Speech, language and hearing sciences and the family health strategy: implication of structural dimension in the quality of speech, language and hearing care

Fonoaudiologia e estratégia de saúde da família: implicação da dimensão estrutural na qualidade da atenção à saúde fonoaudiológica

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ABSTRACT

Purpose: Assess the perception of quality related to the structural aspect of the of Speech, Language and Hearing Sciences residents in the Family Health Strategy in the urban area of Sobral, Ceará. **Methods:** The social actors in the study were the speech, language and hearing pathologists that worked as residents in the Family Health Strategy in the city of Sobral through the Family Health Training School Visconde Sabóia, who accepted to participate in the study by means of a Informed Consent Term. Information was collected during the year of 2013, from interviews. Data were analyzed by Content Analysis according to Bardin. **Results:** The structure assessment identified negative points such as shortage of materials, a limited number of speech, language and hearing pathologists working together with the communities and a lack of trained professionals to work at this level of health care. As a positive point, the training of professionals through the Multi-professional Residency in Family Health at the Family Health Training School Visconde de Sabóia was highlighted. **Conclusion:** Finally, despite the inherent limitations to an assessment of quality, the social actors in the study recognized more difficulties than potentialities in the work of the speech, language and hearing pathologists indicating deficiency in the quality of speech, language and hearing health care.

Keywords: Speech, Language and Hearing Sciences; Family health strategy; Quality management; Structure of services; Quality assurance, Health care

RESUMO

Objetivo: Avaliar a percepção da qualidade relacionada ao aspecto estrutural dos residentes de Fonoaudiologia na Estratégia de Saúde da Família, na zona urbana de Sobral (CE). **Métodos:** Os atores sociais da pesquisa foram os fonoaudiólogos que atuaram como residentes de Fonoaudiologia na Estratégia de Saúde da Família da cidade de Sobral. As informações foram coletadas durante o ano de 2013, a partir de entrevistas. Os dados foram analisados por meio da técnica Análise de Conteúdo de Bardin. **Resultados:** A avaliação da estrutura evidenciou, como pontos negativos, a falta de materiais, o número restrito de fonoaudiólogos em atividade junto às comunidades e a falta de profissionais capacitados para atuar nesse nível da atenção à saúde. Como ponto positivo, destacou-se a capacitação dos profissionais em Residência Multiprofissional em Saúde da Família, da Escola de Formação em Saúde da Família Visconde de Saboia. **Conclusão:** Apesar das limitações inerentes a uma avaliação da qualidade, os atores sociais da pesquisa reconheceram mais dificuldades do que potencialidades no trabalho do fonoaudiólogo, indicando deficiência na qualidade da assistência à saúde fonoaudiológica.

Descritores: Fonoaudiologia; Estratégia Saúde da Família; Gestão da qualidade; Estrutura dos serviços; Garantia da qualidade dos cuidados de saúde

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Conflict of interests: No
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Received on: 2/22/2015; **Accepted on:** 9/2/2015

INTRODUCTION

With the implementation of the Family Health Program (FHP) in 1994 and its consolidation as a Family Health Strategy (FHS), it was possible to broaden universal access to health, creating the need for changes, and establishing a new health care model, based on the principles of the Brazilian Health System (*Sistema Único de Saúde* - SUS)[1].

Considering the importance of the theme, the Regional Speech, Language and Hearing Sciences Council, with support from the Public Health Committee at the Brazilian Society of Speech, Language and Hearing Sciences, held, in 2002, a forum with the objective of elaborating a document, in participative manner, which defined a "Proposal for the Inclusion of Speech, Language and Hearing Sciences in the Family Health Strategy"[2].

Together with the multidisciplinary team, the speech, language and hearing pathologist went on to conduct situational and institutional diagnosis, reception, home visits, inter- or transdisciplinary attendance at the nucleus (individually and/or in groups), health education inside the building (in waiting rooms) and/or around the health center (groups for physical activity, health care and interaction, mental health, art [singing, dancing, theater, craft], among others), matrix-based strategies and activities that involve the organization of services, participation in health campaigns, co-participation in the permanent education of teams, conducting and publishing research. In fact, the Speech, Language and Hearing Pathologist is able to execute many actions in the Primary Health Care context[3].

Given the relevance of the actions mentioned above, it is necessary to guarantee that they are being effectively conducted and that there is standardization for the work of the speech, language and hearing pathologist in primary health care, either through the Multi-professional Residence in Family Health (MRFH) or the Family Health Support Nuclei (FHSN). As a member of FHSN, the speech, language and hearing pathologist takes on a new role, in which they conduct practice developed as much in the perspective of the nucleus as in the field, but unfortunately assessment surveys point to work still strongly centered on the professional nucleus[4].

Conducting assessment surveys in the context of primary health care could be of great contribution, as they provide information that assists in the identification of possible problems, in order to guarantee the development of an intervention according to recommendations[5]. Moreover, the theoretical and practical approach of this theme, by means of health assessment, represents the possibility of enriching speech, language and hearing sciences literature, since there are few publications that deal with this theme[6].

In the field of health assessment, structure is one of the components highlighted by Donabedian[7]. His approach is based on the systemic model where the structure corresponds to that which is relatively stable in the system (resources, or financial and human inputs, and the materials used). The structure is denominated as capacity, corresponding to that which propitiates the provision of services. Among these are the analysis of staff, considering the education and training of all those involved in the provision of services and the analysis of installations and equipment, including the building and physical components. The process refers to a range of activities and procedures employed in the management of resources, and the results to the changes identified, either related to an effect in the state of health of the individuals, or alterations in behavior, knowledge or satisfaction of service users[8].

The quality of a health service implies in the incidence of various specific circumstances and it cannot be determined by a single factor. Inasmuch as the assessment of quality implies emitting a judgement of value, there is a need for us to analysis its different components.

In the literature on the quality of health theme, it is considered as a complex value that involves several factors, and it ratifies that a good structure does not determine a standard of quality, however good structural conditions provide a greater chance of resulting in an adequate process of care and in a favorable result faced with precarious conditions[9]. In order to achieve results of quality, we should consider that improvement in health care occurs at the process or structure level, since the effects are always the consequence of something, and to reach them we need to identify fundamental corrective actions in services and sanitary practices[9].

An assessment study on the work of the Speech, Language and Hearing Sciences in FHSN in a city in the State of Pernambuco indicated that the speech, language and hearing pathologist performs his/her role in a coherent manner in FHSN, despite the fact that their performance is based on the work process, alerting for the need to intervene in questions related to structure in order to improve the development of actions conducted in this context[3].

In this manner, this study had as objective to assess the perception of speech, language and hearing sciences residents in the quality of the structural dimension of assistance offered in the Family Health Strategy in the urban zone of Sobral, Ceará.

METHODS

This is a qualitative, assessment type study, with 12 speech, language and hearing pathologists that work in FHS as residents in the Multi-professional Residency in Family Health at the Family Health Training School 'Visconde Sabóia' (FHTSVS) in the municipality of Sobral, Ceará. In this municipality, the category is not part of the multi-professional team at FHSN, in this manner, the speech, language and hearing care offered in primary health care is that provided by residents in the Speech, Language and Hearing Sciences category at MRFH.

This study is substantiated by the assessment framework proposed by Avedis Donabedian which presents a proposal for

health evaluation[8]. For this study only the structural dimension was assessed.

The invitation to participate of speech, language and hearing pathologists were made at the Family Health Center itself, during working hours, or at EFSFVS. All who agreed to participate signed the Informed Consent Term. Data collection occurred during the period from June to December 2013.

According to the qualitative nature of the study, semi-structured interviews were conducted, recorded and stored on an iPod® or iPhone®, and subsequently transcribed by the main researcher. This interview investigated data on physical structure, human resources, education and training of speech, language and hearing pathologists, as well as the material available for the work of the category in FHS, with the guiding questions: a) What structure is necessary for the performance of the speech, language and hearing pathologist in FHS? b) What are the facilitating and limiting factors for the work of the speech, language and hearing pathologists with the structure offered?

In order to ensure anonymity, the interviewees were identified by the letter 'F' (speech, language and hearing pathologist) and the number of the interview. For instance, the first speech, language and hearing pathologist interviewed was identified as 'F1', the second as 'F2' and so on.

For speech assessment, content analysis according to Bardin[10] was used, opting for thematic or categorical analysis, defined as a set of techniques for the analysis of communication using systematic and objective procedures of message-content description in three stages: 1) Pre-analysis; 2) Exploration of the material; 3)- Treatment of results, inference and interpretation.

In this study, the corpus was comprised of 12 interviews, with the phrase being defined as the recording unit, and the paragraph as the context unit. This, in turn, serves as a comprehension unit to codify the recording unit and corresponds to the segment of the message, the dimensions of which (greater than those of the recording unit) are excellent for understanding the exact meaning of the recording unit.

Subsequently, we performed enumeration by means of simple quantification (frequency) and then classification and aggregation (selection of categories). Bardin[10] defines categories as the classes that connect a group of elements under a generic title. Therefore, categories are headings or classes that bring together a group of elements (recording units) on the account of common characteristics. In this study, activity of grouping common elements, establishing categories, we followed two stages: *inventory,* in which we isolated the common elements, and *classification,* in which we distributed the elements establishing certain organization to the message. Finally, we proceeded to the treatment of results and data interpretation.

The results of the analysis were presented in categories and subcategories. Moreover, we described the Recording Units (phrases) that expressed the views of the interviewees.

Below, an organization chart is presented representing the constitution of the corpus of this study (Figure 1).

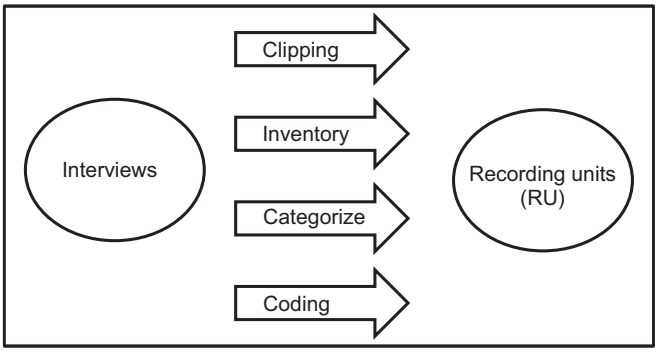

Figure 1. Composition of the corpus study

The study was authorized and approved by the Municipal Secretary of Health and Social Action in Sobral, Ceará, by means of the Nucleus of Studies and Surveys in Health (NSSH), also being approved by the Ethics Committee of *Universidade Estadual Vale do Acaraú* (UVA), and registered under number 90.938.

RESULTS

The resulting dialogues from the open questions in the semi-structured interviews with the speech, language and hearing pathologists concern their work in FHS, in which the following thematic class was identified: management structure for the work of the speech, language and hearing pathologists in FHS with two categories and five subcategories (Chart 1).

The Recording Units (phrases) that expressed the perceptions of the interviewees concerning the categories and subcategories are presented in Chart 2.

Chart 1. Distribution of thematic classes, thematic categories and subcategories, and respective frequencies in the recording units

Thematic classes	Categories (coding)	RU	Subcategories (coding)	RU
Management structure for the work of the speech, language and hearing pathologist in FHS (80 RU)	1. Unfavorable structural conditions	71 (24.4%))	1.1 Unavailability of physical resources	34 (1,6%)
			1.2. Shortage of materials	21 (7.21%)
			1.3. Lack of professionals with training for work in FHS	9 (3.09%)
			1. 4. Lack of human resources	7 (2.4%)
	2. Favorable structural conditions	9 (3.1%)	2.1. Availability of training – multi-professional residency in family health	9 (3.1%)

Note: RU = Recording unit; FHS = Family Health Strategy

Chart 2. Distribution of the recording units (phrases) that express the perception of the interviewees with regards to the categories and subcategories

1. Category – unfavorable structural conditions	
1.1. Subcategory Unavailability of physical resources	*"Generally the centers are very small, they do not accommodate the quantity of professionals." (F10)* *"How many times have I provided assistance under a tree, on the porch of a house, in front of the health center, because there was a real lack of space…" (F11)* *"... so in the centers today we have various professionals, but a very small structure… we need the basics to provide assistance with respect and dignity…" (F8)* *"The ideal structure doesn't exist, everything is lacking." (F5)* *"Since Sobral grew in relation to the Family Health Support Nucleus (FHSN) and the residencies, we ended up without any physical space." (F10)* *"But the structure that I think is necessary, would be a structure where we had larger spaces to hold our groups ..." (F11)*
1.2. Subcategory Shortage of materials	*"I'll take the material for the childcare and prenatal group." (F6)* *"We end up paying for the material." (F1)* *"... I believe that we need equipment that primary health care does not provide." (F7)* *"... the shortage of materials hinders cases that could be better managed and we could avoid referrals to other levels of care." (F12)* *"You don't have any paper, a poster, nothing." (F2)* *"I don't have any materials, then they complain saying there is a series of referrals. Yes, but I have to refer since I don't have a structure where I can work." (F1)* *"Maybe there are things they may even be favorable and for a good prognosis, we can solve everything at the center, but I don't have this material." (F8)* *"... sometimes you have to pay out of your own pocket to bring a toy," (F1)*
1.3. Subcategory Lack of professionals with training for work in FHS	*"The training that we had, academic training that was generally in the clinical perspective. In primary health care we don't work in this perspective." (F6)* *"... it was difficult to insert the speech, language and hearing pathologists in the programs that already exist within the Family Health Program." (F1)* *"... at the time I graduated, we didn't have classes on Family Health, this class was not in the curriculum framework." (F4)* *"I believe that in the university, approach is still very clinical compared to that of the speech, language and hearing pathologist in Primary Health Care." (F6)* *"It is very difficult to work with popular participation since we didn't have this at our faculty and we were not prepared for this approach..." (F9)* *"... because what I knew was that collective health was very theoretical, less practical." (F6)* *"We didn't see this at faculty." (F10)*
1.4. Subcategory Lack of human resources	*"… so I had to take care of three, four health centers…" (F12)* *"... those who take care of two Primary Health Care Centers, end up not taking care of none." (F7)* *"we need more speech, language and health pathologists in the Primary Health Care Centers" (F1)* *"We are unable to give continuity to our work, through the lack of professionals in this category." (F11)* *"... so I had to take care of four health centers, and sometimes, I'd go just once or twice a week to a center … this hampered integration with the multi-disciplinary team." (F12)*
2. Category – Favorable structural conditions	
2.1. Subcategory Availability of training – multi-professional residency in family health	*"... I came to do my residency. I feel like a professional in the Family Health Strategy ... this is what the Unified Health System is." (F8)* *"I understand that the residencies in family health have evolved a lot ... I think that today the resident has better working conditions, he is much better assisted." (F10)* *"... with this wider viewpoint, in 6 months of residency, I have stopped clinical assistance because I saw that this was not the path, right." (F9)* *"When I arrived in the residency, it was what I tried to do, that thing restricted to the speech, language and hearing pathologist in an isolated manner. With time, I saw that this was not our role, ours is the role of the health promoter." (F9)* *"... I came from a reality that I was used to in secondary and tertiary care. Then, when I came to primary, it made a difference." (F1)* *You, in a certain manner, open your horizons with the residency." (F1)* *"Residency promotes a different approach, other knowledge, other practices." (F9)*

Note: FHS = Family Health Strategy

DISCUSSION

With the subcategory "Unavailability of physical resources", it was possible to observe that most health centers were not physically apt to receive new professional categories, resulting in a failure in the organization of services. The structural challenges faced by the speech, language and hearing pathologists in Primary Health Care, impel them to take considerably more action at a curative level, enhanced by the offer of individualized assistance, favoring the hegemony of the biomedical model, restricting care to isolated practices of health care[4]. In contrast, the lack of space in the Primary Health Care Centers (PHCC) for group activities or meetings, may hinder collective activities with the community, the articulation of assessment practices, and planning among professionals at the unit[10]. The frequent use of buildings with residential characteristics for the installation of the PHCC, without adequate adaption, is an factor that highlights the fact that little value is given to the structural aspects in the PHCC[11].

In addition to restricted physical space, the lack of suitable materials for the development of the work was highlighted, which can result in low resolubility of this subcategory at this level of attention, as the speech, language and hearing pathologist ends up referring patients to secondary health care. This increase in the number of referrals creates excessive demand for the other levels of care, affecting the functioning of the Primary Health Care Network in the municipality. Lack of adequate equipment influences in the quality of care for users, because it may hinder the execution of health promotion and protection activities, compromising the continuity of care[9]. Other studies have also emphasized the dissatisfaction of speech, language and hearing pathologists who work in FHSN, with regards to infrastructure, in which they highlight the insufficiency of materials and the lack of a place for team meetings, which in turn ends up impairing their work and showing the lack of preparation in relation to this parameter in implementing FHSNs[12].

The literature has demonstrated that this lack of material does not occur exclusively in the Speech, Language and Hearing Sciences category. A study on work in FHS found that the workers continuously cope with the insufficiency of materials considered basic for the performance of activities such as inputs, instruments, equipment and physical space, which may result in perceptible wearing and increased insecurity among workers and the population regarding the services provided[13].

Another flaw observed in the structural aspect was the lack of professionals with training for work in FHS, since the curriculum frameworks in graduate level courses only slightly address this issue, and do not adequately train the student to develop a befitting profile for work in primary health care.

The National Education Council, by means of National Curriculum Guidelines in the Speech, Language and Hearing Sciences area, characterizes the speech, language and hearing pathologist as a professional of generalist nature, with solid humanist, ethical-philosophical and political training, with the capacity to intervene in the field, with perception and a critical--reflexive posture, and competence to serve the present health system in the country. However, we observed that the major challenge for the Speech, Language and Hearing Sciences training schools is knowing how to articulate technical training with current ethical-political education in Brazil[14].

Universities have sought to fit in to this field of performance, reorganizing their curriculums so that professionals are able to work in health promotion, as, until recently, the work of the speech, language and hearing pathologist was restricted to work in medium and high complexities[4]. The shift in graduation level curriculums for Speech, Language and Hearing Sciences is taking place gradually, not following the rapid transformation of other health courses and the needs of the service networks[15]. Thereby, the work of the speech, language and hearing pathologist in Primary Health Care is marked by the lack of professional training for work at this level of health promotion[16].

FHS needs speech, language and hearing pathologists who are prepared to deal with this level of care[17]. It requires these professionals to provide generalist actions, developed according to a network of progressive care, linked to other areas of knowledge, and in the perspective of integrality in health care. Moreover, the training of the speech, language and hearing pathologists must provide skills for the exercise of practices ranging from Primary Health Care to management[18]. For this purpose, their training must contemplate scenarios and practices belonging to the real world, focused on local reality with emphasis on humanizing care[19].

This fragility leads to a stereotyped image of Speech, Language and Hearing Sciences, with work limited to rehabilitation[20] and mistakenly seen as a professional for specialized care only, which reduces the possibilities of work within FHS[21]. This distancing generates incipient knowledge on behalf of managers in relation to the importance of Speech, Language and Hearing Sciences in Primary Health Care, leading to few employment opportunities in this scenario[4], and hence generating a lack of human resources.

The number of professionals for the great demand in Sobral (CE) is inadequate, leading to deficiency in the quality of assistance[22]. One of the major challenges of this category, at this level of health care, is the organization of resources and infrastructure, which mainly involve, insufficient offer of speech, language and hearing services and insufficient human resources with qualification needs[23]. A study conducted in Recife identified that the number of speech, language and hearing pathologists in FHSNs is lower than that of the other health professions[15].

There is a need for discussion and organized participation of professionals in the definition of awareness raising strategies for managers and health professionals on the importance of inserting the speech, language and hearing pathologist in Primary

Health Care, through the systematization and analysis of health problems, the needs of individuals and social groups, as well as proposals and actions that may contribute to the improvement of health indicators[24].

An example of this, was presented by a study conducted in Sobral, Ceará, showing that the presence of the speech, language and hearing pathologist in Primary Health Care promoted follow-up and monitoring for the early diagnosis of hearing alterations, guaranteeing an improvement in the quality of life of children in the municipality[25].

We need to highlight that, although the participants in the study were speech, language and hearing pathologists, all of them have undergone or are still in the process of training in MRFH at FHTSVS. This training is the single favorable aspect assisting in the development of necessary skills for the work of Speech, Language and Hearing Sciences within FHS.

Inexperience and lack of qualification for speech, language and hearing sciences in public health, especially in FHS, may hamper service planning and organization[26]. Since training, in the professional area, has contributed little to work in FHS; MRFH programs have provided an opportunity to build the knowledge and teamwork practice that is required in this kind of work[1].

In Brazil, MRFH arises as a manner to bridge the gap in professional health training. The proposal of these residency programs is for on the job training in multi-professional teams in order to fill a gap originating from graduation level courses in the area of health, using, as theoretical background, the concepts of field and nucleus in the organization of the collective work process[27]. It also promotes, interdisciplinary work with other categories inserted in the program, together with the basic team from the Family Health Centers (FHC), providing intersectoral work and articulation with Speech, Language and Hearing services in Secondary Care, creating important tools to enhance Speech, Language and Hearing actions in Primary Health Care[28].

Due to the lack of experience of speech, language and hearing pathologists in FHS, we observed that MRFH contributed significantly to the work conduct of this professional category, as well as strengthening it in this area of practice, standing--out as a very important indicator of structural quality. The results of this training may be seen in the shift of the praxis of speech, language and hearing pathologists in relation to the actions performed, with the appreciation of collective actions, but without the detriment of individual actions that become necessary and belong to the work of the professional in Primary Health Care[28].

CONCLUSION

Structural evaluation identified an absence of physical space and materials for the work of the speech, language and hearing pathologists, a limited number of speech, language and hearing pathologists working together with the communities, and a lack of trained professionals to work at primary health care. These fragilities in the structural aspect need to be corrected to improve the quality of care provided by Speech, Language and Hearing Sciences.

Structural aspects may influence directly on the quality of care, which demonstrates the need for commitment from managers, in order to invest in structure and human resources, for work in primary health care.

We recognize inherent limitations to this quality assessment. For this reason, we suggest conducting further studies that discuss the issues raised, but not dealt with in sufficient depth in this study.

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