Original Article

Artigo Original

Evaluation of speech-language pathology care in the family health strategy from user perspective

Avaliação da assistência fonoaudiológica na estratégia de saúde da família pela perspectiva do usuário

Loise Elena Zanin[1]
Izabelle Mont'Alverne Napoleão Albuquerque[2]
Maria do Socorro Melo Carneiro[2]
Daniel Hardy Melo[1]

Keywords

Speech, Language and Hearing Sciences
Family Health Strategy
Quality Assessment
Primary Health Care
Health Evaluation

ABSTRACT

Purpose: To evaluate the satisfaction of users assisted by speech-language pathologists during their Multi-professional Residency in Family Health, considering the structural, organizational and relational categories. **Methods:** Qualitative assessment conducted with 30 Family Health Strategy (FHS) users. Data were analyzed using Bardin's content analysis. **Results:** The organizational category presented aspects associated with the organization of speech-language pathology (SLP) services, describing the specific practice and role of speech-language therapists in the FHS, as well as referral and waiting time for care, speech-language therapy actions, clarification of problems, and promotion of self-care. The relational category showed the relationship between residents and users, with emphasis on humanized care and bonding. The structural category described the dimensioning of speech-language pathologists in the FHS and the aspects related to the resources available in the health unit. **Conclusion:** User satisfaction was associated with the rapid access to the service and the humanized care provided by the residents, promoting a welcoming service and bonding between residents and community. User dissatisfaction was associated with the reduced number of speech-language pathologists available at FHS.

Descritores

Fonoaudiologia
Estratégia de Saúde da Família
Avaliação da Qualidade
Atenção Primária à Saúde
Avaliação em Saúde

RESUMO

Objetivo: Avaliar a satisfação dos usuários atendidos pelos residentes de fonoaudiologia da Residência Multiprofissional em Saúde da Família, considerando-se as dimensões estruturais, organizacional e relacional. **Método**: O estudo foi avaliativo do tipo qualitativo, no qual participaram 30 usuários. Para a análise de dados, foi utilizada a Análise de Conteúdo de Bardin. **Resultados**: A dimensão organizacional apresentou aspectos referentes à forma como está organizado o serviço de fonoaudiologia, descrevendo a atuação específica da fonoaudiologia, o papel da fonoaudiologia na Estratégia de Saúde da Família, encaminhamentos para fonoaudiologia, tempo de espera para atendimento fonoaudiológico, ações da fonoaudiologia na Estratégia de Saúde da Família, esclarecimento sobre o problema fonoaudiológico e promoção do autocuidado. A dimensão relacional demostrou o relacionamento entre os residentes e o usuário, enfatizando o cuidado humanizado e o vínculo. Já a dimensão estrutural descreveu o dimensionamento dos fonoaudiólogos na Estratégia de Saúde da Família e os aspectos referentes aos recursos disponíveis na Unidade de Saúde. **Conclusão**: A satisfação dos usuários ocorreu pelo acesso rápido ao serviço de fonoaudiologia, pelo cuidado humanizado realizado pelos fonoaudiólogos, promovendo um atendimento acolhedor e o vínculo entre a categoria e a comunidade. Já a insatisfação ocorreu pelo número reduzido de fonoaudiólogos atuando na Estratégia de Saúde da Família.

Correspondence address:
Loise Elena Zanin
Rua Coronel Diogo Gomes, 1225, Centro, Sobral (CE), Brazil, CEP: 62010-150.
E-mail: loisefono@gmail.com

Received: October 18, 2016

Accepted: August 07, 2017

Study conducted at the Curso de Pós-graduação em Saúde da Família, Universidade Federal do Ceará – UFC - Sobral (CE), Brazil.

[1] Universidade Federal do Ceará – UFC - Sobral (CE), Brazil.

[2] Universidade do Vale do Acaraú – UVA - Sobral (CE), Brazil.

Financial support: nothing to declare.

Conflict of interests: nothing to declare.

INTRODUCTION

User satisfaction with health services is a current concern. It is also an important indicator of service quality, because it addresses the users' perceptions, values, and expectations in relation to the health services. In this context, understanding the perception of this population is a major step forward in improving the quality of care provided[1].

User perception on the resolution of health care is fundamental for the reorganization and improvement of services, using the analysis of user satisfaction as a measure of quality of care[2].

In addition, user satisfaction surveys bring health services closer to the community and can provide clues for the success or difficulties of services in meeting the users' expectations and needs, and they are an important tool in the research, administration, and planning of these services[3]. They also enable organization of this assistance most appropriately to the needs and demands of its users, thus considering the importance of the subjectivation processes that are present in caring and assessing[3].

Therefore, evaluating the level of user satisfaction with the practice of speech-language pathology (SLP) in the Family Health Strategy (FHS) would be important for this professional category, as it would provide data regarding the weak points of the service and ensure the development of more assertive care in this scenario.

As the theme of user satisfaction is still little explored within the context of the FHS, this study aimed to evaluate the satisfaction of users assisted by speech-language pathologists during their Multi-professional Residency in Family Health (MRFH), considering the structural, organizational, and relational categories.

METHODS

Field data collection began after the study was approved by the Research Ethics Committee (no. 90.938) of the aforementioned Institution. The study respected the human condition and fulfilled all the requirements for autonomy, non-maleficence, justice, and equity described in Resolution 466/2012 of the Brazilian Ministry of Health.

This study was evaluative because aimed to assess the quality of health care provided by the speech-language pathology (SLP) teams of the Family Health Strategy (FHS) in the urban area of the municipality of Sobral, Ceara state, Brazil. Sobral was chosen because it is a reference in the structuring of Primary Health Care (PHC), as well as for the large coverage of the FHS in this municipality's population[4].

In this context, the speech-language pathologists are not a part of the multiprofessional team of the Family Health Support Center - NASF and the specialized assistance provided by PHC is performed by residents attending the Multi-professional Residency in Family Health (MRFH) of the School of Education in Family Health "Visconde de Saboia" in the municipality of Sobral, which has offered three vacancies per year for residents in SLP since 2004.

Students conclude their training process in the MRFH in 24 months. The residency program includes three speech-language therapists in the first year and three in the second year, totaling six residents. A preceptor of the area, with a workload of 20 hours per week, assists the residents with teaching, advising, and guiding their development in the territory. The National Commission for Multi-professional Residency in Health, through its advisory office, suggests availability of 40 hours of preceptorship, enabling the monitoring of up to five residents, whereas 20 hours of preceptorship allows the monitoring of up to three residents, according to its Resolution no. 2 (13 April 2012)[5].

Residents have a workload of 60 hours a week and develop their practical activities in the Basic Health Units (BHU) of the municipality and their theoretical activities at the School of Education in Family Health "Visconde de Saboia".

Competences of the SLP residents include acting directly or indirectly with the population; conducting home visits; working in schools and daycare centers; organizing health promotion and prevention groups; discussing cases with the team; contributing to the diagnosis of the health situation in the area of coverage, including aspects that can interfere in human communication; and proposing instruments for the assessment of SLP actions in accordance with the FHS guidelines.

All these activities of the residents are aided by the preceptor of the category. This is a qualitative study. The qualitative approach allows recognition of subjectivity as an integral space of the social phenomenon without losing the objectification of the research process. This approach is appropriate for the analysis of speech-language therapy practice and the relationships it establishes between individuals at PHC, considering that it seeks to understand the meaning of the quality of this assistance for FHS users.

Initially, contact was made with the BHUs scheduling a visit and requesting that the speech-language pathologists made available the medical records of the users accompanied by the category in 2012. Next, the researchers conducted a field search of the records in order to identify users for the study. Inclusion criteria were as follows: users accompanied by SLP residents in health promotion and prevention groups; users accompanied in home visits; users who underwent SLP rehabilitation at home or at a BHU; and users undergoing speech-language therapy for longer than three months. Users who changed the territory of SLP assistance were excluded from the study.

Data collection occurred between June and December 2013. Some difficulties were found during this process, namely, absence of the 2012 appointment books of the SLP residents with the names of the users, and absence of other types of entry in the family records that determined the actions performed by the speech-language therapists and the duration of therapy. Consequently, only 30 users who met the inclusion criteria were found, but three of them did not agree to participate in the study. Therefore, 27 users were identified. Faced with the small number of individuals available, we decided to include all of them in the study.

Due to the qualitative nature of the study, semi-structured interviews were conducted at the BHUs or at the participants' homes, when the user presented locomotion difficulty. The interviews were recorded and stored using iPod® and iPhone® and were later transcribed by the principal researcher.

Study participants signed an Informed Consent Form (ICF) prior to study commencement. The interviews comprised the following questions: a) Why did you need speech-language therapy?; b) Who referred you to therapy?; c) How long did it take to receive assistance?; d) Was the treatment good? Were the results satisfactory? If not, why?; e) Did the speech-language therapist clarify all your doubts?; f) In your opinion, what is the speech-language therapist's function in your neighborhood?

In order to ensure anonymity, the participants were identified by the letter U (user) and the interview number, i.e., the first respondent was identified as U1, the second as U2, and so on.

Speech data were analyzed using Bardin's content analysis[6], with an option for thematic or categorical analysis. The results were presented in categories and subcategories. In addition, the recording units (sentences) that expressed the interviewees' impressions were described.

RESULTS AND DISCUSSION

Dialogues arising from the open questions of the semi-structured interviews with the users refer to the results of speech-language pathology (SLP) assistance in the Family Health Strategy (FHS), in which a thematic class was addressed: *Assessment of SLP care in the FHS*, with three categories and eleven subcategories.

Organizational category

This dimension includes aspects associated with the organization of the speech-language pathology (SLP) service, involving working hours, waiting time, scheduling of appointments, search for the speech-language therapist in the Family Health Strategy (FHS), and referrals. This category was divided into seven subcategories.

The subcategory *Specific Care in SLP* contemplated the reasons why users were undergoing SLP monitoring, in which a general practice was observed, with speech-language therapists developing activities in all areas of specific action, such as voice, language, speech, writing, hearing, orofacial motricity, and dysphagia, providing dissemination of SLP knowledge and practice in the territories.

> *My grandson cannot speak. (*User 15 = U15)

> *I was all stiff after I had a stroke; I was speaking badly; when I drank water, I was all crooked; I could barely eat; my speech was unclear."* (U2)

> *Because I am practically deaf.* (U8)

Speech-language therapists in Primary Health Care (PHC) should be general practitioners capable of identifying the most important changes in human communication in the community where they work and, thereby plan actions to promote, prevent, and recover communication health, providing integral and quality service to the population[7]. SLP practice allows early identification of hearing loss, stuttering, vocal alterations, reading and writing disorders, etc. and contributes to the reduction of these conditions through promotion and prevention actions[7].

Although SLP practice in PHC should be of general nature, actions limited to specialty fields were observed, as punctuated in the subcategory *Role of the Speech-language Pathologist in FHS*. The users' statements evidenced a perception of absence of health promotion activities, and they contemplated only preventive and curative actions in the communities.

> *I think they teach people how to speak better, teach some types of exercises that would enable a person to speak better.* (U23)

> *I think they do exercises such as stretching, and exercises for the mouth, throat, and tongue. They have already asked me to do quite a few exercises.* (U14)

> *The speech-language therapists collaborate in the rehabilitation of the patients ... they may also assist with speech therapy and other things.* (U8)

This fact might arise from actions that are strongly directed to the core of SLP, resulting in a timid professional practice in the social field. Similar data have been found in the specific scientific literature, reporting that speech-language pathologists working at the Family Health Support Center - NASF are ideologically engaged in preventive practice, but usually develop individualized curative actions as the only resource for assistance[8].

The subcategory *Referrals to Speech-language Pathology* showed that patients are referred to speech-language therapists by several members of the multi-disciplinary team.

> *I was referred to you by the nurse at the BHU.* (U1)

> *It was a physician.* (U3)

> *It was a health agent.* (U8)

Moments of discussion and experience exchange with the FHS teams enhance the construction of knowledge and articulation with other health areas[9]. The insertion of speech-language therapists in the FHS teams ensured knowledge about SLP practice and enabled the multi-disciplinary teams to identify the demands for communication disorders and make more accurate referrals, consequently, reducing of the problem.

With respect to the subcategory *Waiting time for SLP care*, the users declared having rapid access to this service at the BHUs in the municipality of Sobral.

> *I was undergoing therapy in less than a month.* (U3)

> *It was quick; the therapists' work is very good, as well as the accessibility* […] (U7)

It was fast; the attendants at the BHU arranged everything for speech-language therapy. I've got nothing to complain about. (U20)

This reality observed in Sobral differs from that reported in the literature, which shows a high level of dissatisfaction regarding waiting time for treatment in health services. Generally, dissatisfaction among FHS users is associated with waiting time at the BHU reception, waiting time for care, poor user embracement, and difficulties in the relationship with the professionals, with service organization as the most important request for improvement made by the users, considering that they believe that appropriateness in this regard would enable a faster and more effective service[3]. Users report that access to PHC is bureaucratic and time-consuming: waiting time between scheduling the appointment and the day of consultation, as well as the service process as a whole[10].

As for the subcategory *SLP Actions at the FHS*, the users reported referrals to other levels of care as the main action of the speech-language therapists. This fact demonstrated a limitation in the speech-language pathologists' resolving capacity in this scenario, because many of these problems could be solved on site.

At the very first appointment, she referred me to the Rehabilitation Center, and said that I had to undergo treatment there. (U23)

She referred me to the Rehab Center. (U16)

It happened through the group of pregnant women, we were there every 15 days, and it was an improvement both for us to meet with the therapist and for her to meet with us. We resumed the therapy after I had the baby. (U24)

These actions need to be rethought by speech-language therapists and the management of this health area, after all they directly influence the quality of care provided to the users. This weakness may result from the precarious structure offered for SLP practice[11] and/or from work processes inadequate for this level care, aggravated by the practice of professionals with little competence to act in this scenario[12].

Regarding the structural aspect, the literature highlights limited physical space and lack of adequate material for the development of this assistance as factors that directly contribute to the low resolution of this health area at this level of care[11]. The lack of adequate equipment for the care of this population can prevent activities of health promotion and injury prevention from being conducted, jeopardizing the continuity of health assistance[13].

Although the SLP practice at the FHS of this municipality is being performed by speech-language therapists in the process of formation by the Multi-professional Residency in Family Health (MRFH), many technical training deficiencies still need to be overcome, and this is the main limiting factor in the practice of these professionals[12].

The health professional training mode has been a complicating factor, in which excessive emphasis on disease appreciation and specialized training is observed. In this context, the curricular contents do not provide sufficient information in the subjective, preventive and social dimensions for health care delivery[14].

Issues related to training require attention not only for the current professions in the FHS (physicians, nurses, dentists, health agents, technical and auxiliary level professionals), but also for those that may be included in the future owing to the epidemiological and demographic transition[15].

Another study shows that referrals to other levels of health assistance are not a reality experienced only by SLP, and reports that, from the standpoint of users, the over-regulation of access to medical consultation, coupled with the personal impression that health problems are urgent, make them seek other ways to solve them, preferring emergency or specialized care[16]. Thus, the lack of filtering in PHC not only increases considerably the number of unnecessary consultations, but also overburdens Secondary Care, increasing the risks for patients[16].

There is a high proportion of care provided in emergency rooms that could be appropriately resolved in BHUs[17]. Research conducted in the city of Fortaleza, Ceara state, demonstrated that local health has suffered over time with the overcrowding of high complexity services, and indicated that many of these visits refer to outpatient procedures that could be performed in lower complexity or basic care units[18]. Therefore, the use of effective economic technologies, such as guidance groups associated with well-trained professionals and basic infrastructure, can promote a high resolution of cases at inexpensive costs[19]. Because the speech-language therapists who work at BHUs are general practitioners, they have the possibility of developing more comprehensive and versatile actions, which may impact not only the treatment of diseases, but also the general health of the population[20].

Nevertheless, the subcategory *Clarification of problems* showed satisfaction of the population with the explanations given by the speech-language therapists on communication health.

She explains everything […] *she explains about the face, how we have to do, to chew, she explains everything very well.* (U11)

She explains, she teaches me some movements, such as what I have to do to keep the movement - she explains." (U22)

They clarified all my doubts […] (U6)

At the FHS, the exchange of information and commitment between the health team and the users is of great importance. Users' access to information ensures autonomous decisions and fosters health citizenship. The involvement of the community in a health service is capable of promoting alterations in decision-making processes in PHC, and may change the cultural behavior of practices conducted at health services[21].

When health professionals respond to the questions that users are encouraged to asked, the answers they obtain, or the spontaneous explanations and guidance given to them, provide them with safety and promote increased interpersonal trust

relationships[21]. Trust is considered the mainstay of human society. Bonding begins to be amalgamated based on the trust of the users in the health professionals.

Most users claimed to have received information about their health or treatment; however, in this study, it is not possible to judge whether the information given was complete with regard to diagnosis, treatment guidelines, and explanations, and especially if they were adequate to the language of the recipient.

The subcategory *Promotion of Self-care* emerged through the dialogue between community and speech-language therapists, with empowerment as the main theme in the users' speeches.

> […] *we are working with my son, we have been doing everything, we have been working* […] (U4)

> *The speech-language therapist asked us to work with the vowels a lot, so we started working more on them.* (U5)

Empowerment is built on the model of promoting, raising awareness, and providing information on the field of health and vital skills, enabling the individual to make autonomous choices. This concept is considered one of the pillars that support the health promotion model that has been guiding health policies worldwide[22]. In order to build empowerment, a qualitative change in the form of support offered by health institutions is required, that is, the biomedical model of self-care would be open to negotiation, abandoning its prescriptive character, to be addressed in the context of conversation, and adjusted to the needs and priorities defined by the patients[22].

Information about health transformed into knowledge leads to appropriation of information by patients, empowering them and bringing them possibilities to effectively exercise their rights to health[23]. A study showed that mothers and caregivers who participated in an infant monitoring program acquired comprehensive knowledge on the aspects of child development when speech-language therapists assisted with empowering the families in question[24].

Relational category

This category refers to the relationship between SLP professionals and PHC users. The FHS users showed great satisfaction with the residents at the MRFH. This was evidenced in the emphasis they placed on the humanized care provided by the speech-language therapists to the community, as described in the subcategory *Humanized Care*.

> *It is a blessing; he comes only after God. Everything he told me to do, I did.* (U2)

> […] *the therapy sessions started here in the outpatient clinic; we were very well assisted; I have no complaints; she really has a way with children.* (U1)

> *It was great! Her assistance was very good, she is very attentive, very concerned with the patients.* (U6)

Humanized care rendered by therapists allows them to establish a closer relationship with their patients, which provides exchange of experiences, solution of problems, and knowledge about limitations, even if the communication between the participants is not verbal[25]. For the speech-language therapists, humanized care offers integral care with equity in all professional practices and considers each user as indivisible, with no possibility of dissociating biological, psychic, spiritual and social aspects[26].

All care begins with a dialogic relationship in which there is room for real exchange, enabling the construction of new meanings, individual and collective meanings about the health-disease-care process[27].

Therefore, the trust that the users deposit in the speech-language pathologists enables the creation of bonding, promoting more satisfactory results of the SLP services in the territory, as described in the subcategory *Bonding*.

> *It is a blessing; he comes only after God. Everything he told me to do, I did.* (U2)

> […] *the therapy sessions started here in the outpatient; we were very well assisted; I have no complaints; she really has a way with children.* (U1)

> *It was great! Her assistance was very good, she is very attentive, very concerned with the patients.* (U6)

The central points of the FHS are establishing bonding and creating commitment and accountability between health professionals and the population. The bonding between the families accompanied at FHS and speech-language therapists favored the exchange of knowledge and the establishment of a horizontal relationship, because the users' knowledge is as valued as that of the professionals[28]. Through human communication, speech-language therapists and users can establish emotional bonding and an accountability relationship that are critical to resolve complaints comprehensively, involving all aspects required to provide health and quality of life[29].

Structural category

The structural dimension is associated with the way speech-language therapists are structured to embrace the users at the FHS and with the aspects related to resources available at the BHUs. This category presented two subcategories.

The subcategory *Human Resources* showed the dissatisfaction of the community with the insufficient number of speech-language therapists available at PHC. As there are no vacancies in the SLP service at the FHS in the municipality of Sobral, these professionals are eventually absorbed by other scenarios of practice.

> *It could be better, not only here but at the BHU as well, because there is a therapist here, but when we look for one in the BHU, we cannot find anyone.* (U1)

They need to allocate a therapist in the neighborhood. There isn't one here. (U3)

It is important, but I see no therapists here, and they do not go to my house either. (U11)

The lack of job offers for SLP in PHC is a consequence of the incipient knowledge of managers regarding the importance of this category for this field[12]. In order to create new positions, municipal and state managers need to assess the necessity to increase the number of speech-language pathologists in the local public health network, considering the population, epidemiological and service criteria[30]. This fact reinforces the need for speech-language therapists to invest in the creation and analysis of health indicators associated with human communication.

Moreover, SLP needs to show positive evidence of its practice through the publication of scientific research[29] and list PHC as its reordering axis at the Brazilian National Health System - SUS as the first step to solve the problems of service organization, management, and financing of SLP health[7].

Furthermore, the users' speeches expressed a desire for a larger number of speech-language therapists qualified to act according to SUS guidelines in the territories, as reported in the subcategory *User Expectations*.

We expect that a community professional is allocated. (U24)

It is very important, I do not know whether another speech-language therapist is being allocated here, but the FHS should have a bit of each and every health specialty. (U24)

If you mention SLP to me, I believe my quality is getting better... it would be essential for me […] (U22)

The expectations presented by the users of the SLP service were similar to the findings reported in the national literature on this theme: users refer to insufficient offer of SLP service provided at SUS[11,24]. Another study indicated as a major challenge for SLP at the FHS the organization of resources and infrastructure mainly involving insufficient availability of these services and insufficient and unqualified human resources[11,12]. Unfortunately, the inexperience and lack of preparation of SLP at PHC, especially at the FHS, can negatively affect the planning and organization of the service[19]. In this context, there is need for a larger number of speech-language pathologists working in PHC, and these professionals should be prepared to cope with this level of care[29].

CONCLUSION

This study aimed to assess user satisfaction with speech-language pathology (SLP) services at Primary Health Care (PHC). The results indicated a positive evaluation of these services in this scenario, but evidenced some contradictions, considering that at a few moments SLP problems were solved in the Family Health Strategy (FHS) and that the users were referred to secondary care in most cases.

Thus, it was possible to identify that user satisfaction was associated with rapid access to the service and the humanized care provided by the SLP residents, promoting a welcoming service and bonding between residents and community. In contrast, the reduced number of speech-language therapists allocated to the FHS, the practice of this professional category focused on its core, and the low resolution at this level of care were indicated as weaknesses in this assistance.

One of the limitations of the present study is that it focused on the investigation of SLP practice at PHC in a specific region. However, it was possible to raise relevant matters about user satisfaction regarding SLP from structural, organizational and relational assessment, which can contribute to the construction and strengthening of SLP actions in this model of health care.

Therefore, we suggest that further studies should be conducted on the problematization of the issues raised but not deepened in this study, addressing the perspective that assessing user satisfaction is an important tool to formulate new proposals of practice, in addition to enabling more effective planning and intervention in the health-disease process of the community.

REFERENCES

1. Lima JC, Santos AL, Marcon SS. Percepção de usuários com hipertensão acerca da assistência recebida na atenção primária. Rev Pesqui Cuid Fundam. 2016;8(1):3945-956.
2. Rosa RB, Pelegrini AHW, Lima MADS. Resolutividade da assistência e satisfação de usuários da estratégia saúde da família. Rev Gaucha Enferm. 2011;32(2):345-51. PMid:21987997. http://dx.doi.org/10.1590/S1983-14472011000200019.
3. Claris JWB, Silva LMS, Douradom HHM, Lima LL. Regulação do acesso ao cuidado na atenção primária: percepção dos usuários. Rev Enferm. 2011;19(4):604-9.
4. Carneiro MSM, Melo DMS, Gomes JM, Pinto FJM, Silva MGC. Avaliação do atributo coordenação da Atenção Primária à Saúde: aplicação do PCA Tool a profissionais e usuários. Saúde Debate. 2014; 38(especial):279-95.
5. Brasil. Secretaria de Educação Superior. Comissão Nacional de Residência Multiprofissional em Saúde. Resolução CNRMS nº 2, de 13 de abril de 2012. Diário Oficial da União; Brasília. 13 abr 2012.
6. Bardin L. Análise de conteúdo. Lisboa: Edições 70; 2010. (Trad. Luís Antero Reto e Augusto Pinheiro).
7. Lima TFP, Acioli RML. A inserção da fonoaudiologia na atenção primária do Sistema Único de Saúde. In: Silva VL, Lima MLLT, Lima TFP, Advíncula KP, editores. A prática fonoaudiológica na atenção primária à saúde. São José dos Campos: Pulso Editora; 2013. p. 25-42.
8. Costa LS, Alcântara LM, Alves RS, Lopes AMC, Silva AO, Sá LD. A prática do fonoaudiólogo nos Núcleos de Apoio à Saúde da Família em municípios paraibanos. CoDAS. 2013;25(4):381-7. PMid:24408488. http://dx.doi.org/10.1590/S2317-17822013000400014.
9. Ferreira RC, Varga CRR, Silva RF. Trabalho em equipe multiprofissional: a perspectiva dos residentes médicos em saúde da família. Cien Saude Colet. 2009;14(Supply 1):1421-8. PMid:19750351. http://dx.doi.org/10.1590/S1413-81232009000800015.
10. Campos RTO, Ferrer AL, Gama CAP, Campos GWS, Trapé TL, Dantas DV. Avaliação da qualidade do acesso na atenção primária de uma grande cidade brasileira na perspectiva dos usuários. Saúde Debate. 2014; 38(especial):252-64.
11. Zanin LE, Albuquerque IMN, Melo DH. Fonoaudiologia e estratégia de saúde da família: implicação da dimensão estrutural na qualidade da atenção

à saúde fonoaudiológica. Audiol Commun Res. 2015;20(3):255-61. http://dx.doi.org/10.1590/2317-6431-2015-1546.

12. Zanin LE, Albuquerque IMN, Melo DH. Fonoaudiologia e Estratégia de Saúde da Família: o estado da arte. Rev CEFAC. 2015;17(5):1674-88. http://dx.doi.org/10.1590/1982-0216201517513414.
13. Moura BLA, Cunha RC, Fonseca ACF, Aquino R, Medina MG, Vilasbôas ALQ, et al. Atenção primária: estrutura das unidades como componente da atenção. Rev Bras Saude Mater Infant. 2010;10(Suppl 1):69-81. http://dx.doi.org/10.1590/S1519-38292010000500007.
14. Moretti-Pires RO. Complexidade em saúde da família e formação do futuro profissional de saúde. Interface. 2009;13(30):153-66. http://dx.doi.org/10.1590/S1414-32832009000300013.
15. Arantes LJ, Shimizu HE, Merchán-Hamann E. Contribuições e desafios da Estratégia Saúde da Família na Atenção Primária à Saúde no Brasil: revisão da literatura. Cien Saude Colet. 2016;21(5):1499-510. PMid:27166899. http://dx.doi.org/10.1590/1413-81232015215.19602015.
16. Lima AS, Feliciano KVO, Kovacs MH. Acessibilidade à atenção fonoaudiológica em serviço de média complexidade. Rev CEFAC. 2015;17(2):461-74. http://dx.doi.org/10.1590/1982-021620156114.
17. von Randow RM, Brito MJM, Silva KL, Andrade AM, Caçador BS, Siman AG. Articulação com atenção primária à saúde na perspectiva de gerentes de unidade de pronto-atendimento. Rev Rene. 2011;12(especial):904-12.
18. Barbosa KP, Silva LMS, Fernandes MC, Torres RAM, Souza RS. Processo de trabalho em setor de emergência de hospital de grande porte: a visão dos trabalhadores de enfermagem. Rev Rene. 2009;10(4):70-6.
19. Molini-Avejonas DR, Mendes VLF, Amato CAH. Fonoaudiologia e Núcleos de Apoio à Saúde da Família: conceitos e referências. Rev Soc Bras Fonoaudiol. 2010;15(3):465-9. http://dx.doi.org/10.1590/S1516-80342010000300024.
20. Bazzo, LMF, Noronha CV. Privação da oferta de serviços fonoaudiológicos no Sistema Único de Saúde (SUS) e a reforma do Estado: a mediação do debate. R Ci Méd Biol. 2007;6(2):190-96.
21. Guilherme F, Callegari D, Carvalho BG, Iglecias VA, Santos ER, Campreguer ES. Reflexões de uma equipe de residentes multiprofissionais em saúde da família sobre o processo de reativação de um Conselho Local de Saúde. Rev Bras Med Fam Comunidade. 2012;7(25):265-71. http://dx.doi.org/10.5712/rbmfc7(25)250.
22. Lopes AAF. Cuidado e empoderamento: a construção do sujeito responsável por sua saúde na experiência do diabetes. Saude Soc. 2015;24(2):486-500. http://dx.doi.org/10.1590/S0104-12902015000200008.
23. Leite RAF, Brito ES, Silva LMC, Palha PF, Ventura CAA. Acesso à informação em saúde e cuidado integral: percepção de usuários de um serviço público. Interface. 2014;18(51):661-71. http://dx.doi.org/10.1590/1807-57622013.0653.
24. Botasso KC, Cavalheiro MTP, Lima MCMP. Avaliação de um Programa de Acompanhamento de Lactentes Sob a Óptica da Família. Rev CEFAC. 2013;15(2):374-81. http://dx.doi.org/10.1590/S1516-18462013000200014.
25. Cândida C. Cuidado humanizado na Unidade de Terapia Intensiva: uma revisão da literatura. Rev Saúde e Desenvolvimento. 2013;4(2):184-97.
26. Celín SH, Gobbi FHA, Lemos SMAM. Fonoaudiologia e humanização: percepção de fonoaudiólogas de um hospital público. Rev CEFAC. 2012;14(3):516-27. http://dx.doi.org/10.1590/S1516-18462012005000015.
27. Barbosa SP, Elizeu TS, Penna CMM. Ótica dos profissionais de saúde sobre o acesso à atenção primária à saúde. Cien Saude Colet. 2013;18(8):2347-57. PMid:23896917. http://dx.doi.org/10.1590/S1413-81232013000800019.
28. Almeida EC, Furtado LM. Acolhimento em Saúde Pública: a contribuição do fonoaudiólogo. Rev Ciências Médica. 2006;15(3):249-56.
29. Fernandes EL, Cintra LG. A inserção da Fonoaudiologia na Estratégia da Saúde da Família: relato de caso. Rev Atenção Primária a Saúde. 2010;13(3):380-5.
30. Santos JN, Maciel FJ, Martins VO, Rodrigues ALV, Gonzaga AF, Silva LF. Inserção dos fonoaudiólogos no sus/mg e sua distribuição no território do estado de Minas Gerais. Rev CEFAC. 2012;14(2):196-205. http://dx.doi.org/10.1590/S1516-18462011005000088.

Author contributions

LEZ was responsible for the study design, literature survey, collection and analysis of data, and writing of the manuscript; IMNA was the study adviser, contributed in the study design and data analysis; MSMC contributed in the literature survey and writing of the manuscript; DHM was the study co-adviser, responsible for the final review of the manuscript.