Teaching comprehensiveness in child health care within physical therapy programs: advances and challenges

O ensino sobre a integralidade na atenção à saúde da criança em cursos de fisioterapia: avanços e desafios

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Date of first submission: April 9, 2025
Last received: June 19, 2025
Accepted: August 26, 2025
Associate editor: Ana Paula Cunha Loureiro

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Abstract

Introduction: The concept and practices of comprehensiveness in health care, a core principle of the Brazilian National Health System (*Sistema Único de Saúde* - SUS) are central to the education of health professionals. **Objective:** This study examines how comprehensiveness in child health care is taught in undergraduate physical therapy programs. **Methods:** A qualitative study was conducted with undergraduate physical therapy programs in North-east Brazil. Data were collected through document analysis of course curricular documents and semi-structured interviews with faculty members responsible for teaching child health. **Results:** The study involved three public undergraduate physical therapy programs in Northeast Brazil and interviews with nine female professors responsible for teaching child health care. The course documents demonstrated an emphasis on multiple levels of care, supporting the integration of comprehensiveness into the curriculum. According to the interviews, comprehensiveness was consistently valued and identified as a guiding principle of the SUS, particularly in relation to professional practice that considers the individual as a whole and promotes service integration. **Conclusion:** In the programs analyzed, the teaching of child health incorporated the concept of comprehensiveness into the education and training of future physical therapists, a principle recognized and valued by faculty.

Keywords: Higher education. Child health. National Health System.

Resumo

Introdução: *O conceito e as práticas da integralidade na atenção à saúde, um dos princípios do Sistema Único de Saúde (SUS), constituem importantes norteadores da formação do profissional de saúde.* ***Objetivo:*** *Analisar como se processa o ensino da integralidade da atenção à saúde da criança na graduação em fisioterapia.* ***Métodos:*** *Trata-se de um estudo qualitativo, que incluiu cursos de graduação em fisioterapia da Região Nordeste do Brasil. Os dados foram obtidos por meio de análise documental dos projetos pedagógicos dos cursos e entrevista semiestruturada aplicada a docentes envolvidos no ensino da saúde da criança.* ***Resultados:*** *A pesquisa foi conduzida em três cursos de graduação em fisioterapia de instituições públicas da região Nordeste, envolvendo entrevistas com nove docentes do sexo feminino, atuantes no ensino da saúde da criança. Os conteúdos dos documentos voltados ao ensino da saúde da criança contemplaram ações em diferentes níveis de atenção, favorecendo a abordagem do tema integralidade. Verificou-se, com base nas entrevistas com as docentes, que a integralidade é valorizada e identificada como princípio do SUS, com ênfase na atuação profissional, que considera o indivíduo na sua totalidade e na articulação dos serviços.* ***Conclusão:*** *Nos cursos analisados, o ensino da saúde da criança abordou a integralidade na formação do fisioterapeuta, conceito valorizado e reconhecido pelos docentes.*

Palavras-chave: *Ensino superior. Saúde da criança. Sistema Único de Saúde.*

Introduction

In Brazil, physical therapy was formally recognized as a higher education profession by Decree-Law No. 938/69, which defined its scope of practice, granted professional autonomy, and established that "it is the exclusive responsibility of the physical therapist to apply physical therapy methods and techniques aimed at restoring, developing, and maintaining the patient's physical capacity".[1] Although the decree framed physical therapy primarily within curative and rehabilitative functions, it represented progress compared to Official Opinion No. 388/1963, which limited physical therapists to carrying out physician-prescribed techniques and exercises.[2-4]

The creation of the Federal Council of Physical Therapy and Occupational Therapy (COFFITO) and Resolution No. 08 in 1978 marked a new stage for the profession. These measures broadened the scope of practice to include different levels of care (primary, secondary, and tertiary prevention) and promoted a more holistic approach to health, extending beyond physical capacity alone.[5,6]

The establishment of the Brazilian National Health System (SUS, Sistema Único de Saúde, commonly translated as Unified Health System) in 1988 defined health as a universal right and a duty of the State.[7] Its implementation, guided by well-defined principles, introduced significant changes in health care delivery for the population, including targeted policies for people with disabilities, which broke from a historically philanthropic care model within which physical therapy had traditionally practiced.[8,9]

Achieving the principle of comprehensiveness has been a major challenge in implementing and consolidating the SUS. As a legal and institutional mandate, this principle ensures that health care is provided across all levels of service complexity, encompassing health promotion, disease prevention, treatment, and rehabilitation, while also fostering integration between collective and individual actions.

Comprehensiveness can be considered a guiding attribute for health practices, service organization, and policy development. Two main dimensions support its implementation in the SUS.[10,11]

The first dimension addresses the work process of health professionals, emphasizing a holistic view of the person receiving care. Comprehensiveness is expressed in the act of caregiving, in listening and responsiveness, and in the professional's ability to identify individual health needs beyond the immediate complaint. It also highlights the importance of multiprofessional teams and coordinated efforts in health promotion, disease prevention, treatment and rehabilitation.

The second dimension emphasizes comprehensiveness in service integration and continuity of care, aiming to build an effective health care network. This requires intersectoral collaboration, whereby health initiatives are coordinated with actions from other sectors and community efforts to generate synergistic effects in complex situations.

In child health care, several public policies reinforce the role of comprehensiveness. Among them, the National Policy for Comprehensive Child Health Care (*Política Nacional de Atenção Integral à Saúde da Criança -*

PNAISC), established by Ordinance No. 1.130 on August 5, 2015, reaffirms the principle of comprehensiveness, underscoring the importance of strong bonds between child, family, and health professional, with shared responsibility as a core element of this approach.[12]

Implementation of the SUS and policies aimed at overcoming fragmented care, the reductionist biological view of health, and the divide between individual and collective actions, have necessitated a new set of professional competencies. Notably, Article 200 of the Brazilian Constitution had already established the SUS as a central actor in guiding professional training.[7,13] In this context, the National Curriculum Guidelines (NCGs) for health programs, including physical therapy (Resolution No. 4 of February 19, 2002), were established in 2001-2002. These guidelines emphasized the ability to work within the Health Care Network with a comprehensive and humanistic approach.[3,14] In the 2000s, interministerial education and health initiatives reinforced NCGs, promoting the integration of practical training in health services, closer ties with communities, multiprofessional teamwork, and an understanding of SUS principles and strategies, especially comprehensive care.[15]

These initiatives brought significant advances to health professional education, including a broader range of training environments, multiprofessional experiences, collective approaches, and health promotion activities. However, this has been accompanied by persistent challenges,[16,17] such as curriculum design and faculty understanding of health service organization and SUS principles and strategies, which are essential for effective professional training.

To contribute to a better understanding of these ongoing changes, this study aimed to describe how comprehensiveness in child health care is taught in undergraduate physical therapy programs in Northeast Brazil, and explore how faculty involved in the training of physical therapists conceptualize comprehensiveness in health care.

Methods

This qualitative, exploratory, and descriptive study analyzed public higher education institutes (HEIs) offering undergraduate physical therapy programs in the states of Alagoas, Paraíba and Sergipe, in Northeast Brazil.

The region has 15 undergraduate physical therapy programs in public institutions, six in state and nine in federal HEIs. Three of these programs were included in the study based on distinct characteristics: one of the oldest programs in the region, one undergoing curricular restructuring to align with NCGs, and one established during the implementation of NCGs. To ensure confidentiality, the programs were anonymized as HEI C1, HEI C2, and HEI C3.

The study included two components: 1) document analysis, based on course syllabi available through the Ministry of Education's e-MEC system); and 2) interviews with professors responsible for teaching child health.

Document analysis considered the political-pedagogical projects (PPPs, the official curriculum framework for undergraduate programs in Brazil) and syllabi that included the terms "child", "pediatrics", "infant," or "neonatology" in the title or description. Information was collected on practice settings, course content, and teaching strategies in child health courses that promoted comprehensiveness in health care.[18] The analysis followed the model proposed by Seixas et al.,[19] which organizes information into three categories: (1) theoretical, philosophical, and pedagogical foundations, including the competencies and skills defined in the institutional graduate profile and the teaching methodologies adopted (training process); (2) curricular structure, focusing on how the course curriculum incorporates child health, either through specific courses/modules or broader courses that address the theme in relation to comprehensiveness; and (3) professional practices, examining internships with regard to practice settings, organization, and areas covered in training.

The interviews were conducted with permanent faculty members, identified by program coordinators, who were actively teaching child health at the time of data collection and had at least one year of experience at their institution. Of the 10 eligible professors at the three institutions studied, nine agreed to participate.

Interview questions addressed the following: participants' understanding of comprehensiveness; how their courses or modules were planned to incorporate comprehensiveness into child health education; strategies and methodologies used to address theoretical and practical aspects of comprehensiveness in child health; practice settings employed to incorporate comprehensiveness into child health education; activities in the child health courses/modules that engage families and

caregivers to foster comprehensiveness in care; and the extent to which interprofessional activities were included to support comprehensiveness. The responses to open-ended questions were analyzed using Bardin's content analysis method,[20] consisting of initial reading, pre-analysis to record preliminary impressions, followed by thematic analysis of the material.

The study was approved by the Research Ethics Committee of the Federal University of São Paulo, approval no. 1.890.164.

Results

The document analysis findings are presented following the model proposed by Seixas et al.[19]

Theoretical, philosophical and pedagogical foundations

Evaluation of the expected graduate profile revealed common elements across the HEIs in terms of program characterization, desired competencies and skills, and professional practice areas. All three HEIs (C1, C2 and C3) offered courses and modules based on curricula approved under the NCGs for undergraduate physical therapy programs, designed to develop competencies, skills, and knowledge that prepare future professionals to work according to SUS principles and guidelines. The programs prepare graduates to work across all levels of health care through a comprehensive, evidence-based education grounded in ethical and cultural principles.

Curricular structure

The programs studied were full-time, lasting 10-16 semesters with curricular integration. The child health-related courses/modules in HEIs C1, C2 and C3 totaled 240, 405, and 230 hours, respectively, and were organized progressively according to the complexity of the practice settings.

Analysis of institutional documents enabled the systematization of child health content in the three HEIs, summarized in Table 1.

Table 1 - Summary of child health-related content in courses/modules of physical therapy programs at higher education institutions (HEI)

HEI	Syllabi/Content
C1	The role of physical therapy in public health: an overview of the child and adolescent care pathway; Stages of motor development/milestones; Importance of play and psychomotricity; National policies for comprehensive child health care (routine care, neonatal screening, breastfeeding, nutrition and immunization, monitoring growth and development, Kangaroo Method, and Rede Cegonha); Physical therapy methods and techniques in neonatology and pediatrics; Comprehensiveness in child health care; Sensorimotor stimulation in the NICU and PICU; Physical therapy in neonatology and pediatrics.
C2	Understanding normal child development and growth, prevalent diseases, and the role of physical therapy in prevention, treatment, and rehabilitation; Educational and preventive activities in schoolchildren; Assessment and application of physical therapy methods and techniques in neonatology and pediatrics; Sensorimotor stimulation in newborns; Home care; Multi- and interprofessional approaches; Physical therapy assessment and treatment in neonatology and pediatrics.
C3	National policies for comprehensive child health care (routine care, neonatal screening, breastfeeding, nutrition and immunization, monitoring growth and development, Kangaroo Method, etc.); Maternal/paternal role and child psychological constitution; deprivation (affective, nutritional, and environmental); Accident prevention in schoolchildren; Toys and play; Comprehensiveness in child health care; Physical therapy assessment, methods, and techniques in neonatology and pediatrics.

Some courses/modules were not specifically focused on child health but contributed to the teaching of comprehensiveness, including Health and Society IV, Practice and Teaching in the Community II, and Public Health at HEIs C1, C2 and C3, respectively. All three HEIs addressed the PNAISC,[13] and comprehensiveness in child health care was explicitly included in the syllabi of C1 and C2. The syllabus of C1 specifically addressed the Maternal, Neonatal, and Child Health Care Network (Rede Cegonha), part of Axis I of the PNAISC.[12]

HEIs C1 and C3 emphasized guidance for parents and caregivers and communication between therapists and children, aiming to strengthen relationships and deliver comprehensive care. Interprofessional practice was mentioned only in the material from HEI C2.

Teaching methodology

All three HEIs used diverse, complementary teaching-learning strategies, including active learning methodologies, in line with NCGs.

Professional practice

Analysis of the mandatory internships in the programs showed workloads between 900 and 1,000 hours, consistent with NCGs. All three HEIs offered internships in child health, but only C1 and C3 included outpatient, hospital, and primary care activities; C2 offered only outpatient and hospital experiences.

Faculty perceptions of comprehensiveness in child health education

Nine professors teaching child health courses/modules were interviewed, identified by the code of their institution and a randomly assigned number (e.g.: C1P1, C2P1, etc). Their average age was 42 years; all were women trained in physical therapy, with 6 to 35 years' experience, five holding master's degrees and four doctorates. Their field of practice varied, with three working exclusively in outpatient care, three in hospital settings, one in outpatient and hospital care, one in outpatient and primary care, and one in hospital and primary care.

All the professors recognized comprehensiveness as a guiding principle of the SUS. Their statements were organized into two categories based on Mattos' framework: comprehensiveness in the work process of health professionals; and in health services, care networks, and intersectoral collaboration.[11]

Comprehensiveness in the work process of health professionals

Professors emphasized a holistic perspective on the individual, including their history, values, and social and cultural context, and highlighted the importance of caregiving, attentive listening, and establishing bonds. They also pointed to the critical role of multiprofessional teams in health promotion, disease prevention, treatment, and rehabilitation. While recognizing the importance of comprehensiveness, they also noted challenges in practice settings, which can hinder both service delivery and teaching aligned with these principles.

Focus on a holistic view, listening, and building bonds

It means seeing the individual as a whole, not focusing solely on illness, and that's one of the principles of the SUS. (C1P4)

It means caring for a child's needs in every sense, including social aspects [...] *viewing the child as a biopsychosocial being* [...] *not just examining them mechanically* [...] *I often tell my students that treating a child may even mean just letting them sleep, because that's what they needed in that moment.* (C3P7)

[...] *A child is part of a context, which includes their family or caregivers* [...] *You cannot view a child as separate from this context.* (C1P3)

Comprehensiveness means viewing the child as a whole, considering not only biological aspects or disease, but also the social and family context. It requires dialogue with the family, understanding the child's reality, and ensuring humanized care. (C3P7)

Focus on teamwork, integrating knowledge and practices, and challenges to overcome

Our university clinic is an interprofessional setting that also works with external services such as social services and psychology, because physical therapy alone cannot address every aspect of child health. (C3P8)

Care is often fragmented. There are barriers to interprofessional work [...]*, including institutional and management issues. For instance, children attending our university clinic have scheduled times for physical therapy, followed by occupational therapy, which limits communication between professionals* […] *In some cases, Department of Health protocols require interprofessional care, such as children with microcephaly* […] *where professionals from multiple fields collaborate.* (C1P1)

Comprehensiveness in health services and care networks

The professors also viewed comprehensiveness as the coordination of services across all levels of care, including primary and outpatient care, hospitals, communities, schools, and homes. This expands the scope of practice beyond rehabilitation. They highlighted the importance of interprofessional work, collaboration across different levels of care and complexity, teaching-service integration, and diverse practice settings to prepare professionals effectively, although community- and school-based practices were mentioned less frequently.

Focus on health services and care networks

In the modules I teach, we discuss the National Policy for Comprehensive Child Health Care (PNAISC) [...] *I address all three levels of care – promotion, prevention, and rehabilitation – so students gain broader experience in comprehensive child health care* [...] *and move beyond seeing physical therapy only as rehabilitation."* (C1P3)

[...] *We need to work across all levels of care, from promotion and prevention to treatment and rehabilitation. This broader view is comprehensiveness.* (C3P7)

Students rotate across different practice settings – the university clinic, the neonatal ICU, the community, and primary care. (C3P7)

[...] *In the child health module, internships take place in year five* [...] *in the Rehabilitation Center (CER), giving students a broader perspective of child health care*. (C1P3)

In hospitals and even primary care, there is ongoing dialogue between service staff, faculty, and students [...] *These experiences are vital to ensure comprehensive care and prepare students beyond the university clinic, thanks to the integration between universities and external health care services* [...] (C3P7)

Focus on the community and intersectoral action

Students also work in primary care settings like schools [...] *where they perform anthropometric measurements and posture evaluations. These activities support prevention and health promotion [...] Health promotion activities are carried out with children from the community, usually in schools.* (C2P6)

Discussion

The SUS is one of Brazil's greatest social achievements. Together with advances in education and sanitation, it has contributed to clear improvements in key health indicators over recent years.[21] However, the implementation and consolidation of the SUS have been marked by disputes over the State's role and the scope of its guiding principles: universality, comprehensiveness, equity, an expanded concept of health, and social control.[20,22] This has been accompanied by changes in health professional education, shaped by contrasting perspectives on professional roles and practice. While on one hand, NCGs call for a broad education, equipping graduates with the necessary knowledge, skills, and attitudes to meet the needs of both the SUS and contemporary society, on the other, a narrower approach persists, which does not recognize healthcare networks as fundamental spaces for learning and future professional practice. In the case of physical therapy, its historical focus on rehabilitation and disease adds further challenges to the transformations expected and stipulated in NCGs.[22,23]

Two decades after the introduction of NCGs, this study shows that meaningful progress has been made, though limitations remain. Analysis of the PPPs indicates that the programs studied propose a broad, humanistic, critical, and reflective approach, preparing graduates for professional practice across all levels of health care, considering both individuals and communities. Borges[14] examined PPPs in Goiânia, Goiás state, and also reported advances in general NCG-recommended competencies and skills, and curriculum design.

The syllabi reviewed here reveal another positive finding: the inclusion and integration of public policies, with special emphasis on the PNAISC. This policy is organized around seven strategic axes and highlights the importance of multiprofessional teamwork, the central role of primary care in coordinating care, the structure of care networks, and the need for intersectoral action. Within the PNAISC, Strategic Axis VI – Health Care for Children with Disabilities or in Specific and Vulnerable Situations - is particularly significant because it assigns physical therapists as essential role.[12] This exposes students to varied experiences and equips them to work across multiple levels of care and technological settings, guided by comprehensiveness.[14] When practiced in primary care settings, whether through fieldwork or internships, this approach allows students to engage in health promotion for individuals and communities alike, including schools,[24] while also undergoing their own transformation as they encounter the realities of professional practice.[25] Nonetheless, despite the broader use of practice settings, Borges found that hospital environments have remained predominant.[14]

Professors perceived comprehensiveness as a core SUS principle that advocates a broader view of the individual, their personal history, values, and social and cultural context. They emphasized the importance of caring relationships, active listening, and establishing therapeutic bonds, and highlighted the central role of multiprofessional teams and integrated actions in health promotion, disease prevention, treatment, and rehabilitation. They also associated comprehensiveness with the integration of services and the strengthening of care networks as essential practice settings, noting in particular the Specialized Rehabilitation Center, part of the Care Network for People with Disabilities in the SUS.[26,27]

Supporting these findings, Gomes et al.[28] identified primary health care as a key practice setting for teaching comprehensiveness, offering opportunities to engage with health teams, individuals, families, and communities. Although the authors underscored that academic initiatives are furthering this understanding, there are inconsistencies in how comprehensiveness is addressed by faculty. Similarly, Lima et al.[29] examined nursing education and concluded that practice-based experiences in health services foster reflection for both students and educators, and that the pedagogical relationship in nursing is shaped by elements that reinforce the teaching of comprehensiveness.

A systematic review of 32 studies across different health professions,[30] including physical therapy, also identified faculty perspectives as a critical dimension. Professors recognized comprehensiveness as an ongoing process that students must experience firsthand, requiring strong links between academia and health services as well as innovative teaching-learning methods. They also acknowledged their own limitations and stressed the need for individual and collective investment in the learning process.

Overall, the evidence suggests that teaching comprehensiveness effectively depends on faculty preparation and on PPPs that combine active methods and diverse practice settings. In this study, examples included child health care in the early years of life and developmental follow-up, which enables actions such as early and sensory stimulation and the prevention of complications.[31] These themes were present in the curricular documents of all three HEIs, with C2 and C3 also reporting activities for health promotion and disease prevention using schools as practice settings, recognized as especially favorable for educational initiatives.[32,33] Teamwork and interprofessional practice emerged as central elements, emphasized as essential to education both by faculty and in the literature.[34]

The findings collectively underscore teamwork as central to comprehensiveness, with its effective implementation requiring updated pedagogical approaches. The professors themselves recognized this as fundamental to the development of comprehensiveness.

Conclusion

This study investigated three HEIs in Northeast Brazil and found that their PPPs aligned with the 2002 NCGs, promoting broad training and the development of knowledge and skills for practice across all levels of the SUS. The curricula and graduate profiles reflected an effort to move beyond the historically rehabilitation-focused role traditionally associated with physical therapists. Professors recognized comprehensiveness as a core principle of the SUS and highlighted the SUS itself as a key practice setting for developing this concept. Their perspectives emphasized work across all levels of the care network, with a particular focus on primary health care, and underscored the importance of a holistic approach, attentive listening, and building therapeutic relationships in diverse social and cultural settings.

The findings reveal ongoing efforts to transform teaching practices within institutions and among faculty, driven by continuous efforts to overcome challenges and train professionals with the knowledge, skills, and attitudes needed to support public policies and the SUS.

Authors' contributions

ARCM led the doctoral research on which this article is based, and was responsible for its conception, development, and execution. In this study, she designed the research, collected and analyzed data, and wrote the manuscript. BJF co-supervised the study, assisting with research execution and critically reviewing the manuscript. RFP supervised the research, contributing to the methodological design, result analysis, and critical review of the manuscript.

References

1. Brasil. Decreto-Lei nº 938, de 13 de outubro de 1969. Provê sôbre as profissões de fisioterapeuta e terapeuta ocupacional, e dá outras providências. Brasília: Diário Oficial da União; 1969 Oct 13. https://planalto.gov.br/ccivil_03/////Decreto-Lei/1965-1988/Del0938.htm

2. Bispo Jr JP. Fisioterapia e saúde coletiva: desafios e novas responsabilidades profissionais. Cienc Saude Coletiva. 2010;15 (Suppl. 1):1627-36. https://doi.org/10.1590/S1413-81232010000700074

3. Marães VRFS, Martins EF, Cipriano Jr G, Acevedo AC, Pinho DLM. Projeto pedagógico do curso de Fisioterapia da Universidade de Brasília. Fisioter Mov. 2010;23(2):311-21. https://doi.org/10.1590/S0103-51502010000200014

4. Borges KP. Políticas para o ensino superior e a formação do fisioterapeuta no Brasil. Saude Pesqui. 2014;7(3):531-40. https://periodicos.unicesumar.edu.br/index.php/saudpesq/article/view/3543

5. Brandenburg C, Martins ABT. Fisioterapia: história e educação. Proceedings of the 11º Encontro Cearense de Historia da Educação e 1º Encontro Nacional do Núcleo de História e Memória da Educação; 2012 Jun 28-30; Fortaleza, CE. Fortaleza: Imprece; 2012. p. 1674-84.

6. COFFITO. Resolução nº 08, de 20 de fevereiro de 1978. Aprova as normas para habilitação ao exercício da profissão de fisioterapeuta e terapeuta ocupacional e dá outras providências. Brasília: Diário Oficial da União; 1978 Nov 13. https://www.coffito.gov.br/nsite/?p=2765.

7. Brasil. Constituição da República Federativa do Brasil de 1988. Brasília: Diário Oficial da União; 1988 Oct 5. https://www.planalto.gov.br/ccivil_03/constituicao/constituicao.htm

8. Bernardes LCG, Maior IMML, Spezia CH, Araujo TCCF. Pessoas com deficiência e políticas de saúde no Brasil: reflexões bioéticas. Cienc Saude Coletiva. 2009;14(1):31-8. https://doi.org/10.1590/S1413-81232009000100008

9. Fonseca TMA. A deficiência no interior da política de assistência social: um balanço sócio-histórico. Soc Quest. 2013;16 (30):327-52. https://osocialemquestao.ser.puc-rio.br/cgi/cgilua.exe/sys/start.htm?infoid=123&sid=20

10. Cecilio LCO. As necessidades de saúde como conceito estruturante na luta pela integralidade e equidade na atenção à saúde. In: Pinheiro R, Mattos RA, organizadores. Os sentidos da integralidade na atenção e no cuidado à saúde. Rio de Janeiro: IMS-UERJ; 2001. p. 113-26.

11. Mattos RA. Os sentidos da integralidade: algumas reflexões acerca de valores que merecem ser defendidos. In: Pinheiro R, Mattos RA, organizadores. Os sentidos da integralidade na atenção e no cuidado à saúde. 8th ed. Rio de Janeiro: Abertura; 2009. p. 43-68.

12. Brasil. Ministério da Saúde. Portaria nº 1.130, de 5 de agosto de 2015. Institui a Política Nacional de Atenção Integral à Saúde da Criança (PNAISC) no âmbito do Sistema Único de Saúde (SUS). Brasília: Diário Oficial da União; 2015 Aug 5. https://bibliotecadigital.economia.gov.br/handle/123456789/1044

13. Ellery AEL, Bosi MLM, Loiola FA. Integração ensino, pesquisa e serviços em saúde: antecedentes, estratégias e iniciativas. Saude Soc. 2013;22(1):187-98. https://doi.org/10.1590/S0104-12902013000100017

14. Borges KP. Competências para formação do fisioterapeuta no âmbito das diretrizes curriculares e promoção da saúde. Saude Pesqui. 2018;11(2):347-58. https://doi.org/10.17765/1983-1870.2018v11n2p347-358

15. Haddad AE, Brenelli SL, Cury GC, Puccini RF, Martins MA, Ferreira JR, et al. Pró-Saúde e PET-Saúde: a construção da política brasileira de reorientação da formação profissional em saúde. Rev Bras Educ Med. 2012;36(1 Suppl. 1):3-4. https://doi.org/10.1590/S0100-55022012000200001

16. Madruga LMS, Ribeiro KSQS, Freitas CHSM, Pérez IAB, Pessoa TRRF, Brito GEG. O PET-Saúde da Família e a formação de profissionais da saúde: a percepção de estudantes. Interface. 2015;19(Suppl. 1):805-16. https://doi.org/10.1590/1807-57622014.0161

17. Belga SMMF, Jorge AO, Silva KL. Continuidade do cuidado a partir do hospital: interdisciplinaridade e dispositivos para integralidade na rede de atenção à saúde. Saude Debate. 2022;46(133):551-70. https://tinyurl.com/56wff6cz

18. Gil AC. Métodos e técnicas de pesquisa social. 6th ed. São Paulo: Atlas; 2011.

19. Seixas PS, Coelho-Lima F, Silva SG, Yamamoto OH. Projeto pedagógico de curso e formação do psicólogo: uma proposta de análise. Psicol Esc Educ. 2013;17(1):113-22. https://doi.org/10.1590/S1413-85572013000100012

20. Bardin L. Análise de Conteúdo. 3rd ed. São Paulo: Edições 70; 2004.

21. Victora CG, Aquino EML, Leal MC, Monteiro CA, Barros FC, Szwarcwald CL. Maternal and child health in Brazil: progress and challenges. Lancet. 2011;377(9780):1863-76. https://doi.org/10.1016/s0140-6736(11)60138-4

22. Bispo Jr JP. Formação em fisioterapia no Brasil: reflexões sobre a expansão do ensino e os modelos de formação. Hist Cienc Saude-Manguinhos. 2009;16(3):655-68. https://doi.org/10.1590/S0104-59702009000300005

23. Gauer APM, Ferretti F, Teo CRPA, Ferraz L, Soares MCF. Ações de reorientação da formação profissional em Fisioterapia: enfoque sobre cenários de prática. Interface. 2018;22(65):565-76. https://doi.org/10.1590/1807-57622016.0852

24. Góes AB, Araújo FRO, Marques AP, Schmitt ACB. Panorama dos cursos de graduação em fisioterapia no Brasil: realidade atual. Fisioter Mov. 2017;30(4):661-9. https://doi.org/10.1590/1980-5918.030.004.AO01

25. Souza MCA, Costa EMA, Mendonça MA, Gonçalves SJC, Côrtes Jr JCS, Silva MAM. Inovação metodológica na integração ensino-serviço na educação médica. Medicina (Ribeirão Preto). 2016;49(3):284-91. https://doi.org/10.11606/issn.2176-7262.v49i3p284-291

26. Brasil. Portaria nº 793, de 24 de abril de 2012. Institui a rede de cuidados à pessoa com deficiência no âmbito do Sistema Único de Saúde. Brasília: Diário Oficial da União; 2012 Apr 25. https://bvsms.saude.gov.br/bvs/saudelegis/gm/2012/prt0793_24_04_2012.html

27. Pereira JS, Machado WCA. Referência e contrarreferência entre os serviços de reabilitação física da pessoa com deficiência: a (des)articulação na microrregião Centro-Sul Fluminense, Rio de Janeiro, Brasil. Physis. 2016;26(3):1033-51. https://doi.org/10.1590/S0103-73312016000300016

28. Gomes TLCS, Higa EFR, Passos AHR, Otani MAP, Souto BGA. Percepção docente sobre a integralidade na atenção primária à saúde no processo de ensino-aprendizagem. Rev Bras Promoc Saude. 2016;29(Suppl. 5):148-55. https://doi.org/10.5020/18061230.2016.sup.p148

29. Lima MM, Reibnitz KS, Kloh D, Silva KL, Ferraz F. Relação pedagógica no ensino prático-reflexivo: elementos carcterísticos do ensino da integralidade na formação do enfermeiro. Texto Contexto Enferm. 2018;27(2):e1810016. https://doi.org/10.1590/0104-070720180001810016

30. Makuch DMV, Zagonel IPS. A integralidade do cuidado no ensino na área da saúde: uma revisão sistemática. Rev Bras Educ Med. 2017;41(4):515-24. https://doi.org/10.1590/1981-52712015v41n4RB20170031

31. Brasil. Ministério da Saúde. Secretaria de Atenção à Saúde. Diretrizes de estimulação precoce: crianças de zero a 3 anos com atraso no desenvolvimento neuropsicomotor decorrente de microcefalia. Brasília: Ministério da Saúde; 2016. https://bvsms.saude.gov.br/bvs/publicacoes/diretrizes_estimulacao_criancas_0a3anos_neuropsicomotor.pdf

32. Brasil. Ministério da Saúde. Secretaria de Atenção à Saúde. Departamento de Atenção Básica. Saúde na escola. Brasília: Ministério da Saúde; 2009. https://bvsms.saude.gov.br/bvs/publicacoes/cadernos_atencao_basica_24.pdf

33. DallaCosta M, Rodrigues RM, Schütz G, Conterno S. Programa Saúde na Escola: desafios e possibilidades para promover saúde na perspectiva da alimentação saudável. Saude Debate. 2022;46(spe 3):244-60. https://doi.org/10.1590/0103-11042022E318

34. Peduzzi M, Agreli HLF, Silva JAM, Souza HS. Trabalho em equipe: uma revisita ao conceito e a seus desdobramentos no trabalho interprofissional. Trab Educ Saude. 2020;18(s1): e0024678. https://doi.org/10.1590/1981-7746-sol00246