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Original Article

Artigo Original

Insertion and performance of Speech-Language Pathology and Audiology in Family Health Support Centers

Inserção e atuação da Fonoaudiologia nos Núcleos de Apoio à Saúde da Família

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Keywords

Public Health
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Job satisfaction

ABSTRACT

Purpose: To analyze the structure of the Centers for Supporting the Family Health (NASF), in 2010, identify the satisfaction degree of speech language pathologists who work in this area and compare the model proposed by the Brazilian Ministry of Health with practice. **Methods:** Prospective and descriptive study, with 40 speech language pathologists inserted in NASF type one, from all Brazilian regions, in 2010. It was used a questionnaire with nine questions related to different topics (work infrastructure, NASF team, actions developed by these professionals and satisfaction about the work), sent by electronic mail to the speech language pathologists. Descriptive statistics, χ^2, ANOVA and Pearson coefficient of variation were used to analyze variables. Significance level of 5% was adopted. **Results:** The speech language pathologists reported that, in their working places (NASF), there was an average of 12.2 Health Family Teams, with 8.9 professionals and 1.6 speech language pathologists. Most of them work 40 hours per week. Routine activities cited by speech language pathologists were: promotion and health prevention actions, matricial, therapies, support to health community workers, referrals, home visits, intersectoral actions and administrative tasks. There was variability in the satisfaction score: the majority of interviewees indicated the degree "Somewhat satisfied" for work infrastructure and referrals, as well as reported "Very satisfied" degree for home visits and support for health community workers. Comparing the model proposed by the Ministry of Health with the speech language pathologists' practices, there was no significant difference. The results show that 40% of speech language pathologists consider that the NASF actions are below the proposed model. **Conclusion:** The NASF structure varied in terms of the number of Family Health Teams, professionals involved and actions performed. There was also significant variability in the satisfaction degree among the subjects studied.

Descritores

Saúde Pública
Fonoaudiologia
Atenção Primária à Saúde
Saúde da Família
Satisfação no emprego

RESUMO

Objetivo: Analisar a estrutura dos Núcleos de Apoio à Saúde da Família (NASF), vigentes em 2010, identificar o grau de satisfação dos fonoaudiólogos que atuam nessa área e comparar o modelo proposto pela portaria 154 do Ministério da Saúde com a prática fonoaudiológica. **Métodos:** Estudo prospectivo e descritivo, com 40 fonoaudiólogos inseridos em NASF tipo um, de todo território nacional, em 2010. Utilizou-se um questionário com nove perguntas que abordavam diferentes temas (infraestrutura de trabalho, equipe do NASF, ações desenvolvidas pelos profissionais do NASF e satisfação com o trabalho desenvolvido), enviado por correio eletrônico para os fonoaudiólogos. Para a análise das variáveis estudadas, foram utilizadas medidas descritivas, os testes do χ^2, ANOVA e o coeficiente de variação de Pearson. Foi adotado o nível de significância de 5%. **Resultados:** Os fonoaudiólogos relataram que nos NASFs em que atuavam havia em média 12,2 Equipes de Saúde da Família, 8,9 profissionais e 1,6 fonoaudiólogos por NASF, sendo a maioria com carga de 40 horas semanais. As atividades de rotina citadas pelos fonoaudiólogos foram: ações de promoção e prevenção de saúde, matriciamento, terapias, suporte aos agentes comunitários, encaminhamentos, visitas domiciliares, ações intersetoriais e atividades administrativas. Houve variabilidade na pontuação do grau de satisfação: a maioria indicou o grau "Pouco satisfeito" para infraestrutura de trabalho e encaminhamentos efetivados e "Muito satisfeito" para visitas domiciliares e suporte aos agentes comunitários de saúde. Comparando o modelo proposto com a prática dos fonoaudiólogos, não houve diferença significativa, mas 40% deles consideraram que as ações do NASF estavam abaixo do esperado. **Conclusão:** A estrutura dos NASFs apresentou-se bastante variada em termos de número de Equipes de Saúde da Família, profissionais envolvidos e ações executadas. Também houve variabilidade significativa no grau de satisfação entre os temas estudados.

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INTRODUCTION

The role of the speech-language pathologist has shown a significant growth in the Unified Health System (SUS), in parallel to the high number of instances of communication disorders reported by people who use health services[1-4]. This scenario is a result of changes that occurred in the concept of health care, reorganization of health services, model of health care, and the training of health professionals[1,4,5].

Regarding primary care, to reorganize and restructure this level of care according to the precepts of SUS, the Brazilian Ministry of Health created the Family Health Program (Programa Saúde da Família), later renamed the Family Health Strategy (Equipes Saúde da Família, ESF)[6,7] in 1994.

Since its inception, ESF has shown significant growth in the country, as evidenced by the number of deployed teams, which grew from 4,428 in January 2000 to 30,440 teams in January 2010, corresponding to a population coverage of 9.2% and 50.82%, respectively[8].

The ESF teams consist of doctors, nurses, nursing assistants or nursing technicians, community health agents (CHAs) and an oral health team[6]. These teams work in Basic Health Units, in homes and in mobilizing the community[9]. However, the addition of other health professionals was necessary to achieve comprehensive care and interdisciplinarity[5,10].

Aimed at complementing the ESF teams (EqSFs), the Family Health Support Center (Núcleo de Apoio à Saúde da Família, NASF) was created in 2008 by Administrative Rule 154 of the Brazilian Ministry of Health. The goal of this program was to expand the breadth and scope of activities of basic care, as well as its resolvability, supporting the introduction of EqSFs in the service network and the process of territorialization and regionalization of primary care[4,11-14]. The NASFs create, along with the EqSFs, spaces for meetings and discussions, to improve the quality of care for the population[1,15]. It is noteworthy that NASFs do not constitute an entrance to the system but a support for EqSF, and they adopt, in some cases, the Matrix management necessary for the team to work in partnership with other ESF professionals[1,16,17].

As a professional introduced in this field, the speech-language pathologist has an important role in maintaining the population's health and quality of life, since communication is closely related to the individual's interaction with the social environment, with learning and with emotional factors[13]. Among the professionals expected to join type 1 NASFs (linked to at least 8 and a maximum of 20 EqSFs) and type 2 NASFs (linked to at least 3 EqSFs) are the speech-language pathologists[13,18]. It is noteworthy that the Administrative Rule No. 3124 (2012) changed the number of EqSFs to which NASFs are linked and created a new type of NASF (type 3)[19].

In Brazil, the number of type 2 NASFs grew from 22 to 345 and that of type 1 NASFs grew from 245 to 1,512 during 2008–2012. In 2012, a total of 841 speech-language pathologists composed the NASF teams nationwide, with 48.1% consisting of type 1 NASF and 28.1% consisting of type 2 NASF[20].

NASF's speech-language pathologist works primarily on rehabilitation, mental health and child health activities[21,22]. This professional is a generalist and able to adopt prevention solutions to health, besides working on the paradigm of collective actions, to engage social actors involved in the pursuit of change and solving problems encountered[23].

Given the important role of the speech-language pathologist in primary care, and the complexity of the organization of the health system and the rapid growth in the number of NASFs in the national territory, it is necessary to understand and analyze the structure and quality of services offered from the perspective of speech-language pathologists.

This study aimed to analyze the structure of NASFs (in 2010), to identify the degree of satisfaction of speech-language pathologists working in this area and to compare the model proposed by Administrative Rule 154 of the Brazilian Ministry of Health with the Speech-Language Pathology and Audiology practice.

METHODS

The project was approved by the ethics committee of the School of Medicine of *Universidade de São Paulo* (FMUSP) (no. 238/10). The procedures were started after participants signed the free and informed consent form.

This is a prospective, descriptive study with 40 speech-language pathologists working in different regions of the country and representing five regions where type 1 NASF were included. The objective of the study was not to establish a profile for each region of the country but to characterize the whole country.

A questionnaire, consisting of nine questions (both open and close ended), developed for this study was used as an instrument to collect data. The questions included topics such as work structure and level of satisfaction with regard to several items (Appendix 1). Question 8 (items A–E) used a crescent scale (0–10) to measure the level of satisfaction with 0–3 corresponding to "Dissatisfied," 4–6 corresponding to "Somewhat satisfied," 7–9 corresponding to "Satisfied" and 9–10 corresponding to "Very satisfied."

The questionnaire was sent via email directly to speech-language pathologists registered on the Web site Telessaúde – Brazil Redes (www.telessaudebrasil.org.br); a national action that seeks to improve the quality of health care and primary care in the public health system, integrating teaching and services through information technology tools that provide conditions to promote telecare and tele-education). Along with the questionnaire, a free and informed consent form and an explanation of each question (goals and ways to respond) were sent. Of the 70 questionnaires sent, 40 speech-language pathologists responded and returned them to the researcher.

The variables considered for the analysis were number of EqSFs; number of professionals working in each NASF; activities performed by speech-language pathologists; workload of speech-language pathologists; satisfaction of speech-language pathologists regarding work infrastructure, referrals carried out, home visits, joint actions with community agents and the

ESF; model established on the creation of NASF; and effectiveness of NASF to date.

For the last two items of Question 8 (model established at the creation of NASF and the effectiveness of NASF to date), the marks obtained for each were compared with the model proposed by Administrative Rule 154 of the Brazilian Ministry of Health and categorized as above, equal or lower than expected.

For the analysis of variables studied, descriptive measures, as well as χ^2 test, analysis of variance and Pearson's coefficient of variation, were used. For all analyses, the significance level used was 5%.

RESULTS

Structure of Family Health Support Centers

There were on average 12.2 EqSFs per NASF (a minimum of 5 and a maximum of 22 teams, SD=5.11). One respondent was unable to report the number of EqSFs.

On average, there were 8.9 (SD=3.77) professionals working in each NASF. Of the 355 professionals comprising all NASFs, 17.7% were speech-language pathologists and 73.3% were from other professional categories (acupuncturist, social worker, physical educator, pharmacist, physical therapist, gynecologist/obstetrician, homeopath, nutritionist, pediatrician, psychologist, psychiatrist, occupational therapist, geriatrician, internist and sanitarian). The average number of speech-language pathologists per NASF was 1.6 (SD=1.26).

Among the activities mentioned by the professionals were health promotion and protection measures, Matrix management, therapies, training of community agents, referrals, home visits, intersectoral actions and administrative activities.

Regarding the workload of interviewees, 87.5% reported working 40 hours a week and only 12.5% had a workload of less than 40 hours a week.

Level of satisfaction

Regarding the score per question and the total score obtained for the questionnaire (Table 1), it is noteworthy that the averages were approximately 5–6 points for all questions. It is also observed that the score range was high, as can be verified by Pearson's coefficient of variation, for both the questions individually and for the total score for all questions.

The distribution of responses within the categories "Dissatisfied" "Somewhat satisfied" "Satisfied" and "Very Satisfied" differed significantly between the seven variables analyzed ($p<0.001$; Table 2), which again shows the variation of scores obtained for the questionnaire. For example, most of the answers for infrastructure and referrals are in the "Somewhat satisfied" category, whereas answers to home visits and support to CHAs are in the "Very satisfied" category.

Comparison between model proposed for the Family Health Support Center and the performance of participants speech-language pathologists

Most professionals (40%) consider that the actions of NASF are "below" expectancy in relation to the previously proposed model. However, the occurrences in each category show no significant difference (p=0.356; Table 3).

Table 1. Distribution of grades reported by speech-language pathologists on the topics studied

Themes	Work infrastructure	Referrals	Joint actions with ESF	Home visits	Support to CHAs	Proposed the model established on the creation of NASF	NASF's effectiveness	Questionnaire total
Average	5.38	5.18	5.70	6.65	6.40	6.78	6.63	42.7
SD	2.39	2.30	2.92	3.05	3.14	2.64	2.51	18.94
VC (%)	44.53	44.39	51.22	45.88	49.00	38.91	37.86	44.36
Minimum	1	1	0	0	0	0	0	6
Maximum	10	9	10	10	10	10	10	65

Caption: ESF = Family Health Strategy; CHAs = community health agents; NASF = Family Health Support Center; SD = standard deviation; VC = Pearson's coefficient of variation

Table 2. Level of satisfaction attributed by speech-language pathologists on the issues analyzed

Level of satisfaction / Themes	Dissatisfied n (%)	Somewhat satisfied n (%)	Satisfied n (%)	Very satisfied n (%)
Work infrastructure	8 (20)	**18 (45)**	9 (22.5)	5 (12.5)
Referrals carried out	7 (17.5)	**21 (52.5)**	9 (22.5)	3 (7.5)
Joint actions with ESF	10 (25)	**11 (27.5)**	**11 (27.5)**	8 (20)
Home visits	9 (22.5)	4 (10)	13 (32.5)	**14 (35)**
Support to CHAs	8 (20)	7 (17.5)	12 (30)	**13 (32.5)**
Proposed model established on the creation of NASF	5 (12.5)	8 (20)	**18 (45)**	9 (22.5)
NASF's effectiveness	5 (12.5)	7 (17.5)	**21 (52.5)**	7 (17.5)

χ^2 test: $p<0.001$; numbers highlighted represent higher values of frequency of occurrence and percentage of each theme

Caption: ESF = Family Health Strategy; CHAs, community health agents; NASF, Family Health Support Center

Table 3. Comparison between the model of action proposed by the Family Health Support Center and the opinion of speech-language pathologists

Categories	Above	Equal	Below
Occurrences (n)	10	14	16
Average	0.25	0.35	0.40
Standard deviation	0.43	0.48	0.49
p-Value*	0.356		

*ANOVA test

DISCUSSION

The aim of this study was to analyze the structure of NASFs in 2010, to identify the degree of satisfaction of speech-language pathologists working in this area and to compare the model proposed by Administrative Rule 154 of the Brazilian Ministry of Health with the Speech-Language Pathology and Audiology practice. Such information can assist in identifying strengths and changes needed for the expansion and consolidation of this health-care model, which can positively impact the health of the population.

Regarding the number of EqSF per NASF, there was an average of 12.2 teams, with a minimum of 5 and a maximum of 22 teams. This is in accordance with the provisions of Administrative Rule 154[18]. However, the minimum and maximum values observed indicate heterogeneity in the NASFs investigated in this study, which may reflect the difference between the population size of the municipalities, as well as bureaucratic barriers to the deployment of these centers[24].

It is noteworthy that, for municipalities in the North region, with less than 100,000 inhabitants, a minimum five teams are recommended by NASF[18], which may explain the minimum number of teams considered in the present study. However, the maximum number (22) of teams shows the need for expansion of NASFs, because some are working above the capacity prescribed by the Administrative Rule, which may compromise the quality of health care for the population of the area covered by that NASF.

The Administrative Rule 3124[19], which reduces the number of EqSFs for adhesion to NASF and creates another form of NASF nationwide, may contribute to the further expansion of NASFs in the coming years, as well as resolve the issue of the number of EqSFs above the proposed limit.

As for the total number of professionals working in each NASF, there was an average of 8.9 professionals. The Administrative Rule 154[18] describes that each type 1 NASF must be composed of at least five professionals among the following categories: acupuncturist, social worker, physical education teacher, pharmacist, physical therapist, speech-language pathologist, gynecologist, homeopath, nutritionist, pediatrician, psychologist, psychiatrist and occupational therapist. In this study, it appears that NASF teams relied on at least 5 professionals and a maximum of 12, which is in accordance with the Administrative Rule.

Defining the professionals who will make up the NASF teams is the responsibility of municipal managers and should follow local priorities in relation to the health needs of the population in that region. Within this logic and taking interdisciplinarity, intersectionality, popular education, territory, completeness, social control, ongoing health education, health promotion and humanization as responsibilities, NASF seeks to overcome the fragmented logic of health for building health and care networks, sharing that responsibility with the ESF[25].

Moreover, it appears that, among the professionals that make up the NASF teams, 73.3% belonged to another professional category and 17.7% were speech-language pathologists, and the average number of this professional per NASF was 1.6. According to data from the Department of Health Care of the Brazilian Ministry of Health[20], of all the professionals that comprise NASF types 1 and 2, approximately 7.5% are speech-language pathologists, a percentage that is below the one observed in the present study. Other data from the Brazilian Ministry of Health refer to the number of professional in NASFs types 1 and 2; it was reported that speech-language pathologists appear as the sixth professional category most present in these NASFs (48.1 and 28.1%, respectively), demonstrating the importance of this professional from the perspective of primary care. One can also infer that the possibility of expansion of Speech-Language Pathology and Audiology practice in NASFs is real and urgent, because other professional categories, such as psychologists or therapists, have a stake of approximately 87% in NASFs nationwide[19]. It is noteworthy that the survey was conducted with speech-language pathologists, and therefore, all NASFs surveyed had these professionals in the team. New studies, in which having a speech-language pathologist on the staff is not an inclusion criterion, are recommended.

Regarding the workload of interviewees, 87.5% reported working 40 hours a week and only 12.5% had a workload of less than 40 hours a week. This finding contradicts what was proposed in Administrative Rule 154[18], which was the law in force at the time of data collection. According to this Administrative Rule, the workload of NASF professionals must be at least 40 hours per week, with the exception of doctors, physical therapists and occupational therapists, for which there may be the replacement of one professional working 40 hours by two professionals working 20 hours.

With Administrative Rule 3124[19], the issue of workload of NASF professionals has also changed. Currently, for NASF type 1, the sum of the workloads of all professionals should be 200 hours per week, at least, and, for each occupation, it should be at least 20 hours and a maximum of 80 hours.

It is important to consider that both the question of having more than one speech-language pathologist per NASF and the question of the workload less than 40 hours may be related to the time between the issuance of Administrative Rule 154[18] and the collection of data for this study. Because data were collected approximately 2 years after the release of said Administrative Rule, it can be hypothesized that some of the participating NASFs were still making adjustments in their structure and functioning. In addition, one should consider that the composition of each NASF is "defined by municipal managers, according to priority criteria identified from

the local needs and availability of professionals from each of the different occupations" (Administrative Rule 154)[18]. Thus, requirement for including more than one speech-language pathologist per NASF would be defined by the managers themselves, which arises from the health needs of the local population or the unavailability of professionals from other professional categories.

On the other hand, the Administrative Rule itself establishes that the transfer of federal funds to NASF may be suspended in case any of the following is verified: the absence of any one of the professional or staff for a period greater than ninety (90) days, with the exception of periods in which hiring of professionals is prevented by specific legislation, or incompliance with the minimum workload required for NASFs professionals, among others.

Thus, based on the data collected, it is impossible to determine the specific reason for the differences observed. It is crucial that the NASFs are suited to comply with standards required, aiming to a proper functioning and ensuring quality health initiatives for people and the community.

Level of satisfaction

Regarding the questionnaire score, the averages for all questions were about 5–6 points, which indicates that for all variables NASF's speech-language pathologists are "Somewhat satisfied." It should be emphasized that the score range was high both for individual questions and for the total score for all questions. This response regarding satisfaction can be explained by the heterogeneity of NASFs involved, with regard to both the health needs of the population to which NASFs are bound and the infrastructure of the locations in which they work.

The responses within the categories "Dissatisfied" "Somewhat satisfied" "Satisfied" and "Very Satisfied" differed significantly between the seven variables analyzed ($p<0.001$), which again shows the variation in the scores. For example, most of the answers for infrastructure and referrals are in the "Somewhat satisfied" category, whereas those for home visits and support to CHAs belong to the "Very satisfied" category.

It is observed that the variable guidance/support to CHAs showed positive results, because most of the speech-language pathologists reported "Very satisfied" Working with CHAs provides a better understanding of the community, as well as of the role of these health professionals as intermediaries to the needs of the local population[26]. Some speech-language pathologists who reported to be "Somewhat satisfied" and "Unsatisfied" described the lack of time for guidance/support to CHAs due to the overwhelming demand of other issues to be met.

The variables classified by most as "Somewhat satisfied" are the activities with EqSFs, referrals carried out and work infrastructure.

Activities with EqSFs are a challenge to be faced, which can promote great improvements in relation to the extended concept of health by SUS. The structuring of the process of working together with EqSFs provides technical support for expanding the resolvability of actions in primary care, ensuring the reordering of health work as well as interdisciplinarity in practice and knowledge[4]. Thus, the dissatisfaction of speech-language pathologists with respect to this variable can be linked to difficulties some professionals have accepting the proposals and guidelines of NASF, and also as a reflection of receiving training (graduate education) that did not emphasize these new concepts[13].

Regarding infrastructure, the speech-language pathologists highlighted the lack of materials and lack of a place for team meetings, which ends up hindering the work and shows the lack of preparation in relation to this parameter when opening the centers.

About referrals carried out, it is noteworthy that the NASF should act to reduce unnecessary referrals to other services, consequently reducing queues[27]. However, this becomes possible only after working effectively with EqSF, and this process takes time. Matrix support, the expanded clinic and the singular therapeutic project integrated and articulated between EqSFs and NASFs will assist in reduction of unnecessary referrals, as well as the increased resolvability[28], which in turn will bring greater satisfaction to both users and health workers involved.

Regarding home visits, many speech-language pathologists reported that users requested specialized service, often missing the point of what was proposed by NASF. Home visits should be part of the centers' routines, as they allow more effective actions, focusing on health promotion and prevention of comorbidities[29]. Thus, the transformation of the Speech-Language Pathology and Audiology practice by overcoming the biomedical paradigm, centered on individual and fragmented actions, contributes to a more comprehensive form of interdisciplinary and collective care method[4].

Comparison between model proposed for the Family Health Support Center and the performance of participants speech-language pathologists

Regarding the proposal of the model established at the creation of NASF and its effectiveness, it was observed that the majority of interviewees considered it as "below" the expected level. The NASF is going through an adjustment period, which indicates a new learning opportunity for all actors that compose it. The project is still new, but the efforts of these professionals to achieve the proposed objectives, although sometimes the reality is not favorable to the established model, are remarkable[13].

Speech-Language pathology and audiology practice is gaining strength in primary care, and the result is the improvement of living conditions of the population, taking into account that there is still a difficulty of access to this specialty in the public network. The NASFs are not, in all respects, working in accordance with what was proposed by the ministerial Administrative Act; however, this is a relatively new project that is under adequacy by both professionals and municipal managers.

The ongoing research addressing this subject is essential for monitoring the performance of Speech-Language pathology and audiology practice in the NASFs. Thus, it is suggested that further studies be conducted with more objective protocols, to characterize other specifics related to work within the NASF.

CONCLUSION

The number of EqSFs and working professionals is in accordance with the provisions of Administrative Rule 154; however, the results indicated heterogeneity. There was a significant difference in the degree of satisfaction of speech-language pathologists, showing variability between subjects analyzed, that is, interviewees were not very satisfied with the infrastructure and the process of referral and counter-referral, and very satisfied with home visits and support to CHAs.

The majority of interviewees considered that the actions of NASF were below the expectancy in relation to that established by Administrative Rule 154; however, there was no significant difference between the response categories.

The new experiences in the performance of speech-language pathologists in NASF point to a path of progress with regard to the concept of health proposed by SUS, aimed at comprehensiveness, universality and equity. Some difficulties regarding work situation and composition of NASFs according to these professionals' performance in primary care remain to be faced in this journey.

Ongoing research addressing this subject is essential for monitoring the evolution of Speech-Language pathology and audiology practice in NASFs.

**DRMA elaborated the research project; participated in the collection, analysis and interpretation of data and in writing of the article; MSA collected and tabulated data; participated in the analysis and interpretation of data; MIVC participated in the analysis and interpretation of data; assisted in writing the article; AGS participated in the data analysis and writing of the article.*

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Appendix 1. Questionnaire applied to speech-language therapists included in the Family Health Support Center

Department of Physical Therapy, Speech-Language Pathology and Audiology and Occupational Therapy, School of Medicine, University of São Paulo

Name or no. in NASF:_____
Geographic Area of Work: _____
Estimated Population: _____

1. How many speech-language pathologists there are in the NASF you work?
_____

2. The NASF in which you work is linked to how many ESFs?
_____

3. Are there vacant speech-language pathologist positions?
( ) Yes ( ) No ( ) I don't know

4. How many hours do you work per week?
( ) less than 40 hours ( ) 40 hours ( ) over 40 hours

5. Among the professionals below, which and how many you work with?
( ) _____ Physical Education Professional
( ) _____ Nutritionist
( ) _____ Physical Therapist
( ) _____ Social Worker
( ) _____ Psychologist
( ) _____ Psychiatrist
( ) _____ Occupational Therapist
( ) _____ Gynecologist/Obstetrician
( ) _____ Pediatrician
( ) _____ Acupuncturist
( ) _____ Homeopath
( ) _____ Pharmacist
( ) Other. Please specify._____
( ) I don't know.

6. How is your work into the NASF divided?
_____

7. Do you perform therapies in NASF?
_____

8. Please rate, on scale of 0 to 10, your opinion on the following questions:
A – Infrastructure in which you work: _____
Please specify reason: _____
B – Issuance and completion of referrals:
Please specify reason: _____
C – Development of joint activities with ESF:
Please specify reason: _____
D – Conducting home visits for guidance, adaptations and monitoring:
Please specify reason: _____
E – Training, guidance and support to Community Health Agents:
Please specify reason: _____
F – Proposed model established on the creation of NASF:
Please specify reason: _____
G – Effectiveness of NASF in which you work, to date:
Please specify reason: _____

9. What are your thoughts on the insertion and action of Speech-Language Pathology and Audiology in NASF?
_____
_____