ISSN: 2230-9926

Available online at http://www.journalijdr.com

IJDR

International Journal of Development Research
Vol. 07, Issue, 11, pp.16756-16763, November, 2017

ORIGINAL RESEARCH ARTICLE **OPEN ACCESS**

ACTIONS PERFORMED BY THE FAMILY HEALTH SUPPORT CENTERS: AN ANALYSIS OF THE RESULTS FROM THE SECOND CYCLE OF THE NATIONAL PROGRAM FOR ACCESS AND QUALITY IMPROVEMENT IN PRIMARY CARE

[1,*]Jailson Alberto Rodrigues, [2]Izaias Almeida Belas, [2]Filipe Melo da Slva, [3]João Agnaldo do Nascimento, [4]Ulisses Umbelino dos Anjos, [5]Juliana Sampaio and [6]Ana Maria Gondim Valença

[1]PhD in Models of Decision and Health from the Federal University of Paraíba (UFPB) – João Pessoa (PB), Brazil, Assistant Professor I at the Bachelor in Nursing course at the Federal University of Piauí (UFPI) Campus Amílcar Ferreira Sobral (CAFS) – Floriano (PI), Brazil.

[2]Undergraduate degree student of the Bachelor in Nursing course at CAFS/UFPI - Floriano (PI), Brazil

[3]PhD in Statistics from the University of São Paulo (USP), Assistant Professor IV at the Department of Statistics at UFPB- João Pessoa (PB), Brazil

[4]PhD in Statistics from the University of São Paulo (USP), Professor at the Department of Statistics at UFPB- João Pessoa (PB), Brazil

[5]PhD in Public Health from Oswaldo Cruz Foundation, Assistant Professor at the Department of Health Promotion at UFPB, João Pessoa (PB), Brazil

[6]PhD in Social Odontology from the Fluminense Federal University (UFF) - Niterói (RJ), Brazil, Associated Professor at the Department of Social Clinic and Odontology at UFPB - João Pessoa (PB), Brazil

ARTICLE INFO

Article History:

Received 19th August 2017
Received in revised form
23rd September, 2017
Accepted 20th October, 2017
Published online 29th November, 2017

Key Words:

Decision Support System; Community Health Networks; Family Health.

ABSTRACT

Matrix support, in Brazilian primary health care, is characterized as a device for reorganization of the work processes, which encourages the expansion of the clinical approach, the resolution potentiality in this area and the reflection of established practices. From this perspective, the Family Health Support Centres were created to work in partnership with primary care teams, instituting specialized assistance and aiming to provide comprehensive care. Given this established situation, this study intended to analyse the actions developed by the support centres. For that, it was used the data from the results of module II in the second external evaluation cycle of the National Program for Access and Quality Improvement in Primary Care, made available by the Brazilian Health Ministry. The sample of this study counted with 17,156 teams of primary care. The modality 1 of support centres was predominant, and demonstrated to perform home visits; individual consultations; group therapy; actions of community intervention and health education, among others actions listed by the program of improvement. The way data from the second cycle of the National Program are showed, according to the proposal presented in the external evaluation instrument, does not allow a more detailed analysis of the frequencies of activities performed. The Family Health Support Centres have proven to be more of an extension of the teams of primary care than a supportive or protective rearguard.

Corresponding author

Citation: Jailson Alberto Rodrigues, Izaias Almeida Belas, Filipe Melo da Slva, João Agnaldo do Nascimento, Ulisses Umbelino dos Anjos, Juliana Sampaio and Ana Maria Gondim Valença, 2017. "Actions performed by the family health support centers: an analysis of the results from the second cycle of the national program for access and quality improvement in primary care", *International Journal of Development Research*,7, (11), 16756-16763.

INTRODUCTION

One of the indicators of the passage from the biomedical, curative and privatized health model, centred in the hospital and medicalization, to the current model of primary health care in Brazil was the implementation of the Family Health Strategy (FHS) in 1994. As a component of Primary Care, among other objectives, the strategy aims to enable the health service to make available what is advocated as doctrinal principals of the Brazilian Unified Health System: universality of access, equity among the users and integrality of care to all individuals (Sampaio, 2012).

Over the years of primary care operation, it was notable that the FHS, by itself, could not ensure everything that is agreed as a fundamental organizing principle of the system, regard to primary care, especially when it comes to integrity and resolution in assistance. To this end, the Brazilian Health Ministry created on January 24, 2008, through Ordinance No. 154, the Family Health Support Centres (NASF) as a component of primary care. These centres are aimed at service users on a shared basis with the FHS, and the establishment of therapeutic projects that consider the uniqueness of the individuals (Brazil, 2014a). For this purpose, Campos and Domitti (2007) have considered the concept of matrix support. The matrix support, which is offered by the professional teams of NASF, aims to provide expert support to the teams in charge of assistance of health issues, having the mechanisms of referral and counter-referral, protocols and centres of regulation as working methodology. This service relies on its offering of technical-pedagogical and clinical-assistantial support (Campos *et al*, 2007).

NASF should base their actions on the guidelines of primary care, such as interdisciplinary and intersectional approach; permanent education in health for professionals and population; development of the concept of territorialisation; integrality of care; social participation; popular education and health promotion. Furthermore, preferably, it must operate in accordance with the recommendations of the Health Ministry in two macro dimensions: technical-pedagogical and clinical-assistantial. It is also set that they will not constitute a gateway to the system, but a support to the teams of primary care and family health (Brazil, 2014a).

In the clinical-assistantial dimension, the professionals' actions of the matrix support team in NASF will focus directly on the user, which does not necessarily happen in the technical-pedagogical actions. In this other dimension, the focus of actions, conduct and dialogues are aimed, preferably, to health professionals of the referral team (Brazil, 2014a).In this sense, NASF was created to offer technical services and pedagogical support, as well as to expand the clinical care, as a solution for a better provision of assistance to the demands of the population that was not covered by the FHS. This provision of care might consider the needs of a population that stands in need of effective actions in a timely manner (Anjos *et al*., 2013). The kind of assistance provided is also developed in contrast to conventional models of care, which preferred fragmented and individual expert assistance.Considering that the actions developed under the matrix support principle demonstrates themselves as a relevant strategy for the operation of health care networks, this rearrangement in the methods of promoting health has shown a positive impact on territorial realities. For that reason, it was intended to carry out this research, as an investigation aiming to analyse the actions developed by NASF, from the results provided by the Brazilian Health Ministry, referring to the second cycle of the National Program for Access and Quality Improvement in Primary Care (PMAQ-AB).

METHODS

This is a census descriptive and exploratory research, with a cross-sectional design and a quantitative approach. The scenario is composed by all Primary Care teams that responded the instrument of external evaluation, from the module II of PMAQ-AB, and declared to have received support from NASF on the moment of its second cycle, performed between 2013 and 2014. 258,741 health teams participated of the evaluation in this stage, of which 25,140 had received support from NASF teams at that moment. For the present study, we considered the evaluation performed by 17,156 teams distributed in 2,287 Brazilian municipalities.
Considering that NASF influences the working process of primary care teams through the development of shared actions, by means of theoretical and methodological tools of the individual therapeutic projects, matrix support and expanded clinical attention, variables of the external evaluation instrument available in http://dab.saude.gov.br/portaldab/ape_pmaq.php?conteudo=2_ciclo were used in this study. Those variables cover the components focused on the aspects of articulated actions of the technical-pedagogical and clinical-assistantial support, which are addressed by the variable NII.33.17 (Brazil, 2014a).

The variables were encoded by the Health Ministry, which provides a decoder dictionary on its aforementioned webpage. Data were organized by the ministry in spreadsheets in Microsoft Excel format, and made available on their home page at no costs and for public access. On this database, in most cases, the variables have four possible responses: 998= does not apply; 999= do not know / did not respond; 1= in case of affirmative response; 2= in case of negative response. The external evaluation in the second cycle of PMAQ-AB was managed by Brazilian Federal Institutions of Higher Education and Research by means of assessment teams formed by field coordinator-teachers; field supervisors and quality assessors, as well as the overall coordination; and teams of technical support. The data collection for PMAQ-AB was made by the evaluation teams using tablets, where the evaluator recorded the information provided on the on-site interview. Such information could be provided by a single professional from the team or by the entire team together, then it was passed to the coordination teams of higher education, and finally to the Health Ministry.

To process this study, it was sought some of the spreadsheets provided by the ministry on the website http://dab.saude.gov.br/portaldab/ape_pmaq.php?conteudo=microdados. From those spreadsheets, the variables and the sample units of interest were selected and the new database was organized. It was also included in the database, the NASF

modality installed in the municipalities, when the external evaluation of the second PMAQ-AB cycle was carried out. Those informations were found at the website http://cnes2.datasus.gov.br/Mod_Ind_Equipes.asp of the National Registry for Health Establishments from the Brazilian Health Care Secretary. After the organization of database, the statistical treatment was performed. Therefore, descriptive statistics was used for presentation of the relative frequencies and inference. It was also performed the test of comparison of two proportions for independent samples. Such procedures were performed with the aid of the free distribution software R Studio version 3.2.2. It was considered the statistical significance level of alpha = 0.05 as a mark for inferences and presented the confidence intervals of the relative proportions, of which the test obtained the Chi-square value, considering maximum failure percentage 50.0% (maximum proportion of verification of the event of interest p = 0.50), as this is a single sample. In line to the recommendations of the National Commission of Ethics in Research and National Health Council, placed in resolution No. 466 (Brazil, 2012b), which discuss ethical standards focused on research involving human beings, the external evaluation of PMAQ-AB was submitted to the Ethics Committee of the Federal University of Rio Grande do Sul and approved by getting opinion No. 21,904 on 01/03/2012.

RESULTS AND DISCUSSION

Figure 1 shows the percentage of Primary Health teams certified on the tripartite process involving the Brazilian Health Ministry, National Council of State Health Secretaries and National Council of Municipal Health Secretaries of Brazil, in the second cycle of PMAQ-AB. The percentage of teams are showed in the figure by each Brazilian federative unit, represented by its abbreviation.

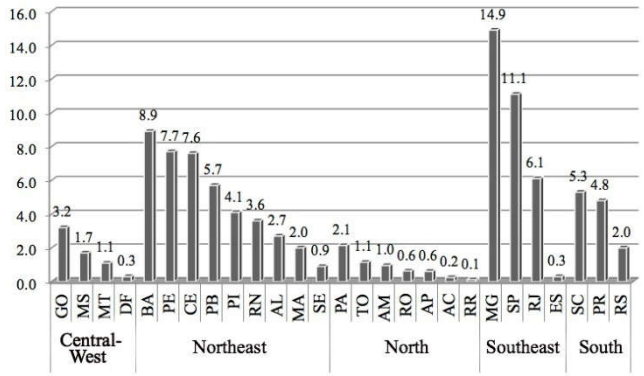

Figure 1 – Percentage distribution of primary care teams that participated of the second cycle of PMAQ-AB, by federative unit, in the universe

The Northeast and Southeast Brazil counted with the participation of 43.2% and 32.5% of all certified primary care teams, respectively. The South and Central-West counted with 12.1% and 6.3%, while the north of the country had the lowest participation in number of teams, with 5.7%. The results show that the participation of NASF teams in PMAQ-AB is not homogeneous, as there are more certified teams in some regions than others. In addition, NASF covers each region of Brazil differently, according to the Department of Primary Care. That is, the program falls within a relative national reality. Designed based on the challenges and advances of the Primary Care National Policy, PMAQ-AB mobilized and involved the three levels of management of the Brazilian Unified Health System in the process of change, which seeks better qualification for its service. Therefore, adherence to the program was voluntary, considering the assumption that personal and collective motivation of managers, professionals and users should aim at the construction of this continuous and progressive process of stimulus-induction-transformation (Brazil, 2013c). The concept of adherence is broad and used in many different ways. The term adherence, in this context, converges for individual behavioural practices and coercive actions, not only assuming partnership, but recognition, agreement and establishment of bonds and duties, as well as search for answers and affirmative action (Moraes *et al*, 2009; Amaro, 2013). In this sense, the adherence of NASF teams in each municipality started from what Amaro (2013) presents as a prerequisite to the act, the advantage. Advantages are attributed to the predisposing team, which, for this situation, is intended to be of a lasting or even permanent, reorienting, transforming and collective nature. This has direct implications for the municipal funding and salary floor for primary care, according to the adherence of health teams to the program. These funds are intended for financing strategies pursued under primary care services, and can also be paid to workers, transferred by implementation of actions. Based on this value, according to each team's performance in PMAQ-AB, and a financial incentive for each of them in the variable salary floor would be increased (Brazil, 2013b).

SF

NASF teams have different professional formation, depending on diverse factors of the context of referral staff, the actions performed by the support teams involved in differences in functions, and ways of working between them and the referral teams. That might be generating conflict situations, which are complemented on the positivist logic of productivity adopted by the health system, especially in primary care. This gap should be discussed for greater use of support tools, not instituting NASF as a simple tool of extension of the teams solely responsible for the assistance (Gonçalves *et al*., 2015).

Figure 2 shows the distribution of teams by federative units, according to the specific modality of NASF. The figure highlights the predominance of modality 1 in most states and Federal District (DF). The states of Espírito Santo (ES) and Mato Grosso (MT) are exceptions to this fact, showing predominance of modality 2 among the participating teams, while the states of Tocantins (TO) and Piauí (PI) had more teams corresponding to the modality 3 of NASF.

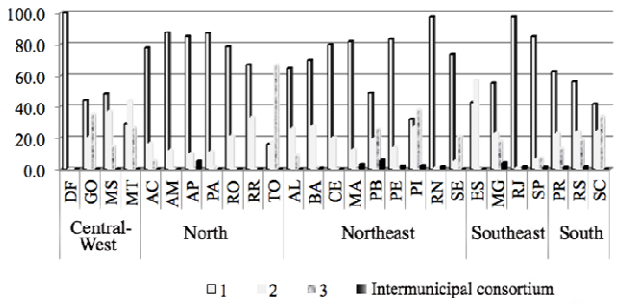

Figure 2 – Percentage distribution of NASF teams by modality, federative unit and region

The NASF modalities of organization are implemented considering the amount of primary care teams supported by them. According to Ordinance No. 3124 of Brazilian Health Ministry, NASF 1 must meet at least five and at most nine teams, NASF 2 might cover three or four teams, and the implementation of NASF 3 stipulates that it may offer support up to two teams of primary care (Brazil, 2012c). The predominance of modality 1, can be explained considering two main facts. First, many municipalities that have joined the PMAQ-AB have medium to large population assigned, which is directly linked to the process of establishment of each NASF modality. It also considers the fact that family health teams, for example, must cover an ascribed population of up to 4,000 people in a given territory (Brazil, 2012a). Soon it follows that the larger the population of the city is, more family health teams, therefore more NASF teams, especially of modality 1, will be implemented. Second, the ministerial funding logic for NASF provides funding for a single modality of NASF to each municipality (Brazil, 2012c).

Brazilian Health Ministry stated, for the second cycle of PMAQ-AB, that at least five teams of family health and/or primary care for specific population had concurrently adhered to the program for modality 1 of NASF; at least three teams for modality 2; and adherence of at least one of those teams for modality 3. Regardless of the modality of NASF, their actions are based on an intersectional and interdisciplinary basis, aiming to support; improve; and qualify the management of primary care, and also to overcome the fragmentation of assistance. Its composition should also respect the epidemiological patterns and the technical needs of the Family Health Strategy and population. (Brazil, 2012a). In summary, the actions taken by NASF teams during the second cycle of the external evaluation of PMAQ-AB, from the perspective of supported professional, which imply in defining characteristics of their profile of actions, are presented in Figure 3. Therefore, it presents NASF actions in the national territory, so that it can identify how many and which activities are developed by the teams.

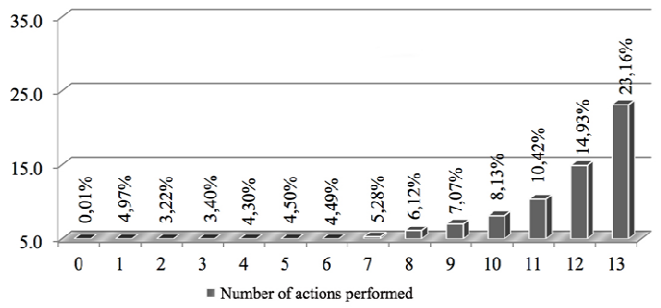

Figure 3 – Percentage distribution of the number of actions recommended by PMAQ-AB, performed by NASF teams in Brazil

There is a predominance of teams that perform the greatest possible number of actions planned for NASF, from the perspective of the professionals of the referral teams, regarding the second cycle of PMAQ-AB. It focusses attention on the limited scope of activities presented in the instrument of external evaluation for the program. The referral teams that participated of the second cycle of PMAQ-AB reported a frequency of more than 55.0% of holding at least ten of the actions listed in the external evaluation instrument. That was not statistically significant at the alpha 0.05 level (p-value = 0.219). Therefore, there is strong statistical evidence to reject the hypothesis that NASF teams are, in fact, performing the actions reported by primary care teams. This can point to an information bias during collection in the evaluative cycle, or even the lack of knowledge of primary care professionals in what concerns the attributions and activities developed by NASF. “The work that is recommended for NASF teams is broad, encompassing multiple tasks of different natures and still has little description regarding the specific contribution of each professional category" (Gonçalves *et al*., 2015, p. 70). The results presented in Figure 3 and supplemented in Table 1 point to a clear attempt by local management to broaden primary care teams and reinforce the thesis that they are insufficient in regard to professional composition and the amount thereof. Considering the number of different actions and the nature of these activities, which are developed by NASF teams, such limitation of the referral teams may compromise the resolution, comprehensiveness of care and assistance to the demand. NASF can offer services and develop individual and collective actions, punctual or not, that broaden the scope of action for primary care that the professionals of the Family Health Strategy would hardly perform without support. The clinical, epidemiological and socio-political reasoning of NASF teams about the health situation will therefore support the achievement of individual or collective interventions, promoting, preventing, diagnosing or rehabilitating conditions (Brazil, 2014a).

NASF’s profile should be set by the pact between management and referral teams, to be organized according to local demands and availability of professionals (Furtado and Carvalho, 2015). It must, however, consider the theoretical framework of matrix support (Campos and Domitti, 2007). In this way, the existence of NASF teams ends inducing a constant reorganization of primary care teams and requiring considerable amount of time in the schedule of local administration (Prado and Reis, 2014). Falleiro *et al*. (2014) point out that the matrix support arrangements offered by NASF, regardless of the location where they occur and ways of acting, whether more clinical-assistantial or technical-pedagogical, empower the actors of the health-disease process and decentralize decisions on the demand for resolution; values autonomy and the role of individuals and group when it uses the matrix support tools. Thus, this experience has provided new discourse and way of administer the services, producing positive changes in the organization logic in health, going against the suggestion of reduction of number of teams recommended by the current macro management of health services in the country, proposed in the Primary Care National Policy (Brazil, 2017), what have proven to be a failure. In addition, these results demonstrate that the fact that teams from the same sphere of assistance, frequently with identical professional composition, have been performing different actions are legally bound by Ordinance No. 3124 and the Notebook of Primary Health Care No. 39 (Brazil, 2012c; 2014a), which allow for multiple interpretations of the format and performance of NASF. This focus on the existence of different models of performance for NASF teams in the country, regardless of geographic region, city or population.

Considering the presentation of the frequency implementation of NASF activities, Table 1 complements the information presented in Figure 3, ranking, while categorizing, the activities performed by the teams. It is possible, from this information, draw up a work profile of NASF teams in the country.

The historical trajectory of NASF implementation, in practice, is not yet related to the change in social indicators. This has been based on the expansion of the provision of health services of the Family Health Strategy, especially the ambulatory ones (Moretti and Fedosse, 2016).

Table 1. Actions of NASF teams grouped by dimension of operation, in ascending order of performance frequency

Description	%Performer NASF teams	CI*	p-value	Ranking
Assistantial Actions:				
Home visits	86,8	78,2 – 92,4	<0,001	1ª
Individual consultations	85,4	76,6 – 91,4	<0,001	2ª
Shared consultations	63,1	52,8 – 72,4	0,011	3ª
Collective actions, health education and pedagogical demands:				
Therapeutic groups / Health education	75,8	66,0 – 83,6	<0,001	1ª
Community interventions	75,7	65,9 – 83,5	<0,001	2ª
Discussion of cases and formulation of singular therapeutic project	69,2	59,1 – 77,8	<0,001	3ª
Discussion of content and actions for permanent education	68,9	58,8 – 77,6	<0,001	4ª
Actions of planning and management:				
Organization of demand for individual service	71,7	61,7 – 80,0	<0,001	1ª
Support to the organization of work process of primary care teams	69,3	59,2 – 77,9	<0,001	2ª
Planning and evaluation of	68,5	58,3 – 77,2	<0,001	3ª
Definition of criteria for access and flow	65,1	54,8 – 74,2	0,004	4ª
Monitoring and evaluation of	59,8	49,5 – 69,3	0,063#	5ª
Flow management	54,6	44,4 – 64,5	0,412§	6ª

*Confidence interval. #Significant to level alpha 0,10. §No statistical significance.

The home visits proved to be the most frequent activity in a daily basis for NASF, performed by 86.8% of the reports. Flow management was the less prevalent (54.6%). The data reinforce that, based on the PMAQ-AB instrument, it is not possible to distinguish whether certain actions such as home visits are performed by the NASF professional alone or accompanied. This can further consolidate the idea of a trial of the management and the supported team itself to have NASF as an extension of the services already performed by primary care teams. It is also clear, from the data presented, that from the scope of actions, the three most commonly performed actions are mainly of clinical-assistantial nature. The actions of educational profile such as discussion of a singular therapeutic project, shared consultations and other action of permanent education, which are the strongest features of matrix support, had frequency of operation of, approximately 20.0% lower.

Home health care is an activity recommended in the Notebook of Primary Health Care No. 39, and is seen as an opportunity for early diagnosis and longitudinal therapy. Also, the shared consultations, which the notebook refers to as one of the most frequent NASF activities, serves to strengthen links, provide opportunities for discussion and allows the supporter to contact users (Brazil, 2014a). Activities, such as performing shared consultations, according to Gonçalves *et al*. (2015), demand not only conciliation in the agenda, but especially availability of both teams for the exchange of knowledge and openness to learning. Because of this, and because of the intention to transfer responsibilities, most NASF services are not shared. Reflecting on the NASF design in Campina Grande - PB, Sampaio *et al*. (2012) found strong indications of a predominantly technical-assistantial profile, as clinical practice prevails. Individual consultations and group assistance, in response to restrained demand, had support of local management by the lack of resources of the health care network, making NASF responsible for care management.

Gonçalves *et al*. (2015) also reinforce the importance of paying attention to the fact that the transfer of responsibility for care, with consequent overload in the NASF agenda, is due not only to the ineffectiveness of the health system, but also to the lack of understanding among those involved in the process of deployment, organization and practice of matrix support. The technical-assistantial nature of support offered by NASF, from the perspective of Campos *et al*. (2014), should be based on conjoint intervention with primary care teams, such as in consultations, home visits and in cases that require specialized actions. Shimizu and Martins (2014) analysing experiences of the support process in primary care units of the Federal District (DF) observed a shortage of extramural activities. Both medical and nursing care, in addition to the actions performed by NASF, prevailed through individual consultations in the units.

The technical-pedagogical support, in the assistantial context, presupposes a conjoint, formative and educational action for the referral teams in the development of their practices. Concrete interventions (consultations, home visits and therapeutic/discussion groups) should aim at qualifying the referral team to expand its ability to meet and consider the subject in its complexity and uniqueness. This does not exclude the care dimension of matrix support. The demands that require specialized monitoring can and should happen, but always avoiding the transfer of responsibility, medicalization and other damages arising out of traditional logic of health care (Campos *et al*., 2014). Saldanha *et al*. (2014, p. 1057) point that "in the construction of the singular therapeutic project, the professionals involved are invited to compose the referral team in the care network, identify health needs and build their questions". This action serves as a survey of the reality of user, family and community, identifying the knowledge of the workers about the health networks to which they belong. In addition, variant in the conduction of care.

The design of a singular therapeutic project, activity often developed by most groups, with the various actors involved in the care and management strategies, for example, in the logic of matrix support, does not attend the normative and curative traditionalism focused on the disease. It uses an integral, interdisciplinary and multiprofessional action, and coordinates services, proposing itself to become a reality in a territory (Saldanha *et al*., 2014; Anjos *et al*., 2013). The organization of the work processes of the Family Health Strategy and NASF should establish spaces for discussion of cases, management, construction and consolidation of the health model. It should also aim at collective learning, increasing autonomy and guiding the care process. That is referred to the technical-pedagogical dimension of matrix support (Anjos *et al*., 2013).
Primary care is a privileged environment for the teaching-learning process. The permanent education in health comes to guide the process of professional practices and pedagogical actions in a continuous way. It also aims to strengthen the work process, awaken self-criticism, creativity, deliberative action and autonomy. That must be the daily reality of NASF and the support it offers (Silva, 2016).

The processes of formation of health professionals, even with strong features of the biomedical model associated to the lack of permanent education processes in health, has not allowed these professionals to act in a qualified way in the construction and development of an expanded clinical care. In this logic, the emotional, symbolic and sociocultural universe of the subjects, in the clinical practice of NASF in the matrix support perspective, should be considered. It must escape the positivist look, which fragments the subject and reduces the knowledge to mere technique (Figueiredo and Campos, 2014). Paulon *et al*. (2014) state that for these reasons, the NASF teams have been unable to mobilize co-production to transform reality in a group, because they are plural. The achievement of therapeutic groups must aim at rehabilitation of users' self-care ability (Brazil, 2014a).

The work dynamics of NASF must not only seek to modify along to the health status of the population or to promote self-care culture, but the realization of community interventions in the territory. It should also serve as a measurement of the work teams, expanding the base of actions and perceptions of demands (Brazil, 2013a). The adversities of the territory and the health situation of the population served by NASF (Brazil, 2013a), added to the frailties of the health system, most of the time, undermine the work of the teams (Paulon *et al*., 2014).
Gonçalves *et al* (2015) present some NASF activities as routine and others as activities of determined periodicity, mentioning the meetings with teams for planning their actions. In addition, other contributions such as flow management and definition of access criteria for NASF teams, or pact assignment, must be defined since the implementation of the supporting staff. In this context, it opens the possibility of various designs for configuring NASF teams. Many municipalities develop unique models of support, convenient to the local reality, which even might have been expected in the external evaluation instrument of PMAQ-AB, when listing the activities undertaken by NASF. The actions of planning and evaluation are presented as essential to expand the technical look and scope of operation, as well as it is an irrefutable tool to determine roles and responsibilities. Nevertheless, also contribute to the knowledge of the technological tools of work for NASF, which are often unknown by the professionals from primary health teams, as well as NASF team professionals (Gonçalves *et al*., 2015). This reality, as pointed by the actual outcomes, may be in process of overcoming, considering that these practices are increasingly implemented. Based on the Paideia method, the evaluation processes on NASF's work should not associate care and management. Their support seeks to overcome the distance between those who plan and those who execute the actions, promoting democratic governance and involving the various actors in the health-illness process into an interim involving discussion, problematizing, planning and action (Moura and Luzio, 2014). Silva *et al*. (2012) point that the work of NASF intends to overcome the positivist rational logic of the health system that prioritizes quantity. The evaluation of the impact of the results from programmed actions in NASF's agenda aimed at improving service quality and resolution in primary care. Our results illustrate an overview of what PMAQ-AB, in fact, aims, which is to induce changes in the work processes, considering that some essential activities planned for the matrix support are not yet a reality.

To support the work processes in primary care, without privilege of any specific knowledge area, specialisms, hierarchy or fragmentation is an indispensable task in finding a dialogic and interdisciplinary relationship that occurs in matrix support. Thus, support for the work processes of the referral teams should target to developing common projects and integration with the supporting staff (Silva *et al*., 2012). In this sense, the professionals of NASF should not act as a manager of the health referral system, but optimize the routing flow, seeking the quality of care, coordinating the services of primary care networks, enabling the resources available, and not assuming the role of other health care levels (Silva *et al*., 2012). This overcoming, possibly occurs only when there is epistemological deconstruction of knowledge in the health field, as it requires one singular deconstruction about the universality of access determined by the model of health and established concepts (Macerata and Soares, 2014).

Considering the pluralities of regional realities of the country, its continental size and the polysemy of matrix support, NASF has developed different and divergent performance standards to support primary care teams. In many contexts, marked by conformations provided by the Health Ministry, however, it is still not recommended in their norms. Therefore, this reality leads to the need for studies focusing on more particular scenarios to be developed. The work of NASF is still in process of appropriation, not only for the professional from support and referral teams, but also for the management and, especially, for the users. It is a new tool that confronts old habits, such as the focal problem solving in a quick and timely manner. That is the reason why this different logic of working in health, while still dealing with the old model features, faces many challenges (Gonçalves *et al*., 2015).

Conclusion

The NASF, above all, aims at the qualification of the actions in Primary Care, incorporation of knowledge and shared management of the health-disease process.

The quantitative metrics of production, parameterized in the frequency and quantity, exhaust its meaning, to the extent that many of the actions and tools used have subjective nature and longitudinal focus. These centres have shown themselves more often as an extension of the primary care team than a supportive or protective rearguard, what is established by the Health Ministry only for the modality 3 of NASF. The way that data from the second cycle of PMAQ-AB are presented, in accordance with the proposal brought in its external evaluation instrument, does not allow the academy to perform more detailed analysis of the frequency of activities performed. It only records the dichotomy between those who does and those who does not perform such activities, which can be configured in an information bias. However, it has shown itself much more as a tool of induction than a reflection of reality.

It is necessary a new direction and adequacy of the ways to evaluate the work of NASF, including the printed forms (evaluation forms, data collection forms and others) that adequately reflect the actual production of the teams and the impact of their work. This will enable the achievement of more reliable indicators of their impact and a solid image of their performance. The conditions for the development of the work process of NASF, and also primary care as a whole system, require special attention from the public administration, to enable it to be effective. Therefore, ongoing evaluation and self-criticism, with a view to improving the service, should be a daily reality for the teams, but also for society in general.

The lack of trained staff in both teams (matrix and matrixed) and in the management sphere, in what concerns the understanding of NASF and its practices, the gap between legal provisions and ways of acting of NASF in practice was evident from the results of this research. Therefore, the maintenance and improvement of tools such as PMAQ-AB are important to point new ways of qualification, overcoming of such situations, change of reality and strengthening, not only for NASF, but for all services of primary care. It is believed that these results can contribute to a reflection and improvement, both as regard the practice of NASF and its process of agreement, implementation and public health policy.

REFERENCES

Amaro JHS. 2013. Cláusulas abusivas nos contratos de adesão. Revista Jus Navigandi[online]. 18(3514). Available from: https://jus.com.br/artigos/23623.

Anjos KF *et al*. 2013. Perspectivas e desafios do núcleo de apoio à saúde da família quanto às práticas em saúde. Saúde em Debate. 37(99:672-680

Brazil, Health Ministry 2013a. Saúde mais perto de você – acesso e qualidade. Programa nacional de melhoria do acesso e da qualidade da atenção Básica (PMAQ-AB). Manual Instrutivo para as Equipes de Atenção Básica. Brasília, DF: Departamento de atenção Básica – DAB.

Brazil, Health Ministry, 2012a.Política Nacional de Atenção Básica. Secretaria de Atenção à Saúde. Departamento de Atenção Básica. Política Nacional de Atenção Básica. Brasília: MS. 110p.

Brazil, Health Ministry, 2012b. Resolução nº 466. Conselho Nacional de Saúde. Comissão Nacional de Ética em Pesquisa – CONEP. Brasília.

Brazil, Health Ministry, 2012c. Portaria 3.124. Gabinete Ministerial. Redefine os parâmetros de vinculação dos Núcleos de Apoio à Saúde da Família (NASF) Modalidades 1 e 2 às equipes de Saúde da Família e/ou Equipes de Atenção Básica para populações específicas, cria a Modalidade NASF 3, e dá outras providências. Diário Oficial da União, Brasília, DF. Available from: http://bvsms.saude.gov.br/bvs/saudelegis/gm/2012/prt3124_28_12_2012.html.

Brazil, Health Ministry, 2013b. Nota Metodológica da Certificação das Equipes de Atenção Básica Participantes do Programa de Melhoria do Acesso e da Qualidade na Atenção Básica. Secretaria de Atenção à Saúde. Departamento de Atenção Básica. Brasília, DF. 92p.

Brazil, Health Ministry, 2013c.Manual instrutivo para as equipes de atenção básica (Saúde da Família, Saúde Bucal e Equipes Parametrizadas) e NASF. Secretaria de Atenção a Saúde. Departamento de Atenção Básica.

Brazil, Health Ministry, 2014a. Núcleo de Apoio à Saúde da Família: ferramentas para a gestão e para o trabalho cotidiano. Cadernos de atenção básica nº 39. Secretaria de Atenção à Saúde. Departamento de Atenção Básica, v. 1, Brasília: Ministério da Saúde, 116p.

Brazil, Health Ministry, 2017. Política Nacional de Atenção Básica. Minuta PNAB. Consenso GT-CIT com contribuições do CONASEMS, CONASS e DAB.

Campos, G.W.S. *et al*., 2014. Aplicação da metodologia Paideia no apoio institucional, no apoio matricial e na clínica ampliada. Interface (Botucatu). 18(1):983-95.

Campos, G.W.S., Domitti, A.C. 2007. Apoio matricial e equipe de referência: uma metodologia para gestão do trabalho interdisciplinar em saúde. Caderno de Saúde Pública, v. 23(2):399-407. Available from: http://www.scielo.br/scielo.php?script=sci_arttext&pid=S0102-311X2007000200016&lng=en&nrm=iso

Falleiro, LM*et al*. 2014. Experiências de apoio institucional no SUS: da teoria à prática. Org.: FALLEIRO, L.M. 1ª. ed. Porto Alegre: Rede UNIDA. 263 p.

Figueiredo, M.D., Campos, G.W.S. 2014. O apoio Paideia como metodologia para procesos de formação em saúde. Interface (Botucatu). 18(1):931-43.

Furtado MEMF, Carvalho L.B 2015. O psicólogo no NASF: potencialidades e desafios de um profissional de referência. Rev. Psicol. Saúde. 7(1):9-17. Available from: http://pepsic.bvsalud.org/scielo.php?script=sci_arttext&pid=S2177-093X2015000100003&lng=pt&nrm=iso

Gonçalves RMA. 2015. Estudo do trabalho em Núcleos de Apoio à Saúde da Família (NASF), São Paulo, Brasil. Rev. bras. Saúde ocup. 40(131):59-74.

Macerata, I., Soares, J.G.N., Ramos, J.F.C. 2014. Apoio como cuidado de territórios existenciais: Atenção Básica e a rua. Interface (Botucatu). 18(1):919-30.

Moraes, A.B.A., Rolim, G.S., Costa, Jr. A.L. 2009. O processo de adesão numa perspectiva analítico comportamental. Rev. bras. ter. comport. Cogn. 11(2):329-345.

Moretti, P.G.S., Fedosse, E. 2016. Núcleos de Apoio à Saúde da Família: impactos nas internações por causas sensíveis à atenção básica. Fisioter. Pesqui. 23(3):241-7. Available

from:http://www.scielo.br/scielo.php?script=sci_arttext&pid=S1809-29502016000300241&lng=pt&nrm=iso

Moura, R.H., Luzio, C.A. 2014. O apoio institucional como uma das faces da função apoio no Núcleo de Apoio à Saúde da Família: para além das diretrizes. Interface Comunicação Saúde Educação. 18(1):973-86.

Paulon, S.M., Pasche, D.F., Righi, L.B. 2014. Função apoio: da mudança institucional à institucionalização da mudança. Interface (Botucatu). 18(1):809-20.

Prado, V.M.G., Reis, A.M. 2014. Apoio Institucional à Gestão Municipal de Saúde para implantação do Acolhimento. In: Experiências de apoio institucional no SUS: da teoria à prática. Org.: FALLEIRO, L.M. 1ª. ed. Porto Alegre: Rede UNIDA. 263 p.

Saldanha, O.M.F.L. *et al*. 2014. Clínica-escola: apoio institucional inovador às práticas de gestão e atenção na saúde como parte da integração ensino-serviço. Interface (Botucatu). 8(1):1053-62.

Sampaio J *et al*. 2012. O NASF Como Dispositivo da Gestão: Limites e Possibilidades. REBRASA. 16(3):317-24.

Shimizu, H.E., Martins, T. 2014. O apoio institucional como método de análise-intervenção na Atenção Básica no Distrito Federal, Brasil. Interface (Botucatu). 18(1):1077-87.

Silva, D.A.J. 2016. A Regulação no processo de trabalho do Núcleo de Apoio à Saúde da Família - resolutividade nas ações em saúde. Academus Revista Científica da Saúde. 1(2):1-8.

****