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Review Article

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Physical therapy in the Extended Family Health and Primary Care Centers: a literature review

A fisioterapia nos Núcleos Ampliados de Saúde da Família e Atenção Básica: uma revisão de literatura

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Abstract
INTRODUCTION: Primary Health Care is efficient, effective, and expands access to health care services worldwide. In Brazil, the Expanded Family Health and Primary Care Centers were created, where the performance of the physical therapist is foreseen, aiming at expanding the scope of actions and the resolution in this level of care, configuring themselves as support for the minimum teams of Primary Care. OBJECTIVE: To describe the work process of physical therapists at NASF-AB. MATERIALS AND METHODS: This is a systematic review elaborated from the guidelines for Systematic Reviews and Meta-Analysis – PRISMA, with studies that addressed the performance of the physical therapist at the NASF-AB, and guided by the question: what is the work process of the physical therapist at NASF-AB? RESULTS: With the search, 202 articles were found, of which, 14 were included in this review. The panorama of the physical therapist's work process was characterized by his/her broad insertion in NASF-AB, developing individual and group care and home visits from a great repressed demand for physical therapy services in the Health Care Network. CONCLUSION: The results presented show that the physical therapist, as a professional member of the NASF-AB, performs rehabilitation actions for users, incorporating, in different measures and incipiently, health education, prevention and promotion with a view to self-care.
Keywords: physical therapy; primary health care; work. review.

Resumo
INTRODUÇÃO: A Atenção Primária à Saúde mostra-se eficiente, resolutiva e amplia o acesso aos serviços de saúde mundialmente. No Brasil, foram criados os Núcleos Ampliados de Saúde da Família e Atenção Básica, onde é prevista a atuação do fisioterapeuta, objetivando a

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ampliação do escopo de ações e da resolutividade neste nível de atenção, configurando-se como apoio às equipes mínimas de Atenção Básica. OBJETIVO: Descrever o processo de trabalho do fisioterapeuta no NASF-AB. MATERIAIS E MÉTODOS: Trata-se de uma revisão sistemática elaborada a partir das diretrizes para Revisões Sistemáticas e Meta-Análises – PRISMA, com estudos que abordavam a atuação do Fisioterapeuta nos NASF-AB e orientado pela pergunta: qual o processo de trabalho do fisioterapeuta no NASF-AB? RESULTADOS: Com a busca, foram encontrados 202 artigos, dos quais 14 foram incluídos nesta revisão. O panorama do processo de trabalho do fisioterapeuta foi caracterizado pela sua ampla inserção no NASF-AB, desenvolvendo atendimentos individuais, coletivos e visitas/atendimentos domiciliares a partir de uma grande demanda reprimida por serviço de fisioterapia na Rede de Atenção à Saúde. CONCLUSÃO: Os resultados apresentados revelam que o fisioterapeuta, como profissional integrante do NASF-AB, executa ações de reabilitação de usuários, incorporando, em diferentes medidas e incipientemente, a educação em saúde, prevenção e promoção com vistas ao autocuidado.
Palavras-chave: fisioterapia; atenção primária à saúde; trabalho. revisão

Introduction

The Dawson Report, in 1920, made recommendations to restructure the health care model in England and can be considered the first milestone in the discussion of Primary Health Care (PHC) as an organizer of Health Systems. It proposed the organization of health care services according to the level of complexity and treatment costs. Primary services are responsible for solving most of the health problems, being configured as the entrance door and center of the Health Care Systems, being linked to and supported by the secondary services and the hospital network[1].

The Declaration of Alma-Ata, in 1978, boosted, worldwide, the formulation of policies, strategies and plans for the incorporation of PHC in national health systems. Forty years later, in 2018, in order to reaffirm the commitment to the development of universal health coverage through PHC, the Global Conference on Primary Health Care was held, which resulted in the Declaration of Astana[2].

One hundred years after the Dawson Report, with the consolidated understanding that a structured PHC is efficient, problem-solving and expands access to health services worldwide, the World Health Organization encourages its strengthening globally and recognizes it as a condition for the promotion of more equitable health conditions and human development[3]. As presented by Reed et al.[4], PHC is considered a central element in improving the health of the population, as well as controlling health costs.

The publication of the document "*Primary Health Care and Community Based Rehabilitation: Implications for physical therapy based on a survey of WCPT's Member Organizations and a literature review*"[5] is an important milestone in the area of PHC Physical Therapy. It pointed out the insufficient supply of physical therapists in the world and suggested the development of models of Physical Therapy services that would favor the expansion of access. These issues were justified, among others, due to the growing number of people with disabilities, the existence of an international policy to promote PHC and the need for a stronger orientation towards rehabilitation at this level of health care, balanced with the emphasis on health promotion and disease prevention[5].

In the 1990s, with the creation of the Unified Health System (SUS) in Brazil, the centrality of PHC in the organization of the health system gained prominence. In 1994, the Family Health Program (FHP), currently called Family Health Strategy (FHS), was established as a strategy to reorient the healthcare model, aiming to expand PHC coverage, promote equity and improve the quality of care to the general population. Since then, the FHS has become

the preferred model of PHC organization in Brazilian municipalities[6].

Evidence indicates that the FHS has been producing impacts on the population's health conditions, although universal access to this service has not been achieved[2, 7]. However, as presented by Pinto and Giovanella[8], the expansion of access to PHC in Brazil can be dimensioned when considering the growth in the number of Family Health Teams (EqSF) implemented in the last 20 years (1998 = 2.054; and in 2017 = 41.619) and the estimated population coverage of 70% of the population in 2017. It should be noted that its implementation was progressive, initially standing out in small cities and with low HDI and expanding later in large cities and capitals[9].

From the consolidation of the FHS as the inducing model of PHC, in 2008, the Family Health Support Centers (renamed in 2017 as Expanded Family Health and Basic Healthcare Centers – NASF-AB) were created by the Ministry of Health[10]. They aimed at expanding the scope of actions and resolution in PHC and were configured as support for PHC teams[9]. The NASF-AB are teams with five workers from at least three different professions, such as physical therapists, nutritionists, psychologists, social workers, pharmacists, speech therapists, physical education professionals, among others. The definition of composition is defined according to the needs of the municipality/territory[9,10]. Here, through a federal initiative, the possibility of insertion of the Physical Therapist in the context of PHC was configured. However, the financing model for PHC adopted by the Ministry of Health in 2019[11] came with the revocation of federal funds transferred to municipalities for the maintenance of NASF-AB, which represents a threat to its continuity.

It is necessary the construction of robust evidence to support effective government policies related to PHC and improved clinical practices[4], as, in this case, those produced by the physical therapist at NASF-AB. Studies that aim at identifying the work process of these professionals in NASF-AB teams are essential to plan actions that can subsidize discussions that contribute to their consolidation and, consequently, expand the resoluteness of actions in the PHC setting[12]. However, it has been observed that in the production field of specific knowledge in Physical Therapy, little attention is given to this type of study.

In this context, twelve years after the implementation of the NASF-AB in Brazil, discussing the work process of the Physical Therapist is necessary. It is extremely important to know the actions developed by this professional at NASF-AB, aiming to consolidate this field of action. In order to contribute to this field, a systematic review of the literature was carried out, with the aim of describing the work process of physical therapists at NASF-AB.

Materials and Methods

It is a systematic review elaborated from the guidelines for Systematic Reviews and Meta-Analysis – PRISMA[14]. A screening in the electronic databases PubMed and BVS (Virtual Health Library – Brazil) identified studies that addressed the role of Physical Therapists at the NASF-AB. BIREME/VHL includes articles published in journals indexed in the Latin American & Caribbean Health Sciences Literature on Health Sciences (LILACS). PubMed is a free-access platform to the MEDLINE database, which has most articles in English, so it is recommended to search for words in that language.

To design the search sequences, the Boolean "AND" connector was used to combine the terms "Fisioterapeuta", "Fisioterapeutas" and "Fisioterapia" with "Núcleo de Apoio à Saúde da Família", "Núcleos de Apoio à Saúde da Família", "Núcleo Ampliados de Saúde da Família e Atenção Básica", Núcleos Ampliados de Saúde da Família e Atenção Básica", "NASF" and "NASF/AB", to be searched at Bireme. In PubMed, we used "Physical

Therapy", "Physiotherapy", "Physical therapist", "Physical therapists", "Physiotherapist" and "Physiotherapist's" with "Family Health Support Unit Team", "Family Health Support Unit Teams", "Expanded Cores of Family Health and Primary Care", "Extended Health of the Family Center", "Extended Health of the Family Centers", "NASF" and "NASF/AB".

In the Bireme database, the search for evidence was performed by searching the combination of words in the "title, abstract, subject" and in PubMed in the "title, abstract" and activation of the "*full free text*" filter in both bases. The search for articles occurred on June 10, 2020 (BIREME/VHL) and June 26, 2020 (PubMed). A total of 161 articles were identified in the BIREME/VHL and 41 in PubMed.

The documents that met all of the following criteria were included in this review: (1) article format, (2) with the presentation of empirical results that aimed to investigate the role of the Physical Therapist in Family Health Support Centers or Expanded Health Center of the Family and Primary Care or the performance of the teams of the Family Health Support Centers or the Expanded Nucleus for Family Health and Primary Care, with the presentation of empirical results of the practice of Physical Therapists. Review articles, opinion articles, full-text article not available and articles not available in English, Portuguese, Spanish, German or French were excluded.

The final selection of studies was operationalized by the following procedures: (1) excluding documents in a format other than articles, (2) excluding duplicates, (3) screening potentially eligible articles by reading titles, (4) reading the objective and (5) reading the results. After this process, the complete articles were retrieved. Two properly trained reviewers independently selected the retrieved studies for eligibility. There was no disagreement in any of the stages of the double-blind assessment. From this process, 14 articles were included in this review (**Chart 1**). **Figure 1** summarizes the search process and final definition of articles.

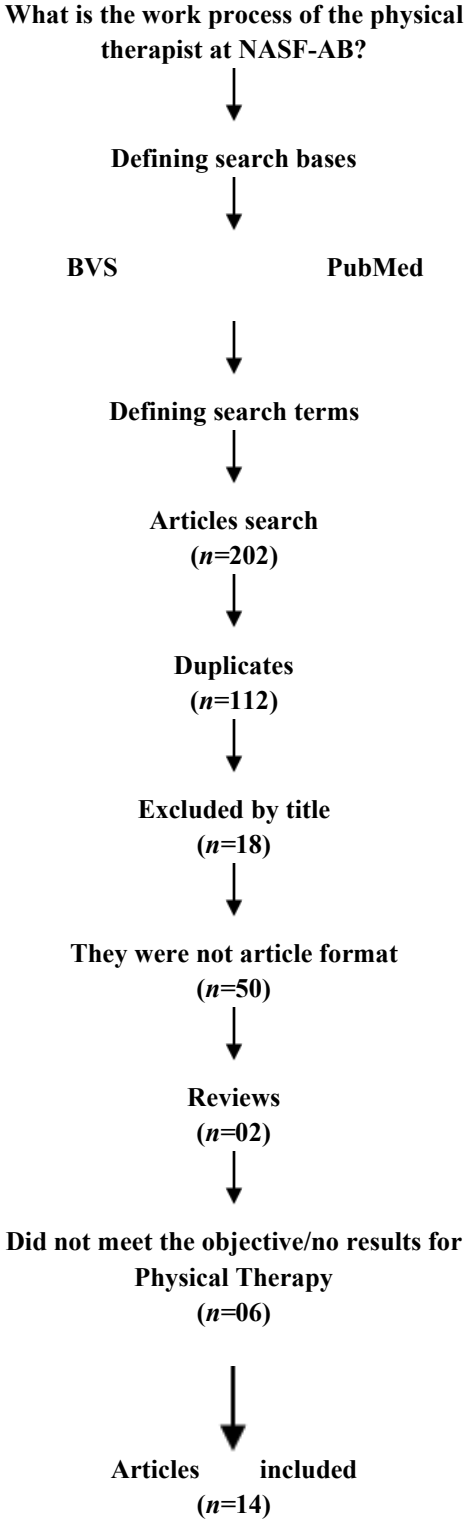
Chart 1 – Articles included in the review.

AUTHOR	YEAR	OBJECTIVE	SUBJECT/DATA SOURCE
Dibai Filho; Aveiro[15]	2012	Analyze the work of physical therapists in the Family Health Support Centers (NASF) with senescent individuals residing in the city of Arapiraca-AL, Brazil.	8 physical therapists, of both sexes, who worked with interventions with the elderly in the NASF/Questionnaire and interview.
Beletinni *et al*.[16]	2013	Identify the competencies, challenges and main demands of physical therapists who are members of NASF of the State of Santa Catarina.	16 physical therapists members of the NASF of the State of Santa Catarina/Questionnaire.
Souza *et al*.[17]	2013	Understand the challenges of the praxis of the physical therapist in NASF.	14 individuals divided into 3 groups (managers, health professionals, users)/Semi-structured interview
Ferretti; Lima; Zuffo[18]	2014	Know the perception of FHS professionals about the need for the physical therapist to be part of the team.	33 professionals (3 nurses, 3 physicians, 3 dentists and 24 CHAs) from 4 FHS, in a city of Santa Catarina/Interviews and field diary.
Souza *et al.*[19]	2014	Analyze, from the point of view of managers, professionals and users of the family health strategy, the	14 individuals divided into 3 groups (managers, health professionals, users)/Semi-structured interview.

		role of the physical therapist in NASF.	
Ribeiro; Flores-Soares[20]	2015	Identify how the physical therapist is included in the PC and the vision of health managers of the role and insertion of this professional in the health team.	Municipal health secretaries from 22 municipalities in the State of Rio Grande do Sul/Interviews using a semi-structured questionnaire.
Souza *et al.*[21]	2015	Understand the health care produced by the physical therapist at NASF.	14 individuals divided into 3 groups (managers, health professionals, users)/Semi-structured interview.
Braghini; Ferretti; Ferraz[22]	2016	Present the perceptions of the staff, coordinators of the Family Health Centers of reference and NASF about the performance of the physical therapist in the centers.	4 coordinators of the FHC, the general coordinator of the cores, and 8 members of the NASF team/Semi-structured interview in the case of the coordinators and focus group with the team professionals.
Fernandes *et al.*[12]	2016	Analyze the work process of physical therapists in NASF, the use of technological tools and their training for the work.	37 physical therapists of the NASF of Mato Grosso do Sul/On-line semi-structured questionnaire.
Braghini; Ferretti; Ferraz[23]	2017	Analyze the performance of the physical therapist and the barriers to carrying out their work at the NASF.	8 physical therapists working at NASF/Participant-observation and semi-structured interview.
Faria; Araújo; Carvalho-Pinto[24]	2017	Describe the profile of NASF's RF to post-CVA individuals using PC.	44 post-CVA individuals/analysis of medical records and application of the Modified Rankin Scale.
Carvalho *et al.*[25]	2018	Describe the growth and regional distribution of higher-level professions registered in BHU.	14 higher-level professions (social workers, biologists, biomedical, dental surgeons, physical education professionals, nurses, pharmacists, physical therapists, speech therapists, physicians, veterinary doctors, nutritionists, psychologists, and occupational therapists)/Data extracted from the database of the Department of Informatics of the MH (DATASUS).
Bim; González[26]	2020	Identify the distribution of physical therapists in the state of Paraná and to know their participation in NASF-AB teams in the host cities of the state's health regions.	Data from the databases of the National Register of Health Facilities – CNES, Regional Council of Physical Therapy and Occupational Therapy of the 8th Region – Crefito-8, and the Brazilian Institute of Geography and Statistics were used.
Vendruscolo *et al.*[27]	2020	Analyze the characteristics and performance of NASF-AB teams in SC.	In the quantitative data stage, 359 professionals working at NASF participated; in the qualitative stage, 43/A survey instrument was used in the quantitative stage; in the qualitative stage, collective interviews were used.

Source: own elaboration.

Figure 1 - Study selection flowchart for inclusion in the review.



Source: own elaboration.

Once the included articles were defined, two properly trained reviewers extracted the results of each study. The extracted data included the name of the first author, year of publication, geographic location and research participants. A third reviewer examined the compiled data and study abstracts, with no disagreement between them. A qualitative (narrative)

synthesis of the evidence found answered the research question.

Results

From the evidence included in this review, the wide insertion of the Physical Therapist at the NASF-AB[12,15,17,19,21,23,26] teams was identified. A nationwide study highlighted that, between 2008 and 2013, Physical Therapy had one of the highest growth rates (78% nationally, 146% in the North region and above 100% in the Northeast region) among the registered professional categories in Health Care Centers/Basic Health Units in the National Registry of Health Facilities[25].

Physical therapists[16], managers[21,22] and PHC workers[18,19] identified a great repressed demand for Physical Therapy services in the health care network, which often determined the orientation towards curative/rehabilitation actions. There was a tendency of managers to perceive NASF-AB as a secondary level service and identifying the physical therapist as a rehabilitation professional only[17,20].

Consequently, individual consultations were strongly present in the daily work process of physical therapists at the NASF-AB[12,16,27]. Three studies[15,22,27] revealed that during these appointments, users were screened and referred to other care points of the care network, such as outpatient clinics or to specific groups of NASF-AB – FHS.

Group care was also reported by physical therapists as part of their work process in NASF-AB[12,15,16]. A participant observation identified that this type of care was part of the routine of physical therapists, operationalized by therapeutic exercises and guidance[23]. In the perception of PHC managers and workers, the physical therapist developed education and prevention actions, carried out in group activities[20,22]. The collective core of knowledge activities were performed more often than the field activities[27].

The demands for the creation of groups came from the FHS and were made operational together with NASF-AB professionals[27]. Physical therapists conducted collective activities with several population groups, such as hypertension, pregnant women, schoolchildren, people with chronic pain, women, childcare, for motor development, postural reeducation, with caregivers of bedridden and/or elderly people, obese people, and oriented walking, among others[16].

The production of physical therapy care through home care/visits also emerged in this review [15,16]. For managers, they constituted a common practice of Physical Therapy [17,21,22]. The evaluation of medical records of post-CVA users of a Basic Health Unit indicated that home visits by physical therapists occurred, in most cases, for orientation and evaluation[24].

The performance of guidelines during home visits was also verified during the observation of the work process[23]. For PHC workers, during home visits, guidance and monitoring are provided by the physical therapist[17,23]. They were performed for those who are unable to travel to the Physical Therapy services[17,23]. Users recognized that when the physical therapist goes to their home, there is a more appropriate intervention, improving the quality of life and promoting a reduction in the demands of the unit[21].

Regarding the challenges for the performance of the physical therapist, it was identified, among others, the scarcity of material, infrastructure and financial resources, lack of training and low use of technological tools recommended for the NASF-AB, disarticulation/insufficiency of the network, failure in counter-referral, lower workload of physical therapists in relation to other professionals, and individual care to the detriment of operative groups[12,15,16,20]. Another issue pointed out was the difficulty of articulation between the Family Health teams and the NASF-AB[15,16], justified even by the accumulation of FHU to support[19, 22]. The PHC workers indicated, based on their experiences, that planning, that is, the articulation of the

physical therapist with the FHS still needs further qualification[19, 22].

Discussion

The insertion of the physical therapist through NASF-AB teams in the Brazilian PHC represents a great achievement for the professional category and for the expansion of access to care historically concentrated in the secondary level of health care to SUS users. Results of the analysis of the 2nd cycle of the National Program for Improving Primary Care Access and Quality, nationally based, held in 2013/2014, confirm what was verified in this review, by identifying the presence of the physical therapist in more than 80% of NASF/AB teams[28]. However, this numerical growth needs to be associated with the workload of this professional to work in NASF/AB.

While other professionals, such as nutritionists, psychologists, social workers, pharmacists, speech therapists, and physical education professionals have weekly workloads of 40 hours, the workload of physical therapists is at least 20 and at most 30 hours, by virtue of Law 8856/94[29]. Considering that each Family Health Care team is responsible for coordinating the care of at least 3.000 people and that each NASF-AB team supports at least 3, this workload of the physical therapist can cause work overload and fragility of the link between this professional and the other team members. One alternative adopted by the municipalities to address this issue is to hire two physical therapists for each NASF-AB team.

According to Silva *et al*.[30] access to specialized services in the SUS, which includes those of Physical Therapy, is characterized by different bottlenecks, caused by the care models adopted by the municipalities, the degree of resoluteness of the PHC and the dimensioning and organization of the supply of services. Therefore, access to Physical Therapy services is characterized by a large pent-up demand causing long waiting lines[31], as pointed out by this review. A study with data from the National Register of Health Facilities (CNES) identified that, even with the increase in the provision of rehabilitation professionals from 2007 to 2015 in the SUS, it was still low and unequal[32].

Silva *et al*.[33] identified the disarticulation of the NASF-AB with the FHS as the main obstacles to the work of the physical therapist in the NASF-AB; lack of infrastructure and transport; difficulty working in a multidisciplinary team; deficit and weakness in academic training; disarticulation of the NASF-AB with the health network; lack of knowledge of users, managers and health professionals about the role of physical therapists; in addition to the insufficient workload. Complementarily, Souza *et al*.[34] found that the Physical Therapist's attributions proposed by the NASF-AB are not yet well developed within the training, which has a technicist character, centered on the disease and rehabilitation, predominantly individual activities. Furthermore, it is highlighted that in undergraduate and graduate programs, health professionals are not prepared to act in the integrated logic of matrix support and that teamwork, bonding and care coordination are other weak points in relation to the training of these professionals[35].

In addition, the physical therapist working at the NASF-AB finds difficulties regarding the dimensioning of the workload to meet the demands of all the FHS supported[36]. Still, the number of FHS and their respective demands often exceed the responsiveness of the NASF-AB, with an excessive demand referred to the physical therapist in the PHC[37]. The guidelines related to the NASF-AB show that, in addition to individual rehabilitation practices, physical therapists should encourage collective activities, promoting comprehensive care for the user[35]. However, the population's lack of desire and commitment to participate in collective

activities promoted by the team, hinders their adherence, constituting a barrier to performing group care[37].

Two questions emerge from the above. The first one is that the insertion of the physical therapist in NASF-AB can be perceived by municipal managers, PHC workers and physical therapists as a solution to the difficulties of access to this professional in specialized services. However, it cannot be considered the "*pandora's box*" for this situation. It is expected that PHC has an adequate back up from other levels of care, especially for more complex cases. Thus, it is necessary to think and discuss not only the expansion of access to the physical therapist in the PHC, but in the whole health care network.

The second one refers to a possible "*Sofia's choice*" imposed on NASF-B physical therapists. When facing the users' care needs and when they do not have a support network of specialized care, they have to choose between reproducing the outpatient/curativist model in NASF-AB or watch the worsening of functional conditions due to the long waiting lines for specialized Physical Therapy services.

Souza and Medina[38], when investigating the technical and social relationships established between the NASF-AB and the EqSF in a municipality in Bahia considered successful in implementing the PHC, identified a mismatch between the expectations of PHC professionals (NASF-AB to meet the repressed demand) and the performance planned for the NASF-AB. This scenario may explain the important dedication given by the NASF-AB physical therapists to individual and curative actions.

Individual care has assumed, in some studies of this review, characteristics that point to the possibility of expanding the conception of action of the physical therapist. They had the role of organizing the flow of users and qualifying referrals to PHC and specialized services, which is provided for in Ordinance 154 creating the NASF-AB[10]. However, as pointed out by Moreira *et al*.[39], obstacles in the articulation between the teams and other RAS points compromise this process. It is noteworthy that individual care is provided for in the work process of the physical therapist at NASF-AB, however, collective care must be prioritized[10].

The place is recognized for group interventions that incorporate core knowledge, education and health promotion in the context of PHC and with that, can expand access to health services. They should aim both at the management of functional conditions and changes in habits and co-responsibility, with the potential to promote improvements in the quality of life of the participants and expand the bond between them and the health teams[40,41]. In the Brazilian case, the production of care through groups can be considered an innovation in the traditional work process in PHC[41].

For Physical Therapy, group interventions are effective for various clinical situations, mainly chronic ones, especially after individuals reach adequate functional levels after individual treatments, whenever necessary. The groups are configured as safe, effective and economically viable spaces for the physiotherapeutic follow-up of users[42]. Studies have verified the impact of group physical therapy practices carried out in the context of Brazilian PHC. They were effective in promoting improved flexibility and also in minimizing pain complaints due to musculoskeletal changes[43], in addition to positively benefiting several aspects, such as: functionality, cardiorespiratory conditioning, gait speed, balance and quality of life in post-CVA patients[44]. Furthermore, they provided the construction of knowledge that involves, in addition to the biological dimension, the shared formation of knowledge, active participation, the strengthening of bonds and the autonomy of users[39].

Home visits/care can be considered an alternative model of physical therapy assistance, thus favoring access to this

service[45]. Globally, home care in Physical Therapy has been consolidated and its effectiveness has been proven[46]. They have advantages, as they increase functional independence in the home environment and strengthen self-care strategies. Furthermore, regular home interventions by health professionals ensure continuity of care and provide patient satisfaction[47], which was also verified by this review.

In the context of NASF-AB, they are indicated for users with difficulty or physical inability to move to a Health Care Unit, who demand care less frequently and with less need for health resources[6]. In the case of Physical Therapy, they allow the approach to users, considering their needs based on the singularities of their community, family, and home environment. According to Linhares *et al*.[48], this broadening of physical therapy care favors the development of actions aimed at self-care, including the integration of the caregiver in this process. These aspects were identified in this review.

The global epidemiological profile, with a high prevalence of chronic and elderly involvement, which require continuous monitoring by health services, poses challenges for PHC workers. In this context, the shift from the focus on healing/rehabilitation to self-care, prevention and health promotion in physical therapy practice represents an important shift in the care paradigm, which is suggested by actions such as group care and home visits/monitoring performed by physical therapists of the NASF-AB. Literature indicates that it must be assumed that longitudinal monitoring implies a shift from the centrality of the professional, characteristic of the traditional model of health care, to the individual living with chronic diseases. Furthermore, self-care can contribute both to co-responsibility and to reducing the burden on the health system[40].

The perception of a performance based on individual curative care, guided by the outpatient logic historically consolidated by physical therapy services, can contribute to the fact that issues such as insufficient material resources and their own infrastructure are considered barriers to the practice of the physical therapist at the NASF-AB. This model, which depends on highly technological apparatuses associated with physical therapy, also implies in difficulties for these workers to incorporate the care tools suggested for NASF-AB (Individual Therapeutic Projects, Expanded Clinic, among others). The study that identified the low use of such tools by physical therapists of NASF-AB suggested that the explanation for this fact could be the lack of training for the work process in this PHC team at undergraduate, graduate or continuing education level[12].

The lack of articulation between the work of the physical therapist and the EqSF is not a problem faced exclusively by this professional. Souza and Medina[38] identified the disarticulation between the actions of the NASF-AB and the EqSF-AB, caused by the dichotomy between the traditional work process and the logic of matrix support. These authors point out as alternatives to overcome these challenges, such as reducing the number of EqSF supported, expanding the supply of permanent education activities, reorganizing management and work, among others.

Conclusion

The panorama of the work of the physical therapist was characterized by the broad insertion of this professional in NASF-AB, developing individual and group care and home visits/services based on a large, repressed demand for physical therapy services in the RAS. These actions were oriented to the rehabilitation of users incorporating, in different measures and incipiently, health education, prevention, and promotion aiming at self-care.

Even 12 years after the creation of the NASF-AB, physical therapists face obstacles to their performance, and many of them associated with the lack of permanent education and changes in the physical

therapy training process that break with the rehabilitative/curative, outpatient model, individual and dependent on technique and material technology. Furthermore, the lack of a consolidated theoretical framework about the physical therapist's work process makes it difficult to analyze the issue.

Considering the complexity of the object of study "work process" and the small number of studies included in this review, it is suggested that mixed methods research should be carried out in order to deepen the understanding about the performance of the physical therapist at NASF-AB. Their results may expand the robust evidence that subsidizes discussions for the strengthening of physical therapy care within the Brazilian PHC.

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