Family Health Support Center and the transformation of reception in primary care

Núcleo de Apoio à Saúde da Família e a transformação do acolhimento na atenção básica

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ABSTRACT It was sought to perceive the understanding of the professionals of a Family Health Support Unit about the support offered in the transformation of reception in Family Health Units in the city of Jaboatão dos Guararapes (PE), using the methodology of Discourse of the Collective Subject. The subjects consider the technical-pedagogical support important, with positive results for the supported teams, for the population and for the group itself. There are difficulties for the actualization of this support and, as an overcoming, they mention the dialogue, sharing of knowledge and problematization. It is necessary to rethink reception in the primary care, maybe using, for that, the support of these Centers.

KEYWORDS Humanization of assistance. Reception. Primary Health Care.

RESUMO *Buscou-se conhecer a compreensão dos profissionais de um Núcleo de Apoio à Saúde da Família sobre o suporte oferecido na transformação do acolhimento em Unidades de Saúde da Família na cidade do Jaboatão dos Guararapes (PE), utilizando-se a metodologia do Discurso do Sujeito Coletivo. Os sujeitos consideram o suporte técnico-pedagógico importante, com resultados positivos para as equipes apoiadas, para a população e para o próprio grupo. Há dificuldades para a realização desse apoio; e, como superação, citam o diálogo, partilha do conhecimento e problematização. É necessário repensar o acolhimento na atenção básica, podendo utilizar, para isso, o suporte desses Núcleos.*

PALAVRAS-CHAVE *Humanização da assistência. Acolhimento. Atenção Primária à Saúde.*

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Introduction

Launched in 2003, the National Humanization Policy (NHP) has the intention of putting into practice the principles of the Unified Health System (SUS) in the routine of health services, generating improvements on management and care by encouraging communication between managers, workers and users in order to promote collective processes to combat fragmentation and verticalization in work processes. These are aspects that hamper relationships between health professionals and between these and users, automate the contact between these characters, generate an approach about the disease that does not establish the primary bond in the act of promoting health, besides inhibiting co-responsibility and the autonomy of professionals in their work processes, and users (BRASIL, 2004).

In its specific guidelines for Primary Health Care (PHC), the NHP proposes the establishment of ways of welcoming the users of health services that promote their optimization, risk ranking, the end of long waiting queues and access to the other levels of the system (BRASIL, 2004).

Franco, Bueno and Mehry (1999) report that the intercessory space that occurs in everyday meetings among health professionals and service users sustains a clinically evident technological dimension of health work: the technology of the relationships, a proper space of light technologies. In these meetings, processes are carried out that aim at the production of listening and accountability relationships, which are related to the formation of bonds and commitments in therapeutic projects. According to these authors, the reception is one of these intercessory processes and should be part of a clinical practice performed by any health worker, being possible, through its analysis, to think about the work process and its consequences

in attention models, generating a debate among workers based on a user-centered perspective, as well as on how these users are received in the services.

As a gateway to the health system in Brazil, primary care, as PHC in the Country is known, is a primary welcoming environment, which is initiated mainly by the Family Health Strategy (FHS). Initially as a Program, the FHS was created in 1994, originating in the reformulation of the priorities of the Ministry of Health in relation to PHC, having as fundamentals to work with a focus on the family, creating bonds through a multiprofessional team (MARQUI ET AL., 2010).

The PHC can be understood as the set of health actions developed in community, both individually and collectively, with a view to coordinating the integrality of care through integral attention that impacts health and the social determination of the health-disease process, working in team in a multiprofessional and interdisciplinary way (BRASIL, 2011).

To meet the paradigms proposed by the FHS, health workers are invited to the constant challenge of rethinking their practices, values and a service restructuring aimed at the needs of users, who are also carriers of practices and values, in social context, in which the team is inserted (COELHO; JORGE; ARAUJO, 2009).

In 2008, the Ministry of Health created the Family Health Support Center (Nasf), which proposes to compose teams of professionals from different areas of knowledge to work together with the professionals of the Family Health Teams (EqSF) sharing health practices in the territories under the responsibility of the FHS teams in which Nasf is inserted (BRASIL, 2011).

The actions developed by the Nasf can be evaluated in their clinical-assistance or technical-pedagogical dimensions, in which the latter produces educational

support action with and for the teams, in which Nasf can also (and sometimes needs) to support the organization of the process (BRASIL, 2014).

Jaboatão dos Guararapes is a city located on the coast of the state of Pernambuco, in the metropolitan region of Recife, with a total area of 258.694 km² and an estimated population of 695.956 people (IBGE, 2010). The municipal territory is divided into seven regional political-administrative, each containing a Regional Health Coordination (JABOATÃO DO GUARARAPES, 2017). The municipality has basic care coverage of 55.61%, considering the FHS with 50% coverage, and having two Nasf teams implanted, of a ceiling of 10 teams in the municipality (BRASIL, 2017).

The Health Coordination of the Regional IV manages eight EqSF that are supported by a Nasf team (Nasf coverage of 100% for the territory); and based on the technical-pedagogical practice of the work of this equipment, the coordination requested the realization of a plan to sensitize these teams to rethink the practice of welcoming spontaneous demand and transform the work process, having as main focus to avoid the long queues for care still existing, humanizing care.

Nasf professionals made the awareness of these teams through five meetings, one with management, three in the form of workshops with the teams and one involving staff and community. In the first, they discussed with the management about the intervention, studied the reception process and elaborated the work proposal based on workshops. The second meeting was with the EqSF, in which they made the proposal of the workshops and, after acceptance, discussed what is the reception, what is a welcoming posture and reflected on how it is given and how it should be the reception in the Family Health Units (FHU). In the third, it was discussed ways of welcoming, flows and organizational

change. The fourth moment was evaluation of the reception proposal brought by the team. The last meeting took place with the community, in which they proposed the new form of reception and heard the opinions of the community members. The reassessment was made according to the needs brought by the FHU professionals. That is, in order for humanization to consolidate itself as a transversal policy in health actions, it is important that work and planning relationships are horizontal and include users, because considering health as use value is to have as a standard in attention the bond with these, guaranteeing their rights and their families, stimulating that they also put themselves as actors of the health system through their action of social control. In addition, it is fundamental to offer better conditions for professionals to carry out their work in a dignified manner and to create new actions, becoming co-managers of their work process (BRASIL, 2004).

The work carried out by the professionals of Nasf led to the elaboration of this study which is part of the conclusion of the Residency Course in Collective Health of the University of Pernambuco (UPE), which aimed to provide an understanding of the technical and pedagogical support offered by Nasf in the transformation of the process of reception in FHU in the city of Jaboatão dos Guararapes (PE).

Material and methods

This is a qualitative approach study, exploratory, using the Discourse of the Collective Subject (DCS) methodology to analyze the data, and was approved by the Research Ethics Committee of the University Hospital Oswaldo Cruz (HUOC) of the University of Pernambuco (Opinion nº 2.001.179/2017).

The study was carried out in the city of Jaboatão dos Guararapes, Pernambuco,

Brazil, as inclusion criterion for the recruitment of subjects: being a professional in the Nasf of the Regional IV of the municipality in question, who participated in the entire planning and sensitization process of the EqSF supported for the transformation of the reception process; and as an exclusion criterion, the non-signing of the Informed Consent Form (ICF).

The professionals were invited to participate in the study by making personal contact at the workplace by the researcher himself and by his electronic addresses. Five professionals were interviewed. Only one professional did not agree to participate.

Data collection was scheduled based on the time availability of the informants and happened where it was convenient, as long as this place was a more restricted and quiet environment. The instrument used for this was the semi-structured interview, since it allows the combination of open and closed questions, in which the subject interviewed has the possibility to discuss the proposed theme (BONI; QUARESMA, 2005). After the interview, the subjects were asked not to comment their contents with the other professionals who had not yet participated in the study.

The script of the interview was guided by five questions, which rescued since the understanding about the role of Nasf in supporting the teams in relation to the reception process, till the difficulties for the accomplishment of this technical-pedagogical support and possible ways of overcoming them. They were: how do you understand Nasf's role in supporting teams in transforming the reception process? What are the relevant aspects that you identify as a result of this work in relation to the teams, the population and your group? Are there challenges for technical-pedagogical work such as this developed with teams? If so, what are they? What are the possible ways to overcome them?

The interviews were conducted in 2017, being recorded in electronic audio, transcribed, read exhaustively and analyzed using the DCS methodology. The analysis methodology of the DCS was proposed by Lefèvre and Lefèvre at the end of the 1990s and it is a synthesis discourse, fruit of the fragments of individual discourses reunited by similarity of meanings. This technique differs from the Traditional Discourse Analysis because it is based on the Social Representations Theory, which is strongly associated with the construction of collectively shared common-sense theories (LEFÈVRE; LEFÈVRE, 2014).

In the words of Gondim and Fisher (2009, P. 14, FREE TRANSLATION):

> To summarize, what is collective in this discourse constructed artificially by the researcher? If individual discourse reveals not only individual speech, but what is collective (diverse social voices, polyphony and heterogeneity), collective discourse is the joining of individual discourses, respecting the senses and the level of sharing. Strictly speaking, individual discourses are nothing more than collective discourses uttered by just one person.

The DCS technique consists of analyzing testimonials and other verbal materials, extracting from each one of them the Central Ideas or Anchorages, from the key expressions to which they refer. Key expressions are fragments of discourse used to identify the senses. In this first stage, the literalness of discourse is respected in order to establish a continuous dialogue with it, since in the discourse can be found several senses arising from the polyphony and heterogeneity that define its materiality. After identifying the key expressions, it is necessary to create a linguistic expression that describes the meanings of each of the homogeneous groups of key expressions. The Central Ideas are, thus, named by the researcher. From then on, one or many discourses-synthesis are

the discourses of the collective subject (GONDIM; FISHER, 2009).

Results and discussion

Regarding the sociodemographic characteristics of the interviewees, there was a predominance of the female sex, the mean age was 33 years old, with a minimum age of 27 and a maximum of 46 years old. As for the elapsed time after graduation, the average was 9.3 years, with a minimum of 5 and a maximum of 18 years. Regarding the level of education, the majority had postgraduate degrees of *sensu lato* (four subjects

had specialization) and *sensu stricto* (three subjects had a master's degree), however, only one of the interviewees had a master's degree in public/collective health. One of the subjects had no postgraduate degree. About the time of exercise in the Nasf, the average was of 1.05 year.

It is also worth mentioning that none of the subjects performed internship/experience at Nasf during graduation, remembering that these were created in 2008.

The analysis of the discourses led to the identification of five Central Ideas, with their respective Anchorages, and to the formulation of discourses-synthesis, as explained in the following chart:

Chart 1. Discourses of the Collective Subject structured from the key expressions related to their respective Anchorages and Central Ideas based on the speeches of the subjects, Jaboatão dos Guararapes, 2017

Central Idea	Anchorage	Discourse of the Collective Subject
Technical-pedagogical support of Nasf to the Family Health Teams.	The importance of Nasf in the technical-pedagogical support to the family health teams in the transformation of the reception process in PHC.	*I first understand Nasf as matrix support. It's the main role. Helping teams to do this reception process is one of the functions of Nasf: in sensitization to achievement, in understanding what is the reception... I consider this work important. It was fundamental the participation regarding this awareness of the staff because we suddenly have a vision they did not have. So, we were able to change all the way the reception took place, and, sometimes, in fact, we just clicked them, so they could think and manage to move. Nasf was important to get out of this comfort zone that the team had, thinking they were practicing reception.*
Results of the Nasf support in the transformation of the reception process.	Organization of the work process, professional satisfaction, greater interaction, re-signification of knowledge and optimization of the attendances identified as results of the technical and pedagogic support of Nasf in the transformation of the reception process for the teams.	*Nasf brought a new vision to the professionals of the Units. For example, they thought they were practicing reception, but according to the reception guidelines, they were not. So we managed to break it. I think the teams can breathe a little bit more because working organized is much better. There was this break, there was an organization, that people thought they had, but, actually, in the process, we saw that they did not have it. There was not in fact a flowchart of what was done with the patient when the patient arrives. I think their work has been optimized. This we notice when we move around through the Units and that the teams are happier with the result of the work. They started to know each other because we noticed in some Units that even the team did not know each other, what the other did.*
	Work overload for the medical professional.	*For the doctor it may not be so cool, that serves more people in a day than before the reception.*
	Increase in the number of accesses, including the population of areas without registered Community Health Agents (CHAs), and humanized care identified as results of the technical-pedagogical support of Nasf in transforming the reception process for the population.	*In relation to the population, it optimizes the trip to the Health Unit. So, they no longer must face the queue, they do not have to pick up a form any more, to arrive at dawn, to undergo an inhumane service. There was much more access to the community that was not assisted, that was not covered by the Unit. The number of calls has increased. I think that was very relevant.*

Chart 1. (cont.)

	New knowledge, visibility, self-satisfaction and organization of access identified as results of the technical-pedagogical support of the Nasf in transforming the reception process for the own group.	*First the question of knowledge because I had no concept of what reception was. And the other one that brought visibility to us. People began to see more our role, they began to request us. Our coordinator inflated our ego because of the reception issue. The group gains mainly in satisfaction to know that it is even modifying the life of the people. The joint work of matrix-based strategies we have how to measure and have a return of it. It organizes the access also to get in the Nasf and the flow.*
	Amount of Nasf request by teams without suffering variation.	*I thought the Nasf would be much more requested after the reception, and it hasn't been much.*
Challenges of the technical-pedagogical work in the reception.	The challenge of convincing teams to transform the reception process.	*We are arriving in environments that already worked in a way, and we arrive, a new team with new ideas, and sometimes the teams are so closed, there are people who are sometimes closed to the new. The challenge is actually getting the group out of the comfort zone, especially the CHA that have been in the teams for the longest time. They were accommodated in their work routine.* *The challenge is to awaken in the staff the desire to want to change, to offer the best for the community. We need to convince the teams that the reception brings gains not only to the population, that is our main target, but also to the teams themselves. So, the main challenge for me was the awareness of the team for everyone to participate.*
	Challenge to know the teams faithfully before supporting them	*So, I missed it a little bit: knowing it! Because we practically went to a meeting to know how it worked there, and it's difficult for us to try to change the reality of that place without knowing so faithfully how it works.*
Overcoming the challenges of technical-pedagogical work	Dialogue, sharing of knowledge and workshops with practical situations as ways of overcoming the challenges of transforming the reception process.	*Supporting the teams, sensitizing, bringing them to understand what reception is, through a lot of talk and, not only talking, but also demonstrating and showing what went right in the other Units. Placing practical situations, we could break it. We could put them in the other's situation. And supporting during the process so that in the middle of it they do not give up the realization of the reception. I think the important thing was this, we opened the opportunity for trials and did not impose anything, we built together.*
Suggestions for continuity of technical-pedagogical support.	Need to evaluate and re-evaluate the process of transformation of the reception.	*What we must do is go back there to see how everything is going on because we never went again. There must be a conversation. After it's over, call those people who have had some form of resistance to know what's going on, because they do not want to. And from there we come together and think of a way to optimize that.*

The first Central Idea reveals that the subjects believe in the importance of technical-pedagogical support, which is a dimension of the 'matrix support' mentioned in the discourse, considering it one of the main functions of their work, being fundamental for the sensitization of EqSF professionals in the transformation of the reception process.

The matrix support is a concept by Campos and Domitti (2007), which has become a methodology of care management, being an organizational arrangement that requires the "[...] shared construction of clinical and sanitary guidelines among the components of a team of reference and the specialists that offer matrix support", in the perspective of co-responsibility, ensuring dialogic integration between different specialties and professions. The work of the Nasf is guided by the theoretical-methodological reference of the matrix support applied to PHC (CAMPOS; DOMITTI, 2007, P.400, FREE TRANSLATION).

For these authors, the reference team (such as the EqSF) has the responsibility for conducting an individual or collective case and is formed by a set of professionals essential for the performance in a given case. The matrix supporter (like the Nasf

professional) is a different expert from those professionals present in the reference team, who adds resources of knowledge and technicians, which contributes with interventions that increase the resolving capacity of these teams.

The second Central Idea refers to the results identified by the Nasf professionals who came from the transformation of the reception process after the matrix-based strategies of the teams.

Regarding the results for the teams, the analysis of the interviews indicates that there was organization of the work process, professional satisfaction, greater interaction, re-signification of knowledge and optimization of services.

Contrary to these results, in an article dealing with the development of an action-research about the accessibility of users in a FHU of the Municipality of Itabuna (BA) with the purpose of promoting changes in the work processes of this place, the authors have identified that although the work process has modified at the entrance door of the FHU, it did not undergo changes within the teams, in which a process centered on the doctor still prevailed, little relational. However, in relation to accessibility to the FHU, the implanted reception provided greater integration of the team and better user perception (ANDRADE; FRANCO; FERREIRA, 2007).

Still according to these authors, through the participant observation, problems were revealed in the work process of the teams, with repercussions on the assistance to the users, such as delays of the receptionist and other professionals to the FHU, overload of work of the nursing technician, little recognition of non-medical professionals in the care functions and an excessive structuring of the work processes by the medical knowledge, leaving to the margin of the processes the other knowledge that are inscribed in the other professional practices. In the present study, the interviewees identified during the technical-pedagogical support that, in some Units, the professionals had difficulty in knowing the work of each other, which probably generates difficulty in the resolution of some cases. What can be observed in the speech: *"They started to know each other because we noticed in some units that even the team did not know each other, what the other did"*.

Although the majority of the speech indicates benefits for the teams, the speech brought by one of the interviewees, reporting that *"for the doctor it may not be so cool, who attends more people in a day than before the reception"*, reveals the hypothesis that perhaps the reception process has not yet been well understood by the teams, that should be decentralizing the care of the doctor to other professionals, which generates work overload for this professional, insofar as more people could have access to the unit, necessitating that the demand is directed to other professionals. Otherwise, medico-centered logic continues to persevere and overload the medical professional. Another hypothesis is that, due to the restriction of the number of consultations before the transformation of the reception process, this professional may be dissatisfied with the increased demand and feel overwhelmed. It is also observed, and seems quite revealing, that this result was not mentioned for the other members of the team, because it is still trying to break with the medical-centered model.

Still in relation to the second Central Idea, as results for the population, the statements of the interviewed allow us to infer an increase in the number of accesses, including the population of areas without registered Community Health Agents (CHA), and improved humanized care based on support technical and pedagogical of Nasf in the transformation of the reception process.

It also corroborates these results the action-research by Andrade, Franco and Ferreira (2007), in which the resolution of 9.5% of the cases that occurred in the spontaneous demand, soon after the implantation of the reception, is significant and reinforced for the purpose of the queues that accumulated in the door of entrance for medical consultation (also mentioned in the speech of the interviewees of this study).

These authors also report that there has been little displacement to other care technologies in conditions to absorb demand, since there is a low supply of other assistance practices, promotion and protection of health, from a perspective of integral care. That is, the reception and the light technologies that came to dominate the work process in the access of the users were 'hidden' in the entrance door of the Unit. These data may also serve as a hypothesis to explain the lack of speeches regarding the emergence of new care offerings other than reception, such as group formation and other health promotion practices, which were not mentioned by the interviewees in the present study.

In a similar way to our results, a study by Miter, Andrade and Cotta (2012), which deals with the advances and challenges of reception in the operationalization and qualification of SUS in primary care, through a critical analysis of bibliographical production in Brazil, from 1989 to 2009, revealed that several articles show that the implantation of the reception resulted in advances in the expansion of access in services of the PHC and health professionals more sensitive to the needs of users and communities, which can also be perceived in this study through of speech:

> *So, they no longer must face the queue, there is no more need to pick up the form, to arrive at dawn, to undergo an inhumane service. There was much more access to the community that was not being served.*

However, the aforementioned authors affirm that it is still observed the maintenance of the care model centered on the clinical model and the organization of the work process from the medical consultation.

Additionally, the authors still report that the excess of demand and the lack of health professionals generate work overload, fatigue and stress in the workers, signaling as examples two articles that show precarious conditions of work of the CHA, factors that can cause difficulty of these professionals for the transformation of the reception. According to them:

> The suffering caused, in this type of work, can lead them to use defensive strategies, assuring a certain normality by the apparent insensitivity against what can cause him/her suffering, contrary to the one recommended by the parameters of the NHP. (MITER; ANDRADE; COTTA, 2012, P. 2081, FREE TRANSLATION).

In this study, this last data can serve as a hypothesis to explain the reason for the speech of one of the interviewees:

> *The challenge is actually getting the group out of the comfort zone, especially the CHAs that have been in the teams for the longest time. They were accommodated in their work routine.*

Still corroborating our results, another study, this time an integrative review about the scientific literature regarding the reception in primary care published between January 2007 and May 2014, reports that researches show that the reception as a humanization device has the potential to reduce repressed demand, providing greater access to services, making the entire team responsible for the care and satisfaction of the user (COUTINHO; BARBIERI; SANTOS, 2015).

It is pertinent to highlight that interviewees do not cite as a result for the population the increase in self-care

capacity of the users, since conversations with them and, above all, the reception experiences they experience can facilitate the construction of bonds with workers, as well as to increase that capacity, insofar as they are able to recognize their situation and are sure about the possibility of being welcomed by the teams (BRASIL, 2013A).

As results for the professionals of Nasf themselves, they report the acquisition of new knowledge, greater visibility, self-satisfaction and organization of access for them after the technical and pedagogical support offered in the transformation of the reception process, which makes the group feel probably more motivated to continue investing in this dimension of work and to intensify the bonds with the managers and the professionals of the supported teams, making work a pleasant space. The comparison with other studies that demonstrate similar or even discordant results of the latter did not occur due to the lack of studies on the technical and pedagogical role of Nasf in the transformation of the reception or even the existing studies did not address results in relation to the matrix team.

Another result is identified in the speech of the interviewee: *"I thought Nasf would be much more requested after the reception, and it hasn't been much more"*, which leads to two hypotheses: the reception may have had no effect beyond the entrance door, considering that it would facilitate a greater flow for Nasf despite the growth of the demand as a whole, what would be expected for Nasf's work in its clinical-assistance dimension; or the demand is having their health needs met at the reception and/or by the unit team without the need for matrix support by the Nasf.

The third Central Idea refers to the difficulties for technical-pedagogical support, such as the work that guided this study. It is possible to identify by means of the analysis of the speeches of the interviewees: the challenge of convincing the

teams supported for the transformation of the reception process and the challenge of getting to know them faithfully before supporting them in this regard.

It can be observed, in the speech of one of the interviewees, suspicions about the causes of the difficulty of sensitization:

There is resistance by the own speeches in the reception workshops. People think it would be an extra work, that the population would not understand, that would disrupt their routine. Because they think that they are going to waste a lot of time in the reception and they are going to waste time like this... to attend, to be doing the actions, the same service activities, the visits, the individual attendance [...].

It can be understood that the subject comprehends three reasons for this difficulty: the first would be the perception of the accumulation of one more task for the professional of the EqSF; the second would be the lack of understanding of the process of reception by the population, which would require the availability of the professional to make it understood; and the third, the difficulty of valuing health promotion and prevention practices, with the understanding that it places greater value on curative interventions.

Corroborating this study, Andrade, Franco and Ferreira (2007) identified, through the sensitization of the team for the implantation of the reception in an action-research, that the challenge was mainly due to the criteria of change, linked to the desire and perception of feasibility. The process required the identification of the problems to be solved, to allow the transition from the current situation to the objective situation.

According to Gonçalves *et al*. (2015), it is worth highlighting that, even when working together, the work process of the Nasf and EqSF teams differ in relation to several aspects, such, for example:

management; time to perform tasks; productivity required; expected demand; tools used; constitution of teams, among others. These differences, as well as the selection of priorities among the teams, can also serve as hypotheses for the difficulty encountered by the subjects during the technical-pedagogical support.

Another explanation for the challenge of team awareness in relation to the care model is brought in the review study by Miter, Andrade and Cotta (2012), in which they consider that the biomedical model, centered on the disease, is emphasized by the professionals and demanded by the users, leaving little space for educational actions, health promotion and prevention and, on that logic, also for the reception process.

There is, however, a warning about the relationship between the current capitalist economic model and the reception process, since, according to Affonso and Bernardo (2015), the reception proposals would be in line with the neoliberal context, in which what has been happening is that the 'production' of care becomes the main indicator for the evaluation of the work performed by health professionals, which is not compatible with the announced 'humanizing' reception proposals. According to the authors:

> Living in such a contradictory context can have consequences for both the responsible workers and the population itself. It should be remembered that the reception, by itself, is already exhausting, since it is the gateway to the health services, having to answer questions that, in most cases, are not under the control of professionals who do so because they relate to the larger social context. Such fact, coupled with pressures for production and job instability, characteristics of the managerial proposals that have been implanted in the health services, suggests that the exercise of this activity causes more suffering to the professional. (AFFONSO; BERNARDO, 2015, P. 28, FREE TRANSLATION).

Still in relation to the difficulties, the subjects do not mention about the problem of working in an interdisciplinary way. It is known, however, that one of the limiting factors that can arise in the process of insertion of Nasf in the PHC concerns the professional formation, in which, commonly, the professionals did not receive formation in the graduations and post-graduations in health to work in the logic of the matrix support, in addition to teamwork being rarely deepened, which makes it difficult for the categories to act in an integrated and interdisciplinary way (BRASIL, 2014).

In this logic, a study about the challenges and potential of the Nasf shows that the subjects indicate that in the initial phase of the work of these teams must occur the sum of isolated knowledge, since the professionals do not yet have experience in this reality, therefore, a multidisciplinary relationship. It is hoped, however, that over time, with a growing appropriation of the cases and the characteristics of the territory, in addition to integration with the EqSF, it becomes possible to build new knowledge that will be carried over the different specialties dynamically, for transdisciplinarity (SILVA ET AL., 2012).

Another Central Idea raised refers to the ways of overcoming understood by the professionals of the Nasf in relation to the challenges listed above. These are: dialogue, sharing of knowledge and problematization with examples of practical situations.

Dialogue, problematization and the shared construction of knowledge are three of the principles of the Popular Education in Health Policy (BRASIL, 2013B). The first concerns the encounter of knowledge historically and culturally constructed by subjects, in the intersubjectivity, which occurs when each one, in a respectful way, shows what he knows with disposal to increase the critical knowledge

of everyone about reality, contributing to the processes of transformation and humanization. The problematization reveals the existence of dialogic relations and proposes the construction of health practices based on reading and critical analysis of reality. The last principle consists in communicational and pedagogical processes between people and groups of different knowledge, cultures and social insertions, seeking to understand and transform collective actions of health from its theoretical, political and practical dimensions.

The last Central Idea refers to the suggestion of continuity of technical-pedagogical support, anchored in the need to evaluate and re-evaluate the process of transformation of the reception so that it may, effectively, happen, convincing professionals that it is part of the work process and which is part of the NHP.

Final considerations

One of the initial points in the work to support health teams is to ratify the importance of SUS as a proposal for comprehensive care, considering the health-disease process of users in all their complexity. In this perspective, it is fundamental for Nasf to demonstrate to the teams that it is in the same 'boat' of the SUS, that it comprehends the processes of this System and seeks to know how it happens in its innermost, before making propositions. From there, the specific role of Nasf will be understood as a way to improve SUS itself. Thus, research that gives visibility to the actions developed should be stimulated, so that other sites can enjoy the benefits of the performance of this team.

In this context, the realization of this work allows us to consider that the interviewees understand the technical-pedagogical dimension of the matrix support of the Nasf as an important part of the work process itself, including fundamental

awareness of the transformation of the reception process in PHC. It is believed that this dimension should be explored with the same intensity as the clinical-assistance dimension.

The group also perceives results for the supported teams, such as organization of the work process, professional satisfaction, greater interaction, re-signification of knowledge and optimization of the attendance, as well as for the population, as an increase in the number of accesses, including the population of areas without CHA registered and humanized care; and also for the group itself, such as acquisition of new knowledge, visibility, self-satisfaction and organization of access.

There are difficulties in carrying out the technical-pedagogical support, such as, for example, persuading supported teams to transform the reception process, but it is also fundamental to know them faithfully in the aspects that involve their work processes and then contribute to this change. As a way to overcome these difficulties, they cite dialogue, knowledge sharing and problematization, with examples of workshops with practical situations.

It is necessary to consider the continuing education of the professionals of the PHC as important for the quality care of both EqSF and Nasf, since this is an important policy for the strengthening of SUS. Rethinking the process of welcoming spontaneous demand in the PHC with FHU professionals requires respect for their speeches, with a listening capacity of the various actors involved, being attentive to their anxieties, stimulating solutions and contributing to innovations. Therefore, in discussing the process of reception with these teams, the Nasf should also become welcoming.

The professionals of the Nasf are important supportive parts of the PHC because they bring a new vision, with their different

training baggage and their care experiences. Knowing dialogue while maintaining a relationship of mutual and horizontal construction is something of a priority. Thinking about how the meetings between the Nasf, teams and the population, together with the management, will take place is also necessary. Evaluate and reevaluate all the steps and maintain permanent monitoring to the population and the professionals allows to identify the advances and critical nodes as well as the challenges.

The incentive to continuing education, respect for the principles of SUS and the guidelines of Nasf, as well as the basis of actions in the Popular Health Education Policy, are fundamental factors to subsidize the work of the PHC teams, favoring the implementation of the NHP in all sectors of SUS. In this sense, it is essential that managers and health teams understand and value the work of Nasf professionals.

Finally, in the understanding of the authors of this work, it seems clear the need to recover the valorization of the technical-pedagogical dimension as one of the priority tools of the work of the Nasf, since the supported teams greatly explore the clinical-assistance activity. Not balancing these dimensions well can compromise the results of both the Nasf and the teams and generate losses for the assisted population. This is a great challenge that managers can assume to improve the performance of both equipment.

Collaborators

Wellington Duarte contributed substantially to the conception and planning of this work, as well as to the analysis and interpretation of the data. Tânia Falcão and Alexandre Beltrão contributed substantially to the data systematization and critical revision of the content. All participated in the drafting and approval of the final version of the manuscript. ∎

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