the promotion of health and prevention of health issues to fully provide such service/care[7]. Nascimento and Nakamura (2018)[4] reported that the absence of the SLT in the health team is a reflection of the poor distribution and insufficient human resources destined to the health field, leading to negative impact for the community as a lack of access to such services, in addition to the potential lack of knowledge on the possible roles of the speech-language professional[9].

As such, this study analyzes the perception concerning the roles of the SLT in PC of the professionals that constitutes the FHSC in a capital of the South Region of Brazil.

METHODS

This qualitative, cross-sectional, observational study included professionals belonging to the FHSC of a capital in the South Region of Brazil. All constitutive FHSC professionals who voluntarily accepted to participate in the research were included in this study and those away from work or in a vacation period at the time of data collection were excluded. It should be noted that the SLT is not part of the FHSC teams in the municipality, despite the professional being present in the medical complex and the hospital network.

Initially, contact was made with the coordinator of each Health District of the municipality to clarify the purposes of the research and enable participation in meetings with the FHSC teams. Subsequently, ideal day and time were chosen for the researcher to participate in the meeting in order to clarify the aspects inherent to the research to the participating professionals.

A semi-structured questionnaire (open and closed questions) was applied for data collection, including information concerning the professional profile, activities developed as a member of the FHSC, and knowledge about the role of the SLT.

The professionals were invited by the researcher at a FHSC meeting to participate voluntarily in this research. Those who accepted signed the term of free and informed consent after its reading.

The data were described and, for the analysis and interpretation of the aspects of the discursive questions, a thematic modality was chosen[10]. After the transcription, the material was read by the researchers, performing an initial analysis of the data, which were later grouped into thematic subcategories and finally categorized.

This study is part of a larger project called "Health Promotion: possibilities in the role of speech-language therapists in primary healthcare" and was approved by the Ethics Committee of the institution of origin under protocol CAAE No. 57795116.1.0000000121.

RESULTS

This study included 39 professionals that constitute the FHSC pertaining to the five health districts. Each FHSC has on average eight professionals, with a minimum of five and a max of ten members. The mean age of these professionals was 31 years (SD=15), with a minimum and maximum of 23 and 54 years, respectively. The majority (89.74%) belong to the female gender, as shown in Table 1.

Table 1. Profile of the professionals that constitute the FHSC teams

Gender	N	%
Female	35	89.75%
Male	4	10.25%
Undergraduate	**N**	**%**
Physical Education	7	17.94%
Physical Therapy	7	17.94%
Nutrition	7	17.94%
Psychology	6	15.38%
Social services	5	12.82%
Pharmacy	4	10.25%
Medicine	3	7.69%
Level of Education	**N**	**%**
Lato Sensu	22	51.28%
Stricto Sensu	12	30.76%
Training region (undergraduate course)	**N**	**%**
South	20	51.30%
Northeast	1	7.70%
Southeast	3	2.60%

According to the Municipal Health Secretariat of the municipality, during the research period (March to August 2017), the PC organization system was constituted by 50 Health Centers, subdivided into five health districts, which are responsible for the administration of the network at regional level: Continente, Center, East, North and South. With regard to the FHSC, there are 12 teams, distributed as follows: three in the Continente District, three in the South District, two in the Center District, two in the East District and two in the North District (CNES, 2016)[11].

These FHSC teams include, most notably, professionals with training in Physical Education, Physical Therapy and Nutrition, corresponding to 17.94% each, with 51.30% having come from the South Region. The highest degree mentioned by the participants was *lato sensu* (Professional Degree) (51.28%), with mean working time at UHS of seven years (minimum 12 and maximum 21 years).

Their mean working time at FHSC was 56 months (minimum 12 and maximum 96 months). Each FHSC team supports on average 12 FHS (minimum three and maximum 32 FHS) and on average five health centers (minimum one and maximum 15 health centers).

Analysis of the open questions showed that contribution of the SLT in PC was mentioned by 38 (97,44%) professionals.

Analysis of the responses by the FHSC professionals allowed for categorization into (I) SLT contribution to PC, (II) actions carried out in PC with the support of the FHSC professional, (III) health promotion and health issues prevention groups carried out in PC.

Speech-language therapist contribution to PC:

The answers provided with use of the questionnaire showed that the SLT can contribute in several ways to the other FHSC professionals. This can happen in the team's matrix work, in the training of FHS professionals, in home visits, in the support of teams, in case discussion, in the participation of team meetings, in the actions carried out by the Health at School Program (HSP), and when considering the demand of the Health Center, as shown in the sections below.

"Speech-language therapy can contribute to PC by matrix care for FHS, participating in HSP meetings and meeting demands." (P1)

"By supporting the teams for the specific demands of speech-language therapy as well as helping to broaden the scope of FHS actions, thus contributing to the promotion of Health". (P13)

"[...] activities of FHSC such as home visits, enrollment with FHS [...]. Also in all activities that can be improved with the specific knowledge of the field" (P19).

"Team capacity, matrix support, decreasing the number of referrals to secondary care." (P22)

"Matrix support with the FHSs for case discussion, permanent education at the FHS." (P37)

The role of the SLT can be performed in all life cycles, from birth to senescence, through collective and individual strategies, thus meeting existing needs, whether individual and/or collective. In addition, these actions are also carried out outside the scope of the Health Center, as reported below:

"With extramural measures in schools, community center, companies." (P8)

A total of 16 (41.02%) participants carried out referrals to the SLT due to the demands and needs presented by the patient, given the wide range of pathologies that focused mainly on issues related to the speech and language of children.

"Learning disorder evaluation, language development, ADHD investigation, stuttering, mutism, investigation of hearing/speech issues." (P2)

"Language, learning and reading/writing issues, communication issues in disabled people and people in the autistic spectrum". (P10)

"Children with learning disabilities/improving swallowing for older people/improving vocal health in teachers'". (P19)

UHS has many demands for professionals in specific fields, as is the case of the SLT. Below, the participants' statements show that the greatest demand is directed to the children's audience with language issues, however, as previously mentioned, other audiences would also benefit from the knowledge of a SLT.

"[...] I can see the need to strengthen the connection with the speech-language therapist to discuss complex cases and draw a therapeutic plan because of many cases, mainly

involving children, learning disabilities, exchange at the language level, among other cases". (P2)

"The most frequent need as I see it is related to patients who suffered from stroke, with deglutition issues and speech […] problems related to children's development and facial paralysis in adults". (P15)

"[…] children with learning disabilities, teacher groups, prevention of vocal health and reduction of body pain, groups of caregivers for older people, essential care for bedridden people. Also in all activities that can be improved with the specific knowledge of the field". (P18)

"Guidelines for post-stroke patients (and follow-up), guidelines for breastfeeding, for learning disabilities, for guidelines and the follow-up of patients with speech and deglutition issues and guidelines for patients with facial paralysis". (P33)

"With professional training, care and guidance of patients with diction problems, hearing problems." (P39)

Actions carried out in the PC with the support of the FHSC professional:

Among several actions carried out in PC that have the support of FHSC professionals, there are: matrix support meetings, shared and specific individual care, shared and specific home care, shared and specific collective activity, and the elaboration of supporting materials, routines, protocols and other measures of permanent education, as reported by the professionals of this study, in the following lines:

"FHS matrix support, individual and collective care, participation in mental health meetings and in the HSP writing groups". (P2)

"Individual care, matrix support, home visits, joint consultation, health promotion/recovery groups, and permanent education." (P3)

"Individual care and interconsultations, home visits, participation in health education groups, school education activities, matrix support actions, permanent education with professionals, and so on." (P6)

"Individual care and group attendance, home visits, teaching residents, matrix support with the FHSs, and contact with the intersectoral network." (P18)

"Drug management, pharmaceutical consultation, auriculotherapy consultation, auriculotherapy groups, matrix support with the teams." (P32)

"Groups to provide guidelines about care, stretching, and injury prevention. Case discussion with the FHS, home visit, individual care for evaluation and/or follow-up". (P33)

"Matrix support with the FHS s and case discussion, interconsultations with the FHS, group participation with the FHS, individual and group care of patients referred to the nutritionist." (P37)

In this study, the most cited actions were matrix support, home visits and group actions, as noted in what was stated by the participating professionals. It should also be noted that the members of the FHSC team, in addition to the services provided at the health unit, can also contribute with actions carried out at the HSP and with family reception:

"FHS matrix support, individual and collective care, participation in mental health meetings and in the HSP writing groups". (P1)

"Welcoming, case discussion (matrix support), home visits, therapeutic groups." (P8)

Health promotion and prevention groups performed in Primary Care

Among all groups, the groups most mentioned by the professionals were: Physical Activity 28.23%; Anti-smoking and Healthy Habits 9.68%; and Diabetics, 8.87%. The least mentioned groups were Physical Therapy and Vaccination.

There was prevalence of professional participation in Physical Education and Nutrition. Among those surveyed, seven reported not participating any group activity. In addition, 82,05% pointed out information regarding the perception of conducting health promotion measures performed in groups. Of the total of 49 mentions about creating groups, 15 were compiled according to the theme presented by the professionals, as shown in Table 2.

Table 2. Description of group activities performed in the Health Centers, Florianópolis, 2017

	N	%
Professionals participating in groups	32	82.05%
Groups	**N**	**%**
Physical Activities	35	28.23%
Anti-smoking	12	9.68%
Healthy Habits	12	9.68%
Diabetes	11	8.87%
Children and Adolescents	10	8.06%
Pregnant Women	10	8.06%
Pain Reduction and Rehabilitation	9	7.25%
Mental Health	6	4.83%
Health Promotion in general	5	4.03%
Health Program at School	4	3.22%
Caregivers	3	2.41%
Community Garden	3	2.41%
Medicalization/Demedicalization	2	1.61%
Physical Therapy	1	0.80%
Vaccination	1	0.80%

As far as intersectoral measures are concerned, it seems not to be a common practice among the professionals of this study, since only two mentioned it as follows:

"Groups of parents and caregivers, psychological support group, HSP listening group, matrix support in mental health (case discussion, interconsultation), intersectoral meetings, meetings between FHSC and categories, individual care articulated with the RAPS". (P34)

"[...] intersectoral meeting, meetings between NFS and categories, individual meetings articulated with the RAPS". (P34)

"Individual care and group attendance, home visits, teaching residents, matrix support with the FHSs, and contact with the intersectoral network." (P18)

DISCUSSION

This study verified the perception of the professionals that constitute the FHSC teams concerning the role of the SLT in PC, finding a prevalence of female professionals (89.75%), with mean age of 31.41 years (SD=15.05), an aspect similar to what is observed in other studies[12,13].

The group composition consists of more women than men. This may be related to professions dealing with care that, according to the literature, in the past, domestic activities and family care (husband and children) were tasks exclusively attributed to the female sex. There is a historical and cultural process that has changed over the years[14].

It is important to point out that the SLT in public health dates from the seventies or eighties, and is thus not very expressive and nor are they as accessible. With the creation of UHS in the 1980s, health is considered a right of every citizen and the organization of the system provides full access to health measures and services. Over the years and throughout the growing discussion on the role of professionals in Primary Care, proposals emerged and today PC operates under the model of FHS, focusing on the territory, its needs and demands, and its inhabitants[15].

Thus, in 2008, a new team was incorporated into the FHS s based on Matrix support, seeking to increase the scope of actions in PC. This way, the FHSC was created, which is organized under the logic of Matrix support, of the creation and maintenance of unique therapy projects in conjunction with FHS s and users, betting on the redirection of the specialized look to the extended clinic[16].

The FHSC constitution is defined according to the needs of the territory and of the health teams and it is up to the municipal managers to establish and distribute the number of professionals that should constitute the teams of each region[16]. The presence of the SLT as part of the FHSC professionals caused an increase in its total number in PC, but still far from ideal for the Brazilian population and unequally distributed between the various regions of the country[17]. This unequal distribution impacts universal access to these professionals and their actions of health promotion and health issues prevention.

As noted in this study, ways of organizing the work of FHSC teams were mentioned, most of them contemplating matrix-related measures, home visits, actions with the HSP, group meetings, and discussion of cases with the other teams. It is worth noting that the formation of the SLT is still focused on individual clinical activity, which can sometimes hinder the performance of this professional in PC. The FHS and FHSC propose an organization of work focusing on the team and on joint action among professionals, favoring the use of soft and soft-hard technologies in clinical practice[15]. It is extremely important to focus on in-service training, such as Multi-Professional Family Health Residency Courses with the experience of day-to-day service, and meetings with various professionals and users[2,6].

As reported above, one of the forms of action of speech-language therapy in FHSC pointed out by the interviewed professionals is participation in matrix support. Matrix support is a form of joint work between distinct teams, including direct contact with the user population of the service provided, which follows the daily life of health practices, and the presence of the team into helping think and organize the most beneficial care projects for each person or group[12].

As such, matrix support is an important tool in the construction of healthcare projects and a way to bring teams together in everyday service[8,19]. For language-speech therapy, It is a powerful mechanism for the language-speech therapist insertion in collective practices, being able to assist in a bigger discussion about their own clinical practice, since as a supporter they should use other forms of work: team discussions, organization of service flows in the service network, among many other tasks besides the individual clinical performance[12].

For such, one of the tools used by FHS and other PC teams is home visits. As previously seen, home visits were mentioned as the second most common activity among the team's professionals, a positive aspect given the visibility of this type of care among the professionals working in the analyzed municipality. Home visit are conducted for those people/families who have issues going to a health unit to receive the necessary healthcare, however, not all professionals carry out this activity in their care routine[2]. It is also a way of being in the territory, of knowing and acknowledging the reality experienced by users in their social environment. This information helps teams propose healthcare projects as well as expand their look, benefiting the extended clinic.

The speech-language therapist is favored by home visits, as it is the moment to know the patient's real living conditions, in addition of establishing relations and family or friendship ties. This information helps in decision-making concerning which therapy to follow and adaptation methods, if necessary. But again the deficiency in the training of these professionals becomes a hindrance, as they may not have had contact with this kind of experience during their training, hindering the expansion of the professional's perception that stretches beyond the biomedical perspective.

The recorded sentences show that at least four of them refer to the role of the SLT in the care of issues related to the literacy period, where they mention that the SLT can act in conjunction with "learning disorders", "ADHD", "reading and writing issues", as well as their presence in the actions of the HSP. It should be noted that the diagnosis and intervention of language issues need to be carried out early since the first years of the child's development are essential for the acquisition of linguistic content[20]. Therefore, the warning signs of such

changes should be observed carefully by all professionals who are involved with the care of the child population[21].

As for the role of the speech-language therapist in language-related aspects, a previous study conducted with PC professionals showed only 53.33% of participants were able to identify possible language issues. This same study found that PC professionals have an interest in deepening the knowledge on the development of language in childhood[20]. These data are extremely important for speech-language therapy, since their presence in PC is justified, either by supporting FHSs in the discussion of cases involving language issues, or by proposing permanent education measures with the same professionals.

These findings show the need to have a SLT working in conjunction with the other professionals who constitute these teams in order to share their knowledge, so that they can contribute to future measures to be taken by the FHSs for health issues prevention and the promotion of human communication[21].

Only two professionals mentioned mental health in this study. Mental health should be one of the issues addressed in the discussions by the professionals of the teams, since it is an essential topic to assist the subject in maintaining social balance, as well as enabling the insertion of such individuals in the community where they live. This is an issue that must be discussed in order to modify the paradigms in the field of health[22] and improve the care provided to people with such needs.

In the FHSC team, the SLT has the ability to act in the context of family and society as well as supporting and participating in the transformation of health care by working together with other staff in the development of therapeutic projects, and contributing to the practice of the clinic and extended clinic, which takes into account individuals and their needs[5,9]. Faced with such possibilities, it would be enriching if, in the municipality analyzed, managers knew/acknowledged the possibility of including the SLT into the teams in favor of healthcare with a resolution-oriented and integrated nature as provided for in the guidelines and foundations of the National Primary Care Policy (NPCP)[3].

This way, the FHSC team can articulate with their knowledge so that they can jointly share practices in health by meeting the demands of the territory[21]. With the exchange of information and experiences of participants in this study, it is possible to develop strategies that offer the population an interdisciplinary quality service involving PC professionals.

The presence of the SLT in PC, as already described, can help in the early detection of language or hearing issues, and in the proposition of collective and intersectoral measures focused on the literacy process; all of these activities taking place in the health unit, in the school, and in the territory in which patients are situated. By focusing on collective and shared measures in PC the SLT increases the access of the population to their actions, and the flow of appointments in secondary care by assisting in the organization of the health system as well as the optimization of human and material resources.

In order for this sharing of knowledge and learning to be accomplished, there must be communication between professionals. Thus, the interdisciplinary follow-up can be seen as a way to promote the dialogue between various kinds of knowledge, performing a mutual and continuous exchange in order to face the challenges encountered[9]. In this study, professionals reported having done this exchange of information and knowledge through meetings and case discussions held by family health professionals.

In addition, it was observed that only two professionals mentioned participation in intersectoral actions. Intersectoral actions should be planned with the aim of integrating the reference teams of each territory[3]. However, these are scarce in the routine of health professionals, following a management model with low integrative, vertical actions, focused on assistentialism, weakening one of the foundations of Primary Health Care (APS), that is, the engagement between the teams and the assigned population. It should be stressed that interdisciplinarity can focus on the implementation of actions to promote health, confront and modify the Social Determinants of Health[23].

In order for the network to be able to meet the high demands that arise, health promotion and health issues prevention can be carried out by focusing on the development of groups. Collective care provides many benefits to the participants, since it results in exchange of information, experience, knowledge, among others[24]. By utilizing groups in certain cases, it is possible to reduce the waiting list and provide welcoming to users who are waiting for assistance with the professional of a particular area/specialty.

The presence of group activities in the health units is recommended as a way to extend access to discussion concerning specific topics, which is often focused on health conditions (hypertension, diabetes, gestation) or specific groups (older adults, children, women). In fact, groups are a powerful tool to provide care, it is a space for sharing knowledge, be it technical or popular, as well as a space for welcoming and the formation of community networks[25,26].

Still concerning integrated activities, speech-language practices can be present in group activities with an enriching service, while allowing for the possibility to exchange knowledge and experiences[24]. Although emphasis is placed on individual performance, as the study by Andrade et al. (2014)[6] demonstrates, as they verified that a large part of the SLT who participated in their research carried out individual and collective services, the interventions performed individually prevailed, considering the specific demands of their field.

Some groups who handle specific themes can count on the presence of the SLT and their technique in a more direct manner, such as the anti-smoking group, in which the participation of the SLT enriches dialogue given the impact of smoking on voice issues, respiratory diseases, heart problems and head and/or neck cancer[27].

The Healthy Habits group involves aspects of care that may contribute to the prevention of comorbidities such as diabetes mellitus, hypertension and cardiovascular diseases[28]. In the literature, showed scarce participation of speech-language science in group activities, especially with regard to healthy habits.

For example, there exist diabetics groups which help in the control of the disease and orientation to the population since this space allows for exchanging information and experiences in a fluid manner between peers[29]. Speech-language science

can act in this clinical practice by helping in the planning of public health strategies that lead to changing the current picture of each patient and, consequently, improving the quality of life of such individuals, in addition to reducing social costs[30].

Other health promotion groups mediated by the SLT can be done, such as the group of pregnant women, by addressing issues on the development of the child as well as breastfeeding; and the group of older adults, by providing them healthy aging caused by the maintenance of their functional capacity[30].

In the literature concerning speech-language science, little is discussed about the process of developing group activities with speech-language therapy while including the participation of other health professionals. It should be noted that group activities focused on quality of life are unusual practices among health teams regarding the participation and contributions of the SLT. It is worth reflecting on the need and possibility of group activities, since this practice contributes to inter-professional activity and to the internal communication between teams in favor of providing the best care to the patient.

As a limitation of this study, during data collection there were certain challenges regarding the schedule of date and time to participate in the meeting of each sanitary district, as they occurred every two months. In addition, some participants took longer than expected to complete the questionnaire, which was a hindrance at times, due to the time extension of the meeting agenda.

The questionnaire constituted of open and closed questions, wherein some open questions were submitted with no answers, others with succinct information and, at times, some were difficult to understand. Lastly, some professionals reported preferring questionnaires containing only closed questions.

CONCLUSION

According to the analyses performed in accordance with the obtained responses, the participants of this study demonstrated a limited perception regarding the role of the SLT, as well as their interdisciplinary and intersectoral contributions involving PC.

The actions contemplated by the professionals participating in this research are directed to those that the SLT professional could contribute, enriching dialogue as well as demands resolution. Given this context, management is required to be acquainted with such scenarios, since the contribution of the SLT can go beyond the (re)habilitating process, including the promotion of health and the strengthening of PC.

In the literature, there are few studies concerning the role of SLT in concurrent actions with other health professionals, such as those in moments linked to the creation of groups and collective actions.

Future studies could demonstrate, for the different professional and management categories, the benefits of the SLT's presence in PC and in the healthcare actions directed to the population, being part of support teams as well as with the PC teams and by extending the access of this professional. This aspect can help in the resignifying of the activities provided by this communication professional, modifying the current stereotyped perspective where the SLT is restricted to rehabilitation which can be mistakenly understood as a profession focused on specialized care.

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Authors' contributions

SBG, AMAB contributed in study conception and design, data analysis, and wrote the initial drafts of this paper. CRS and AMAB reviewed the manuscript and final approval of the version to be published. All authors agree to be responsible for all aspects of this study, ensuring that issues related to the accuracy or integrity of any part of the study are properly investigated and resolved.