Contributions of the physical therapist to primary health care based on multiprofessional residency

Contribuições da fisioterapia para a Atenção Primária à Saúde a partir da residência multiprofissional

Lorena de Oliveira Freitas [1]
Jonas Loiola Gonçalves [1*]
José Edmilson Silva Gomes [1]
Juliana Freire Chagas Vinhote [2]
Raimunda Magalhães da Silva [3]
Luiza Jane Eyre de Souza Vieira [3]

[1] Escola de Saúde Pública do Ceará (ESP/CE), Fortaleza, CE, Brazil
[2] Universidade Federal do Ceará (UFC), Fortaleza, CE, Brazil
[3] Universidade de Fortaleza (Unifor), Fortaleza, CE, Brazil

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***Correspondence:** jonasloiola10@hotmail.com

Abstract

Introduction: Multiprofessional residency in health (MHS) is a professional training program focussed on Brazil's Unified Health System that aims to reorient techno-assistance logics and significantly contributes to the insertion and consolidation of physical therapy into primary health care (PHC). **Objective:** To understand the perceptions of health professionals and managers about the contributions of the MRH to the insertion of physical therapy into PHC. **Methods:** This qualitative study was based on hermeneutics and was conducted in the municipality of Aracati, Ceará, Brazil, with 15 professionals making up a convenience sample. Eligible were PHC professionals with higher education working in urban areas. The data were collected from March to June 2023 through semistructured interviews with the researchers. The data analysis was based on reading the material, organizing it into themes, and interpreting these in depth. **Results:** The first contact with physical therapy occurs in scenarios that range from individual and shared consultations to health programs at school, whose actions are optimized by PHC from the MHS. There are numerous physical therapy care strategies, especially actions focussed on biopsychosocial aspects. The involvement of physical therapists in health promotion is revealed by the inclusion of professionals in health promotion groups. Health education from a multiprofessional perspective enhances care through promotion and prevention. **Conclusion:** The MHS strengthens the need for physical therapy in PHC and enhances primary care.

Keywords: Interprofessional education. Physiotherapy. Primary health care Professional training in health.

Resumo

Introdução: *A partir da Residência Multiprofissional em Saúde (RMS) ocorre uma capacitação profissional mais direcionada para o Sistema Único de Saúde, visando a reorientação das lógicas tecnoassistenciais e contribuindo de forma significativa para a inserção e consolidação da fisioterapia na Atenção Primária à Saúde (APS).* ***Objetivo:*** *Compreender a percepção dos profissionais e gestores de saúde sobre as contribuições da RMS para a inserção da fisioterapia na APS.* ***Métodos:*** *Trata-se de um estudo qualitativo fundamentado na hermenêutica, desenvolvido no município de Aracati, Ceará, Brasil, com 15 profissionais por conveniência. A elegibilidade dos participantes centrou-se em profissionais de nível superior da APS em área urbana. A coleta de dados aconteceu de março a junho de 2023, através de uma entrevista semiestruturada elaborada pelos pesquisadores. A análise de dados ocorreu com base na leitura do material, organização em temáticas e interpretação por profundidade.* ***Resultados:*** *O primeiro contato com a fisioterapia acontece em cenários que envolvem desde a consulta individual e compartilhada a programas de saúde na escola, cujas ações são otimizadas pela APS a partir da residência. As estratégias de cuidado da fisioterapia são inúmeras, principalmente ações centradas nos aspectos biopsicossociais. A inserção da fisioterapia na promoção da saúde é revelada pela inclusão do profissional em grupos de promoção da saúde. A educação em saúde na perspectiva multiprofissional é potencializadora do cuidado pelas ações de promoção e prevenção.* ***Conclusão:*** *A residência multiprofissional fortalece a inserção da fisioterapia na APS e potencializa os cuidados primários.*

Palavras-chaves: *Educação interprofissional. Fisioterapia. Atenção Primária à Saúde. Formação profissional em saúde.*

Introduction

Interprofessional education (IPE) in health is part of the Brazilian National Curriculum Guidelines for the training of health professionals, whose practice is mediated by collaboration between professions and is focussed on improving public health.[1] The World Health Organization recognizes a fragmentation of care in global health systems and advocates IPE to overcome the global challenges of health services.[2,3]

IPE is a mediator through which students from two or more professions learn about each other, with others and among themselves, to facilitate collaboration and improve health indicators. Thus, by understanding what it is like to work interprofessionally, students are ready to enter the workplace by integrating collaborative practices to solve complex problems in their territories[2,3] because the state has a low capacity to reorient training models for health professionals and because the organizational support of universities and health services is described as a key element for both the implementation and long-term viability of IPE. In this sense, making time and space in the curricula for IPE has been a challenge in Brazil due to curricular rigidity, which reinforces the incompatibility of schedules for integrated interprofessional activities.[4]

Given these challenges, government programs and actions to qualify the workforce in and for the Unified Health System (SUS) were developed in Brazil. Among these, the Multiprofessional Residency in Health (MRH) and the Uniprofessional Health Residency established by the Ministry of Health stand out.[1,4] An MRH is a lato sensu postgraduate modality with an emphasis on in-service teaching–learning and theoretical-practical articulation aiming to improve the skills and abilities of health professionals.[4] The MRH becomes a differentiator in the continuity of the training of professionals to work in the SUS since the curricular components reinforce the basic principles and guidelines of the SUS.[5]

Given the interprofessional characteristics of the MRH, the above modality provides a broader view and facilitates the resolution of demands in the SUS since the work process in primary health care (PHC) comprises several professional categories.[5] PHC demarcates a set of actions for the promotion, prevention, protection, and recovery of health, on an individual and collective basis, in an ascribed territory, in which it should be the main means of access for the user to enter the health care network (HCN).[6]

The breadth and depth of the actions developed by PHC derive from activities carried out by the Family Health Strategy (FHS), and the work process is established in the territories, with linkage and healthcare responsibility of the assigned areas.[7] This configuration has faced structural challenges for decades due to underfunding and its implications for PHC management.[8,9] An example of funding is the Programa Previne Brasil and Technical Note No. 3/2020, which impacted the accreditation of new teams and demobilized multidisciplinary care in the national territory, the ultimate decisions depending on the municipal managers.[10]

The state of Ceará was a pioneer in the reorganization of health models and services, with emphasis on the creation of the Community Health Agents Program and the expansion of secondary care and health regionalization.[11] The municipality of Aracati stood out at the state level when management chose to maintain the Expanded Nuclei of Family Health and Primary Care (NASF-AB). In addition, the insertion of the MRH was optimized to ensure the provision of multidisciplinary actions.[8,9] With their multiprofessional scope, physical therapists are linked to the NASF-AB, acting in individual consultations, home visits, and intra- and extramural collective actions.[12,13]

Brazilian law 635/2023 establishes guidelines for the financial incentives and implementation of multiprofessional teams (eMulti), resulting in a differential of the modalities of monthly transfers by the federative body, which may vary according to the care arrangement, workload, relationship, and professional composition of the team.[14]

In view of the insertion of the MRH in the municipality of Aracati, questions are raised about the disarticulation of the NASF-AB, the underfunding of PHC, and the perceptions of health professionals and managers about the contributions of multiprofessional residencies in family and community health to the insertion of physical therapy in PHC. This study aimed to understand the perceptions of health professionals and managers about the contributions of MRH to the insertion of physical therapy in PHC.

Methods

This qualitative study was anchored in a theoretical-hermeneutic perspective. This qualitative study design is noteworthy for being able to incorporate the question of meaning and intentionality, which are inherent to acts, relationships, and social structures, composing significant human constructions in the sociohistorical process.[5]

From the hermeneutic perspective, the aim is to collectively represent the meanings attributed by professionals, residents, and health managers to the initial contact and forms of care of the PHC physical therapist based on their understanding of the phenomenon.[16]

Study location

The study was conducted in the municipality of Aracati, in the state of Ceará, Brazil. The data came from five health units and were complemented by strategic coordinators linked to the municipal health department. The study site has an estimated population of 75,392 inhabitants and a human development index of 0.655.[17] The organization of PHC in the urban area of Aracati has nine units: Pedregal and Nossa Senhora de Fátima (each with two teams), Abengruta I, and II, Farias Brito, São Cristovão, São Rafael, Campo Verde and Várzea da Matriz. The rest of the units are located in the countryside and near beaches. Aracati is a hub for the health region, and within its municipal area, it has 80% PHC coverage.[13]

Participants

The group of participants in this study were 15 professionals selected as a convenience sample (nine nurses, three nutritionists, one social worker, one speech therapist, and one physical therapist), 13 of whom worked in the care service and two of whom were managers (nurses). Three professionals were residents of the studied service (a nurse, a social worker, and a nutritionist). Most professionals were female, had a *lato sensu* postgraduate degree, had worked in the service for between 1 and 26 years and had a salary range of two to three minimum wages. The data collection process, with participants from all professional categories, was developed anchored in the theoretical saturation method. Thus, after reading and rereading the material, at each interview there was a discussion about the material produced in the interviews, including the data saturation.[18]

Inclusion and exclusion criteria

Participants were eligible if they were professionals with a higher education who worked in the spheres of PHC in the municipality of Aracati, an urban area, with at least 3 months of experience in the studied scenario. We excluded professionals on holiday or on sick leave.

Data production

The data production period occurred from March to

June 2023, guided by the following steps: First, the municipal health department was contacted, followed by visits to the health units. The participating professionals were contacted by the researchers through local management and/or during work practice, followed by invitations to participate in the study. Soon after, the research objectives were presented, creating a cordial relationship with the participants, and later the respondents signed the free and informed consent form if they wished.

Instrument

A single semistructured interview was conducted by a female student and a *lato sensu* graduate student, both of whom were multiprofessional residents. The material was prepared by the researchers, who, calling upon their training for this study, asked guiding questions. The instrument consisted of questions about the sociodemographic characteristics and role of physical therapists in PHC in view of their experience with multiprofessional residency in family and community health.

Organization and analysis of the data

The study records were audio recorded individually with the participants, with an average duration of 20 minutes. The organization was performed by transcribing the interviews in full, in order, through classification and analysis, without the support of software. The data were analysed by reading and rereading the material. The data were initially organized by nuclei of meaning, separated into themes, and, later, comprehensively interpreted and discussed in the context of the relevant literature.

Ethical aspects

All study participants signed the informed consent form, according to their category of activity. The participants' coding by profession was adopted, followed by the contract regime (contractor = C; permanent = E; resident = R) and a numeral according to the order of the interviews (Nutritionist/C3). The study followed Resolution 466/12 of the National Health Council on ethics in research with human beings[19] and Resolution 510/2016 on research with human beings anchored in the social and human sciences.[20] The study was approved under protocol number 5,921,294.

Results

Contact with the resident physiotherapist in the PHC

First contact with physical therapy according to the perceptions of professionals and managers occurred in different PHC settings. The participants first made contact through interprofessional collaborative practice, with the execution of shared consultations, immersion in the School Health Program (PSE), and integration of the training contact optimized by residency.

In consultations shared between nurses and physical therapists. In the PSE (Nurse/R1).

In the monthly thematic activities held at the PSE. In addition to the team meetings that are held weekly or fortnightly. And the groups that we form in the localities of the city (Nutritionist/C1).

Professional contact included collective health studies, shared care between nutrition and physical therapy, health education, lectures, and the PSE (Nutritionist/C3).

Residents and professionals converged in emphasizing the potential role of residency in initiating the first contact of physical therapy in PHC, both between health professionals and with service users, highlighting residency as a teaching process for the development of the expanded clinic:

This contact started with the residency program, which already comes with the premise that we are always providing shared care; it started there and complemented when we arrived in the municipality because we make up a NASF-AB team (Assistant Social/R1).

Through a consultation, we had the first contact with physical therapy, and we treated a patient, and the resident arrived through the residency program (Physical Therapist/C1).

Contact occurs mainly through residency. We have meetings, and we work through the NASF-AB on the multiprofessional team (Nutritionist/R2).

Initial contact with the PHC physical therapist is recognized by immersion in the programme. In view of the proposal, management accompanies these professionals through various paths, with a view to insertion and qualification in the service and undergoing training for numerous situations.

The first contact, as I am in the articulation in the coordination of the residency strategy, whenever they [the residents] arrive, we already have an initial contact. This contact lasts for 2 years, in the qualification of the schedule of activities, in the organization of care, and how they will make the journey in the municipality (Manager of NASF-AB/E1).

It was through contact with a family, when they got there they started talking, it was a psychologist, a physiotherapist, it was that team, and each one developed a little bit in their profession, their mission (Manager of Continuing Education/C2).

The immersion process of the residency is seen as an opportunity for contact for the articulation and potentialization of teaching, research, and especially the improvement of health care in PHC, given the insertion of physical therapy from the professional nucleus and the remodelling of curricula.

Physiotherapy care strategies in PHC

The physical therapy care strategies in the PHC context are actions that consider biopsychosocial aspects, aiming to ensure care for different populations. The participants view shared consultation as a fundamental resource for meeting the needs inherent to human subjectivity in the face of a search for the service and as a central pillar in health promotion and prevention activities.

Shared care in the unit and home visits (Nurse/C3).

Shared consultations, especially in women's health, are performed about the pelvic floor. There are many women with urinary incontinence, so the physical therapist guided the pelvic floor exercises to improve this incontinence (Nurse/C4).

There are numerous opportunities in addition to the shared care proposed by physical therapy in PHC. The understanding of the reports shows that physical therapy and the MRH proposal involve dynamics that permeate individual care, especially with collective strategies focussed on health education to strengthen care in PHC.

Individual consultations, home visits, shared consultations, health education, continuing education, PSE, and collective action (Physiotherapist/C1).

The resident physical therapist has his role in the NASF-AB, the individual care that is his outpatient clinic. In the health units, he is responsible for collective activities, shared care among other professionals from the same team, the NASF-AB, health education in schools and units, and lectures (Nutritionist/C3).

The understanding we gained from the reports introduced new perspectives on physical therapy care strategies in PHC. Particularly, it showed the need for new curricular models integrated with the service aimed at prevention and health promotion.

The insertion of the physical therapist in health promotion in PHC

In view of the activities reported by the participants, health promotion groups emerged as a potentiating proposal for care in PHC, especially through the inclusion of physical therapists. The groups were shown to be important for the care of several specific PHC groups, reinforcing the importance of including physical therapy in PHC.

Physical therapists perform many group activities with hypertensive patients, diabetic patients, and pregnant women, to talk about a physical therapy subject that is relevant to health (Nurse/C2).

The importance of having him here is that we have been working together with the physical therapist resident at the NASF; these are health promotion activities; in all the professional physical therapy activities, he participates, both in groups and in case discussions, thus performing a shared role starting from its insertion (Nutritionist/R7).

Residents emphasize these activities a lot, and I know that physical therapy is not only curative and rehabilitative, so I know that they do it, they do health education, they do prevention and health promotion, they do support groups (Manager of the NASF-AB/E1).

Given the context of offering health care through groups, the act that is focussed on health education not only benefits one-off measures but is an articulator that enhances care and attention in a network in the face of collective proposals. The groups bring an opportunity to strengthen care, so the absence of the physical therapist may detach care from PHC, leading to referral to secondary and/or tertiary services.

Promotion groups focussed on health education. A network of care emerged, with shared care and various other activities (Speech therapist/E1).

*Without the physical therapist here in the unit, we would need to refer patients to secondary care (*Nurse/C4).

In this context, the importance of including groups with the role of physical therapy in PHC is reinforced, recognizing the organizing role of PHC in Brazil, which can even be strengthened when the number of professionals and trainings are expanded to include new or consolidated existing care strategies.

Health education from a multiprofessional perspective

In the context of PHC, health education has become a catalyst for multiprofessional care to users who seek primary health services. The care offered through this method provides health promotion and prevention actions in the different contexts in which PHC is incorporated.

In primary care, we work a lot with an educational and preventive approach, such as collective work, guidance, and health education, in the most different areas (Social worker/R1).

The professionals recognize that the physical therapist, in this context of health education, becomes a potentiator for this care since, in addition to potentiating multiprofessional care, the skills and competencies of this professional potentiate the articulation of priority groups in PHC.

The physical therapist teaches some manoeuvres that help when it is time to give birth. Hypertensive, diabetic, or obese patients, there is always something, as the NASF-AB is a multiprofessional team; they sit down, meet, and make a plan and release the information to the population and answer questions (Nurse/C6).

The NASF-AB develops actions here in the unit; every month, we try to do some action or conversation circle with our patients present. The public is usually patients with hypertension and diabetes, which is the largest population we have here. There, we also carry out actions in the square in which the NASF-AB also participates (Nurse/C3).

Given the provision of actions and articulation of the service, it is possible to offer primary care outside the structures of health facilities, going to squares and making PHC increasingly closer to the enrolled population.

Discussion

The participants recognized that the integration of initial contact with physical therapy, often mediated by MRH, also occurs through the provision of multiple forms of care, from specific programs to nucleus circles, health-promoting groups and the PSE. In this context, PHC becomes crucial for this contact, both for HCN users and for health professionals and managers, based on the IPE since PHC is a potentiator of integration and ensures continuity, horizontality, and interprofessionality.[6]

International experiences reinforce the importance of universal, inclusive, and multicategory health systems at the primary-care level. Canada invests in strengthening PHC with a community focus, becoming an international reference through the inclusion of multiple professionals in the PHC context.[21,22] The Portuguese health model reinforces the importance of PHC as a precursor to universal and first-line access to reduce costs and enhance the quality of health services and user satisfaction.[23]

Professionals and managers recognize that an MRH and the training models adopted for and aimed at PHC accompany contemporary dynamics so that the roles and purposes of this profession change. In the United Kingdom, since 2013, new training contexts for PHC with an emphasis on physical therapists have been essential in this field, as professionals are recognized as one of possible first contacts for PHC users.[24]

From this perspective, a comparative analysis of successful international experiences is of paramount importance. In the Brazilian context, however, physical therapy is gaining space, contributing significantly to strong and effective PHC and FHS. Brazilian researchers have recognized PHC as an essential field of practice for the training context since graduation, making direct and successful contributions to improving people's quality of life, especially in the treatment of people with disabilities, diseases, chronic diseases, and health education and with a focus on the community.[25]

When experiencing initial contact and knowing about the possibilities of care in PHC, it is recognized that the role of physical therapy in this field is to be divider for

training meetings on the exchange of knowledge, skills, and attitudes, which in turn make PHC even more powerful in public health care. The MRH in the Brazilian context, the inclusion of physical therapy in PHC and the availability of curricular internships during graduation enhance the debates about and successful experiences with the insertion of this professional in HCNs.[25-27]

On the other hand, the role of physical therapists in Brazilian PHC faces challenges, as its insertion and performance are not well known due to political-economic and organizational peculiarities,[25] and given the history of the profession, as priority is given to conditions already installed and damage is caused by the fragility of the composition of the networks.[28]

Faced with these challenges, the need for the inclusion of this professional class in PHC is reinforced as a potentiator of care, as well as a potentiator for reducing the economic impacts of HCNs.[25-27] Health professionals and managers recognize that the provision of physical therapy focussed on primary care decreases referrals to the secondary health care axis, making care issues better resolved. From the offer and insertion of physical therapy, professionals and managers recognize that collective strategies arise, focussed on the priority demands of the service. According to the participants' perceptions, however, specific care emerges, but all of this care involves prevention and health promotion actions. Thus, it is recognized that the care offered by the multiple activities of PHC implies the solvability of PHC.[28]

Based on the production of data and evidence from the international context, the importance of including professionals in this level of care is reinforced. In Danish primary care, tools for tracking low-back pain and its possible disability decrease public spending on health care.[28] This finding agrees with the experience of Brazilian researchers in the context of PHC, who highlight the need for physical therapy intervention for urinary incontinence, emphasizing that the implementation of care at this level reduces costs for users and health systems.[30]

It is reiterate that the actions related to rehabilitation in the community should not be annulled but rather add new possibilities and needs for action, as they must be in accordance with the organization of the SUS and the level of complexity of the HCN.[5] There is evidence that health promotion and early screening interventions that focus on empowering individuals and the community to improve the quality of life and health are effective at preventing and controlling numerous chronic conditions.[31,32]

Even with the recognition of the multiple activities performed by physical therapists in PHC and the fact that collective actions are key for care, researchers point out that the training and practice scenarios are still centred on the disease and on the perpetuation of the hegemony of the biomedical model. In this scenario, the importance of an even broader insertion of professionals into PHC can be seen, along with the majority integration of the education and health sector by higher education institutions to generate and consolidate the activities and care of the profession in PHC.[33]

In this scenario, the MRHs are recognized as spaces to improve and acquire skills, with the use of active methods and insertion in the HCN offered to various professional categories, such as nursing, nutrition, physical education, social work, dentistry, psychology, and physiotherapy. The training process takes place together with the activities in the service, expanding the teams' ability to solve problems, strengthening the change in the health care model, and facilitating the improvement of work processes.[34]

Comprehensive inferences from health promotion groups can be used to optimize and broaden the perceptions of residents, professionals, and health managers regarding the care of PHC populations. It is reinforced, based on scientific evidence, especially the Brazilian experience, that the therapeutic groups coordinated by PHC, focussed on health promotion, are inserted as potentiating strategies for care at the primary level.[35-37] The inclusion of physical therapy in PHC, especially coupled with strategies in health promotion groups, minimizes the impacts of existing demands, optimizing the acts of promoting health in a broader way. Particularly noteworthy is the support that these groups play in the field of health education, in which they should aim at therapeutic/holistic care, breaking the hegemony of curative practices and optimizing human care.[26]

It is noteworthy that this action is not centred on mere prescribing acts (complaint-conduct) but allows qualified listening to understand functionality in PHC, whereby, from therapeutic groups open to various audiences and being monitored by professionals from PHC primary care, MRHs and the inclusion of physical therapy contribute to the formation, performance, and comprehensive care in the community context.[38]

In fact, health promotion groups focussed on community care have shown improvements in functionality and thus in the quality of life of the population served.

Whether this practice is performed by the MRH, by physical therapists, or by other health professionals, its consolidation in PHC is essential. Notably, group physical therapy is an efficient option that promotes health and alleviates clinical complications that permeate HCNs but requires greater service–user–community integration.[39]

Collective practices favour numerous health actions and access to care and self-care, including group modalities with integrative and complementary health practices in the FHS. There are many experiences of this type in municipal territories for the production of health based on therapeutic practice. Thus, the MRH have a prominent role in conducting these group practices, both in the scope of prevention in health and in the aspects of health promotion for the community.[40]

Our results reveal the role of multiprofessional care with an emphasis on health education, in which, based on an action between an MRH, physiotherapy, and the multiprofessional team, users reflected and raised awareness about the lifestyle. Thus, the provision of collective or individualized care is relevant to PHC care, especially by promoting the particularities and singularities of the users served, with a focus on risk stratification, prognosis, and health care.[34]

Multidisciplinary action in health education is increasingly being strengthened by the insertion of MRHs and IPE. This finding demonstrates that working together with professionals from different areas significantly improves the quality of life of users, emphasizing the importance of developing communication and collaboration skills to provide more efficient and integrated care.[38]

The experience of our respondents reinforces the debate about the need for holistic, humane, and interprofessional training, as it is essential to face complex and multidisciplinary challenges with guaranteeing comprehensive care in PHC. Thus, health education developed by the MRH and other PHC actors, in an inter- and multiprofessional nature, plays a key role in consolidating the axes of health promotion and prevention and subsidizes the preparation of qualified professionals for the SUS.[34,40]

The limitations of this study include the challenges of finding professionals available to participate in the interviews, the inability to conduct focus groups, and the focus on a single municipality in Ceará due to technical and budgetary constraints.

Conclusion

The MRH strengthens the inclusion of physical therapy in PHC and raises the quality of primary care. The results of this study allow us to understand that contact with physical therapy is established and strengthened by the offer of multiprofessional residency in PHC. Therefore, care strategies are expanded through the interaction of the physical therapist with the residents. The increase in this training modality and the consolidated insertion of physical therapists in PHC teams provide subsidies to bring professionals from both categories together and enhance comprehensive care for patients.

Authors' contributions

LOF conducted all stages of the research, and JLG supervised it. Both were responsible for the initial writing of the article. All authors conducted the formal analysis and critical review of the article and approved the final version.

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