



## REVIEW OF IMPLEMENTATION OF THE TEAMS OF NUCLEI OF SUPPORT FOR FAMILY HEALTH

### AVALIAÇÃO DO PROCESSO DE IMPLANTAÇÃO DAS EQUIPES DOS NÚCLEOS DE APOIO À SAÚDE DA FAMÍLIA

### REVISIÓN DE LA IMPLEMENTACIÓN DE LOS EQUIPOS DE NÚCLEOS DE APOYO A LA SALUD DE LA FAMILIA

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#### ABSTRACT

**Objective:** to evaluate the implementation process of the teams of Cores to Support Family Health. Method: a qualitative research conducted through document analysis and semi-structured interviews with coordinators, district managers and professionals Corps Support Family Health, in Campina Grande/PB/Brazil. For the treatment and analysis of the data we used the technique of content analysis. The study was approved by the research project by the Ethics in Research under the CAAE 0177.0.133.000-10. **Results:** the city studied did not meet all the criteria established by the Ministry of Health to implement the NASF. Conclusion: how tenuous the Ministry of Health to guide the deployment of NASF, coupled with the management model of each municipality eventually establish a model that does not always NASF supports the proposal of reorganizing the network of health services. **Descriptors:** Evaluation; Support Center for Family Health; Family Health Strategy.

#### RESUMO

**Objetivo:** avaliar o processo de implantação das equipes dos Núcleos de Apoio à Saúde da Família. **Método:** pesquisa qualitativa, realizada por meio de análise documental e entrevistas semiestruturadas com coordenadores, gerentes de distritos e profissionais dos Núcleos de Apoio à Saúde da Família, no município de Campina Grande/PB/Brasil. Para o tratamento e análise dos dados empregou-se a técnica de Análise de Conteúdo. O estudo teve aprovação do projeto de pesquisa pelo Comitê de Ética em Pesquisa sob o CAAE 0177.0.133.000-10. **Resultados:** o município estudado não atendeu a todos os critérios estabelecidos pelo Ministério da Saúde para implantação dos NASF. **Conclusão:** a forma tênue do Ministério da Saúde em orientar a implantação dos NASF, aliada ao modelo de gestão de cada município, acaba por estabelecer um modelo de NASF que nem sempre atende à proposta de reorganizador da rede de serviços de saúde. **Descritores:** Avaliação; Núcleo de Apoio à Saúde da Família; Estratégia Saúde da Família.

#### RESUMEN

**Objetivo:** evaluar el proceso de implementación de los equipos de Núcleos de Apoyo a la Salud de la Familia. **Método:** un estudio cualitativo realizado a través de análisis de documentos y entrevistas semi-estructuradas con los coordinadores, gerentes de distrito y los profesionales de la salud de Apoyo del Cuerpo de Familia, en Campina Grande/PB/Brasil. Para el tratamiento y análisis de los datos se utilizó la técnica de análisis de contenido. El estudio fue aprobado por el proyecto de investigación por el Comité de Ética en Investigación en el marco del CAAE 0177.0.133.000-10. **Resultados:** la ciudad estudiada no cumplió con todos los criterios establecidos por el Ministerio de Salud para aplicar la NASF. **Conclusión:** lo tenue del Ministerio de Salud para orientar la implementación de NASF, junto con el modelo de gestión de cada municipio con el tiempo establecer un modelo que no siempre NASF apoya la propuesta de reorganización de la red de servicios de salud. **Descritores:** Evaluación; Centro de Apoyo a la Salud de la Familia; la Estrategia Salud de la Familia.

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## INTRODUCTION

In many countries, the answers to the health problems have been given through reforms in primary care building on health promotion, increased attention to chronic diseases, the integration between levels of health care and user participation.

Among the actions consolidation of primary care in Brazil, the Ministry of Health proposed in 2008 the creation of Centers of Support for Family Health (NASF) to ensure technical and pedagogical support to the teams of the Family Health Strategy (FHS) in view of the reorientation of health care practices.

According to Ordinance No. 154/2008, the NASF professionals must be committed to the improvement of the practices developed by Family Health teams, working in an interdisciplinary and intersectoral, so that each health professional, from his specific knowledge, can contribute in solving health problems in the territories.<sup>2,3</sup>

Therefore, the NASF should follow the guidelines already present in primary care, such as: the territorialization, completeness, interdisciplinarity, intersectionality, social control, health promotion, continuing education and humanization.<sup>4</sup>

With regard to the imposition of teams NASF, Ordinance 154/2008 provides for municipalities, the deployment of NASF NASF type 1 and type 2, which differ in their composition, scope and funding.<sup>2</sup>

For realization of this proposal in the health care network, is a crucial stage of the deployment process NASF teams. Ordinance No. 154/2008 defines that to deploy the NASF is required to submit, by municipalities and the Federal District, a project of the MS, which should include the proposal management, planning and intervention of the NASF.<sup>2</sup>

In this sense, despite the Ordinance to establish general guidelines for what to include in the deployment project in the municipalities of NASF, is the responsibility of each City Department of Health to assume the role of organizational actions of NASF and consequently define the deployment process municipalities.<sup>2</sup>

To support this deployment process, only a year after the publication of Ordinance No. 154/2008, the Ministry of Health publishes Notebook Primary No. 27, which discusses the principles and guidelines that guide the actions that will be developed by teams NASF, which includes: the work process among professionals, being addressed in this item

assignments common to the members of the teams and actions by strategic area, and technological tools for the NASF, which can be listed as management support and support attention.

Regarding the number of teams in the country NASF in 2008 were deployed 369 teams NASF type 1 and type 2 26 teams, totaling 395 teams. Currently, that number is almost four times as there are 1378 teams NASF type 1 and 147 type 2 NASF teams, which corresponds to a total of 1525 distributed teams nationwide. In this scenario, the Paraíba currently has 96 teams NASF, all type 1.<sup>5</sup>

Being a recent proposal, yet there are few studies that evaluate the operational teams NASF in Brazilian municipalities. Few studies have reported the impact of the actions of NASF assisted in population health. Still, it is stated that from NASF is possible to offer the public the best technology and treatment for most chronic diseases, 6 NASF of professionals are recognized as important backers of health promotion. Other studies weaves reflections on professional skills for work in process or discuss the proposal NASF NASF in the organization of health services.

However, what is observed is that most of the work is restricted to the analysis of the actions developed by professional categories of NASF10, without addressing the process of team work that makes up the inside of the service organization and the health system.

Whereas processes define not only the results, but it is essential to investigate how was the deployment in light of the proposed dimensions, this study aimed to evaluate the process of deploying teams of Cores to Support Family Health.

## METHOD

The study focuses on the qualitative approach, conducted through case study seeking to understand contemporary phenomenon in real-life context, especially when they are not clearly quite limited. It was used as a technique for data collection to document analysis and semi-structured interviews.

The documents considered relevant for this study were: Ordinance No. 154/GM of 24 January 2008 establishing the Centers to Support Family Health Primary Care Booklet No. 27 of the Ministry of Health published in 2009, which presents guidelines for the functioning of NASF and Project Implementation teams NASF in Campina

Grande / PB / Brazil, submitted to the Ministry of Health in April 2008.

In the case of semi-structured interviews, we chose this instrument considering interviews as sources of information built from the dialogue with the individual respondent and reflection are the same about the reality they experience. Thus, there were 36 semi-structured interviews with coordination, district managers and professionals of 06 teams NASF of Campina Grande. The sample size was intentional, according to accessibility to respondents. With a view to ensuring the anonymity of the participants, they were identified by the letter "G" when the lines are related to the coordination and district managers and the letter "P", where statements are professionals, plus Arabic numerals according to the sequence of interviews.

The research project was approved by the Ethics Committee of the Universidade Estadual da Paraíba / CEP / UEPB, under protocol number 0177.0.133.000-10.

## RESULTS AND DISCUSSION

The deployment project NASF in Campina Grande, prepared in April 2008 proposed the formation of 09 teams NASF type 1 distributed among the 06 Health Districts health.

According to the ministerial standards, the process of deploying teams NASF should be operationalized, from the first moment, the joint assessment of the initial situation of the territory, with the actors managers, teams of family health and local councils who know deeply the health needs in their territory and can identify issues / situations that need more support.

The deployment project NASF in Campina Grande was prepared by the staff of the Board of Health Care. It does not contain the description of the analysis process between managers, primary care teams and health advice for defining the implementation of this program with the goal of establishing the professionals who will be part of the teams NASF, since these guidelines were published only after the implementation of NASF in the city.

### ♦ Deployment Process of the county teams NASF

To build the deployment project teams NASF becomes necessary to initially consider the characteristics of the territory where professionals will act and, therefore, identification with teams FHS.

Therefore, the orientation of Ordinance No. 154/2008 regarding the service territory of NASF indicates that this should be formed by contiguous areas where teams are willing family health. By analyzing the characteristics of the territory in the county under study, it was revealed that the project had a registered population of each Family Health Team, each NASF responsible for covering 08 to 11 family health teams, assisted with the population ranging from 21 thousand to 35 thousand users.

With regard to the design of local health services, Campina Grande is divided into 06 Health Districts demarcating geographical areas and population, but not administrative. The logic of the Sanitary District reflected in regional teams NASF at the time of implantation, as revealed in the following statement:

*But then we created a model that would fit with Primary Care and Family Health Strategy and adapted to what we've been doing (G1).*

The importance of health districts gives up the opportunity to contribute to the organization of health care in the municipalities, since the proposal arises from its structure to the process of decentralization and regionalization of health and is intended to function as a strategy for implementation of SUS recognition of it as an operational unit of the National minimum health. Furthermore, the services offered in each health District must meet the demands of that population, through improved technical and spatial distribution of health services in this area, exceeding the bureaucratic aspect administrative-which is often associated with the definition of health districts.

In this perspective, it is consistent to assume that the NASF should be organized in logical Sanitary District, so each team to act as responsible by sharing cases and actions with the SF teams, empowering them in the territory in which they are embedded. The distribution of teams by NASF Health Districts can be viewed in Figure 1, except the team 3, since there is no description on the project.



NASF	Location of headquarters in the territory	COVERAGE DS	Contiguous areas	Number of ESF covered
NASF 1	Within the territory	DS I e III	Yes	08
NASF 2	Within the territory	DS I	Yes	08
NASF 3	No description of the project	–	–	–
NASF 4	Within the territory	DS IV	Yes	08
NASF 5	Outside the territory	DS IV e V	Yes	08
NASF 6	Outside the territory	DS V e VI	Yes	11
NASF 7	Outside the territory	DS VI	Yes	11
NASF 8	Within the territory	DS II	Yes	09
NASF 9	Outside the territory	DS II e VI	Yes	10

Figure 1. Distribution of the geographic area of NASF in relation to Health Districts, Campina Grande, 2010. Source: Project Implementation of NASF in Campina Grande.

As seen in Table 1, some teams are accredited NASF in health units located outside of the DS they cover, which does not match required by Decree 154/2008, which requires health services to which they are accredited NASF should be included in the territory of the FHT linked.

The register of NASF in Health Centres and other referral services, which act as their headquarters theoretically possible different interpretations by professionals about this space these services, as some agree with the need for the existence of these spaces, others disagree because of the difficulty of population's access to them and others still unaware of the existence of these spaces.

*We have no headquarters, say they have a project to take a seat there, but so far nothing (P1).*

*Imagine that you people is the headquarters of the Municipal Service, you think we can*

*afford to stay there at the Municipal Service if the population of people is there in Ramadinha? The people have no money to eat, you'll have money to take the bus to go to the Municipal Service? It has! We can not afford to be thirsty, I personally, I think not. I do not see the NASF at least within a large center-based (P2).*

*So we gathered on Friday to assess, plan and see some action plan that we have. We do not have a local headquarters, so we gather at the home of one of us, at the mall, at a diner, looking for alternative spaces, but finding that need to be assembled (P3).*

Furthermore, by introducing 09 teams NASF to reference 06 Health Districts, the logic of the organization by DS was compromised, since it implies the support of most teams NASF more than a DS and although meets the criterion of contiguity with respect the DS, it does not always occur in relation to adjacent areas of SF teams, as can be seen in figure 2.

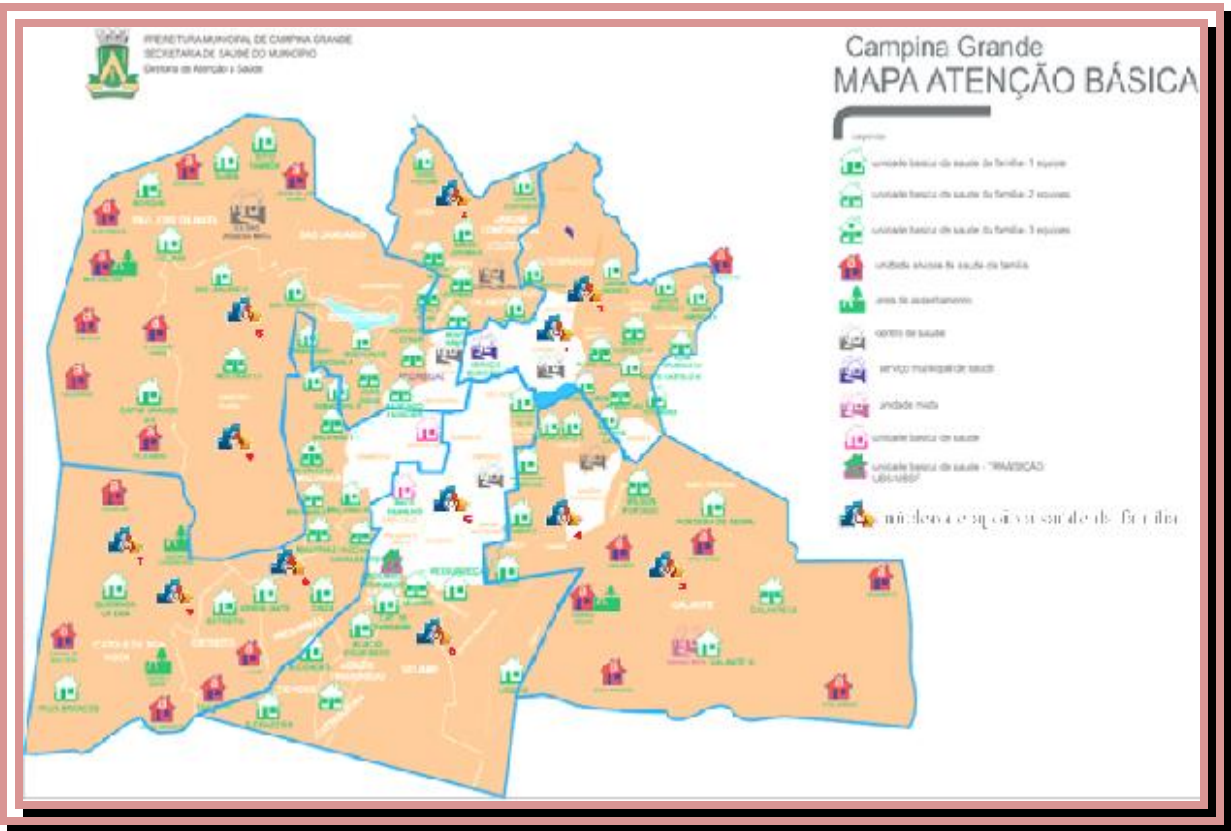


Figure 2. Map of the distribution of teams NASF regarding Sanitary Districts, Campina Grande, 2010. Source: Adapted from the Municipal Health Campina Grande-PB, 2011.

Thus, considering that most of the DS features over a team NASF in their

boundaries, as can be seen on the map, you can not define what criteria were used by the municipality to determine this distribution.

#### ♦ Definition of professionals to be inserted

According to the Primary Care Booklet No. 27, the definition of the NASF teams should occur from an analysis of key issues and needs of local health, ie, one should consider the areas of technical and pedagogical support are priority in that territory.

As for the composition, the NASF 1 must be integrated for at least five professionals, while the NASF 2 by at least three professionals, including: medical acupuncturist, homeopathic doctor, pediatrician, psychiatrist and gynecologist, occupational physician, veterinarian, psychologist, social worker, pharmacist, physical therapist, physical education teachers, occupational therapist, professional training in art and education and health professional sanitarian, he graduated in healthcare with a postgraduate degree in public health or collective.

By analyzing the deployment project, as mentioned earlier, there is no description of the professionals' choice, provided only the support areas of the NASF which includes the following professionals: social worker, pharmacist, nutritionist, psychologist, gynecologist and pediatrician.

Furthermore, not identified in the document reference to health indicators and indicators of management of different territories where the NASF were proposed. Without this statement, it was not possible to see what justifies the choice of professionals at the expense of others.

In this sense, according to some professionals NASF, the absence of some professions undertakes the work, as revealed in the following statement.

*[...] Got a nutritionist, but we're out of the pediatrician, we're out here in the medical team. NASF team has more complete than ours. [...] The gynecologist we do not have, which was supposed to be here, this unit here and to the industry that we're the NASF X, is an area that needs a lot of gynecologist. If I had a gynecologist, was passing us not so much "trouble", have no doctor here in the unit (P4).*

Despite not having been originally contemplated in the project, the physical education teachers already make up the teams currently NASF of said municipality.

Regarding the process of hiring these professionals, the order of the NASF provides

only that, in deployment projects teams NASF be given the form of hiring professionals and their hours of work.

In the deployment project in Campina Grande NASF is specified that professionals would be selected from open competition. There is, however, a difference between what is foreseen in the project and reported by professionals, since they report being in employment policy statement, signed on temporary contract work for 20 or 40 hours, according to the specific professional.

*Thus, the NASF was something that fell by chance in my life, I did not even know I was called, was not even looking, they called me, [...] the NASF arrived because someone knew I had this vague, gave my phone and called me. I went to see, I found interesting, and came NASF pro. (P5).*

*Actually, I was unsure what it was. When they told me the NASF, there ready, now gave me! Actually, neither the nomenclature I knew what it was, because then this job came to us, "Fulano have a business to you!" I will! I did not know exactly what it was, knew I was going to be a physical education teacher, did not know that I would not work within the SUS (P6; Emphasis added).*

This form of contracting seems to bring some implications for the process of working NASF. The first and perhaps most emblematic is the very precariousness of work teams, whose fragility in the employment relationship in health services, one of the aggravating that reinforces the precariousness of work that setor.<sup>16</sup> According to this author, other problems may be associated with the deregulation of labor in health, namely: lack of structure for planning services, discontinuity in care, the exhausting workday seen multiple jobs, the inadequate remuneration, castor professionals and poor working conditions that affect the quality of the user intervention.

It is believed that the workforce is one of the critical aspects in the consolidation of the National Health System, which has been following the trend of labor flexibilization modeled by restructuring productive force in the country.

The second implication refers to themselves as professionals NASF feel with this type of bond, sometimes vulnerable, considering that at any moment the contract can be broken, sometimes slightly compromised, not assuming the responsibilities of the position.

*I'm here with the program, I have no way. Here, my contract ends and I go out. (P3).*

*For as it is a political job, we went in, knowing it would work one day yes, one day no [...] then somehow it complicated, because I gave blood, I did everything that was to do, then it difficult [...] (P6; Emphasis added).*

The third implication relates to how teams are perceived by professionals NASF FHS revealing a discredit the activities of the NASF.

*It was a very big barrier thus clashed when he began the NASF, because the body of the NASF, people who are the NASF, people are hired and the body of the PSF are people no way. So they think that the NASF does nothing in their sight. (P5).*

*"Oh ... NASF this will not work, this job is because no one will work, so never put trust in people (P6).*

The fourth and final implication of the form of hiring professionals NASF is the lack of profile of them to work in public health, compounded by little experience in this area, whether in relation to postgraduate courses (teaching) or previous experience (servicing) . Thus, of the 29 professional teams NASF interviewed, 21 reported some previous work experience, and of these only 4 worked in primary care. Also in this sense, the 24 professionals who have expertise reported, only 9 were in the area of public health / conference. Thus, one can assume that the poor training and little experience in the area of public health seems to define certain profile, as identified by the professional NASF.

*For me, PSF is to use a slipper, walk, take it sun, rain and mud and is found the user, the user is known, there are many people who have profile [for the industry] private: eat ricotta sending nutritionists, nutritional supplements are not compatible with the user's salary (P7).*

This has an impact on the direction of health, and therefore whether or not in solving the problems of the population, since the lack of professional profiles for work in public health, leading to strategies distant reality user.

#### ♦ Performance and integration teams NASF with the network

Ordinance 154/2008 provides in its Annex I, a list of activities common to the NASF professionals that must be developed by all teams and still define actions to be performed in nine key areas: physical activity / body practices, and integrative practices complementary; rehabilitation / health of the elderly; food and nutrition; mental health, social service, child health / adolescent and young, women's health and pharmaceutical care.

Regarding the definition of their professional activities and the deployment project the city has not studied the tasks common to professionals NASF. At the same are defined, only the actions of the areas prioritized by the municipality, namely: Women's Health, Child Health. Physiotherapy, Social Work, Pharmacy Care, Psychology and Nutrition.

The option to define the duties of the priority areas, to the detriment of those shared among professionals seems to indicate greater interest in developing specialized actions, fragmented and curative consistent with conventional models of health care. This is revealed in the following statement:

*The NASF is based on the same information exchange between professionals and prevention education to the community. Not to get stuck only to compliance with therapy. The exchange of information between professionals to discuss the case. In my mind, that's what should substantiate. But that's not what really happens, just work with therapy (P8).*

The proposed work of the NASF seeks to overcome this fragmented logic and based on the specialty, from the co-responsibility and integrated care, shared care and prioritizing therapeutic projects for users assistidos.<sup>8</sup>

One opportunity to redeem the skills and competencies necessary to model change was intended by the SUS Introductory Course teams NASF held before the start of the activities. However, professionals report that:

*[...] The introductory half was [...] was not cool! What was passed to us there, for me it was not enough for us to get to work. Now this training that we was commenting here was really ... was to have been there at the beginning, when we say that was thrown into the post, we played was the same! We did not know what he would do no (P6; Emphasis added).*

*We started with an introductory course in the Health Centre, which was more to pass the time, why was not a course that came from the Ministry, was made by the Department of Health to spend the same time, because it had nothing to do with the NASF (P9).*

From the foregoing, it is observed that as bond issues, welcoming, listening and teamwork, characteristics inherent to SUS, the ESF and from then to the NASF, were not discussed in the introductory course offered by the Department of Health teams. "Among the difficulties encountered in the process of working NASF is the training of professionals who do not meet the needs of SUS, much less of Primary Care."

Following the ministerial standards, after approval of the deployment project NASF is necessary, as a second step of the process, the planning of the work process and the goals that must rely on the cooperation and coordination of managers, NASF, teams health and family users. This initial pact must become, however, a routine process, from the recognition by all actors of their responsibility in co-management processes trabalho.4

Despite these guidelines from the Ministry, not in the deployment project in the city canvas predicting shared agenda between the teams. It could be observed in the speech of professionals that they do not complain about the initial pact between FHS and NASF team, which is reflected in the difficulty of carrying out the actions of the NASF by the ESF.

*[...] And so too was passed over for the PSF professionals who we were and what we were going to do. So from the beginning that this had impeded the PSF accept the presence of people because there was a failure of the Department of Health on call all of the PSF professionals and explain to them what function straight from us, because we were practically thrown within the posts. (P10).*

*When I started, the main difficulty was precisely the PSF, not because she did not accept, but being a new thing they knew, they had not been filed and that the people who came and said: "we are the \_Nós NASF and we will make the call now! (P11).*

Regarding the format of the service network, Ordinance 154/2008 indicates that the deployment project presents NASF NASF team integration with other health care services in the county by setting flows and referral mechanisms and counter, information flow and coordination of access by ESF.

The project under consideration does not include such specifications. The NASF professionals when reporting on the work process report that the Family Health teams identify and refer cases to the NASF, which meets the specific cases in an attempt to solve the problem. When the professional NASF can not solve the case, this is referred to secondary care.

*I realize that this person needs a systematic, long-term therapy [...] I forward to the State University of Paraíba has the Psychological Clinic there (...) I have here a list of all the people that I referred with the date of referral, which is part of the unit, to which I referred and the name of health worker (P12).*

It is considered that, from the moment that the staff Family Health forwards to the NASF, and this starts to mimic the average

complexity, generates a flow in which one does not know where the NASF is inserted. Still, when the professional can not give NASF solving the case, it forwards the user to the medium complexity.

This logic flow integration service levels of the municipality in question reveals the option of service by a service modality in which professional NASF perform actions assists as revealed below:

*[...] The NASF is to be matrix support and assistance, more support matrix that care, but I honestly do care that more support matrix. Why is there a demand, if I'm there and I meet because I will not answer? (P1).*

*Managing she wants a welfare NASF thus words of management, said that it was agreed, when he started the deployment process, he covenanted as welfare, they chose a welfare NASF (P13).*

In search of a format for integrating the network of health services, there was a city manager's intention to follow the provisions of Ordinance 154, however, according to the technical management, which was followed a few standardized and not others.

*The manager gave us autonomy to conduct the process according to what is to be done, we have the support of management. [...] Because I drive the process 90% matrix. Then, when a professional saw that another manager was doing differently, because everyone does it one way, then the trader said: "Oh, I do not want to do such a thing!" Then I said, "So ready, with me you is not! Arranges another. If you want to make your model in NASF X, you will not be able to stay here because we do like the ordinance reads "(G2).*

Importantly, the dynamics of teams working NASF seems fragmented, in part, be explained by the shape of the network of existing services in the city which, although it shows a great evolution in the number of primary care services, and currently with 92 teams Family Health and still 3 Pack program Community Health Workers, offers the services of medium and high complexity operationalized by the private sector in the municipality in question does not fall in a complementary fashion to the health system, but as the main supplier of level of attention.

## CONCLUSION

The categories of analysis of this study enabled the delineation check given to this proposal in Campina Grande from the contrast of the interviews, Ordinance 154/2008, Notebook No. 27 Primary Care and deployment project in NASF that municipality.



The results indicated that the document on the implementation of the county teams NASF, does not include all the specifications required by the Health Ministry, but this was not an impediment to the adoption of this new policy in Campina Grande.

Thus, it is clear that the weakness in the ministerial guidance to direct the deployment of this new project in the allied health determinations of each municipal management, brought about the establishment of a model of NASF that does not match the true purpose of this device. Thus, despite the proposal of NASF be interesting, the city of Campina Grande currently has misrepresented this project, resulting in large part from preceding this deployment.

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