

Matrix support and actions on primary care: experience of professionals at *ESF* and *Nasf*

Apoio matricial e ações na atenção primária: experiência de profissionais de ESF e Nasf

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ABSTRACT The article reports a descriptive research, under a quantitative approach, aimed at characterizing the way actions of matrix support are inserted into daily life; and the tools privileged by physicians and nurses of the Family's Health Strategy (Estratégia Saúde da Família – ESF) and specialists of the Nucleus for Supporting the Family's Health (Núcleo de Apoio à Saúde da Família – Nasf) in a district at the South Region of São Paulo. Seventy-eight professionals (ESF=44, Nasf=34) have filled in a questionnaire about agenda, activities, tools and knowledge. Results indicate that teams face difficulties while performing shared actions of matrix support.

KEYWORDS Matrix support. Family Health Strategy. Health management. Education, continuing.

RESUMO O artigo relata pesquisa descritiva, com abordagem quantitativa, cujo objetivo é caracterizar o modo como as ações de apoio matricial estão inseridas no cotidiano; e as ferramentas privilegiadas por médicos e enfermeiros da Estratégia Saúde da Família (ESF) e por especialistas do Núcleo de Apoio à Saúde da Família (Nasf) de distrito localizado na região Sul de São Paulo. 78 profissionais (ESF=44, Nasf=34) responderam a um questionário sobre agenda, atividades, ferramentas e saberes. Os resultados indicam que as equipes têm dificuldade em executar ações compartilhadas de apoio matricial.

PALAVRAS-CHAVE Apoio matricial. Estratégia Saúde da Família. Gestão em saúde. Educação continuada.

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Introduction

The Family's Health Strategy (Estratégia Saúde da Família – ESF) was conceived to consolidate the organization process of Primary Attention to Health (Atenção Primária à Saúde – APS) at the municipality level, to enable the reorganization process agreed on between adjacent municipalities to flow easier, and to coordinate health care as a whole (ANDRADE; BARRETO; BEZERRA, 2009). ESF formulation was mirrored at care models of family care in place in Canada, Cuba, Sweden and England, which were the reference for Brazilian program (ROSA, 2005). Rizzoto (2000) develops a critical point of view, stating that such model of decentralized public service at the community level, meant to assist poor populations, was a strategy recommended by the World Bank to transfer to individuals, families and communities the responsibility the State should answer for.

In view of health demands and needs existing in the territory, besides needs and limits faced by the teams that deal with basic attention, the Nucleus for Supporting the Family's Health (Nasf) was created on January 2008, meant to widen the scope of health care offered to the users (BRASIL, 2014).

The work carried out by Nasf is guided by the theoretical-methodological referential of the matrix support. According to Brasil (2014), the matrix support is a new way to produce health: in a process of shared construction, two or more teams elaborate a proposal for pedagogical-therapeutic intervention. Applied to APS, it means a strategy for organizing the work in health based on the need for widening the scope of actions carried out by the ESF, bringing forward a multi-professional team that will render health assistance and care in that territory, in an inter-disciplinary way, thus enlarging the potential for both integrality and resolution of cases assisted. The matrix support provided to ESF by Nasf occurs by sharing problems, by professionals exchanging

knowledge and practices, as well as by the articulation of interventions agreed on, considering clear accountabilities, not just those that are common to all actors involved, but also those that are specific of APS teams.

In daily work, using matrix makes possible actions easier, as well as the elucidation of diagnosis, that quite often is the basis for structuring a Singular Therapeutic Project (Projeto Terapêutico Singular – PTS). According to Oliveira (2008), when a team or a professional of matrix support meets a reference team, the idea is to have the matrix support helping the reference team in performing a therapeutic project for a subject, either an individual or a group, in need of a health intervention that the reference team did supposedly face difficulties to perform.

In this sense, Campos and Domitti (2007) explain that the functioning of the matrix support and the reference team depends on organizational arrangements and management concerning the health work that might enlarge the possibilities for the widened clinic practice and the dialogical integration among different specialities. For Chiaverini (2011), the process of health-infirmity-intervention is not either monopoly nor exclusive tool of whatever the speciality: it belongs to the entire health field. Therefore, the matrix process is typically one of inter-disciplinary work, with practices that involve knowledge interchanging and construction.

Matrix support aims at the widened clinic, an efficient tool for widening the work scope of ESF procedures. Over and above the biological, the widened clinic points out to the perspective of transformation of individual and collective attention, which enables for other aspects of the subject that might be understood and worked out by health professionals (CUNHA, 2010).

These days, managers and professionals in the health area who work in Basic Health Units (Unidades Básicas de Saúde – UBS), in both ESF and Nasf, face challenges while performing what is determined by public policies concerning APS and matrix support.

Resistance and difficulties traverse the way of these professionals, mainly those who wish to carry out differed actions in the territory they serve at, yet making sure Nasf may fully develop its function, offering matrix support, PTS, widened clinic, among other technologies involved, so that the assistance will come to meet the goals of integrality and resolution possibilities as determined by the Unified Health System (Sistema Único de Saúde – SUS).

As policies are implemented, actions are gradually transformed and, sometimes, re-invented. Such movement has been followed and justified by research and theoretical studies (ANDRADE; BARRETO; BEZERRA, 2009; CAMPOS; DOMITTI, 2007; CUNHA; CAMPOS, 2011; GOTTEMS; PIRES, 2009; NASCIMENTO; OLIVEIRA, 2010; OLIVEIRA; CAMPOS, 2015; RIZZOTTO, 2010; RIZZOTTO; CAMPOS, 2016; TEIXEIRA; SOLLA, 2015; VILLA *ET AL.*, 2015; AMONG OTHERS), although much is still to be investigated on the subject, mainly as to daily activities during live work.

To confront the complexity of health problems and attention to health, intending to solve them, one must

bring together a multiplicity of 'knowings' and 'doings', and understand the way health production is organized in the field of clinical 'knowings' and practices. (MERHY; FRANCO, 2003, p. 317).

One looks at making operational, as named by Teixeira (2006, p. 25), the dimension strictly technical-assistant, or operative, respective to

the relations established between the subjects of the practices and their work objects, which are measured by the knowledge in technology that operates in the health work process in different levels [promotion in health, risk prevention, damages and recovery and rehabilitation].

Based on concepts by authors in the area of collective health, especially Merhy (2003, 2013), one assumes it would be interesting

to listen to professionals who work in ESF and Nasf in regard of their actions while performing live work and about what is easy and difficult in their daily activities. Those professionals must be attentively listened to in regard of how they have been organizing themselves to render services of health attention and care. Systematization and analysis of such information bring forward elements for thinking about what might contribute for improvement, for enriching actions in APS and for implementing public policies.

The overall objective of this article is to characterize how actions of matrix support are inserted into daily activities, and the tools that are privileged by ESF physicians and nurses and by Nasf specialists. The secondary objective is to analyze similarities and differences between ways to organize the work and to operate matrix support in both services of the APS network (ESF and Nasf), as well as the challenge of articulating those services.

Specific objectives are: to investigate, among activities that compose the daily routine of ESF professionals, what are considered shared construction with Nasf and what associate to matrix support of matrix procedures; to investigate, among activities that compose the daily routine of Nasf professionals, what are considered shared construction with ESF and what associate to matrix procedures; to compare the answers by ESF and Nasf teams relative to matrix support or to matrix procedures; to contribute for the debate on the articulation between services aimed at making matrix support viable as a theme and to evaluate and improve APS public policies.

Methods

This is a descriptive study with quantitative approach, carried out in the South Region of São Paulo City. Professionals in both ESF and Nasf teams were invited to fill-in a

questionnaire on matrix procedures. The project was negotiated with the Regional Health Coordinating Body of the Social Organization (Organização Social – OS), hired by the Health Secretariat of São Paulo City to manage the APS in the South Zone. At the time the research was carried out, the region included three administrative districts, counted 607,929 inhabitants (FUNDAÇÃO SEADE, 2014), 88 ESF teams and five Nasf teams. ESF teams include six community agents, one physician and one nurse and, according to the team, they may also have two nursing assistants and/or one dentist. Nasf teams include mental health professionals (psychologists, occupational therapists and psychiatrists), rehabilitation professionals (physiotherapists, speech therapists, nutritionists), besides pediatricians, gynecologists and social workers.

The outcomes presented are extracted from the Master Degree research (SANTOS, 2015) approved by the Ethics Committee for Research (Comitê Ético de Pesquisa – CEP) of São Paulo Municipal Government (PMSP) and by the CEP of the University where it was developed, under Nr. 921.278/2014, according to Resolution Nr. 466/12. In its first conception, the project would be limited to one Nasf and four UBS, and would include workshops meant to deal with themes related to the organization and development of the work process of both ESF and Nasf teams. However, the Health Coordinating Body of the South Region (São Paulo) did not authorize the workshops to be carried out and suggested the universe of subjects researched to be widened, involving all teams in the region, which included 40 ESF minimum teams (spread over five UBS) and five Nasf teams. Thus, once the universe was widened and a new purpose was established, it became more appropriate to develop an exploratory, descriptive research, with qualitative approach, using the questionnaire as a tool for data collection, and using

both statistic (descriptive and inferential) and qualitative analysis for reading and interpreting those data.

In order to make it easier to schedule the meetings, priority was assigned to the timetable of each UBS team, as those professionals have five hours per week set apart for technical and planning meetings, according to the local agenda as established by Health Coordinating Body of the South Region. It was then decided that, except for buccal health professionals, all others in those meetings would be invited to participate. Data collection took place in January and February 2015. Five meetings previously scheduled were carried out, one at each UBS, lasting thirty minutes each. The researcher in charge introduced the research, explained on autonomy as to participation and on respect to privacy, gave out the instrument to all participants, clearing up doubts, and picked it up 20 minutes later or as participants completed answering the questions.

The instrument used for data collection was a questionnaire to be filled in by each participant, with 16 closed questions and four open questions, intended to obtain information on the organization of activities related to daily work and on activities related to the matrix process, using concepts such as: PTS, widened clinic, inter-sector procedures, matrix support, permanent education, genogram, echo-map, shared activities, home visits and networks.

Data were organized and dealt with using descriptive and inferential statistic analysis. Student's t Test was used for not related samples and for the model of variance analysis with repeated measures. All four open questions were intended to capture expressions the professionals themselves (freely) associate to the concepts studied, but that will not be analyzed in this article. It is worth remarking that the research did not receive any financial support, being fully supported by the researchers.

Results and discussion

Seventy-five professionals took part in the research, which means 60% of the total invited (n=130). Among those who refused taking part, most argued with agenda difficulties, although the meeting had been planned 30 days ahead. Some managers referred to absence of the professionals the day data were to be collected, others alleged they would need the time scheduled for technical meeting for organization of the work process, among other affairs, thus making it impossible to carry out an effective collection. As to respondents, 44 work in ESF programs (18 physicians and 26 nurses) and 34 at Nasf: six occupational therapists, six physiotherapists, six social workers, four speech therapists, four physical educators, four psychologists, three nutritionists and three specialist physicians.

On average, Nasf and ESF professionals are 35 to 38 years old, have from 9 to 10 years of basic graduation, and from 32 to 38 months in the service. One may notice that physicians and nurses are somewhat more experienced. Most professionals (about 805) come from private universities and have no APS specialization.

The questionnaire posed one question on the organization of the work agenda of ESF and Nasf professionals, considering the percentage of fixed and variable commitments that led to occasional variations: a) personal needs; b) duty needs; c) managers' or users' needs. On average, answers were rather different. The predominant answer – 45.2% of ESF professionals and 76.5% of Nasf professionals – was that commitments are subject to some variations according to the service's needs. Such difference is important and significant ($p=0.012$), as it points out to the fact that the work carried out by professionals in the support team is organized differently from the work carried out by physicians and nurses, and depends more heavily on the service's vicissitudes.

The research verified that 21.4% of ESF professionals and 17.6% of Nasf professionals answered that commitments are scheduled according to users' and managers' needs, which points to balance as to this item, despite a slightly larger percentage of physicians and nurses. The option stating that variations occur according to the needs of the professionals themselves was mentioned by 28.3% of ESF respondents and by 5.9% of Nasf respondents. Again, the answers suggest that physicians and nurses have more autonomy as compared do Nasf professionals. In this same sense, 4.8% of ESF professionals declare that their commitments are fixed, while no professional in support teams declares so. As a whole, data reveal that the work organization of Nasf professionals is more subject to external conditions than the work organization of ESF professionals, and that they have less autonomy regarding the time distribution of their activities.

These results are the first indicator that there is a real difference in work operational procedures for both teams, at least as they describe their own activities. The work organization for physicians and nurses is anchored in a fixed agenda of care services, while other Nasf professionals remain in a peripheral position and will be requested according to the services' needs. Santos (2015) remarks that ESF must be better acquainted with the organization of the work carried out in Nasf, and assign more value to the matrix practice, instead of prioritizing individual and specialized care service. In this context, according to Hirdes (2015), the work of Nasf and ESF teams must be adapted to each other, in order to put in practice the matrix support; and this requires taking into account the professional principles that support that practice: inter-professionalism, attachment, integrality in caring, accessibility, resolution capability and longitudinal procedures.

The implementation of Nasf without reviewing documents that guide ESF practices

created some paradoxical situations that must be reconsidered, such as different productivity and work strategies requirements between Nasf and ESF; different demands of population care services, once, unlike Nasf, ESF is taken for the main access to APS; different priorities of actions between Nasf and ESF, mirrored in tasks divisions and the time assigned to each of them, among others.

Regarding the work process of teams, the subjects were asked how much time over the month (in percentage) they usually dedicated to daily activities, considering daily practices. *Chart 1* synthesizes the average percentages estimated by the respondents for each activity carried out or tools used by

ESF and Nasf teams, considering the total for each respondent should sum 100%, including the option 'others'. The participants were also asked what would be the ideal work plan, yet asking them, if they could choose, how much time (estimated in percentage) they would dedicate to the activities mentioned below. The comparison between the answers should lead to a measure as to how far the 'actual' work of respondents is from what they would consider 'ideal'. The difference between those two measures would indicate how deeply those professionals would or would not long for changes in those proportions.

Chart 1. Time dedicated (actually and ideally) to activities/tools of matrix support, according to estimates by professionals of both ESF and Nasf teams

Estimates of activities distribution	ESF	Nasf	ESF	Nasf
According to professionals interviewed	'Actual'	'Actual'	'Ideal'	'Ideal'
1) Clinical care	43,40%	15,44%	37,55%	9,71%
2) Matrix support	6,39%	14,85%	8,17%	17,35%
3) Continued education / qualifications	3,82%	7,35%	7,40%	11,76%
4) Team meeting	9,20%	12,50%	8,61%	10,74%
5) Home visits	12,64%	13,82%	10,64%	11,18%
6) Therapeutic groups	7,52%	18,68%	10,30%	18,90%
7) Administrative tasks	5,77%	7,09%	6,38%	6,24%
8) Others	4,11%	3,00%	2,89%	2,88%

Note: Subjects estimated the percentage of time they dedicate to matrix support activities or tools ('actual') and the percentage they would rather dedicate ('ideal') in one working month. In each case, total estimates summed 100%; percentages presented on the chart are averages for each activity, for each team.

Concerning the distribution of activities, there were differences between the teams. For ESF professionals, activities mentioned as the most frequent were: clinical care, with 43.4%, and home visits, with 12.64%. It may be noticed, therefore, that according to the distribution of physician and nurses who did respond, 65.24% of the actions are (probably)

carried out without Nasf support. As to Nasf professionals, activities declared are not so concentrated. Therapist groups are pointed out more often (18.68%), followed by clinical care (15.44%), home visits (13.83%) and team meetings (12.5%). The amount of time dedicated to home visits is similar for both teams, but we lack data to identify whether they are

or are not shared.

Inferential analysis on how those variables behave, using the model of variance analysis with repeated measures, allow for making sure that time averages in clinical care for the ESF group are significantly larger ($p=0.001$) than for the Nasf group, while time used by the Nasf group is significantly larger than for the ESF group in the following activities: matrix support ($p=0.001$), therapeutic groups ($p=0.001$) and team meetings ($p=0.034$). On average, professionals dedicate more time than they would like to clinical care ($p=0.003$) and home visits ($p=0.011$).

As to the comparison between 'real' and 'ideal' axes, there was, in general, little difference, which could indicate that either Nasf or ESF professionals do not long for that much changes. Nevertheless, some discrepancies may be identified as we analyze each answer. Concerning clinical care, physicians and nurses are closer to ideal conditions, while support professionals consider they do more than would be desired. Both teams aim at more opportunities to practice the matrix support, and when it comes to continued education and qualification programs, they would long to quite twice as much as they can do.

Those are significant results, once they give evidence that assistance and care provided by both teams are not the same. In general, physicians and nurses provide individual care to their patients, while

physiotherapists, occupational therapists, psychologists, social workers, physical educators, nutritionists and specialist physicians provide group care. This structure indicates that the care attention model in place is anchored on individual appointment with physicians, while group care is perpetuated as a multi-professional practice for support professionals. The latter seems to be a technology adopted by Nasf professionals, not always used by physicians and nurses. On the other hand, the number of clinical attendance by Nasf professionals is significantly lower than those by ESF teams.

Researchers were curious about the real possibilities for ESF and Nasf professionals to fulfill prerogatives established by the Ministry of Health, discussing clinical cases, carrying out shared care in both UBS and home visits, and jointly building therapeutic projects, so as to widen interventions over the territory and for health care of population groups (BRASIL, 2014). With that purpose, they asked ESF and Nasf professionals if they have specific timetables in their agenda for joint actions or, on the contrary, such actions take place in a more flexible schedule. The research investigated if, from the respondents' point of view, weekly commitments were: a) fixed; b) structured, allowing for changes and inclusion arrangements; c) not structured. *Table 1* synthesizes the average percentages of answers related to the flexibility of the agenda of commitments among the teams.

Table 1. Organization of work agendas of ESF and Nasf teams

Alternatives chosen by the subjects	Group		Total
	ESF	Nasf	
No	1 2,4%	0 0,0%	1 1,3%
Yes, have fixed timetables	30 71,4%	20 58,8%	50 65,8%
Structured, but may have changes and arrangements	11 26,2%	12 35,3%	23 30,3%
Not structured; happen according to needs	0 0,0%	2 5,9%	2 2,6%
Total	42 100,0%	34 100,0%	76 100,0%

Note: For each case, the numbers on the table correspond to the number of subjects who chose the alternative indicated and to the percentage that number represents relative to the group (ESF, Nasf and Total).

One can notice specificities in the answers provided by the teams. Most ESF professionals (71.4%) declare that their agendas include fixed timetables for meetings with Nasf professionals, while 58.8% of Nasf professionals declare so. On the other hand, Nasf professionals are the majority (35.3%) among those who declare that such meetings are structured, but there might be changes and inclusion arrangements; concerning physicians and nurses, 26.2%. No ESF professional answered that meetings take place as they are required, while 5.9% of Nasf professionals said so. Those differences seem to be wider than could be expected if those were truly shared actions, once, if it were the case, percentages would tend to be closer between both teams.

In order to understand how inter-disciplinary changes take place among professionals of both teams, respondents were asked about the communication means they would prefer. Collective changes during team meetings were preferred by most respondents – 81.4% of physicians and nurses and 67.6% of Nasf professionals. Changes between teams during matrix support were the answer chosen by 25.6% of ESF

professionals and by 17.6% of Nasf professionals. Interdisciplinary changes during care actions were mentioned by 14% of ESF professionals and 20.6% of Nasf professionals; e-mail, SMS, WhatsApp and mobile phone, 18.4% for ESF and 29.4% for Nasf; informal in-person conversation, 14% for ESF and 32.4% for Nasf; and others, 7% for ESF. These results suggest that the condition that would lead changes to be easier to carry out are the meetings, even though they seem more convenient to ESF purposes than to Nasf objectives. It is worth remarking that specialists make use of less formal communication media, such as phone, e-mail, SMS, informal conversation and interdisciplinary changes, while physicians and nurses would rather use more formal alternatives: meetings and matrix support.

When asked to evaluate the proportion (in percentage) of their work they consider innovative, not just restricted to the protocol, ESF professionals answer that 29.26% of their routine is innovative, while a larger proportion of Nasf professionals – 48.06% – report greater flexibility and creativity in their actions. These data are coherent with former answers related to the rigidity of

physicians' and nurses' agendas, which determine great part of their activities and remain essentially centralized in clinical care, using procedures like ambulatory clinic procedures, meetings and scheduled home visits. It is worth evoking Cunha & Campos (2011), who state that workers in the health area would rather prevent from dealing with problems in knowledge nucleuses they are not sufficiently prepared to intervene, while other procedures will occasionally be considered inadequate and inappropriate, or yet invasive. Those are the reasons that lead such professionals to show weak capacity to deal with uncertainties and inter-disciplinary procedures, thus making more difficult working in both intra- and inter-teams.

Chart 2 presents the comparison of

answers provided by both groups of subjects to two questions: what is the proportion of their own work (in percentage) they evaluate as innovative, defining innovation as procedures nor set down in the protocol; and how they respond to the following practices in their daily performance: individual or widened clinic; protocol-driven or singular therapeutic project; care provided at the health unit or actions out over the territory; care provided individually or in groups; initial education or continued education. It is supposed that the answers regarding those pairs of opposed options may point out to the model of primary attention in health guiding their practices. Comparing the descriptive measures for both teams, the following results were obtained:

Chart 2. Comparisons between teams (ESF and Nasf) as to the innovative character of the work and to the option of variables that lead to opposed assistance models

Variables	Descriptive level
Proportion of work evaluated as innovative, not following the protocol	0,002
Individual clinic/widened clinic	0,395
Therapeutic projects following the protocol/singular therapeutic project	0,055
Assistance at the unit/actions out over the territory	0,238
Individual care/group assistance	0,001
Initial formation/continued education	0,293

Note: Subjects were asked to estimate (in percentage) the proportion of their own work they evaluate as innovative, not following the protocol. Then, they should choose between both extreme points of each pair of variables; they should mark a number from 1 to 5, where 1 and 2 are close to one extremity; 4 and 5, to the other; and 3, parity or neutral. In order to compare the answers by the teams (ESF and Nasf) regarding the percentage estimate and each variable, the Student's t Test was used for not related samples.

When reading the results, one may state that there is a statistically significant difference ($p < 0.005$) between the teams as to the following concepts: individual care/assistance to groups, proportion of work considered innovative, not restricted to the protocol. A less remarkable difference, yet pronounced ($p = 0.055$), appears concerning the stress between PTS and the therapeutic

project conforming to the protocol. As to the other concepts (individual or widened clinic, care provided individually or actions out over the territory, and initial education or continued education), answers by both teams did not significantly differ.

Considering data mentioned above, a difference becomes clear as to the health attention model ruling the work of each team.

Physicians and nurses realize a less innovative work, centered on individual care and a therapeutic project conforming to the protocol; on the other hand, matrix support professionals come to be more innovative and more receptive for demands that might come to sight, their work based on group care and on PTS.

In order to understand matrix procedures as an action for those who take part of them, both groups were asked to evaluate their possibilities for solving cases inside ESF, choosing among the options: excellent, good, medium and bad. In the answers, matrix procedures and its solving possibilities are considered good for both groups – 50% for ESF, 57.6% for Nasf; medium – 40.5% for ESF, 12.1% for Nasf; and excellent – 4.8% for ESF, 12.1% for Nasf. The option ‘bad’ was only assigned by ESF, with 4.8% of the answers. Most answers in both teams were ‘good’, with 53.3%, although Nasf team seems more optimistic when compared to the ESF team. Regarding professional satisfaction, participants were asked how often they quit their work place satisfied with the solutions they found in their professional practice. Satisfaction seems to be greater among Nasf professionals: 79.4% answered ‘often’, while among ESF professionals only 67.4% chose that option. Among ESF professionals, only 2.3% answered ‘never’, and 23.3% chose the option ‘seldom’. Among Nasf professionals, 17.6% chose the option ‘seldom’. One may observe that physicians and nurses are more demanding and show greater level of dissatisfaction than the support team.

Lancman *et al.* (2012) observe that Nasf professionals face difficulties in articulating with ESF professionals, considering assistance productivity goals the latter are submitted to and work processes already in place. Data collected confirm their remarks and corroborate former researches that point out to the need of making a new pact on the work, with a new arrangement of agendas and a new dimensioning of time proportions

dedicated to the different activities (CUNHA; CAMPOS, 2011; GONÇALVES *ET AL.*, 2015; MOLINE-AVEJONAS; MENDES; AMATO, 2010; NASCIMENTO; OLIVEIRA, 2010). Difficulties to perform teamwork and to carry out shared actions have also been observed by Gonçalves *et al.*, (2015), who warn for the need of both time and availability for learning.

Final considerations

Nasf was created aimed at widening the scope and resolution possibilities of APS actions, and to make it easier for the population to access a more comprehensive health care system, avoiding forwarding clients to other health care levels. Nevertheless, as results indicate, there is not to date effectiveness of policies proposed. Based on the research, one may affirm that services rendered by physicians and nurses is organized according to a quite heavy agenda of appointments and meetings, leaving not much time available for not planned activities. However, professionals can manage to adapt their agendas according to conveniences, with some autonomy, while specialist professionals organize their work according to service demands, thus partially missing the control on the organization of their own work. Analyses suggest that both operation systems are not as articulated as, in theory, they should be. ESF professionals provide less innovative services, focused on individual care and on a therapeutic project conforming to a protocol, based on interdisciplinary changes formally carried out in meetings. On the other hand, matrix support professionals come to be more innovative and more receptive to new demands, their work based on group care and PTS, open to less standardized communication formats and agenda organization.

Public policies suppose Nasf and ESF professional teams will organize their work processes prioritizing shared and

interdisciplinary care, assigning value to exchanging knowledge and qualification, always focusing on integrality, humanization and health promotion all over the territory they are responsible for.

Moreover, other factors must be considered that do also make it difficult carrying out matrix support actions, which should be discussed and rearranged, such as: the high demand for health care and the metrics for the production evaluation that rules the performance of physicians and nurses; academic education and experience of each professional; how easy or difficult it is for

each of them to share some actions; requirements of both the population in the territory and the local management; the fact that the network of reference services in the territory, health services in particular, is not sufficient to fulfill existing needs, thus creating continuous overburden on all care levels.

It must be remarked that new pacts depend on both active and collective movement of the social actors involved, health professionals and population, involving as well political decisions and economic calculations. ■

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