

Speech therapists/ audiologists professional activities in Primary Health Care in Brazil: expert consensus

Atividades profissionais do fonoaudiólogo na Atenção Primária à Saúde no Brasil: consenso de especialistas

Actividades profesionales de logopedas en atención primaria de salud en Brasil: consenso de expertos

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Abstract

Introduction: The insertion of Speech-Language Pathology and Audiology in Primary Health Care (PHC) in Brazil took place more strongly with the creation of the Family Health Support Centers (NASF), starting in 2008. However, the NASF, together with the PHC and the Unified Health System (SUS), has been increasingly attacked by the shortfall caused by the current political situation. It is necessary that health managers recognize the importance of maintaining this profession in this scenario and, therefore, they need to know the activities developed by speech therapists in PHC. **Objective:** Identify the professional activities of the speech therapists/audiologists in PHC in Brazil. **Methods:** E-Delphi was used to obtain consensus, whose criterion was 70%. **Results:** 45, 31 and 26 public health speech therapists participated (in stages 1, 2 and 3) and 28 speech therapists/audiologists from other areas in stage 4. Common activities included: teamwork, shared care, continuing education, referral / counter-reference, elaboration of educational material, health surveillance, reporting / advice and management exercise. The specific activities included: matrix support in speech therapy, health policies and planning of care networks focused on speech health, promotion, prevention, situational diagnosis, reception, guidance and follow-up speech therapy, construction and systematization of epidemiological

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data, promotion of healthy environments to human communication, guidance on the scope of speech therapy, individual, collective and home care, actions aimed at specific population groups, screening and speech management. **Conclusion:** The activities pointed out in the study are in line with the literature and touch the attributes of PHC.

Keywords: Primary Health Care; Speech, Language and Hearing Sciences; Audiology; Professional practice; Unified Health System; Public Health.

Resumo

Introdução: A inserção da Fonoaudiologia na Atenção Primária à Saúde (APS) no Brasil se fortaleceu com a criação dos Núcleos de Apoio à Saúde da Família (NASF), a partir de 2008. No entanto, os NASF, juntamente com a APS e o Sistema Único de Saúde (SUS), têm sido cada vez mais atacados pelo desfinanciamento causado pela conjuntura política atual. Faz-se necessário que os gestores em saúde reconheçam a necessidade de manter tal profissão nesse cenário e, para tanto, precisam conhecer as atividades desenvolvidas pelos fonoaudiólogos na APS. **Objetivo:** identificar as atividades profissionais do fonoaudiólogo na APS no Brasil. **Método:** Utilizou-se a e-Delphi para obter consenso, cujo critério foi 70%. **Resultados:** Participaram 45, 31 e 26 fonoaudiólogos da Saúde Coletiva (nas etapas 1, 2 e 3) e 28 fonoaudiólogos de outras áreas, na etapa 4. As atividades comuns incluíram: trabalho em equipe, atendimento compartilhado, educação permanente, referência/contrarreferência, elaboração de material educativo, vigilância em saúde, emissão de relatórios/pareceres e exercício da gestão. As atividades específicas abrangeram: apoio matricial em Fonoaudiologia, políticas de saúde e ordenamento das redes de atenção voltadas à saúde fonoaudiológica, promoção, prevenção, diagnóstico situacional, acolhimento, orientação e acompanhamento fonoaudiológico, construção e sistematização de dados epidemiológicos, promoção de ambientes saudáveis à comunicação humana, orientações quanto ao escopo da Fonoaudiologia, atendimento individual, coletivo e domiciliar, ações voltadas a grupos populacionais específicos, triagens e gerenciamento fonoaudiológico. **Conclusão:** As atividades apontadas no estudo encontram-se em consonância com a literatura e tangenciam os atributos da APS.

Palavras-chave: Atenção Primária à Saúde; Fonoaudiologia; Prática Profissional; Sistema Único de Saúde; Saúde Pública.

Resumen

Introducción: La inserción de la Logopedia en la Atención Primaria de Salud (APS) en Brasil se produjo con mayor fuerza con la creación de los Centros de Apoyo a la Salud de la Familia (NASF), a partir de 2008. Sin embargo, la NASF, junto con la APS y el Sistema Único de Salud (SUS), ha sido cada vez más atacado por el déficit provocado por la actual situación política. Es necesario que los gestores de salud reconozcan la importancia de mantener esta profesión en este escenario y, por tanto, necesitan conocer las actividades que desarrollan los logopedas en la APS. **Objetivo:** Identificar las actividades profesionales del logopeda en la APS en Brasil. **Metodos:** Para obtener el consenso se utilizó E-Delphi, cuyo criterio fue del 70%. **Resultados:** Participaron 45, 31 y 26 logopedas de salud pública (en las etapas 1, 2 y 3) y 28 logopedas de otras áreas en la etapa 4. Las actividades comunes incluyeron: trabajo en equipo, atención compartida, educación continua, referencia / contra-referencia, preparación de material educativo, vigilancia de la salud, informes/asesoramiento y ejercicio de gestión. Las actividades específicas incluyeron: apoyo matricial en terapia del habla, políticas de salud y planificación de redes de atención enfocadas en la salud del habla, promoción, prevención, diagnóstico situacional, recepción, orientación y seguimiento de la terapia del habla, construcción y sistematización de datos epidemiológicos, promoción de ambientes saludables para comunicación humana, orientación sobre el alcance de la terapia del habla, atención individual, colectiva y domiciliaria, acciones dirigidas a grupos de población específicos, detección y manejo del habla. **Conclusión:** Las actividades señaladas en el estudio están en línea con la literatura y tocan los atributos de la APS.

Palabras clave: Atención Primaria de Salud; Fonoaudiología; Práctica Profesional; Sistema Único de Salud; Salud Pública.



Introduction

Speech-language-hearing (SLH) therapists in Brazil have increasingly worked in primary health care (PHC) since the Family Health Care Support Centers (NASF, in Portuguese) were implemented in 2008. Later, in 2017, the National Primary Health Care Policy changed their name to Extended Family Health and Primary Care Center (NASF-AB), removing “support” from both their name and policy – although activities correlated to this dimension remained in the job description of the teams¹⁻³.

However, Constitutional Amendment no. 95/2016 set a spending limit to the government, and, since then, the Unified Health System (SUS, in Portuguese) has been often criticized, and its budget has shrunk. At the end of 2019, the Ministry of Health launched the Brazil Prevention Program, which completely changed how PHC was funded. It provided no incentives to implement and maintain the NASF-AB teams, leaving it exclusively up to local administrators to decide whether to maintain them^{4,5}.

These circumstances directly affect SLH therapists and their work in PHC – which is already limited nationwide, as pointed out in studies conducted by Viégas et al.⁶ and Rech et al.⁷. They explain the limited presence of SLH therapists in this scenario, and their irregular distribution throughout the country. They are predominantly concentrated in the Southeast region, and only 50.8% of the PHC services count with an SLH therapist in the NASF team.

In order to consolidate their professional activity in PHC, SLH therapists must know their guidelines, requirements, and roles and carry out comprehensive actions with the cooperation of the many professionals and sectors, based on health promotion, prevention, rehabilitation, and continuing education, aiming at comprehensiveness health care^{2,8-11}.

Nevertheless, these professionals’ training in Brazil is still predominantly focused on accumulating knowledge, with early specialization, and centered on specialized care and hospital services¹².

Therefore, we need a more in-depth debate around the SLH professional activities in this scenario to meet the needs of the professional practice and provide the basis for decision-making on the

part of health administrators regarding the importance of maintaining these professionals in PHC.

The research question of this article was: “What are the essential SLH professional activities in PHC in Brazil?”.

The main objective of the research was to identify the essential SLH professional activities in PHC in Brazil – firstly from the perspective of SLH professors in the field of public health in Brazilian SLH undergraduate programs and then compare these data with the opinion of professors in other fields of SLH science.

To this end, we tried to reach an expert consensus on the SLH activities in PHC in Brazil. We used the Delphi technique, which has been broadly used in research in medical education in the field of health. It synthesizes expert opinions to identify and measure fields where evidence is insufficient for decision-making. It has been pointed out as one of the most effective methods to reach a consensus^{13,14}.

Its main characteristics are anonymity, knowledge brought to the group by a specialist, the possibility of controlled feedback throughout the interaction, and the use of statistical information¹⁵.

In this study, we used the e-Delphi, an electronic adaptation whose rounds were conducted online, ensuring anonymity, with feedback from the researchers throughout the process, as advocated in the literature¹⁵.

Method

This Delphi study, conducted to define the professional activities expected from the SLH therapists in PHC, was approved by the Research Ethics Committee (REC) under protocol CAAE 58236816.6.0000.5404.

Data collection procedures

For the e-Delphi, we invited public health SLH professors in Brazilian SLH undergraduate programs. Their contact was provided by the higher education institutions, with support from the Teaching Committee of the Brazilian Speech-Language and Hearing Society (CE/SBFa, in Portuguese). The selection was intentional, as they are directly involved in training future SLH therapists to work in SUS – including PHC. These professors are responsible for providing in the university a training process committed to the population’s true health needs.



We developed the study in four stages, depicted in Figure 1 (below):

In **stage 1**, the participants freely listed five professional activities they deemed pertained exclusively to SLH therapists in PHC in Brazil.

In **stage 2**, they answered a Likert-type scale, analyzing each activity as indispensable, important, little important, or should not be included. To be considered a consensus, the activity had to be qualified as either indispensable or important by 70% or more participants. This score is broadly used to establish a consensus¹⁵.

In **stage 3**, the professors listed the activities surveyed in stage 2 in what they considered their order of relevance. In all stages, they were free to make comments on them.

Stage 4 was meant to minimize the possibility of bias, as the initial group comprised exclusively professors from public health. Thus, with support from CE/SBFa, we conducted this stage (duly approved by the REC, via amendment) during the XXVI Brazilian Congress of SLH Sciences, which was held in Curitiba, Paraná, Brazil. To this end, we invited SLH professors specialized in various fields who were attending the meeting of SLH program coordinators and professors. Those who agreed to participate signed the informed consent form. They likewise listed the activities in order of relevance, as the public health professors had previously done.

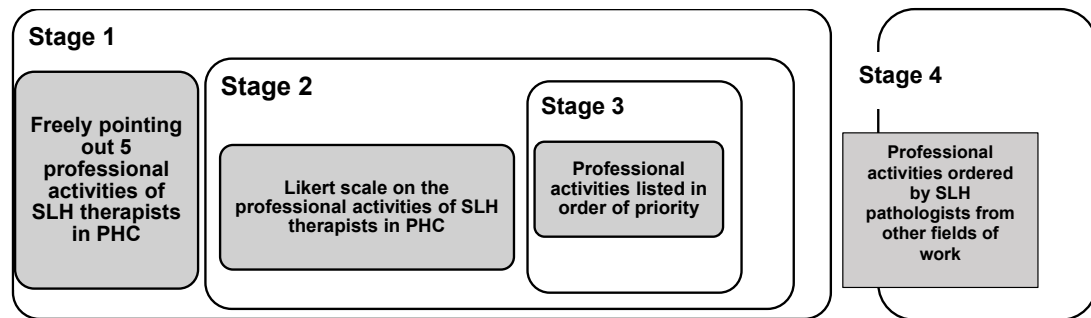


Figure 1. Visual representation of the e-Delphi stages.

Data analysis

We analyzed the activities listed in the expert consensus guided by the theoretical rationale by Campos¹⁶ regarding the health knowledge field and core, namely,

“(…) the core is the identity in a field of knowledge and professional practice; and the field is a space with imprecise borders, where each subject and profession seek support from others to accomplish their theoretical and practical tasks” (Campos, 2000, p. 220).

In this study, the concept of core encompassed the specific SLH professional activities, while that of field encompassed the professional activities common to the various health professionals who work in PHC.

Besides these concepts, we used the essential and derivative requirements and roles in PHC⁸ to

guide the analysis of the professional activities identified in the e-Delphi.

Statistical analysis

For the descriptive analysis, we used absolute and relative frequency tables for the categorical variables and measures of position and dispersion for the numerical variables. We used the Friedman test to compare the order of the items and the exploratory factorial analysis to identify a subset of items of greater importance. Despite the few subjects, we used this analysis as a basis to categorize the items¹⁷.

We used the Fisher’s Exact test to verify associations between professional training and work in PHC. The significance level was set at 5% for the statistical tests.

Results

We invited 81 professors to participate in **stage 1**, based on the survey we made with the CE/SBFa. Of these, 45 agreed to participate, one declined, and the others did not respond. In this stage, the participants listed 159 activities – some of them pointed out less than the five activities we had asked from them. After the researchers excluded the repeated ones and grouped them into related topics, they totaled 45 SLH professional activities in PHC.

In **stage 2**, we invited the 45 participants of the initial stage – 31 participated, with a loss of the other 14 subjects. All 45 activities listed in **stage 1** reached a consensus, based on the previously established criteria mentioned above. Then, the researchers reanalyzed and regrouped them in related topics, resulting in 24 SLH professional activities in PHC.

Stage 3 counted with 26 SLH pathologists, who organized the activities in decreasing order of priority (from the most to the least important) in their perspective. We had a loss of 19 participants from stage 1 – in agreement with the literature, which reports an expected nonparticipation rate of

30 to 50% in the first stage, besides the other losses in the subsequent Delphi rounds¹⁸.

In **stage 4**, 28 SLH professors participated. They were from various SLH specializations (voice, language, fluency, occupational SLH, audiology, oral-motor function, dysphagia, and hospital SLH therapy) and from the five regions of Brazil. In this stage, the participants likewise ordered the professional activities previously listed in the e-Delphi, as in **stage 3**. We will present below a comparison between the ordered lists of professional activities developed by both groups – the public health professors and those of the other fields.

Participants' profile:

Initially, 45 SLH pathologists from the different parts of Brazil participated – 39 (86.7%) were women, their mean age was 39.71 years, with a standard deviation of 9.63. Doctoral was the predominant degree (46.7%/ N=21), followed by master's (35.6%/ N=16). Most respondents were from the Southeast and Northeast regions (N=16 and N=15, respectively), which is shown in Figure 2.

Of the stage 1 participants, 38 (84.4%) reported specific/specialized training in public health, whereas the others (N=7/15.16%) denied having specific training in this field.



Figure 2. Geographical distribution of the participants in stage 1.

As for these last ones, their training had been in oral-motor function (N=2), linguistics (N=1), and communication disorders – not specified (N=2), while one participant did not report their field of training/work.

The consensus about the SLH activities in PHC

The 24 final professional activities are shown in Figure 3, as well as their order proposed by the professors in public health and in the other fields.

PROFESSIONAL ACTIVITIES	ORDER GROUP 1 (PUBLIC HEALTH) n=26	ORDER GROUP 2 (OTHER SPECIALIZATIONS) n=28	P-VALUE MANN-WHITNEY
A1 - Develops, along with the Family Health Strategy and social structures in the area, health promotion and prevention actions encompassing the various fields of SLH work, aimed at people and/or groups in all cycles of life.	2 nd	2 nd	0.4135
A2 - Knows the Health Policies and Programs (child, woman, man, elderly health, and so on) developed in PHC and, based on these, outlines strategies for SLH instruction and/or follow-up aimed at the community needs.	5 th	1 st	0.1076
A3 - Promotes actions aimed at developing healthy attitudes and environments for human communication, considering speech, language, voice, hearing, oral-motor function, and other aspects related to core SLH therapy.	11 th	4 th	0.0050*
A4 - Performs actions aimed at pregnant women regarding breastfeeding, oral habits, and hearing, language, and speech development.	18 th	12 th	0.2372
A5 - Develops educational and informative material aimed at the community needs.	14 th	9 th	0.6387
A6 - Develops actions aimed at older adults to promote healthy aging, improving cognitive skills, communication, and social inclusion.	20 th	14 th	0.1811
A7 - Performs and/or accompanies, along with the health service network, screenings related to core SLH therapy (Universal Neonatal Hearing Screening [UNHS], Tongue-Tie Test, and so on).	23 rd	16 th	0.0497*
A8 - Visits patients at home in cases related to PHC, for SLH assessment and monitoring, as well as referrals, when necessary.	16 th	18 th	0.5787
A9 - Develops situational health diagnosis based on the identification of the risk factors to human communication in the area.	3 rd	3 rd	0.0708
A10 - Welcomes, follows up, instructs, assesses, rehabilitates, and refers patients regarding the lines of care in attention network, in the various fields of SLH work.	7 th	6 th	0.8465
A11 - Participates in mental health care, ensuring that aspects of language, hearing, voice and oral-motor function are considered.	19 th	21 st	0.9348
A12 - Helps set priorities in the health care network regarding access and solution of the needs related to oral and written language (including learning), fluency, voice, hearing, swallowing, and oral-motor function, aiming at comprehensive care in all cycles of life.	6 th	5 th	0.4071
A13 - Provides individual and collective SLH care in cases related to PHC.	15 th	19 th	0.1816
A14 - Makes reference and counter-reference for levels of medium and high complexity.	13 th	11 th	0.6890
A15 - Instructs patients, families, and health teams regarding the core SLH work.	12 th	13 th	0.3275
A16 - Performs SLH management.	22 nd	23 rd	0.7847
A17 - Writes reports, evaluations, and medical records.	21 st	22 nd	0.0689
A18 - Participates in shared health care, aiming at developing Unique Therapeutic Projects.	8 th	15 th	< 0.0001*
A19 - Participates in health teams, developing collaborative multi- and interprofessional practices, aiming at comprehensive health care.	4 th	7 th	0.2941
A20 - Provides team support in both the technical assistive dimension – in cases with SLH needs in PHC – and the teaching-learning dimension – regarding health team training.	1 st	8 th	0.0811
A21 - Participates in continuing education in SUS health care.	9 th	17 th	0.0424*
A22 - Helps define and systematize the epidemiological data that can outline the coverage area, validating the construction of health indicators and SLH work.	10 th	10 th	0.5012
A23 - Holds management positions in health units and/or teams.	24 th	24 th	0.3110
A24 - Develops health surveillance actions.	17 th	20 th	0.9967

Legend: White: Specific activities (Core); Light gray: Common activities (Field); (*): indication of the significance level

Figure 3. Comparative table of the activities listed in order of priority by the speech-language-hearing professors in the field of public health and in other fields of work.

Numerically, the specific professional activities (in white) predominated. These 16 activities are the core ones, which only the SLH therapist can perform in PHC. The other eight are the common professional activities, the field ones (in gray), which any PHC health professional can perform. We must point out that some activities considered common to all were grouped in this study as specific to preserve the consensus, which directed them as specific SLH practices.

The specific professional activities encompassed SLH team support; SLH health policies and priorities in the health care network; SLH health promotion, prevention, and situational diagnosis; SLH support, instruction, and follow-up; construction and systematization of epidemiological data; promotion of healthy environments for human communication; instruction on the scope of SLH therapy; individual, group, and home SLH care; actions aimed at populational groups (pregnant women, older adults, people with mental health problems); screenings; SLH administration.

The common professional activities included teamwork; shared health care; continuing education; reference/counter-reference; development of educational material; health surveillance; reports and evaluations; administration.

Both groups' lists gave priority to the common rather than the specific professional activities. On the other hand, only four of them had a statistically significant difference between the groups: activity **A3** (Promotes actions aimed at developing healthy attitudes and environments for human communication, considering speech, language, voice, hearing, oral-motor function, and other aspects related to core SLH therapy) and activity **A7** (Performs and/or accompanies, along with the health service network, screenings related to core SLH therapy) were more important to the professors of the various fields than to the public health ones.

Activities **A18** (Participates in shared health care, aiming at developing Unique Therapeutic Projects) and **A21** (Participates in continuing education in SUS health care) were more important to the public health professors than to those in the other fields. These findings may suggest that professors in the other fields gave more importance to core activities, which have been performed for longer in SLH care, whereas the public health group gave more importance to the activities focused on collaborative PHC practice¹⁹.

Discussion

This study has some weaknesses, particularly regarding the participants. We invited the whole community of public health SLH professors to participate. However, not all of them agreed to it, and many of those who did withdrew in the process. Moreover, the study design may compromise the possibility of data generalization and use in other contexts, especially when we consider the differences in SLH training and practice both in Brazil and worldwide.

Nonetheless, this is an important step in the national literature, as we reached an unprecedented consensus among those responsible for public health SLH training in the country.

The data on the respondents suggest a heterogeneous profile of public health professors in SLH programs in the country. Despite the said limitation, we can reflect on the professors' training to work in public health, as well as the impact of such heterogeneity on the training of future professionals to work in SUS.

The activities pointed out in the consensus agree with the literature regarding the SLH work in PHC. Costa et al.²⁰ analyzed the SLH practice in NASF in the state of Paraíba. They identified health promotion activities and teamwork and found predominantly core practices, interpersonal relationship barriers, and difficulties carrying out actions to integrate core and field. According to the authors, these can fragment health attention and weaken the patient's comprehensive care. In Recife, Pernambuco, Brazil, Andrade et al.²¹ presented common and specific requirements of SLH therapists in NASF, which agrees with this consensus: developing Unique Therapeutic Projects, team cooperation, home care, instructions, shared health care, and so forth. There are further similarities with the findings of Oliveira and Nascimento² on the SLH practice in NASF.

Fernandes and Nascimento²² identified the SLH professionals' work in NASF in Recife: health diagnosis in the area, home visits, instructions to the families, educational groups, and case discussion meetings.

Collaborative practices and interprofessional work

Peduzzi and Agreli¹⁹ surveyed several conceptual distinctions proposed by various authors

about teamwork and highlighted the importance of interprofessional collaborative practices and elements present in the health services. Escalda and Parreira²⁹ stated that, over the years, the collaborative practices have been increasingly incorporated into PHC, creating favorable room for dialogue between the professions and aiming at comprehensive health care.

In this consensus, some common professional activities pointed to teamwork, considering multi- and interprofessional collaborative practices, shared health care, team support, development of Unique Therapeutic Projects, and continuing education.

Throughout their training, SLH therapists must have theoretical and practical opportunities to get prepared to work in teams. The higher education institutions must provide the necessary tools, including current conceptual bases. These are essential to work in PHC, especially the effective communication of the professionals with one another and with the patients, establishing partnerships with social groups, other teams, and health network services^{19,23}.

The Primary Health Care Notebook addresses some guidelines and tools of interprofessional work in PHC – especially in NASF, where SLH therapists are more broadly inserted. The following tools are used to make team support effective (in technical-assistive and teaching-learning dimensions): working in groups, Unique Therapeutic Projects, genogram, ecomap, shared home health care, shared individual health care, and specific individual health care²⁴.

Some of these were mentioned in the consensus, such as shared care and Unique Therapeutic Projects (**A18** – Participates in shared health care, aiming at developing Unique Therapeutic Projects); working in groups (**A1** – Develops, along with the

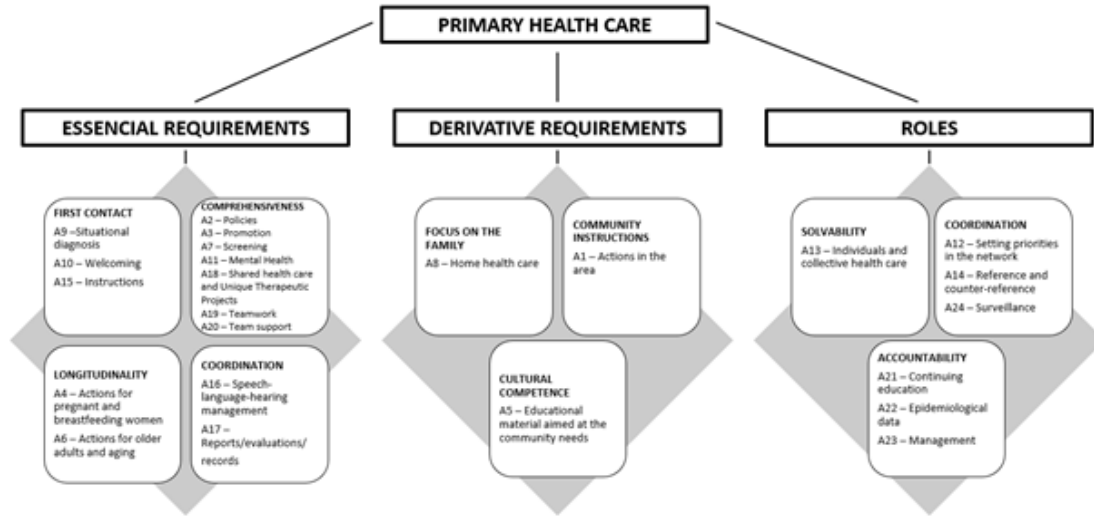
Family Health Strategy and social structures in the area, health promotion and prevention actions encompassing the various fields of SLH work, aimed at people and/or groups in all cycles of life); home health care (**A8** – Visits patients at home in cases related to PHC, for SLH assessment and monitoring, as well as referrals, when necessary); and team support (**A20** – Provides team support in both the technical assistive dimension – in cases with SLH needs in PHC – and the teaching-learning dimension – regarding health team training). These findings agree with Oliveira and Nascimento², who proposed common requirements (situational diagnosis, Unique Therapeutic Projects, team support, and so on) as well as specific ones in NASF (case discussions, health education regarding SLH issues, individual and shared health care).

We observed that some important tools, such as ecomap and genogram, were not brought up in the consensus. This may suggest that, although pointed out in the Notebook, they are not being approached in undergraduate classes.

The PHC requirements and the work of SLH therapists

The practical experiences of SLH students throughout their undergraduate program must take place in SUS, particularly in PHC – the entry point to the system. Such opportunities bring them closer to reality and help them develop the common, specific, and collaborative skills necessary for their future work in this scenario.

Proper work in PHC depends on knowing the abovementioned requirements and roles⁸. Thus, we proposed a visual representation of the correlation between the activities in the consensus and the requirements and roles in PHC (Figure 4). They were grouped considering the activities best aligned with each of the requirements and roles.



Note: Only the theme of the activities is represented here. Their full description is given in Figure 3.

Figure 4. Visual representation of the correlation between the activities listed in the consensus and the requirements and roles in PHC.

Essential requirements

First contact is the use of the services in each new problem or new episode of a problem, for which health care is needed⁸. Hence, the activities correlated with it refer to identifying and welcoming the patients – although accessibility was not brought up in the consensus.

Longitudinality, in which the team regularly provides health care over time⁸, was related to the activities focused on the needs of older adults and pregnant women. However, intentional bonding to favor continuous care was not clearly present.

Comprehensiveness involves providing a set of health promotion, prevention, cure, care, and even rehabilitation actions, considering the determinants of the health-disease process⁸. We grouped the activities that approached knowledge of health policies related to core SLH therapy, health promotion, screenings, actions aimed at mental health, individual and shared health care, teamwork, and team support. Activity **A2**, though close to this requirement, did not make clear the need for coordinated actions, a comprehensive approach to people and their families, and ensured access to the various levels of attention.

The **coordination**, which ensures continuous care coordinated with the Health Care Networks, grouped the activities related to SLH management (term used in identifying the monitoring/follow-up

parameters in dysphagia)²⁵ and reports, evaluations, and medical records – which can be recognized in the reference/counter-reference process⁸. However, neither this aspect nor information to the patients was clear in the consensus.

Derivative requirements

The activity that approaches home health care was aligned with the **focus on the family**. However, it appeared more restricted in the consensus, predominantly aimed at the visit and not the family as the subject of attention. The intention of the participants in valuing the unique role of the family in health care, as advocated, was not clear⁸.

The activity on actions in the area was grouped in **community guidance**, as it made it possible to recognize the family needs in the physical, economic, and social context where they live⁸.

In the **cultural competence**, we grouped the activity related to developing educational material focused on the needs of the community. Noticeably, we must consider not only the needs but also the horizontal relationship between the team and the population, respecting the cultural uniqueness and the patients' and families' preferences^{8,26}.

Roles in PHC

The activity that encompasses individual and collective health care was grouped in **solvability**,

which means that PHC services must provide solutions and be cognitively and technologically capable of attending 90% of the PHC needs⁸. This activity appeared restricted in the consensus, as it was not clear that solving health needs surpassed the attention, being related to essential requirements.

The **coordination** was properly approached in the activities of setting priorities in the health care network, reference/counter-reference, and health surveillance, as it is related to PHC as a communication center of the Health Care Network, setting priorities in the flow and counterflow of people, products, and information on the network sites⁸.

The activities related to continuing education, management, and construction/systematization of epidemiological data were grouped in **accountability**, characterized by the acquaintance and close relationship with the population in the perspective of population-based management and economic and health accountability in relation to the pertaining population⁸.

There are many possibilities of SLH work in PHC in Brazil, pointed out in this study and corroborated in the national literature^{2,20-22,28}. However, their work in NASF has been the main entry point of SLH therapists in this scenario, considering their potentials to bring about changes in the PHC work process²⁹. The SLH work experiences in NASF indicate progress in the concept of health towards reaching the principles of SUS. Nevertheless, difficulties related to the working situation, NASF makeup, and concepts of professional work in PHC must be overcome³⁰. To surpass and broaden the scope of action and inclusion in PHC, SLH therapists must have opportunities, provided by the higher education institutions, to apprehend the PHC requirements and NASF guidelines and tools while still in undergraduate training. Thus, they can work aligned with the needs of the SUS patients, and of their families and communities, to achieve comprehensive health care.

Conclusion

We reached a consensus on the most relevant activities of SLH therapists in PHC. We identified field activities, common to the other health professionals who work in this scenario, and core activities, specific to the SLH therapists, which

agree with the literature that addresses PHC requirements.

These data appear in good timing, as the SLH therapists' participation in this scenario is threatened, due to the resistance made to the NASF, PHC, and SUS as a whole. The activities obtained in this consensus will hopefully contribute to this debate and to decision-making on the part of health administrators, based on understanding how important it is to include these professionals in PHC, meeting the current health work needs in Brazil.

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