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Expanded Family Health Center: an analysis based on fundamental teamwork concepts and attributes

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Abstract *Primary Care work is based on sharing and meeting various knowledge to achieve comprehensiveness. In this rationale, the Extended Family Health and Primary Care Center (NASF-AB) acts as a strategy for teamwork. We aimed to investigate the NASF-AB work process from the fundamental teamwork concepts and attributes. This evaluative, qualitative study was developed from 2018 to 2020, observing the NASF-AB and family health teamwork process, and focus groups with 43 professionals from both teams. Our analysis considered NASF-AB theoretical, methodological, and operational concepts. The results refer to a work attentive to the particularities of the territory aligned with health responsibility, besides recognizing NASF-AB support in clients' autonomy by establishing a bond.*

Key words *Primary Health Care, Health Policy, Matrix Support, Collaboration*

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Introduction

Tuning in with global emergencies, which give rise to human and social responses in health, is an ongoing debate in Collective Health, as it envisages translations and sensitizes perspectives on new objects of study or approaches[1]. This premise reaffirms the interest in analyses that recognize the growing complexity of health needs and the search for people-centered solutions[2], integrating professional practices and public policies.

Given the above, teamwork is referred to as a theoretical concept that can support a (re) approach to health care practices, as it is one of the strategic components for coping with health needs that require an expanded and contextualized approach such as that of organization of network health care services and systems[3].

Interprofessional collaboration has gained greater recognition in PHC to meet the ever-changing needs of society[4]. Therefore, a strengthened and comprehensive PHC is the best strategy for organizing health systems and the most efficient way of addressing health problems and the fragmented actions and system[5].

In the meantime, weaving new perspectives at the Expanded Center for Family Health and Primary Care (NASF-AB) is desirable and timely as it supports PHC, expanding its resolving capacity and the horizon of comprehensive care[6,7]. It represents a specialized rearguard through shared and collaborative work, strategic in care qualification[8,9].

That said, the expectations of meetings required and debated by this study aim to clarify intersections of NASF-AB as powerful interprofessional teamwork, still a pressing healthcare challenge. To this end, we opted to articulate the fundamental concepts of this strategy with theoretical investitures of interprofessional teamwork proposed by Peduzzi and Agreli[3,5].

Interprofessional teamwork's attributes allow differentiating its effectiveness in providing care to clients and producing the best results: interaction and communication between professionals from different fields; construction of a collaborative care project; specificities of specialized jobs versus labor distribution flexibility; and teamwork climate[3].

Articulating fundamental concepts of NASF-AB's work and the interprofessional teamwork attributes is the background that justifies the interest in developing an evaluation study, as this enables analyzing programs implemented to achieve efficacy, efficiency, and effectiveness[10].

Under this premise, we invested in approximations with studies already developed in the field of NASF-AB evaluation, identifying that they explore different dimensions[11,12]. We found, therefore, theoretical-methodological voids that allow a close relationship between the ontological and work fields, especially in the clear expression of NASF-AB's work under the theoretical lens of interprofessional teamwork. Furthermore, indications suggest that the team's characteristics directly affect the team and care processes and have a mediated and indirect influence on health products and outcomes[13]. A team-based PHC is a model designed to supplant the biomedical approach and reach multiple perspectives to support understanding broader health determinants[14].

Thus, we aim to evaluate the NASF-AB work process from the fundamental teamwork concepts and attributes through the NASF-AB Performance Analysis Matrix. This matrix gathers theoretical, methodological, and operational concepts of the NASF-AB work process.

Methods

This evaluative, qualitative, multiple-case study analyzes the NASF-AB work and was conducted in three municipalities in Ceará. The methodological option adopted was based on the proposed analysis of the adequacy of the components of a given intervention, recognized in this study as the NASF-AB, and its relationships with the context in which it is developed[15], considering that the NASF-AB work is a complex social event that requires analysis from a plural perspective and the real world[16].

The following criteria were considered to select the settings: same population size (large); a mean Municipal Human Development Index (MHDI) of 0.7, ranging from 0.6694 to 0.754; and public higher education opportunities. Such criteria were important in the social determination of health, a critical lens to analyze the growing complexity of health needs.

The study was conducted from 2018 to 2020. The object under analysis, NASF-AB work, was explored from four teams distributed among the research settings. Observation and focus groups were used as collection techniques and conducted by the authors of this study. A total of 12 non-participant observations were performed in ESF services (four in each municipality) from November 2018 to May 2019 on normal team

Ciência & Saúde Coletiva, 28(8):2303-2312, 2023

routine days. We aimed to investigate how NASF-AB's support occurs and is embodied in PHC's work process. Each observation had a mean daily duration of eight hours.

Professionals working in the NASF-AB and ESF teams participated in the focus groups[17], a technique that can understand the construction of reality by specific small and homogeneous social groups. Six focus groups were held from December 2019 to September 2020, two in each municipality. Participants included 43 professionals working in four NASF-AB teams and nine Family Health teams (recognizing that an NASF-AB team can support more than one reference team), ranging from 6 to 10 participants per group. The focus groups were simultaneously composed of professionals from the NASF-AB and ESF teams and had a mean duration of 78 minutes.

Observations and focus groups were conducted using specific roadmaps prepared by the authors, in which aspects related to the work of NASF-AB were systematized. The collection *corpus* was submitted to the NASF-AB Performance Analysis Matrix. This Matrix incorporated principles, guidelines, and organizational flows that guide the NASF-AB work process, translated into fundamental concepts, dimensions, and analysis criteria[18]. After the corpus qualitative observation, we applied the Content Analysis technique[19] to organize the discussion into categories that articulated the approximations of what was experienced in the NASF-AB work process, guided by fundamental concepts, with the interprofessional teamwork theoretical conception.

The study complied with Resolution No. 466/2012[20] of the National Health Council (CNS), under Opinion No. 2.102.876/2017. We reiterate that the statements were thus coded: PeSF (ESF team professionals) and PeNASF-AB (NASF-AB team professionals), followed by the transcription order numbering.

Results and discussion

An NASF-AB Performance Analysis Matrix[18] was developed to analyze the results, which elucidates the fundamental concepts that should guide the work process of this teamwork model, with an indication of the correlated dimensions and their respective descriptions, presented in Chart 1.

The qualitative approach of observation findings and focus groups guided the Matrix construction. Thus, the aspects highlighted in the study considered health teamwork essential for NASF-AB, as it encourages interprofessional collaboration and results more consistent with health needs. Interprofessionality favors the construction of links between professionals and the territory and the (re)signification of their actions and, thus, allows them to align with SUS principles and guidelines, ensuring actions translated into comprehensive, participatory, and universal care[21].

The organization of the results was outlined through categories based on the conceptual dimensions identified in the NASF-AB[7] guiding documents (territorialization and health responsibility, production of autonomy, teamwork, and comprehensive care), gathering and articulating the manifestation of actions translating the NASF-AB support and reflected under the interprofessional teamwork attributes. Therefore, we identified life contexts as care production inducers, collaboration to achieve expanded health production, and integrating paths in producing care citizenship.

Life contexts as care production inducers

Starting from the conceptual dimension of territorialization and health responsibility, this category was established to explain the relevance of knowing the territory and based on it, recognizing people's real health needs. Moreover, we aimed to show how the NASF-AB work process is linked to the community, redefines care and health promotion actions, and gives meaning to the territory's subjectivities.

The territory is health work's starting point[22]. Territorialization and health responsibility are essential, attributing the health team and inducing the health reality's clinical, epidemiological, and sociopolitical rationale of the health reality[8]. The statement below expresses the identified determinants and their reflections on doing health:

[...] Health problems, mainly diabetes and hypertension, are directly related to socioeconomic factors. People's educational level and the economic factor have to be considered. So, these external factors harm individual health, and the little we manage to work on is already a victory for us because of these huge external factors (PeSF3).

The critical and comprehensive analysis of the territory to implement the expanded concept of health and embody health indicators in work indicates that territorialization and health responsibility are NASF-AB concepts that structure the actual interprofessional teamwork. It collaborates in building a common care project, trans-

Chart 1. NASF-AB performance analysis matrix.

Fundamental concepts	Dimension	Description of the dimension for the qualitative observance of the NASF-AB performance
I. Territorialization and health responsibility	Situational diagnosis	Recognition of the determinants in the assigned territory as indicators and supporters of NASF-AB.
	Planning based on territory problems	Care production considering the proposition, implementation, and evaluation plan of actions appropriate to the context, with elucidation of what is expected to be achieved, and involving social stakeholders.
	Management of risks, vulnerability, and collective potential	Frequent mapping of the territory's health needs, incorporating technologies to manage recognized risks and vulnerabilities.
	Monitoring and evaluation of the work process	Systematic monitoring of activities, use of recording tools, evaluation, readjustment and monitoring of actions considering the territory.
II. Teamwork	Articulated action with the eSF/eAB	Practices alluding to teamwork, use of care strategies and adoption of shared agendas for planning and conducting actions dialogically and collectively.
	Matrix support in the technical-pedagogical and clinical-care dimensions of the eSF/eAB	Incorporation of continuing education as an educational and transformative tool, and shared action, with the creation of collective spaces for discussion and intervention for users and professionals.
	Management of complex cases with the participation of eSF/eAB	Discussion agendas for the shared elaboration of the PTS and evaluation of health care plans and monitoring of complex cases.
III. Comprehensiveness	Recognition of points of care networks	Intersectoral actions and dialogical adoption of health care network flows suited to the needs of groups, in order to implement a shared responsibility.
	Development of intersectoral actions	Establishment of links with the community and the other points of the care network to produce citizenship and spaces of social control.
	Assessment of complex cases and risk classification	Discussion of cases, based on interprofessional dialogue, with risk classification and definition of flows that support forwarding and shared decision-making.
IV. Individual and collective autonomy	Reception and qualified listening to individuals and groups	Establishment of reception with humane and qualified listening to individuals and communities, focusing on social or affective-cultural risk situations.
	Solidary and longitudinal links	Active participation in community discussion spaces, encouraging participatory management, development of cultural, sports and income generation activities in the community.
	Encouraging individual and collective initiative in the production of care	Development of actions for the production of care and health promotion through therapeutic practices of self-care and quality of life.

Source: Product of the Research "Assessment of the Effectiveness of NASF-AB regarding the clinical control and quality of life of people with arterial hypertension and diabetes mellitus"[18].

lated by recognizing health needs that must be consistent with a permanent movement toward an expanded perspective and reading of social determination guided by comprehensive health[3].

Furthermore, the multiple life contexts and group subjectivity mean that recognizing such needs requires a specialized and flexible approach to health work, transmuting into a view that encompasses and articulates several knowledge cores. This aspect is inherent to the NASF-AB work and favors. It reaffirms interprofessional teamwork as an inducer of transformations in healthcare practices and, possibly, a modulator of existing value tensions. We expect that the health needs are recognized, interpreted, and negotiated at each meeting, respecting the scientific and

Ciência & Saúde Coletiva, 28(8):2303-2312, 2023

technical knowledge of their field of expertise and recognizing the other professionals' work in the team and their interdependence, facilitating the articulation for healthcare[3].

An important point evidenced is related to the convergence between territory and the planning of actions based on the problems of greater impact and in the risk management of collective vulnerabilities/potentialities, stressing the proposition of a common care project. The mapping of the affectations of the territories stirs the keen and sensitive perspective of the – reference and support – health teams toward implementing qualified access to health.

This encourages the recognition of the aspects that the territory evidences as a need and stirs adequate, integrated, and collaborative planning of PHC interventions[8]. To this end, dialogicity allows for fostering decision-making, whether through strategic care management agendas, such as the wheel, or care spaces, such as health promotion groups, issues made explicit in the statements:

[...] in the wheel, we carry out the general planning of our actions and plan according to the needs and demands of our territories (PeNASF-AB5).

Implementing health actions reflects the need for an interprofessional teamwork configuration that fosters participatory practices, subsidizing effective planning and management of health services[23]. The above is consonant with interaction and communication as an interprofessional teamwork[3] attribute since care requires a dialogic action to occur effectively. Two other important aspects of realizing planning and sustainability of actions are work monitoring and evaluation, as they help recognize more assertive paths for decision-making in health:

In the beginning, we made a half-yearly plan in constant evaluation. We already had some groups previously with specific dates. For example, we had a group every week [...] in the evaluation process, and we started to realize the need [to evaluate the periodicity], but always counting on NASF's support (PeSF1).

Here, we reiterate the importance of recording and continuously evaluating interventions for effective processes and results discussed, configuring itself as a production process of genuine and sustainable care between the eSF and NASF-AB teams[8,24]. According to the statement, we emphasize that the qualified registration streamlines team communication and, especially, documenting actions to conduct monitoring and evaluation:

We have the daily production bulletin and the E-SUS form, which we do not feed the system. We fill out the E-SUS form and send it to the Health Secretariat, according to the information (PeNASF-AB14).

Aligned with what was explained, the observations and focus groups identified relevant tools used by professionals to record the work process, such as preparing and archiving reports of meetings and actions taken, electronic medical records, e-SUS AB (printed forms and online system), and cloud information storage (Google Drive). These registration and documentation environments translate strategies that integrate access to information by the reference and support teams, facilitating articulation and prolonged availability.

The evidence presented agrees with the results of research carried out in Ontario, Canada, with PHC interprofessional teams, which identified the importance of team processes (for example, team meetings) and organizational supports (for example, electronic records) for implementing interprofessional teamwork[14].

Reflections on the NASF-AB work in this category allow us to consider territorialization and health responsibility as concepts that strengthen interprofessional teamwork attributes. Therefore, this is induced by NASF-AB's presence.

Collaboration to achieve expanded health production

The expanded PHC scope of action is notable given the continuous complexity of life needs toward achieving the expanded health concept. To this end, health teams are based on interactive and comprehensive actions in a symbiosis that can express a joint effort manifested by effective teamwork. These conceptual dimensions underlie the NASF-AB teams' work process and reaffirm the interprofessionality that must be manifested in this practice.

The NASF-AB teams had similar realities concerning supporting more than one eSF. Thus, organizing activities was essential for effective support. In this sense, the teams dialogued about flexible schedules besides the services provided, but to share cases.

On the other hand, this reality also is a challenge in the work process of the NASF-AB teams, as it generates work overload and requires a strategic organization to preserve links with the eSF and territories that often have their peculiarities. Opportunely, it reflects how this can affect the

teamwork climate, an important attribute for interprofessional collaboration. It is understood as perceptions and meanings shared between the team members in implementing policies, practices, and procedures they experience at work[3].

The articulation between eSF and NASF-AB is vital to implement actions and engage in collaborative and interdependent work with greater capacity for analysis and intervention for individuals and groups[24] since interprofessional teamwork expresses a meeting of knowledge to offer more qualified and comprehensive care.

The statement "*[…] At the end of the month, the entire team, ACS, nurse, doctor, and the NASF team sit down so that this client service calendar is made in harmony*" (PeSF20) shows the planning of monthly attendances and actions to be developed through a calendar, a strategy for better visualization of the planned activities and streamlined physical spaces in the unit, considering the need for the organization since the NASF-AB teams monitor more than one eSF and do not have their physical space, besides recognizing the eNASF-AB as an important element for the quality of the services offered. In this sense, the shared organization of work processes and health practices affects accountability between teams and professionals with different knowledge[25].

Meeting spaces are strategic for the consolidation of interprofessional teamwork, as they enable the definition of joint projects, expand dialogue, recognize the work of others, and increase collaboration[13]. Thus, thinking together a professional agenda to meet the people's demands is a powerful strategy for integrating actions and sharing responsibilities:

[...] As we have our category wheel, we always try to plan relevant topics for them [...] to improve the quality of life (PeNASF-AB4).

The moments for discussing the territory's needs indicate in which directions the team should continue bringing elements required for effective health planning. In this sense, the participants' statements give visibility to the elaboration of actions logically and objectively, correlating them with the expected results and presenting the implementation and plan of the actions established for the enrolled population. Thus, they materialize the communication in favor of a joint project of professional work and express interprofessional teamwork through NASF-AB practices.

The work proposal of the NASF-AB materializes through the matrix support, covering the sharing of problems and the exchange of knowledge and practices under the technical-pedagogical and clinical-care dimensions, which must be planned and implemented, and shared[24]. From the above, matrix support is recognized as a strategy that clearly expresses the attributes of interprofessional teamwork since it encourages integrating Family Health teams with teams or professionals with other knowledge centers different from the NASF-AB[8]. Thus, it incorporates concretely interprofessional teamwork in PHC.

In the technical-pedagogical dimension, we identify continuing education actions and spaces for shared discussion to improve competencies in the eSF and encourage professional leadership:

Sometimes, when you are having a session with another professional, nurse, or doctor, you pass on your knowledge to him, and, at another time, he will not need me, so he will be able to orient without going through an appointment (PeNASF-AB1).

NASF-AB's work has nuances in the observation that underscores the intrinsic relationship of continuing education and moments of knowledge exchange and debate of the work process to transform health practices[26]. Actions targeting the clinical-care dimension are visualized within the framework of matrix support:

[...] We normally prepare these actions in corporal practice groups, in which we develop aerobic gymnastics, localized gymnastics, dance, circuit, functional exercise, and walking. We also develop health education actions with relevant themes: the importance of physical activity, preventive health measures, world arterial hypertension day, and world diabetes day, among other themes (PeNASF-AB5).

We can see in the statements of NASF-AB professionals how the teams conduct the planned actions. We should highlight that group practices are strategies used by the matrix support and aim to expand the eSF care capacity, and are widely used by the NASF-AB. We also see attempts at innovating care production through light technologies and active methodologies within the NASF-AB's scope of action:

[...] some patients cannot read. I'm preparing adhesive labels for medications to identify "day" or "night" or by color because some of them [patients/clients] also have visual difficulties (PeNASF-AB10).

The above aligns with the NASF-AB's relevance for a flexible organization and more effective practices by consolidating care technologies and expanding PHC actions, combined with stimulating individual and collective leadership

Ciência & Saúde Coletiva, 28(8):2303-2312, 2023

in care production and health promotion. In this sense, we understand that healthcare construction has an important pillar anchored in the dialogical relationship between the health team and individuals[27], consistent with interprofessional teamwork attributes. The use of care strategies and devices that address the health-disease process and promote the expanded clinic is recognized, as expressed in this statement:

They also participate in the Singular Therapeutic Project (PTS) of a case. We gather the multidisciplinary team. We have residents and NASF, and we support patient care (PeSF7).

The Singular Therapeutic Project (PTS) is an opportunity for interprofessionality to meet, an aspect intended in the statement, in which shared participation in managing complex cases is encouraged. Thus, it translates into an NASF-AB dialogical organization tool to support the reference teams[28].

The presented announcements allow us to recognize that the NASF-AB work triggers the approximation of professionals and the clinic's centrality clients and groups to make the health system sustainable and strengthen care integralization.

Integrating paths in producing care citizenship

Health as a fundamental right is advocated in the 1988 Citizen Constitution[29]. One of its principles is a comprehensive SUS for realizing this right, provided for in Law No. 8.080/1990, fundamental for articulating and continuity of individual and collective preventive and curative actions and services required for each case at all system complexity levels of the system[30].

In this sense, recognizing clients' citizenship and outlining actions that can place them at the center of their care and autonomy is required to strengthen interprofessional teamwork in PHC. Therefore, it contributes to the qualification of the care offered, sustainable health actions, and longitudinal, continuous, and comprehensive care.

Recognizing the propositions for implementing PHC, comprehensiveness strengthens it as a flow regulator and coordinator in the Health Care Network (RAS) to meet people's health needs and qualifying care lines[31]. In time, some argue that comprehensiveness is a horizon where NASF-AB's work intersects with the interprofessional teamwork attributes in a compelling way.

That said, understanding the RAS is a means of streamlining healthcare actions and practices and favoring the exercise of social rights and duties provided for by the Brazilian State, which is because it consolidates expanded access to health as one of the inherent dimensions of the approach and guarantees respect for people's comprehensiveness:

[...] We work with care lines, also a potential. We know where to refer the patient to work with the potential of our network. I have everything to offer good care [...] (PeSF1).

Besides organizing the health system, the NASF-AB work's main guideline is comprehensiveness. It promotes a comprehensive approach to individuals in their life contexts to ensure longitudinal care and traversing practices that promote health and prevent diseases and illnesses[7].

In this sense, we emphasize that comprehensive, longitudinal care is required to promote client and group autonomy to empower the governance of individuals and enable spaces for participatory discussion, as expressed in the next statement:

The NASF team supporting the Family Health team is crucial. Thus, as a multidisciplinary team, it ensures that all groups are monitored comprehensively. It includes a nutritionist, a physical educator, a physiotherapist, and a psychologist. We manage to treat the patient holistically, not only with medication. They manage to give us this support. They are there to support us (PeSF2).

We noticed the direct relationship between NASF-AB teams' professionals in the operative groups through field observations. This connection provides a space in and with the community where the teams positively evaluate the collaborative work, outlined by establishing bonds with people and encouraging the production of autonomous and more assertive health practices.

There is also evidence of the production of care and health promotion by encouraging individual and group leadership while supporting the management of complex cases and referral to other points in the network. To this end, interprofessional team monitoring permeates intersectoral relationships and establishes therapeutic behaviors, focusing on shared care and quality healthcare:

[...] We support the minimum team with clients in need in a more complex situation. We are working with a particular therapeutic project and do this work [...] (PeNASF-AB5).

However, we underscore some challenges in exercising comprehensiveness in PHC. In the meantime, the discontinuous bond, the culture

of valuing the biological dimension and medicine, and the difficulty in addressing the human subjective dimension clearly affect the fragility of care solidarity and longitudinal bonds. Thus, effects that interfere with the professional work's comprehensiveness and effectiveness in the territory[32] are generated:

[...] people's culture is the medicine-doctor culture. If they go to the doctor, who doesn't prescribe medicines, it's "there it is, but the doctor is no good". They leave angry because the doctor did not prescribe the medicine they wanted. So, the NASF came to change that culture. However, some team members change every two years, and that work that could be built and takes time is dismantled [...] the break weakens, and the group is downplayed (PeSF14).

The statement brings nuances that cross the support of the NASF-AB, but which also catalyze its action since this device attempts and intends to expand actions, mainly regarding group activities, a powerful aspect for improving health actions. Furthermore, it stirs reflective views on actions that still dialogue with grouped professional work and distance the effective integration of an interprofessional team, leading to conflicts that affect people's care quality.

The desire to recognize the NASF-AB as a device in the production of citizenship care encompasses potentialities and challenges that can affect qualified listening to health needs, the professional-client links, and the autonomy of individuals. Thus, there is a need for team deployment in the territories focused on strengthening bonds and spaces for building and consolidating autonomy and citizenship of care.

The results unveiled in this study allow us to (re)affirm the fundamental NASF-AB work process for the realization of interprofessional teamwork in PHC, as its attributes were concretely recognized in the fundamental concepts that guide the NASF-AB practice. Moreover, we reiterate that the approximations built here reveal the coexistence of NASF-AB and interprofessional teamwork, and their permanence generates opportunities to address the health needs, which become complex and give rise to an expanded approach for more comprehensive and sustainable promotion given people's experiences, recognized as the most complex social premise of healthcare.

Final considerations

Recognizing the NASF-AB work process for qualifying the care offered to the population is fundamental for the strengthening and sustainability of this public policy strategy that was strongly threatened by the previous government (2019-2022). We highlight the elaboration and power to use an Analysis Matrix for the adequate and sensitive qualitative evaluation of the NASF-AB's work.

With the Matrix of Analysis, particularities of the NASF-AB support to the reference teams are announced as a specialized rearguard to integrate the production of care in PHC as there is an understanding of the health reality experienced in the territory linked to the establishment of health strategies and actions exposed by NASF-AB teamwork as innovative and sustainable potential of the actions since they are aligned with the life contexts in which health is produced.

We see nuances that cross the NASF-AB support and affect the establishment of solidary and longitudinal bonds for promoting the client's health and autonomy. However, the reproducibility of the evidence systematized in the Analysis Matrix must be carefully examined, given the particularities of the settings involved, such as population size and the ESF, as an organizing strategy for PHC. Furthermore, involving professionals from the support and reference teams in the same focus group has potential but can also reflect a limitation of this research, as it triggers unexpressed tensions.

Furthermore, the availability of a tool for evaluating the NASF teamwork process, its application, and the analyses woven here express the originality of this writing with substrates for application. Moreover, we need to revisit policies and actions that promote the sustainability of the NASF-AB's actions in the abovementioned context.

Ciência & Saúde Coletiva, 28(8):2303-2312, 2023

Collaborations

MS Araújo Dias contributed to the conception and design of the work, planning, analysis and interpretation of results, writing of the manuscript, critical review of the intellectual content and final approval of the manuscript. PV Rodrigues contributed to the planning, analysis and interpretation of results, writing of the manuscript, critical review of the content and final approval of the manuscript version. MP Moita contributed to the planning, analysis and interpretation of results, writing of the manuscript, critical review of the content and final approval of the manuscript version. LCC Silva contributed to the design, collection, elaboration, analysis and interpretation of results, critical review of the content and final approval of the manuscript version. MCC Brito contributed to the conception and design of the work, planning, analysis and interpretation of results, writing of the manuscript, critical review of the intellectual content and final approval of the manuscript.

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