INTERAÇÃO EM PSICOLOGIA

O Núcleo Ampliado de Saúde da Família segundo Agentes Comunitárias de Saúde

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RESUMO

A complexidade do cuidado na atenção primária à saúde em contexto de funcionamento de equipes de saúde da família levou à implementação de Núcleos Ampliados de Saúde da Família, formados por profissionais especialistas, que devem garantir o apoio clínico, sanitário e pedagógico à equipe de referência. Este artigo investigou a compreensão de agentes comunitárias de saúde sobre o Núcleo Ampliado de Saúde da Família (NASF-AB) junto a 13 mulheres que atuavam nessa função em duas equipes de saúde da família no Estado de Minas Gerais, a partir de questionário sociodemográfico e um roteiro de entrevista semiestruturado sobre a sua prática e relação com o NASF-AB. Os eixos temáticos que emergiram mediante análise de conteúdo foram: (1) informar e encaminhar o caso para um profissional do NASF ou mais; (2) discussão de caso e orientações do NASF-AB ao agente comunitário de saúde; (3) visita domiciliar conjunta; (4) função do NASF-AB. As participantes percebem o NASF-AB como uma equipe de especialistas que recebe encaminhamentos e realiza atendimentos grupais. O apoio matricial encontra-se em processo de construção, e não são todos são os profissionais que são reconhecidos como componentes do NASF-AB. Concluímos que há necessidade de valorizar o trabalho das agentes comunitárias de saúde e implementar ações de educação permanente.

Palavras-chave: Agentes comunitários de saúde; Atenção primária à saúde; Saúde da família.

ABSTRACT

Extended Family Health Center from the perspective of Community Health Agents

The complexity of primary health care provided in the context of family health units led to the implementation of *Núcleos Ampliados de Saúde da Família* [Extended Family Health Centers], composed of medical specialists, responsible for providing clinical, sanitary and teaching support to the reference team. This paper presents the perceptions of community health agents regarding the Extended Family Health Center (NASF-AB). Thirteen female agents working in two family health teams in the state of Minas Gerais, Brazil responded to a sociodemographic questionnaire and a semi-structured interview addressing their experience and relationship with the NASF-AB. The following thematic axes emerged: (1) Report and refer cases to one or more NASF professional; (2) Community health agents discuss cases with the NASF-AB staff and receive guidance; (3) Joint home visits; (4) the role of the NASF-PHC. The participants perceive the NASF-PHC as a team of specialists who receive referrals and provide group care. Matrix support is under development and not all professionals are recognized as being members of NASF-AB staff. We conclude that there is a need to value the work of community health agents and implement permanent education actions.

Keywords: Community health workers; Primary health care; Family health.

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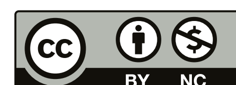

In 2008, the Ministry of Health created *Núcleos de Apoio à Saúde da Família* [Family Health Support Centers] (NASF) in order to strengthen and increase the problem-solving capacity of the actions performed by primary healthcare (PHC), with the main objective to aggregate knowledge and experience with the actions performed by family health teams, improving the resolution of cases (Panizzi et al., 2017).

NASF can provide professional support and train reference family health teams. A specialized multi-professional team enables the delivery of more complex care due to interactions established among professionals from various fields of knowledge with varied experiences and backgrounds. More complex care actions often required within the context of PHC involve biological, social and psychological aspects of individuals and their families, thus, should be performed from a perspective that takes into account humanization, integrality and equity (Kebian & Oliveira, 2015; Ministério da Saúde, 2008).

The role of an NASF team is to ensure that integral physical and mental care is provided to the patients within the network by assisting and complementing the service performed by family health teams through actions that promote jointly performed practices by both teams (Ministério da Saúde, 2008). Therefore, matrix support is the main service provided by NASF teams, which are responsible for creating groups to reflect, discuss and provide care to those individuals receiving care from the reference team (Barros et al., 2015).

The *Política Nacional de Atenção Básica* (PNAB) [National Policy of PHC], published in 2017 (Melo et al., 2018; Ministério da Saúde, 2017) replaced the term "support" with the term "expanded" in NASF's nomenclature, "raising doubts about the role the matrix model assumes among managers responsible for implementing changes" (Melo et al., 2018, p.329). A NASF-PHC multi-professional and interdisciplinary team composed of different professionals from the health field, complement the minimum teams working in PHC focusing on providing clinical, sanitary and teaching support.

Additionally, the existence of NASF promotes varied experiences. The complexity of PHC care is coupled with an "adverse context of management and local-regional care networks"; (Melo et al., 2018, p.337); a need to meet the "specificities of each team's composition and the needs of each service and territory"; "the establishment of assessment strategies, as well as studies and research to provide evidence of the NASF's effects on ESF teams and patients and results obtained regarding them"; and address this topic "in all health residencies in Brazil (medical, non-medical and multi-professional), preparing not only those professionals intending to work with PHC but also those in specialized care, to provide matrix support" (Melo et al., 2018, p. 337).

NASF regulation shows the Ministry of Health's attempt to reorganize the production of PHC, believing in the relationships among team members, as well as in the power of interdisciplinary collaboration and co-responsibility for actions integrally performed by reference and support teams, seeking to establish a relationship in daily practice and education (Panizzi et al., 2017). The NASF identifies the demands of ESF teams, which are communicated by the community health agent (CHA), who is closest to the population, as these agents visit patients and families at their homes on a daily basis.

According to Gozzi (2017), one of the NASF's characteristics is that it qualifies workers in ESF teams and enhances their abilities, always focusing on the development of integral care-based practice. In this context, CHAs are those who directly communicate with the NASF team and the population, reporting about the services provided by this team, as well as the groups coordinated in healthcare units. It is also through CHAs that NASF obtains information about all the cases in the territory under coverage (Maciel et al., 2015).

CHAs are professionals who work in the same area in which they live. They are able to perform health-promoting educational actions and encourage the community to improve quality of life (Mota, 2015). According to Nunes et al. (2018), the work performed by CHAs is characterized by two distinct perspectives: technique, which refers to care provided to families, involves actions intended to prevent diseases and monitor groups at risk; and the political perspective, in which these workers help to organize the territory under coverage, considering changes in the community's lifestyle that directly affect the health conditions of the service's users.

Because CHAs work in the same area where they live, they identify themselves with the community and are considered the link that connects the service and the community (Vidal et al., 2015). For this reason, and supported by care practices, CHAs contact families to understand their dynamics and needs and later propose actions intended to improve their living conditions based on health promotion and disease prevention principles (Kebian & Oliveira, 2015).

Among the actions these workers perform, "the establishment of a demographic, social, cultural, environmental, epidemiological, and sanitary diagnosis of the area under coverage" (Ministério da Saúde, 2017) stands out. CHAs constantly register and update the information of people within their coverage area; perform regular home visits; monitor the situations of families; identify and keep records of individuals and families in at-risk situations; provide education to individuals or groups at their homes, health units, or other locations within the territory; provide guidance regarding symptoms, risks, and disease-transmitting agents, as well as on how the health network's services, equipment and devices existing in the area function;

encourage people to take part in public policies directed to health; communicate with patients regarding dates and times of scheduled appointments and exams; among other actions intended to promote health and prevent diseases.

Based on the considerations presented here, this study's objective was to address how community health agents understand the *Núcleo Ampliado de Saúde da Família* [Extended Family Health Center].

METHOD

The main purpose of this qualitative study was to identify the meanings the participants assign to this phenomenon (Martins, 2004; Turato, 2005). Community Health Agents (CHAs), with at least three months of experience, working in two Primary Healthcare Units focused on Family Health located in the interior of Minas Gerais, Brazil, took part in this study.

After the Institutional Review Board approved the study project (CAAE: 67275917.7.0000.5152), visits to the PHC units were scheduled to present the project, emphasizing its voluntary nature. Each CHA signed a free and informed consent form and a questionnaire was applied collectively to characterize the participants and identify their main tasks. A researcher recorded the participants' phone numbers in order to schedule the individual interviews, which were held on the units' premises according to the participants' convenience and were audio-recorded. A semi-structured interview addressed the routines of these workers and answers concerning their relationship with the NASF team were selected for analysis. The interviews were conducted following Boni and Quaresma (2005) in terms of the questions in the script so that the dialogue resembles an informal conversation as much as possible, in order to achieve the study's objectives. The questionnaire was applied in less than 15 minutes and the interviews took approximately 30 minutes. The city of study is not reported in order to preserve the participants' identities; in that same vein, acronyms were used (e.g., I1U1 indicating the order of interview and unit where data were collected).

Thematic content analysis, following Bardin (1977), was used in the analysis of data. The interviews were transcribed verbatim and independently read by two researchers to establish initial familiarity with the material. New readings were required to identify the themes presented in each interview, which were later grouped into blocks of meanings, selecting excerpts that corresponded to these thematic blocks.

RESULTS

STUDY'S CONTEXT

The *Unidades Básicas de Saúde da Família* [Family Health PHC Units] 1 and 2 were located in single-story residential buildings rented in the same sanitary district of a medium-sized city in the state of Minas Gerais, Brazil and included an oral health team. One of the week shifts was reserved for the team's weekly meeting, a time when the team generally input the number of appointments performed in that week, considering each team has a daily goal to achieve. This systematization was performed at the expense of discussions regarding the cases treated in the unit.

The two units received matrix support by the same NASF-PHC team, which was composed of professionals from the fields of psychology, physical therapy, social work, nutrition and physical education. Each NASF-PHC professional established his/her schedule to visit the health unit, which did not necessarily coincide with the shift reserved by the health family team for their meetings. The NASF-PHC workers provided individual or group appointments (appointments with a nutritionist, psychological care, speeches on nutrition, physical education group, mental health support group) and home visits.

PARTICIPANTS' CHARACTERIZATION

Eight women worked as community health agents in Unit 1 and only one refused to participate in the study. The seven participants were aged between 28 and 55 years old; four had a spouse/partner; six reported practicing a religion; five had children; five reported a monthly income of approximately R$1,200, two did not report their income. While family income was between R$1,200 and R$2,000, the two participants did not report their family income. All the CHAs had worked in the same health unit for more than two years, with a workload of eight hours daily/40 hours a week (Table 1).

Six CHAs worked in Unit II and all took part in the study. They were aged between 36 and 58 years old (one participant did not report her age); five did not have a spouse/partner; all reported a religion; four had children (one did not report); four reported a family income between R$1,300 and 15,000 (two did not report); all worked in the same health unit for more than one year and 11 months; and worked for eight hours daily/40 hours a week (Table 1).

Table 1. *General characterization of the research participants * (F=13).*

Number	Age (years)	Spouse/partner	Children	Religion	Family Income (R$)	Months of work
Unit 1						
1	24	No	0	Evangelical	1.200,00	37
2	32	No	0	Catholic	2.811,00	36
3	44	Yes	2	Catholic	n.i.	34
4	22	No	1	n.i.	1.400,00	44
5	31	No	1	Evangelical	2.000,00	43
6	58	Yes	2	Catholic	n.i.	37
7	29	Yes	1	Cristã	1.187,00	36
Unit 2						
1	58	No	1	Catholic	1.300,00	48
2	56	No	2	Evangelical	n.i.	35
3	52	No	n.i.	Jewish	2.811	48
4	36	Yes	2	Evangelical	n.i.	48
5	n.i.	No	1	Evangelical	15.000,00	23
6	55	No	0	Catholic	n.i.	50

*n.i.= no information

The profile of the CHA mentioned here is similar to that pointed out in other studies regarding gender and age group, reinforcing the idea of feminization of the workforce in the health sector in Brazil (Mota, 2015; Nunes et al., 2018). The activities under the responsibility of the CHAs involve, among others, filling out the registration forms, assisting families, carrying out home visits, participating in the team meeting, accompanying pregnant women and child development and encouraging health promotion actions (Ministério da Saúde, 2017).

ANALYSIS OF INTERVIEWS

(1) REPORT AND REFER THE CASE TO ONE OR MORE THAN ONE NASF PROFESSIONAL

The CHAs establish contact with the service's users during home visits and after identifying a need or request, they directly report the case to a NASF professional because they believe this is the best action to take in caring for a patient: "First we go to the patient and he tells us about his case, for instance, whether it is a case for psychology, you know, a mental health patient, then we transmit information to the psychologist" (I3U2).

This action often results in the NASF professional scheduling an individual appointment without discussing the case with the team: "I go directly to her and say "look [psychologist], it's this and that, what can you do?" So she schedules an appointment and sometimes it is even on the same day. The nutritionist, too" (I3U1). "We pass the case to the psychologist. She makes a pre-analysis and schedules a visit, or she asks us to see whether the patient is in condition to come here for an appointment, and schedules an appointment". (I1U2U2)

Information leads to scheduling an appointment, so this action works as a referral to an expert, who decides whether it is best to schedule an individual appointment or a group meeting;

> [...] the person tells more or less what is happening and we refer to the psychologist [NASF]. So she sees whether it is an individual or group appointment, whether she'll provide individual care. Then we go back to the person and let her know "look, it is scheduled for such a day, and your case is in the group meeting, scheduled for such a day" then if the person is interested, she attends the meeting (I4U1)

In some situations, CHAs ask users whether they would like to schedule an appointment with an NASF professional before discussing the case with the specific professional, or suggest the patients themselves seek a given professional: "I asked her whether she wanted to talk to a psychologist, 'I guess it ends up you've had a traumatic experience', so she said 'I'd like to'. So she wanted and I passed the case to the psychologist." (I4U1)

> I see that consultations are longer, so I always instruct them, I tell them to come and report their needs, I tell patients. So, it depends on the case, sometimes it's a case that requires a long consultation, I tell them to come and present their needs (I4U2)

According to the interviewees, the need to receive care by an NASF professional is identified with the help of NASF professionals, who orient how each case needs to be investigated:

> Well, her hearing is normal, because she said herself she needed to ask, to come, you know. Though, at the beginning, we didn't agree with it, because we know it's not about a psychologist, you know, but then she..., because we summarize what the person tells us, more or less what the person says, so we report it and she draws her conclusions, whether she needs to see the person individually or in a group. Like today I brought the case of child, she'll see the child, she's already scheduled an appointment, so I'll call her mother so the mother can bring him on the day scheduled. (I4U1)

(2) CHAS DISCUSS CASES WITH THE NASF STAFF AND RECEIVE GUIDANCE

The discussions held in the units about cases do not involve the CHAs. In general, the unit's nurse and NASF professionals participate in the meetings when these go to the unit who provides care: "Sometimes there is something, but it is the coordinator or psychologist who talks to them [NASF]" (I5U1)

> They [NASF] discuss with the nurses and then she inform us, so when she think things are more personal, these things, she calls us and says this and that, keep an eye on him/her, if she needs something you talk to him/her, go there, pay greater attention to the case, so we stay alert. (I3U1)

In both units, two professionals are closer to CHAs, the social worker and psychologist: "We don't have much contact with them. The ones that are closer to them are [the psychologist] and [the social worker]. We don't have contact with them [NASF-PHC]." (I5U1). CHAs directly seek these two workers:

> Let's assume I need a social worker, I come and tell her the problem, but it is with the psychologist with whom we talk more frequently, so she discusses the case with us, about what is needed to do, how it is, whether she is going to meet the patient, or it's I who has to go there and tell them how to do it, that it's like this. (I4U2)

These situations allow CHAs to receive direction on how to work with patients, whose problems involve mental health or issues of a social nature: "Yes, we discuss, especially mental health, which is more frequently discussed, social issues, too, but mental health is what we more frequently deal with." (I1U2).

> Discusses cases and when the case has been discussed, we establish an action and see what we need to do for a given patient [...], but I'll talk more about the psychologist, when we have some mental disease, we have to listen to the patient, and then report it to her, you see? So she is going to give them an orientation, whether she is going to make an appointment or not, it helps if she sees the patient, if she doesn't, I have to tell the patient the orientations she gives me. (I2U2)

Case discussion here means receiving direction on how to proceed for the next home visit and does not mean the team discusses and problematizes cases, a process in which different professionals would make their contributions and devise a care plan for patients. The nature of orientation stands out:

> I'll talk more about the psychologist, when we have some level of mental disease, we have to listen to the patient, and then report it to her, you see? So she is going to provide orientation, whether she is going to make an appointment or not, it helps if she sees the patient; if she doesn't I have to pass along to the patient the directions she gives me. (I4U2)

(3) JOINT HOME VISITS

CHAs report that the NASF team generally monitors the more severe cases, such as those involving social issues, mental conditions, or bedridden patients. CHAs realize there is a need to include NASF professionals to monitor the cases of those living in the area under coverage on a daily basis, so they call the professionals:

> We pay greater attention to those more problematic patients, you know. In my case, in my area, I focus on those patients under NASF care, like bedridden patients who are unable to go to the unit, so I go and talk to the psychologist, I talk to the family, I talk to the nutritionist and ask her to go there, to the dentist, social worker. (I3U1)

> Joint home visits are like that, let's suppose I go to a home and I realize that I need the social worker there, I have to go with her, she comes with me, I'll tell her the problem because she is from NASF, so I tell her what the problem is, so she accompanies us. (I4U2)

The most severe cases require a dialogue be established between the minimum team, the NASF and other devices/processes within the network, enabling different types of knowledge to be shared:

> Sometimes we gather the psychologist with the physician, the health network, to take care of a patient with depression, so we get together, makes the visit, orient, talk, invite the patient to a group, do everything that can improve the individual's life conditions, each with his/her own knowledge, you know?! (I2U1)

> I've already visited a home with the physical therapist, physician, nurse and social worker. The patient had had a

> stroke and her living conditions weren't ideal in any aspect, so we got the entire NASF team to help her. That's how we do it. (I6U1)

Only one interviewee highlighted that joint home visits are not common: "To tell you the truth, no. (...) Well, they tell you that they should happen, but they don't." (I5U2)

(4) THE ROLE OF NASF-PHC FROM THE CHAS' PERSPECTIVES

As already mentioned, the NASF-PHC professionals CHAs are more familiar with are the psychologist and social worker. Before the NASF-PHC was implemented in the city, the health units already had the support of these two workers who had their own schedules. These workers are not always seen as members of the NASF-PHC. One of the interviewees, who had already talked about the case discussion with the psychologist and social worker, when asked more directly about the NASF-PHC, answered: "I tell you that I don't remember, it's..., if we had something to do with the NASF, if they ever had been here, I can't tell for sure because I don't remember". (I5U1)

Another confusion regarding the NASF lies in the possibility of providing care in groups instead of individual appointments. The NASF would be a group composed of a group of professionals who value group practice:

> In the beginning our relationship with NASF was a bit complicated because I think the NASF works very well, it is a very good program, but in the beginning, it didn't work here in the unit. Why? Because people would come and ask for individual appointments, since they were used for individual care, but then it all changed, group practice started and that is how it is now. Now they [patients] are getting familiar with the NASF and we are understanding more about NASF. (I6U2)

There is a difficulty on the part of some CHAs in recognizing the NASF's problem-solving capacity:

> [...] only that sometimes, they fail to meet expectations. For instance, there's this boy in my area—the psychologist told me yesterday that he's discharged from the NASF and I said "how come? He's not even [under treatment]" I explained it to her yesterday and she said "look, they sent him here" and I said "nobody sent him here", he has autism, only that his father doesn't want to sent him to CAPS, you know? [...]. I guess that there are things, is it good? It is! But there are weird things, because you don't see the results, you don't results. (I7U1)

The NASF-PHC promotes a search for integral care focused on health promotion:

> [...] but, as everybody gets sick, there is care, but we prevent, and for that, what do we have? There is physical education, there is a nutritionist to provide guidance, there are groups focused on anxiety for those who already take medication to control it, so it's a set of things we have and try to transmit this knowledge to the population so people come to the unit even when they are not sick. (I1U2)

In addition to integral care, the literature assigns the NASF the role of providing continuing education, which however, the interviewees do not acknowledge:

> The most of training we've got from NASF staff, it's like, each professional, both the nutritionist and psychologist, they meet with us in the back [of the unit's building], after three hours, she gathers all the CHAs and talks a little about their work, like, the psychologist talks about disorders, about each, the nutritionist, we've had a meeting with her, but there's been sometimes we have not. (I3U1)

DISCUSSION

The CHAs' reports address the communication of patients' problems to an NASF-PHC professional, assigning this professional the role of deciding whether care will be delivered individually or in group or also whether to provide guidance to CHAs on how to behave or what to ask in the next home visit. Many reports show that this information is considered a referral to a specialist – a logic that the matrix support is intended to minimize or even extinguish. The definition of the Ministry of Health (2014) for matrix support indicates a new way to jointly develop and provide health care, thus, care delivery should be provided by two or more teams, in a shared process, the outcomes of which would be actions and interventions based on a teaching-therapeutic model. The reports show that collaborative work is not common in any of the two teams, as the exchange of knowledge, and a shared production of actions and interventions does not seem to occur. A vertical relationship seems to exist in which an NASF professional receives information individually collected by CHAs and based on this information determines what should be done (guidance, individual or group care), which undermines the logic of a service based on teamwork.

NASF-PHC professionals can basically work in two ways. The first is based on clinical assistance, in which clinical care (individual or collective) is provided to those in the area under the unit's coverage. The second way involves sharing knowledge and actions with the reference team (family health team), thus, has a technical-teaching nature (Ministério da Saúde, 2014). The interviews show that the NASF-AB staff, responsible for providing matrix support to the reference teams, in which the agents interviewed belonged, provide only clinical-assistance care to the population. The study by Maffissoni et al. (2018) also reports that the practice most common to individuals and collectives provided by NASF-PHC is clinical

assistance. Daily work based on the matrix logic can facilitate health actions, enabling clarification for individual or collective issues and help to develop practices that prioritize the individuals' quality of life (Santos et al., 2017). These practices involve linking care to other resources existing in the territory under coverage considering intersectoral logic.

Lack of information and more explicit guidelines on the part of the Ministry of Health on how teams should behave, coupled with a lack of actions focused on continuing education provided to these workers, are the main barriers in this context (Barros et al., 2015; Maffissoni et al., 2018). Martinez et al. (2016) report that some professionals draw attention to the fact that professionals become distant from the context of practice and have difficulty implementing interdisciplinary work; actions are mostly of individual, assistance and curative nature, though.

Melo et al. (2018) emphasize that the supporting role of NASF-PHC requires opportunities to listen, discuss, and share experiences and practice. Lack of information and support on the part of the staff working in the units addressed in this study may directly interfere in actions that focus on the population.

According to the literature, the NASF-PHC should perform educational activities such as taking part in meetings held by the ESF teams, discussing cases and developing joint actions, sharing consultations, home visits, and collaborating with actions performed in the area under coverage, situations in which knowledge can be shared and the capacity of minimum teams to deliver care is improved, ultimately to become a space where continuous education is promoted (Gonçalves et al., 2015). This study shows that the NASF team faces difficulties developing educational actions because few joint actions were developed. Such actions only took place when CHAs requested them and were almost always limited to home visits. The interviews reveal that jointly developed actions (minimum team – NASF-PHC) seldom occur, or when they do occur in groups, they are previously discussed in separate groups, without integrating and sharing knowledge between the NASF-PHC and reference teams. Thus, the work performed by the NASF-PHC team includes providing consultations, often following specialty outpatient logic. According to the Ministry of Health (2008, 2014), NASF actions are expected to be integrated with the work of reference teams in a collaborative manner, always respecting the matrix model intended to promote collaborative work, encouraging activities based on technical-teaching and a clinical assistance rationale.

Tesser (2017) emphasizes the way care is provided in the PHC context. Reference teams are responsible for meeting all demands presented in the units, but NASF-PHC workers do not share this practice, as they face difficulties managing the schedule and believe they have a more generalist role, breaking from the logic of exchange, partnership and cooperation among various types of knowledge, which are based on matrix actions and are essential to implement technical-teaching support effectively. Bispo Júnior and Moreira (2018) note that the logic of health actions based on matrix support has not been well understood or adopted by teams, so that it has not considerably affected or changed the way teams worked before the NASF-PHC was implemented, as it has not expanded educational practices. Lack of integration between the teams translates into loss of production within the health network, which otherwise could provide more complete and integrated care. It also shows there is no exchange or learning between the different teams, which could be learning from one another and developing, seeking to provide the best service to users.

What is the role of a NASF-PHC psychologist according to CHAs? Psychology stands out in the participants' reports in comparison to the other professions, as the psychologist is always mentioned whenever CHAs talk about home visits, exchange of information, referrals, and opportunities for them to talk about and clarify doubts about cases. Leite et al., (2013) emphasize the technical-teaching support provided by psychologists who predominantly aim to work within matrix practice, supporting and orienting reference teams through intersectoral collaboration. The same study notes that psychologists face difficulties delimiting their role within the NASF-PHC and also spend more time with reference teams during the week. The discussion of complex cases (Oliveira, 2010) is one of the ways that can promote the work of NASF-PHC in integration with family health teams. The possibility of a closer dialogue with the psychology professional about the cases for which there are no ready answers (Piccinini & Neves, 2013) possibly indicates the reason why he is the professional most remembered by the interviewed CHAs.

The interviews show that psychologists were the professionals who most closely implemented the matrix model, as they make home visits together with CHAs, were responsible for accepting the cases they brought and also provided guidance to CHAs, whenever asked. Leite et al. (2013) notes that the specific role of a psychologist within a NASF team has not been fully established, and is still being determined, but it is certainly guided by matrix support in mental health care. Note that the matrix support provided by a psychologist should not be restricted to the so-called "mental disorder" cases, rather should include the possibility of understanding those living in the territory under coverage to develop actions involving mental health in terms of promoting health, preventing diseases and providing treatment. Current themes, such as suicide among adolescents or HIV-infection among the elderly, are situations that involve mental health workers, but are not necessarily linked to psychiatric diagnoses.

Iglesias and Avellar (2016) highlight that psychologists rated the matrix model as being challenging, uncomfortable, with poor problem-solving capacity, considering it involves different types of hierarchal knowledge that do not favor the integration of the service's users. Additionally, health workers are not familiar with the matrix model and believe it is something exclusive to the field of psychology. The interviewees in this study did not mention the term matrix even once, while actions inherent to this practice appear to be only related to professionals from within psychology.

Based on the analysis of the interviews collected in this study, the actions of the NASF-PHC psychologists do not promote integration with other fields of knowledge; that is, dialogue and exchange of knowledge with other health fields is not encouraged, restricting actions to individual practices. It is believed that the work of NASF-PHC psychologists should be based on actions that promote interaction and dialogue between workers and patients, with a view to create a practice that is based on collective care, strengthening the individuality, particularity and complexity of each case in the PHC, always respecting all dimensions (social, political, economic and subjective) that influence each case (Iglesias & Avellar, 2016).

The other professionals who are part of the NASF-PHC in the city that served as the setting for this study (nutritionist, physical educator and physiotherapist) develop activities often with the participation of CHAs – as it was possible to notice in visits to health units at the time of articulation with managers to enter the field or even to conduct the interviews – such as stretching groups or conversation circles about food. Despite the CHA's participation in these group activities (inviting the public, carrying out stretching activities with those present, handing out information leaflets), they were mentioned in interviews, but higher education professionals were not recognized as the steering team that characterizes the NASF-PHC, but as actions developed by the unit's nutritionist or by the service's physical educator, which indicates, once again, a functioning in which the division of specialized knowledge remains, without expanding the capacity for analyzing and solving health problems by the family health team (Oliveira, 2010). Thus, the work of the nutritionist, the physical educator, the physiotherapist is evident without the construction of collective care strategies, with co-responsibility for the cases, adding to the lack of promotion of spaces for permanent education (Minozzo & Costa, 2013).

FINAL CONSIDERATIONS

Giving voice to community health agents implies listening to those who have the lowest salary in the health team, the lowest level of education, live daily with the tension of being residents of the same area where they enter from home to home to carry out health guidelines and identify problems to be taken care of. The construction of a new form of care for people – interprofessional, centered on the territory and health promotion – that distances itself from the logic of treating the disease, so common in so many health facilities, must include the CHA. They identify the demands and, therefore, need to actively participate in the construction of the actions to be developed in the service, which requires the implementation of the (difficult) exercise of education permanently. This study enabled exploring and analyzing the perspectives of CHAs regarding the role of the NASF-PHC, so that the objective was achieved. Note there are few scientific papers assessing the perceptions of CHAs regarding the NASF, and this is the greatest contribution of this study. We believe that addressing community health agents of other regions of the city addressed in this study would significantly contribute, as it is a limitation in this study. However, note that as a final paper, this study encourages reflection upon the view of CHAs in regard to matrix support, which was our purpose. In addition, future studies could seek to understand how the NASF-PHC teams evaluate the work developed, in its articulation with other sectors of care for the local population and in partnership with the CHA.

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Os autores declaram que não há conflito de interesses no manuscrito submetido. Apreciação do projeto pelo Comitê de Ética em Pesquisa com seres humanos da Universidade Federal de Uberlândia: CAAE 67275917.7.0000.5152

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