Among us: permanent health education as part of the work process of the Extended Nuclei for Family Healthcare and Basic Care

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Abstract: The article presents a study aimed to analyze the work process of an Extended Nucleus of Family Health and Primary Care (NASF-AB), questioning: who are those that support the matrix supporter? and how these professionals learn/understand their work? The research studied the work process with the NASF-AB supporters and, articulated with the perspectives of servitude and freedom in Baruch Spinoza, problematized how they feel and how they act, evoking thought-affection and thought-action. Methodological choices involved cartography and research-with. It was possible to identify team behavior that promotes permanent education in the healthcare field and the necessary collective enunciation that the NASF-AB must represent. It can be understood that "support for supporters" is objectively expressed through the processes of self-analysis (institutional), measures of permanent health education (among peers) and efforts to allow fear and hope to be expressed so that affections appear genuine and encounters may thrive (freedom). The action among peers, within the NASF-AB to learn, get ownership and practice the matrix support led to the understanding that it is something that happens as "among us" (the supporters themselves), invested with the perseverance of freedom in the face of servitude.

➤ **Keywords:** Permanent Education in the Healthcare Field. In-Service Education. Matrix Support. Primary Health Care. Support for supporters.

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Introduction

Aiming to foster the expansion of the response of primary care actions directed to social needs in health, in 2008, the Ministry of Health launched the proposal of the Family Health Support Nuclei (NASF in the Portuguese acronym). The Family Health Teams (FHT), based on these Nuclei, would receive technical and pedagogical support in order to qualify their professional intervention without resorting to referral to other services in the care network, receiving "supportive" help. After the approval and publication by the Ministry of Health of Ordinance No. 2,436, of September 21, 2017, however, the NASF proposal suffers a setback in relation to funding, work process, and composition of the professional teams. By the new version of the National Policy of Primary Care (PNAB in the Portuguese acronym), they become the Expanded Nucleus of Family Health and Primary Care (NASF-AB in the Portuguese acronym), omitting on the text of the policy, the figure of "support" as an object of analysis.

In 2019, by the issuance of Previne Brasil Program, there is a new inflection, at the same time defunding of basic care for the proposal and work process of support and enhancement under the form of nuclei to the Family Health Strategy/Basic Care (MOROSINI; FONSECA; BAPTISTA, 2020; REIS; MENESES, 2020). The changes in the national policy aimed at Basic Care, including the dismissal of the linguistic turn represented by the terminology Basic Care. The federal government reproposes the terminology Primary Health Care, prior to the Brazilian Health Reform, present, as an assumption of quality, the clinical management, focused on the prevalent and sensitive diseases to care in the territory as well as the impact on the profile of diseases and deaths, according to their statistical reduction, as the general equivalent of care. However, it is feasible to accept that in the many experiences in different local health systems, there are arrangements that dispute, all the time, the meanings for the work of assistance and care, referring to listening and follow-up. In this sense, amidst the return of the medical-disciplinary or sanitary-hegemonic rationality of the "new PNAB" (annulment of the linguistic turn and its discursive and pragmatic effects), the making of a primary care that is sensitive to the social interactions experienced in local health teams and articulated to the diversity of life in their affective networks, demanding support, fostering and sustenance. The present study, conducted in a municipality in the countryside of northeastern Brazil, refers

to the focus and approaches of a nucleus for matrix technical-pedagogical support from "extended teams" to "reference teams" (or "minimum teams"). Only in this sense is the nomenclature "extended" nucleus worth, since instead of "specialized" nucleus, inscribing the Family Health Strategy (FHS) in the challenges of a Basic Care (AB in the Portuguese acronym) original unfolding of the Brazilian Sanitary Reform or of Collective Health studies also original to the "invention of collective health" (CECCIM, 2007).

Therefore, considering the introduction, by PNAB, of the technical-pedagogical support model, matrix support, support from an extended team (of formative back-up) to a reference team (of the longitudinal link) to increase, based on support, the resolutivity of the Family Health Strategy teams and of the services that integrate and "interweave" in the Primary Care network, it was understood the question about how those who support (among themselves/to each other) or how those whose task is to support are supported, that is: how are those supporters supported? It was assumed that, in general, the basic training of the health professionals outlined by the Policy to make up the NASF-AB teams does not include training to act as "supporters" and a specific training has never been a requirement to join the Nuclei. There is even a controversy in the field about whether the support should be limited to in-service education, to specialized back-up care, or include both modalities, hence the question about the extent of the support in terms of resolutivity. For the implementation of the support foreseen by the matrix model, it is necessary that its members develop the appropriation of tools and technical-pedagogical tasks, something that is not intrinsic to the formation of professionals expected to be incorporated by the model, since this competence is not included in the National Curriculum Guidelines (DCN in the Portuguese acronym) of the several professional categories listed, nor in the specialist profile of the several medical specialties listed. It was due to this "restlessness" that qualitative research was outlined in search of the collective and formative processes mobilized inside the work of the supporters hired to work in equipment designated as "Support Nucleus" or "Extended Nucleus" to support and sustain local teams.

We aimed to "explore" this landscape with the segmental lines of "freedom" and "servitude", introduced by the ethical perspective of Baruch Spinoza regarding the predominance of potency or powerlessness (SPINOZA, 2017) within actions

of promoting knowledge, developing practices, creating and expanding sensibilities in "learning encounters" (DALLEGRAVE; CECCIM, 2018). Thus, regarding the relevance of this topic when discussing health work in the scope of the PNAB, it was understood that there is a "formative in act" process that is proper to the team's way of having agency, i.e. to the team agencying ("among us") that take place among workers summoned to a work for which they have no previous experience, at least most of the time. These "agencying" processes are not the spontaneous result of a collegiate of workers, but the emergence of sharing a work proposal, itself mobilized (agencyed) in the conduction of the work. It was verified that in the course of the work in a small municipality, where the expected roles cannot be easily diluted in the diversified network of services and management instances (as in big cities), there is a mixture of affections in the multiple relationships, whose management through Permanent Health Education (PHE) can be determinant of sustaining practices and, in these terms, practices of strengthening care coordination.

The baseline research problematized the support in the work process of a NASF-AB team in northeastern Brazil, southern region of the State of Bahia, a municipality in the range of "up to 25 thousand inhabitants", considered in the management of the Unified Health System as small-sized (CALVO et al., 2016). It was observed that those who support also experience their own need for support. The construction of supporting and being supported among peers and the search for support by the management instances of the local health and intersectoral policy, in addition to the request for support to the FHT to which support is provided, configure learning-in-act. These requests are not necessarily formalized, verbalized, or documented in any way; they belong to the practices that unfold though the interactions, and this should be important to be recognized by the managers, so that they protect the autonomous emergence of this relationship. If creativity is something designated as intrinsic to health work, if there are infinite agencying processes that impact work, and if PHE can be part of the labor process, the segmental lenses of freedom and servitude could be located in the analysis of NASF-AB. It was understood that the "support" contemplates in its technical-pedagogical function an "education-in-act" and "management-in-act" of the work "of territory" undertaken by the health system, in what concerns the Family Health Strategy/Basic Care.

Many questions about the work process

In order to study health management performance evaluation, this small municipality has a particular contribution. The efforts to defragment care, a primary guideline for Primary Care, require networks in shared construction; horizontal relations between services; support in the construction of unique therapeutic projects; local reference teams capable of welcoming, bonding, and resolutivity; specialized support teams capable of providing support, inter-consultation, and complementary care; matrix processes with sharing and negotiation of care strategies; supervision of practices and team education; elaboration of proposals through analysis of the health situation and many other things of difficult organization and articulation, the consideration in small cities configures a laboratory of experiences to interpretation and later extrapolation and transposition.

Reflecting about health practices, it is well-known that many questions are asked about the work process. Therefore, it may be realized how necessary it is to know in depth the processes of subjectivation as well as to agency interactions that escape the curative perspective, protocol and biopolitical imposition. It is with the centrality in living work that workers are able to manufacture devices to face the captures of everyday life, because it is recognized that one of the main attributes of living work is freedom, which places workers not only as agents of change (FRANCO; MERHY, 2013), but keep them less hostages of management as well. However, if on one hand, change emerges in workers' movements, it may be said that conservation emerges as well. The liberal-privatist imaginary, most often, is transferred in the training processes of the various professions (CECCIM et al., 2008), affirming the quality according to the forces of the biomedical model, with the hierarchy between professions and the subordination of users to technical knowledge. The encounters are interwoven in the everyday life as freedom and servitude, segments that play in the scene, and the victory of one pole or the other is not definitive. The strongest validity of the segments is the one inserted in the management practices and in "fields of possibility" that are established among work practices.

According to the PNAB, the composition of NASF-AB teams includes the professional categories of art educator (bachelor or licensed), social worker, physical educator (bachelor or licensed), pharmacist, physical therapist, speech therapist, nutritionist, psychologist, public health (bachelor or specialist), occupational

therapist, and veterinarian. It also includes specialist doctors: gynecologist/obstetrician, pediatrician, internist, psychiatrist, geriatrician, occupational, homeopath, and acupuncturist. We also noticed both the low familiarity with AB among the reference professionals, and the low familiarity with the matrix support. In the case of doctors, even though familiarity with AB is mandatory, as a result of the scope of the DCN, it cannot be expected their readiness, following a specialty acquired through intensive work in hospital environments and under single-professional preceptorship (from medical specialist to medical resident). In the other professions, the exception is when the residency training is in the multi-professional modality in family health/basic care. However, the multi-professional residency in basic care does not have the slightest chance of universal access, considering the currently small distribution of programs and vacancies.

Considering that the work in health is relational and that it happens on the basis of the encounter, one can think of the agencying processes that affect the workers' daily work; therefore, it may be considered the multiplicity of encounters that are produced, as well as their capacity to provoke movements of deterritorialization in the subjectivity, in the imaginaries, and in the established. Regarding this movement, PHE is understood as activation, on one hand, and shelter, on the other, to the construction of other ways of meaning and producing work, opening a "field of possibility," that is, making possible a kind of perspective that makes the transit from servitude to freedom feasible. The politics of work and doing of the AB constitute a field of possibility if they allow or intercede for living, creative work, always implicated with the territory.

The Family Health Strategy has placed its bets over the years on changes in care, but it has been strongly crossed by marketing, hygienic and medical-hegemonic agencying processes that have functioned as a device for capturing the work process: from territory to the clinic focused on diseases of interest to public health. Through these agencying processes, it is verified, in the HFS, the logic of care managed by a kind of portfolio of services, which is structured by the prescriptive act, the consumption of diagnostic procedures and drug therapy (MERHY et al., 2019). We can allude that the major transformations in health work have allowed for advances in professional knowledge, intervention techniques, the precision of examinations, and the specialization of specific knowledge, but have also led to the fragmentation of human beings and their health needs (BRITO; MENDES; SANTOS, 2018),

operating as if biological events could be dissociated from their pulsating experience in the very existence of living.

We observed that the challenge resides in the daily life of workers to overcome the influence of protocol and normative models, seeking, precisely from the specialized supporter, the supervision and learning that deconstructs the specialist imaginary and builds the comprehensive approach. It is noted, therefore, that the supporting professional must be the one who, by obtaining relevant recognition as a specialist, becomes a virtual presence merged to the presence of the primary reference professional. Depending upon the encounter, professionals of specialized knowledge refer to normative and protocol pathways, or they can open escape lines for other (and creative) arrangements of/in care in the territory. The practitioners of NASF-AB are not designated as "specialists" here, since only the doctors, in this technical-pedagogical equipment, are holders of a professional specialty; the others can be specialists, but their criterion for being incorporated, is the basic professional qualification (graduation) in careers other than nursing, medicine, and dentistry, integrated to the FHS as primary reference careers (professionals of the longitudinal link), preferably specialists, themselves, but in Family and Community Health.

In this context, it should be remembered that work in health has as a particularity its collective nature (MALTA; MERHY, 2003), however, the work process organized by the fragmentation of acts leads to the understanding that the attention would need to be "expanded". The very capture of the work centered on procedures ends up limiting the creative capacity and referring the notion of defragmentation to the expansion of the clinic by incorporating hard or light-hard professions and technologies. Santos, Mishima, and Merhy (2018) state that the logic of production by procedures, as well as the agenda oriented to national public health programs, end up as examples of capture of "living work" by "dead work" (already outlined in advance of the encounter in act, according to the application of the diagnostic and therapeutic formulation plan based on prevailing evidence). Therefore, the research proposal implied to "inhabit a territory", to know the intra-team exchanges in NASF-AB and the inter-team exchanges in the action of specialized matrix support to the reference teams.

To inhabit a territory, is to avoid remaining distanced and observant, we "affectively" put ourselves in interaction, we let the affections touch us, summon us, and involve us. With that, if we do not stay at a distance, we can feel-with (FORTUNA; GATTO

JUNIOR; SILVA, 2018), composing ourselves to the work process under research and perceiving, from the affections triggered in the encounters, the development of daily life, its locks, the feelings aroused and the networks of questions, interpretations, answers and reactions. The "we" in the NASF-AB team was remarkable: a team that prepares approaches, discusses intervention cases, exchanges information about the territory, about their professional knowledge, about information sources, about interprofessional collaboration, and about support in consultations and inter-consultations. In the operation of this "among us", a collective is born that sees itself in achievements, but systematically sees itself within the difficulties in its work, in its action of/inside a team, and in its action with local teams.

Cartography as a methodological intercessor

The construction of this study took place through cartography (DELEUZE; GUATTARI, 1996) and research-with (FORTUNA; GATTO JUNIOR; SILVA, 2018). Cartography adds power to describe states and not things, it is interested in the moving, not representations. Research-with presupposes a longer stay in the field and a production "with" the research subjects in a shared way. Both perspectives recognize the knowledge of everyday life from experiences and experimentation. The methodological design is built through the clues that are collected in everyday life. Romagnoli (2009) explains that to map is to allow oneself to dive into the affections that permeate relationships, allowing the researcher to be inserted in the research, therefore being modified by it. Subject and object mix together in the research process, building a mobile map of psychosocial landscapes (ROLNIK, 2016).

The question proposed for insertion in the field was: how has been the work process of support for the resolutivity of the FHS team? Understanding the existing possibilities for knowledge construction and data recognition, the study was organized under the perspective of the "WorkshopClass", a proposal created by Elisandro Rodrigues in his master's thesis and presented by the Brazilian journal Interface, in its section dedicated to health-art-education relations. Rodrigues and his advisor show that it is possible to research in the arrangement of collective spaces soaked by group dynamics, paintings, drawings, collages, murals, conversation rounds and collective dancing, modalities of education that operate by encounters (RODRIGUES; DAMICO, 2015). The "WorkshopClasses" are not workshops,

insofar as there is no goal of a product, nor are they classes, insofar as there is no goal of content transfer, they are meeting spaces operated with activities and knowledge constructivism. The production in act results in a "knowing-with".

Work is multiple in itself and the workers in their work process are affected all the time by the encounters that happen in everyday life. The workers, amidst the crossings, dispute the space of being with procedures, flows, routines, exams, knowledge and teams; that is, the worker is inserted in complex plots of acts (CECÍLIO; MERHY, 2003). Therefore, in addition to the WorkshopClasses, participation in other moments was sought: AB rounds, home visits, NASF-AB team meetings, and physical activity groups. Coffee breaks and walks around the territory with NASF-AB workers or residents were also moments of interaction/interlocution. Notes in field diaries, drawings, doodles, *intuitions*, and the construction of poems accompanied us in this process in which production and analysis occurred concomitantly.

Rolnik (2016) states that the cartographer's practice is fundamentally concerned with the formations of desire in the social field. In this way, a commitment was made to go beyond the limits of the visible and participate in the processes that comprised the work of NASF-AB with the HFS team. The author suggests that the cartographer researcher "carries in his/her pocket a criterion, a principle, a rule, and a brief script of concerns" (p. 65). Disquiet is the compass of the cartographer, so he/she will constantly define and redefine the concerns relevant to research-with. The NASF-AB team in question was composed of nine workers, among five professional categories: physical education (2), pharmacy (1), physical therapy (4), nutrition (1), and psychology (1). The residency class was composed of five residents, one from each category: social work, physical education, nutrition, dentistry, and psychology. All NASF-AB professionals, all residents in Family Health, and two master's and doctoral student researchers in Nursing and Health, a physical therapist and a nurse, totaling 16 participants, which corresponded to the total planned inclusion: who works-worked in NASF-AB, who is-was in training and who trains-in-act for matrix support.

The research is part of a master's degree course in a municipality located in the southern region of the state of Bahia, in northeastern Brazil. The estimated population for 2019 was 20,491 inhabitants, having fluctuated in population data from 21,081 inhabitants in the 2010 census to 27,007 in Wikidata for 2012. The research project

was approved by the Research Ethics Committee of the Universidade Estadual do Sudoeste da Bahia, having met the guidelines set forth in Resolution No. 466, dated September 12, 2012, of the National Research Ethics Commission, regarding research involving human beings. To conduct the research, after clarification of the risks and benefits of the study, all involved signed a Free and Informed Consent Form, agreeing to participate in the research, integrating it. The field immersion took place from August 2017 to September 2018. "WorkshopClasses" were held in the Municipal Health Secretariat and, also, in Basic Health Units of the municipality; they lasted an average of 3h30min each, totaling approximately 15 hours of audio recording, with subsequent transcription.

Since encounters are a rich space for the production of care and health education, the WorkshopClass proved to be interesting for the "living" understanding of NASF-AB's work, in a strong intimacy with its agents. The approach to the scenario, in this form, was carried out in four significant axes: Talking about the work; Suddenly, we are NASF-AB; Education in action in our daily lives; and Tools of NASF-AB for the production of care. The following meaning narratives reverberated: ESF/eSF, Health Care Networks, DCN, Residencies, Matrix Support, Expanded Clinic, Singular Therapeutic Project, Group Work, and Permanent Health Education. The WorkshopClasses were attended by NASF-AB professionals, residents of the Multiprofessional Residency in Family Health, and two graduate researchers who collaborated in the reporting. The concatenation of affective and cognitive processes was built through the formulation of "narrative excerpts", an emission of what was sensitive to the experience and experimentation in the world of practices (ROMAGNOLI, 2009). The data analyzed were drawn from a corpus consisting of speeches, communications, and expressions, where the selection of narrative excerpts was to be meaningful of situated experience. The "selected" excerpts expressed the respective community of practice and problematized reality.

Results and Discussion

Since health work is centered on relationships, practitioners operate in flows, often tense, in which the multiplicity of factors that affect the subjectivity of professionals makes collective work difficult, because each worker means work and care from his or her experiences and worldviews. Then, about these relationships,

Oliveira, Baduy, and Melchior (2019, p. 16) call attention to intercessory meetings "where knowledge, both technical and life knowledge, is shared and conflicts are faced in order to allow that a user-centered care is produced, thus expanding the possibilities of supporting the user in his or her way of walking life. Walking through the territory, the crossings in the work of NASF-AB may be observed: on one hand, obstacles to the implementation of projects with FHT, marked by bureaucracy and protocols; on the other hand, creative and potentially innovative actions, something like "improvisation" (FRANCO, 2015). We realize that professionals set up possibilities to access the teams, building an original work process.

> A moment that is opportune, I get there and suddenly there is a little gap, we propose and already sit down, we always do that, it is suddenly that arises. (NASF-AB Worker).

Owing to its multi-professional and territorial character, the AB is a space of multiple actions and, therefore, a place of permanent tensions as there is a dispute of ideas, wills, and projects among workers, users, managers, the state, and the market. We verified the team's dispute among themselves and with the family health teams about the ways of conducting consultations, organizing team meetings, planning, and fulfilling agendas. In a way, despite all the obstacles, we note the plasticity around the practices that allow operating under the logic of "care production" (MERHY, 2002). Still, according to our perspective, the worker is not free, because servitude and freedom are lines of realization of subjectivity, collective processes and institutional movements.

Franco (2015) helps us think about some lines of subjectivation that incur on individuals and that are important to discuss the tensions between servitude and freedom in the health work process: capitalistic subjectivation, imposing images on the ways of working, learning, teaching, loving, speaking, etc., fabricating norms for the pattern of human's relations with the world; moral ordering, which, from hegemonic precepts of society, establishes rules and behaviors of good living; and dispositions of science, often characterized by the biological look to the health-disease process. The author says that the human dilemma is to live in-between servitude and freedom, imprisoned or liberated along some of these lines. Then, he argues that the option for a certain work practice and the way workers relate to users can be given by the collective agencying that takes place in-act. The processes in which the professionals take part, can lead to the limits of technical knowledge or go beyond

this perspective, opening possibilities to rethink the work, operating a care centered in relationships or from the strength of the encounter itself. In relation to plasticity, there is the tension between conservation and change, both in operation for the maintenance of the instituted or in disposition for an instituting transformation.

Servitude: the obstacles of the work process

Spinoza (2017) understands man to be afflicted with passions and actions. To the extent that their bodies are affected, they may suffer variations in their potency to act. For Spinoza, the affections are "the affectations of the body, by which its potency to act is increased or diminished, stimulated or restrained, and at the same time, the ideas of these affections" (p. 98). When we act only by the effect of external causes, we are in a condition of servitude, for we are subject to the passions, thus the production of life does not operate under its own will. Therefore, servitude is "the human powerlessness to moderate and restrain the affections" (p. 155).

By bringing to the fore some narrative excerpts of NASF-AB professionals, produced in the Workshops, we may perceive good and bad encounters in the daily work process:

> I participated in a team meeting [of a certain area], and a colleague proposed the implementation of the reception, according to the AB Booklet #39. Nobody wanted to study. You have no idea of the uproar that meeting caused, the doctor got up and said all kinds of things, that she was going to change the work process... They didn't even try, she couldn't even finish explaining the reality she saw, it was something that would be very simple and that would only make the service more dynamic, it wasn't something restricted to such and such nursing technician, to such and such nurse, it was to be implemented in the service and I, as a NASF professional, could do this welcoming. The nursing technician could do it, so, like this. She proposed a service and wasn't heard, she couldn't even finish her reasoning, everybody was against her.
>
> I went to a team meeting [of a certain area] that I asked for leave to withdraw my team from there.

It was observed the difficulties confronted by the NASF-AB team when participating in the collective spaces of the FHT, but it is worth mentioning that the teams have different characteristics in their composition and also in their history in the AB. If, on the one hand, there are teams that bet on the decentralization of the medical-centered perspective, others revolve around the physician. Therefore, under disputes, NASF-AB has the challenge of enrolling more or less experienced teams in an attempt to dissolve the hard nuclei of the professions and accentuate

the interprofessional collaboration, including with middle level workers and Community Health Workers.

The affections triggered on the workers' bodies result in good or bad encounters, expanding or reducing their possibilities. Following Deleuze (2002) when our body encounters a body that does not suit us, its potency opposes ours, it operates a subtraction or annulment, and our potency to act is diminished or eliminated. In that way we experience the sad passions, we feel powerless. In an "encounter" in which NASF-AB practitioners have their vitality diminished, this sad passion leads to the condition of impotence. In order not to overcome this state of "lesser perfection", it is necessary to establish compositional relations with other elements in a way that increases the potency to act and think. By increasing it, we accumulate possibilities of affecting and being affected and, therefore, we acquire new possibilities with the world of which we are a part (MARQUES, 2012), but are not even available:

> Me, once there in the unit... It was complicated, waiting for one patient to leave and another to come in, I introduced myself to the doctor, telling him I would like to have a shared consultation with him, he looked at my face and said: "consultation?" I said I was a physical therapist from NASF, and that I could help him, with something, anything, I would be there to help him, so I sat in the room and stayed during the consultation. He found demands for me and started talking: "about that, she will guide you". Then I started. A week later when I went into the room again, he said "not today, because I am going to have a quick consultation". When I left the first appointment, last week, I thought he had enjoyed it and that it had been profitable, which it really was, me and him inside the room, but it was also the first and last appointment. Today, I can't even get a shared home visit. (WorkshopClass).

Regarding the NASF-AB practitioners, a joyful passion came to produce the will to share other consultations, to compose the work with the tools of technical-pedagogical support when present in that team. When confronted with the professional's rejection, disappointment tends to obstruct the will to produce together. Emotions and thoughts influence the body. The human mind, according to the Spinozan proposition, "does not know the human body itself and does not know that it exists except through the ideas of the affections by which the body is affected" (SPINOZA, 2017, p. 70). The mind is the idea, the very knowledge of the human body. This idea is adequate to potency when it acts by the forces of life, of composing more encounters, going from passivity to activity. Inadequate ideas, on the other hand, is when the mind possesses the image of what is produced by other bodies in relation to its own, preventing it from experience. Inadequate ideas are not

false in themselves, they are confused and partial insofar as we do not know them in living experience, we do not act by the agency of our own forces. Nevertheless, the possibility of the passage from inadequate ideas to adequate ones is found in affectivity itself, openness to affections, to knowing more.

In order to allow these affections not to be inadequate ideas, produced by sad passions, it is necessary that the workers understand the effects of these encounters. It is observed the difficulty in accepting other possibilities of work, of using technical-pedagogical tools inherent to NASF-AB for the shared construction of care. If, in the encounters in any activities, the professionals kept the work process away from current affections (refraining from openings to the present/in act), the work will be submitted to the images, but not to the affections and operates in servitude. The WorkshopClasses brought these emotions:

> Because we have to obey. And so, we obey hierarchies.
>
> I mean that our role today has to be formalized, this is exactly what I was going to say, I understand that nothing should be so bureaucratic, I know that we have to break with this bureaucracy, yes, even to move forward, but who is going to support us? If it is not paper, if it is not something formal, bureaucratic?!
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> I think that this bureaucratization of the service disturbs a lot, reflects negatively, because today it is like this, you have to attend such a number of hypertensive and diabetic patients, you have to attend, whether the service will be good or bad I don't know, but I have my records here.
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> And if we don't document, don't put it on paper, it seems that we didn't do some things.
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> If things are not following the norms that we work and have to work with, they should make a document, to say that the conducts are not collaborating to the assertiveness of their work, because I like to work with documents. So, I could take the document to my coordination so that they could be aware of it.

These emotions favor the imprisonment of workers in certain protocols that end up being the "most important encounter," the encounter with the paper, which denotes the capture of work. Spinoza (2017, p. 144) talks about the feelings of fear and hope, placing fear as "an unstable sadness arising from the idea of a future or past thing, of whose attainment we have some doubt" and hope as "an unstable joy arising from the idea of a future or past thing, of whose attainment we have some doubt." This is how meeting goals and the imposition of formal documents, obeying, formalizing and bureaucratizing pass into the inadequate ideas, generating suffering and anguish, besides the dichotomy between prescribed work and real work.

Additionally to the capture of the creative work, the performance based on the "images of thought", not on the "emotions of thought", still comes loaded with the "masks of superheroes" that to some serve to subordination (to bear their invincible burden) and to others to superimposition (to make decision without being able to fail). By the difficulty of problematizing the work process, of establishing relationships of shared support, of envisaging active reflection on the knots that are made in everyday life, instead of persevering in existence, of affirming life and composing power, the desire for a "governing" by punishments arises. For example:

> I think that accountability has to be individual. Starting there with self-evaluation, but I think, the practitioners have to take responsibility for their work, as long as they don't do this, he won't work as a team, because it will be a tug o' war game, right? Until the teams are structured, but in order to structure themselves as a team, each professional needs to re-signify himself, he has to understand what his role is or be punished. It's punishment, he didn't do it, he punished, he changes his salary, do you understand? (WorkshopClass).

We may therefore realize that these stances can further strengthen the existing gap between passion and action, inadequate and adequate ideas, *reason of images* and *affective reason*, making dialogue impossible, perpetuating the individualized and fragmented production. When what is produced in the mind is the inadequate idea about certain conducts, due to the ignorance of the internal forces of the encounters, the workers start to act under the effect of passions, that is, they suffer in servitude. On the contrary, when they act by forces of the encounter, from ideas that originate there, one leaves the passion for action (FRANCO, 2015). In the WorkshopClasses, it was noted that it is from the collection of sad passions, given the encounters that do not raise the potency of the teams, that NASF-AB professionals are led to the feeling of frustration:

> I wish, I want, we propose, all the monthly meetings are proposed, but when you get to the end of the month, you see that your proposal was repressed.
>
> It can be frustrating when we want something so much and we can't get there.

This frustration makes the NASF-AB act in collective activities organized by the team itself in an attempt to value their work. While participating in NASF-AB team meetings, we observed the care taken to welcome the colleagues from the FHT, organizing the agendas for home visits or shared consultations among them. NASF-AB workers matrix their own teams, discuss cases, and turn to the FHT whenever

necessary. It can be interpreted that NASF-AB reflects upon itself, presenting this expression in a narrative excerpt:

> Actually, we do it among ourselves, for example, when we go for a shared consultation among us from NASF. If we are going to make a home visit, we are doing matrix support with each other. To be able to do a nutrition orientation, basic pharmacy orientation, something like that.

Regarding the idea of composing work with bodies that increase their potencies, Spinoza helps us to recognize that *conatus* is not to remain in sadness, but in actions. Ferreira (2009) states that when we are in the grip of sadness, we wish to accuse, to find culprits, to take revenge. Here is the fundamental point that characterizes the man who is in servitude, denies life and chance, feeling wronged by supposed losses.

Freedom: path of the potency of encounters

Freedom, following Spinoza (2017, p. 218), happens when we are able to control the effects of the affections to which we are exposed, the author tells us that "as the mind understands things as necessary, it has greater power over its affections, that is, it suffers from them less." By understanding the happening of things, adequate ideas are formed and, therefore, it is possible to be free. The will is comparable to the force that comes from inside the person and acts as a propulsive energy that moves the person in the production of life and of the world.

NASF-AB, due to its insertion in relationships, necessarily experiences affections that arise from its work in support to the FHT They must be able to affect and be affected. So that the same professional may act in different ways, these variations are due to the affections by which they are taken, professionals sometimes break with the established logics and sometimes institute them. It was observed, therefore, the fact that in order not to remain under the affection of sadness, NASF-AB professionals try to re-signify reality, deviating their practices in the search for joyful passions. To strengthen their vitality, they compose the work among themselves.

The free man, according to Spinoza (2017, p. 201), has "the firmness in escaping on time is as great as that which leads him to fight; that is, the free man chooses escape with the same firmness or with the same courage with which he chooses combat." To be sure of a path is not to know exactly where it leads. One does not totally end fear or hope as if it were possible to achieve the fullest clarity of what and how to do. Certainty is made in an open process, to the extent that we experience it as a sense

and not as a destination. Through meaning we go forward and increase our power to act. Ferreira (2009) elucidates the three genres of knowledge in Spinoza: a free man is not reduced to the first genre of knowledge (imaginative), but conquers the power to think, not only by the knowledge of the second genre (rational), but by the third genre, which is called intuitive science. Whoever knows things through this genre passes to supreme human perfection and consequently is affected by joy, "the more a thing has perfection, the more it acts and the less it suffers, and conversely, the more it acts, the more it is perfect" (SPINOZA, 2017, p. 236). Freedom is the ability to restrain the affections using knowledge.

During their meetings, NASF-AB practitioners tried to create strategies to be understood in the work environment. By the researchers' participation in these moments, it was verified - through the observations and field diary notes - that structuring the team itself can be one of the escape valves to strengthen the role of NASF-AB in relation to the FHT. NASF-AB intends to show its role in spaces called Basic Care Rounds, organized by the Nucleus for Permanent Health Education of the municipal administration, in which several health teams of the municipality participate:

> The proposal is to do a NASF round again, but in a more playful way, more dynamically, to change the dynamics, to be more objective and not just come and talk, NASF does that, but bring a dynamic way so that they can understand. I thought about using TBL [Team Based Learning], using spiral.
>
> Today it is just a proposal, it is an idea, for example, a clinical case that we present, for example, you [the FHT], as NASF, what would you do? Put them in our place, it is an idea.

By experimenting with other possibilities of accessing FHT, the understanding of the work of NASF-AB may be triggered, and thus unfolded in closer approaches and direct discussions with professionals. The knots that bind the work, based on the understanding of what happens in the services and the particularities of each team, can be untied in other ways of doing management and education in health services. Pedagogical actions with the teams can favor paths to the freedom enunciated here. This is the great challenge of PHE in the context of AB. Education, by putting its own actions to the test, can provoke simultaneous self-analysis. Baremblitt (1992, p. 165) explains that it is a "process of production and re-appropriation, by self-managed collectives, of a knowledge about themselves, their

needs, desires, demands, problems, solutions and limits". These movements can produce other interventions in reality, i.e., they make it possible for professionals to regain the ability to produce in the midst of the constraints imposed by the standardization of the world of work:

> It should be a moment of reflection of actions, of reasoning: an outbreak such as this one, why did it happen? Not aiming to blame, but looking for for weaknesses, to try to improve and prevent it from happening again. So I think that the PHE is a very important thing, when we bring to the field of reflection, what we can do to improve.
>
> The PHE should impact how I see the other, there has to be a paradigm shift, it is you going against what is being proposed, which is to maintain the practices. There are studies showing that today this is the way.

The kind of work that is open to reflection and action may be the product of this intervention. Emerging from the knowledge of the causes of the knots that hinder the service, appropriate ideas will produce creativity in strategies, encounters, and ways to organize a service facing an outbreak, for example, or showing how to trigger sensitivity in the improvement of consultations shared with NASF-AB. Within the context of NASF-AB, raised by the power of constituting itself as a collective, the processes of subjectivation will be able to produce new ways of conducting the work. Under other thoughts and other paths, we may leave servitude and progress to freedom.

Final considerations

The study dealt with the matrix support provided to the matrix supporter, seeking for the complexity of NASF-AB's work in what concerns the inside part of its work process, to know how NASF-AB staff may experience its complexity in a field of complexities, uncertainties, and even opposition to the model. The study ended in an initial, exploratory stage, as it dealt with time limits, part of which involved delimiting and reorganizing its investigative question. There is no doubt that the study may fructify in other analyses, scenarios, and circumscriptions. However, it was possible to identify a team behavior, promoting both permanent health education and the necessary collective of enunciation that the research recognized: among us. It was noticeable that these teams, as a result of the encounters with the FHT, need to persevere, aimed to a team design as the desired for the other, can make use of reciprocity in asking for, and receiving support as well, and must

operate under more participatory and articulated perspectives with the teams in territory, establishing territory ties.

The notions of servitude and freedom in Spinoza were brought to the analysis, since logics strongly crossed by the bureaucratic and normalizing character act to standardize the work process, hampering the creativity flow. The study stated that freedom in the health work process can be thought of as the third kind of knowledge, as idealized by Spinoza, that is, the internal force of the encounters and its product as a cause for actions. We are influenced by the force of the affections to build freedom. Therefore, it was alluded that the health work process, due to its power to produce instituting movements in the daily life of health services, may, based on the PHE as a device, provide affection and action to NASF-AB workers in their process of resisting and creating. It was understood that the "support to the supporters" is objectively expressed by the processes of self-analysis (institutional), PHE provisions (among peers) and efforts to exhaust fear and hope so that affections appear genuine and encounters flourish.[1]

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Note

[1] J. M. Germano: field research, systematization and initial interpretation of information, preparation of the manuscript and writing of the article. R. B. Ceccim: evaluation of the research report, its revision and final version, the revision of the manuscript and revisions of the article. A. S. Santos: critical review of the analysis of the field information, the research report and the manuscript. A. B. A. Vilela: supervision of the field research, initial interpretation of the information and its systematization, preparation of the manuscript and revision of the final version of the article.

Resumo

Entre nós: educação permanente em saúde como parte do processo de trabalho dos Núcleos Ampliados de Saúde da Família e Atenção Básica

O artigo apresenta uma pesquisa cujo objetivo foi analisar o processo de trabalho de um Núcleo Ampliado de Saúde da Família e Atenção Básica (NASF-AB), sob as perguntas de quem apoia o apoiador matricial e como esses profissionais aprendem/apreendem seu fazer. A pesquisa estudou o processo de trabalho com os próprios apoiadores de NASF-AB e, articulado às perspectivas da servidão e liberdade em Baruch Spinoza, problematizou como sentem e como agem, evocando o pensamento-afecção e o pensamento-ação. As escolhas metodológicas envolveram a cartografia e o pesquisar-com. Foi possível identificar um comportamento de equipe, promotor da educação permanente em saúde e do necessário coletivo de enunciação que o NASF-AB deve representar. Compreendeu-se que o "apoio aos apoiadores" objetivamente se expressa pelos processos de autoanálise (institucional), providências de educação permanente em saúde (entre pares) e esforço por exaurir medo e esperança para que os afetos apareçam genuínos e encontros vicejem (liberdade). A ação entre pares, no interior do próprio NASF-AB para aprender, apreender e exercer o matriciamento levou à compreensão de que se trata de algo que acontece como um "entre nós" (os próprios apoiadores), investida a perseverança da liberdade ante a servidão.

➤ **Palavras-chave:** Educação Permanente em Saúde. Educação em serviço. Apoio matricial. Atenção Primária em Saúde. Apoio aos apoiadores.