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ORIGINAL ARTICLE

HEALTH PROMOTION ACTIONS IN THE EXTENDED FAMILY HEALTH AND BASIC HEALTHCARE CENTERS

Carine Vendruscolo*
Denise Antunes de Azambuja Zocche**
Maria Elisabeth Kleba***
Kátia Jamile da Silva****
Dara Montag Portaluppi*****
Jacqueline Duartte******
Juliana Andreia Duarte Araújo*******

ABSTRACT

Objective: to analyze actions by the Extended Family Health and Primary Care Centers (Nasf-AB) in Santa Catarina, from the perspective of health promotion. **Method**: this is qualitative research through group interviews with 43 professionals from five Nasf-AB teams, between September and November 2017. The information was treated through thematic content analysis. **Results**: the professionals related their actions to the social determinants based on the reality of the territory, although with little use of indicators for planning the actions. They dialogued with other knowledge centers in the Nasf and with professionals from the reference team, in this case, prioritizing shared action. There is little participation in representative councils or even intersectoral initiatives in the territory, although the data indicate interdisciplinary initiatives or with other services of the Health Care Network. **Conclusion**: there are health promotion actions, in their collective and social sense, developed by Nasf-AB professionals, with educational practices prevailing without user groups. We highlight the aspiration to promote individual and community empowerment, increasing the individuals' autonomy and, therefore, the resolution of Primary Health Care.

Palavras-chave: Primary health care; Health promotion; Family health; Multiprofessional Team; Intersectoral collaboration.

INTRODUCTION

The Ottawa Charter for Health Promotion (HP) emerges from an international movement in defense of a health model that highlights environmental, social, political, economic, behavioral, and biological factors as determinants of the health-disease process. It was produced in 1986, at the first International Conference on HP. The document highlights processes that enable the individual and the community to increase their autonomy for the quality of life and health, understood, not as another life objective, but as a resource for a living[1]. This movement influenced the Health Reform and contributed to the creation of the Unified Health Care System (SUS)[2].

Primary Health Care (PHC), organizer of the Health Care Network (HCN) has the name of Primary Care in Brazil and plays a central role in the formulation of health policies for the qualification of SUS. It is structured through the Family Health Strategy (FHS), and this level of care operates as a privileged locus of HP actions, with a family and community focus and addressing psychosocial and socio-health problems. The FHS seeks quality care through Family Health (FHt) teams, composed of a doctor, nurse, nursing technician or assistant, community health agents (CHA), and may include oral health professionals[3].

To fill the gap from the biomedical model, centered on the curative and hospital-centered ideas, the HP gained prominence in Brazil from the expanded concept of health[4]. Its guidelines were inserted in the Federal Constitution (1988)

*Adjunct Professor of Nursing Department,Post-doctor, Santa Catarina State University. Chapecó, SC, Brazil. E-mail: carine.vendruscolo@udesc.br. ORCID iD: https://orcid.org/0000-0002-5163-4789.
**Adjunct Professor of Nursing Department, Doctor in Nursing, Santa Catarina State University. Chapecó, SC, Brasil. E-mail: denise.zocche@udesc.br. ORCID iD: https://orcid.org/0000-0003-4754-8439.
***Nursing professor (retired). Post-doctor in Nursing, Educator e Independent consultant. Chapecó, SC, Brasil. E-mail: lkleba@unochapeco.edu.br. ORCID iD: https://orcid.org/0000-0002-6703-8375.
****Nurse. Post-graduated in Strategic management of Health Organizations of Maringa University, Maringá, PR, Brazil. E-mail: katiajamiledasilva@gmail.com. ORCID iD: https://orcid.org/0000-0001-8645-1184.
*****Nurse. Post-graduated in Basic Care and Collective Health of Rio Grande do Sul Public Health School. Farroupilha, RS, Brazil. E-mail: dara.portaluppi@hotmail.com. ORCID iD: https://orcid.org/0000-0003-4156-9482.
******Nurse. Master, Municipal Health Secretary. Itapiranga, SC, Brasil. E-mail: jacqueline_hermes@hotmail.com. ORCID iD: https://orcid.org/0000-0003-0201-9920.
*******Nurse. Master in Nursing, Municipal Health Secretary. Xanxerê, SC, Brazil. E-mail: ju_duartte@hotmail.com.ORCID iD: https://orcid.org/0000-0002-2747-3348..

and the Organic Health Law (1990). However, the National Health Promotion Policy (*PNPS*) was only instituted in 2006. Guided by the assumptions of the Ottawa Charter, the document, revised in 2014, highlights the importance of the conditioning factors and determinants of health and has as premises the intra and intersectoriality and the creation of co-responsibility networks that seek to improve the quality of life, although it also recommends care aimed at reducing risks and preventing diseases[4-5].

Faced with the recurring challenges of PHC in Brazil, the Ministry of Health (MH) created the Family Health Support Center (NASF) in 2008 and currently called asthe Extended Family Health and Primary Care Center (Nasf-AB) aimed to expand the scope of collaborative actions with the FHS reference teams, as well as their resolution[3,6]. Nasf-AB is composed of specialist professionals and must be integrated with PHC to develop matrix support with FHt, offering specialized support to demands through specific knowledge and shared actions.

Matrix support is the main activity of Nasf-AB and can be developed in two dimensions: technical-pedagogical support to promote permanent education movements with FHt professionals, and clinical-assistance support, in which they perform individual or collective clinical care by specific demand[7-8]. In both dimensions, the Centers should develop actions in the perspective of HP based on permanent and continuing education activities with the team and popular education, involving patients and the community, with a focus on changing habits and lifestyles, such as healthy eating; physical activity practices; actions to combat the use of tobacco and other drugs; and actions of community empowerment and promotion of citizenship[3,6-7].

The literature review on the performance of Nasf-AB[9] identified that the actions of HP are rarely performed by the Centers. The authors point out that accounting for expanded actions to face and solve problems related to social determinants goes far beyond the actions and services offered by the FHt or Nasf-AB, enabling to address these determinants in a maximum, individual, and community dimension. The actions developed by the teams known as health promoters are sometimes located in the field of disease prevention. Thus, the work of Nasf-AB, within the scope of the HP, as a rule, converges towards expanding the quality of care, in the direction of prevention, impacting accessibility and resolvability[10].

Based on studies[2,4,8-11] that show challenges to work in HP within the PHC, we considered relevant to analyze the actions developed by Nasf-AB, in Santa Catarina (SC), in the perspective of Health Promotion Health, as the objective of this article. The performance of the professionals of these teams is considered substantial for the resolution of the PHC and, therefore, for the HP. For this reason, managers, professionals, and the community, in general, need to be clear about the nature of the practices that belong to the Centers, and the gaps and related challenges.

METHOD

This is descriptive-exploratory research with a qualitative approach. We carried out semi-structured group interviews with professionals from five Nasf teams, one from each municipality in SC between September and November 2017. A total of 43 professionals participated. The five Nasf-AB teams were established by lot, covering four of the eight State Health Macro-regions, suitable according to the feasibility of access to researchers. The number of teams and professionals was also measured by the data saturation criterion. The organization of the participants by different professional categories had the following provision: seven social agents; seven physical education professionals; seven pharmacists; six physical therapists; nine nutritionists; six psychologists; and a speech therapist. They were included according to availability on the day of data collection. The interviews lasted an average of two hours, being conducted by an interviewer, a reporter (who took notes on the profile and sequence of the speakers), and supporters (who circulated the room with the recorders); and were recorded and transcribed in full.

The inclusion criteria for the participants were to work in the Nasf teams, in one of the selected municipalities; have been in the role for at least six months. The exclusion criteria were

professionals removed from work for any reason.

The information underwent thematic content analysis[12]: pre-analysis of the material produced, starting with the floating reading of the transcripts of the speeches to constitute the corpus of information. The exploratory phase resulted in the first codification to reach the core of the understanding/meaning of the text. Finally, the text was cut into registration units, creating two categories: "recognizing the reality of the territory to plan and implement actions" and "public policies, social participation, and intersectoral action".

For the analysis and discussion, we used the concept of Health Promotion from a critical perspective that emphasizes aspects related to comprehensive, interprofessional care, and that considers the social determination of the health-disease-care process and intersectionality as central in the organization and implementation of care. We considered the aspects of education and those related to culture and individual behaviors, with an emphasis on shared resignification of life, avoiding the medicalizing and controlling tendency of prescribing so-called healthy, authoritarian, and ineffective biases[8].

The Human Research Ethics Committee approved the research under opinion 1,812,835/2016. The identity of the participants was preserved and the municipalities were identified with the letters A, B, C, D, and E, preceded by the participant's professional or work category.

RESULTS AND DISCUSSION

Twenty-five (58.1%) of the 43 professionals who participated in the interviews were women. The post-graduation (n = 42/97.6%) was the prevalent level of education in 42 (97.6%) of those surveyed and 1 (2.3%) had a doctorate, maximum degree among the answers. The performance at Nasf-AB, from three to four years, was the most frequent, 32 (74.0%) among professionals.

Then,we present and discuss the categories from the analysis.

Recognizing the reality of the territory to plan and implement actions

The data showed that professionals recognize problems in the territory and can relate the social determination of the health and disease process, considering its social aspects from a more critical perspective than the positivist approach to the natural history of the disease[13]. Faced with this context, when possible, CHAs, FHt professionals, or even colleagues from other knowledge centers dialogue, prioritizing the definition of plans for shared action.

> [...] Of course, we discussed it because the problem of smoking is associated with other things: drugs, drinks, depression. I have been facing some problems that I couldn't solve and I ended up calling the psychologist because it scared me. [...] in these bigger problems, you go and call the team, call the psychologist, social agent [...] **(Pharmacist - D)**.

> We connect with the strategy [FS] and the community agent, and establish in this therapeutic plan, [where] the agent goes to the house [home] more often, to observe how they are doing, if they are at risk, if they have supportive family, triggers a doctor, also triggers and shares with the nurse. [...] **(Psychologist - B)**.

The perspective of collaborative or interprofessional action touches the speeches. It is the relationships between different professions, in the mutual understanding and exploration of means to combine knowledge, to improve the provision of services, the safety of the patient, and the quality of care. Interprofessional work encourages discussions of clinical cases, shared care among professionals, and favors the construction of therapeutic projects[14]. However, we highlight the statement that the institutional performance of Nasf-AB professionals is still linked to the core of specialties, which enhances their specific competence, but neglects the interprofessional performance and the necessary articulation between services to foster the coordination of care by PHC/BC through the FHS[10].

The report below highlights this aspect and shows concern by the professional to meet the health needs of patients: *"[...] you activate the team, you activate the psychologist, social worker [...]*". Among the actions of the professionals, those related to the HP and the fields of the Ottawa Charter stand out: healthy public policies; favorable health environments;

reorientation of health services; community empowerment, and personal skills development[1].

Thus, we found an approximation with another study[15] that reveals, within the scope of the PHC/BC, that the CHA has participated in matrix support activities with a frequency considerably higher than the other professionals of the FHt. In the case of this study, the CHAs are a relevant source of information for the planning of HP actions by professionals from Nasf-AB, indicating their availability for dialogue. This reverberates for the team because the information enablesus to bring elements for decision making and shared action to the agenda of both the FHt and the Nasf-AB. On the other hand, the political substrate of the CHA has been progressively weakened in the latest documents that guide PHC/PC, such as the National Policy for Primary Care (*PNAB*)[3]. The term "community" is less used and, when it appears, its meaning does not indicate the political participation that the work of the CHA should promote, restricted to the place where the promotion and prevention activities are carried out[16].

Consistent with recent studies on Nasf-AB[17], this research revealed that there is still little use of epidemiological indicators in the territory for planning actions:

> We work very little with health indicators. Teams little use this when planning, evaluating **(Psychologist - A)**.

According to the participants, itis the low demand from management combined with the culture of not valuing health planning, that is, planning is not a recurring practice among teams, as the reports reveal:

> [...] but not that we study this [territory indicators] to see what is most needed in that territory. In my Nasf, this is not done, assessing what the Unit's main demands are so that we can do some activity. I realize that we fail a lot on the issue of hypertension and diabetes, but the Unit does nothing to change that. Management does not pressure us for this, there is a lack of pressuring in this sense to improve some indexes. **(Pharmaceutical - A)**.

> [...] I have already worked in other municipalities where the actions were guided according to the indicators, here our Unit does not have this culture. Last week, I was in a group with the Unit's coordinator and a patient asking what would be the prevalence of obesity here, I looked at the coordinator and she said we didn't have this data, she asked about diabetics and hypertensive patients and there was also nothing to be informed. The patient said: but you who work here, don't you know? [...] our population and the Units do not know how many pregnant women there are and neither do we, we do not know the prevalence, we attend to what is appearing **(Nutritionist - A)**.

However, the testimonies demonstrate that professionals are aware of the need to recognize the health determinants of the territory for the development of actions:

> [...] we have prioritized territorialization in all the Units, to be checking the potential and difficulties of this territory and how we can include this in our work. We are in the process of getting to know the territory, photographing, reporting, and then pointing out what will be most important to work in each territory [...] there are many issues of open sewage, health management, food issues, lack of access to education, in short. So, the idea is this, to be in this process. We are building, we do not have a closed diagnosis yet, but we are under construction **(Social Worker - B)**.

From the perspective of public policies, this articulation between social issues and health meet the principle of integrality and consolidates SUS guidelines, expanding the political capacity of all social actors to act in the direction of these complex social issues[13].

With the exposed data, we found that there is still a need to invest in the articulation of the actions developed by the teams with the purposes recommended by the PHC/PC, as weaknesses were signaled in one of the first stages of the work process, which is planning. Expressions such as *"management does not charge us for this, there is a lack of charging in this sense to improve some indexes*" reveal that the actions are not designed based on team planning and inter-teams, but rather due to spontaneous demands or interest and by punctual initiatives by professionals. When the professional reveals that he does not know the indicators of morbidity and risk factors, he exposes a weak organization of his work process.

In this context, the study corroborated the

research on the theoretical and logical models of Nasf, focusing on the work integrated with the FHt, highlighting the insufficiency of organizational devices to support the shared work and the insufficiency of mechanisms for monitoring and evaluating the results achieved[18].

Planning is one of the PNPS guidelines, highlighting the need to recognize contexts and respect local diversity in the definition of territorialized actions. In this perspective, planning enables the development of actions in an articulated way, not only to the services of the HCN but also to other sectors of public administration, "composing commitments and co-responsibilities to reduce the vulnerability and health risks linked to social determinants"[5: s/p]. We observed that PHC health teams, in general, manage their actions, but few use planning and carry it out based on the partial recognition of their HCN reference[19].

Public policies, social participation, and intersectoral action

The results show low involvement regarding the participation of professionals in representative councils and when this occurs, they highlighted instances at the municipal level:

> [...] we work little on this logic, but there is some representation in the Municipal, Health Councils, Social Assistance Council [...] (Social assistant - C).

Among the principles of the PNPS, there are social participation and autonomy, related to the inclusion of points of view of individuals, groups, and communities in the identification of problems and solutions and the valuation of potentialities to favor co-responsibility in planning, execution, and evaluation of PH actions[5].

Empowerment is another principle, which implies motivation and the guarantee of conditions for people and collectives to take control of decision-making about their lives and social determinants, according to the socio-economic-cultural context. Participation and social control are also highlighted among the operational axes of PNPS, considered relevant strategies for HP. They expand the inclusion of people and social groups in the elaboration of public policies and decisions that affect the lives of individuals, the community, and their contexts[5]. In addition to representing new technologies related to the provision of services, HP actions or initiatives require the construction of spaces that favor social health production, in which individuals and groups can participate, assigning meanings, refusing or affirming the relevance of the themes and proposed actions, revealing their needs and desires[17].

The result corroborates the findings of other studies that identified community participation as a low-profile practice among intersectoral work initiatives within the scope of PHC/PC, from the perspective of HP[15], and few initiatives related to the articulation of Nasf-AB with social facilities in the territory[9]. When it occurs, the articulation takes place with government institutions, such as the Social Assistance Reference Center (CRAS), to the detriment of social movements and community leaders[9]. Although intersectoral actions are considered fundamental for the development of HP, studies point to the need to reinforce the skills of agents in policies of this nature through educational strategies[20-21].

Local councils are spaces that favor the mobilization and participation of the community in matters related to health, expanding their capacity and power to act in the formulation, implementation, and inspection of policies and actions with repercussions on their living conditions. As a space for learning and exercising citizenship, local councils enable dialogue and the sharing of knowledge, fundamental aspects of the processes of empowerment, associated with HP[23]. In a recent literature review on the contents and characteristics of the actions developed by Nasf-AB, direct and permanent communication with the population of the territory was incipient, including the dissemination of activities developed by the health unit in the community spaces[13] so the local councils are favorable spaces for discussion and practices.

The information shows the difficulty in carrying out activities with the school, despite attempts to act intersectionally or with other services of the Network. It is noticeable the professionals' understanding of their role in the prevention of health problems and HP within the

PHC scope, and also about the relationship they make between HP and Public Policies and intersectoral action:

> I am working a lot in this part of violence against children and alcoholism; but, I would like to have more tools and power. Alcoholism, for example, I can only visit the family to see if, maybe one day, the patient will be treated. I need tools to solve more complicated cases. I would like to do more health promotion in Primary Care; I have been discussing with two Health Units for several months to do work at school, it is difficult to organize with the health center and also with the school [...] working with prevention is also difficult **(Social assistant - A)**.

> [...] if we could work at school, some issues would not be happening that way. We either run after the demand or we do promotion. Today my agenda is around serving and making promotion groups. [...] Whether we like it or not, we are talking about an already established disease, we know that our patient evolves and improves, but that, eventually, he can get worse, because the disease is already chronic in most cases **(Psychologist - A)**.

> Units do certain activities because, perhaps, they are required or because they are charged, in a certain way, to do an activity at school or to do something different. Now, effective work at school, for example, to assess and see if rates have improved, if teenage pregnancy has decreased do not happen much **(Pharmaceuticals - E)**.

The articulation between health and education is a central strategy of the Health at School Program (HSP), created in 2007 by the Ministry of Health aimed at promoting comprehensive care to students in the school context. The HSP has been referred as an innovation in the intersectoral action and the promotion of citizenship rights, as it strengthens communication between school, health unit, and community[23] and promotes shared management in the planning, execution, and evaluation of actions. However, studies indicate that the intervention prioritizes actions aimed at the identification and prevention of diseases in the format of clinical evaluation and/or lectures[24].

In the referrals to specialists or other levels of health care, the information indicates a performance by Nasf-AB, to a certain extent, aimed at ordering the Network in the relationship they establish with the Reference Center for Occupational Health (CEREST) and the Psychosocial Care Center (CAPS):

> In the case of social work, we are working together with CEREST, and we observed that the indicators showed that many people suffered an accident at work, but did not receive quick assistance. So, we have a partnership between CEREST and Nasf, to improve these indicators. [...] There was once that the team [FS] said that a woman was beaten by her husband, only that they already passed me off without hope: "oh, you look and then, but it's been like this for several years, it won't change", and I forwarded it. I did the procedures without much hope, because they, who are much more experienced, have lived in the neighborhood for a long time, they spoke like this. But then, not only thanks to service but several together, mainly the Maria da Penha law, this time, when the procedure was done, the woman separated from this ex-husband who beat her. So, some things are going on, in terms of public policies [...] **(Social Assistant -A).**

> [...] the referral and counter-referral [...] something improved, when we send to CAPS, through Nasf, we already call, they ask if we are referring a patient, so they welcome our patient [...] CAPS also has an immense waiting list, so when they do not assist these people, they usually go back to Primary Care, they need to validate their recipes with us **(Psychologist - B).**

Nasf-AB professionals monitor and organize the flow of patients when referring them to services such as CAPS or CEREST. Sometimes, they take the individual and family perspective of attention to the patient through home visits focused on specific problems, in which violence was highlighted in the narratives. The culture of peace, which is one of the objectives of the PNPS, suggests the co-responsibility of the sectors in creating opportunities for coexistence, solidarity, respect for life, and strengthening of bonds through the development of social technologies that reduce violence and the construction of solidary practices through education, dialogue, and cooperation, which can be a political strategy for the transformation of social reality[5].

The professionals count on the support of other services of the Care Network, as shown by the data, highlighting reports on HP actions and violence prevention. In this regard, PNPS suggests organizing the surveillance of these events with educational actions, training, and

support for normative measures to institutionalizing protection programs. Among the intersectoral resources, we highlight the Maria da Penha Law (Law 11.340, of 7/8/2006) and other agendas including local ones, which seek alliances outside the health sector[25].

Data from national surveys on patient challenges facing the performance of the FHt and Nasf highlight that the teams are still unable to guarantee access and articulation with the other points of the Network due to the lack of effective communication arrangements and information exchange between the services[19,26].

We could identify the professionals' conceptions of HP that imply their actions and, to a certain extent, they converge with knowledge and discussions about the health-disease process and its determinants in a post-Ottawa perspective. However, there were generic mentions about HP as a synonym for disease prevention, referring to the model of Leavell and Clark[27], in a perspective aimed at changing individuals' behavior and the absence of mention of the quality of life. This view showsa reduction in HP and a broad set of elements that constitute social determinants that interfere in the quality of life of patients and communities[13].

The "biomedical model" remains hegemonic in the teams' ideas and seems to hinder the work of Nasf-AB. This model has influenced the organization of services and the production of health knowledge, not only in Brazil. It comes from the issues raised in the Flexner Report, published in the United States in 1910, in a harsh critique of the configuration of medical schools. The movement contrary to its hegemony assumed international prominence in the 1970s[28]. However, even in the current educational institutions, this model prevails. Proposals that strengthen the incorporation of highly complex technological teaching are presented, with high costs, diagnostic and therapy practices, traditional models of content selection, and evaluation, with emphasis on the importance of specialties, characteristics of the biomedical model[29].

Changes in the articulation between Nasf and FHS require constant investments and represent important initiatives to strengthen interprofessional performance. The World Health Organization (WHO) proposes Interprofessional Education (IPE), which is effective when students from two or more professions learn about others, with others, and with each other to enable effective collaboration and improve health outcomes[30].

FINAL CONSIDERATIONS

In the performance of Nasf-AB in the municipalities studied, we can conclude that there are initiatives for the development of HP actions and movements that affect individual and community empowerment to resolve PHC. HP can be recognized to some extent, incorporated into the micropolitical space of health production, in its expanded conception. However, challenges remain such as the non-participation in representative councils, few intersectoral initiatives for articulation between professionals and between services, and the institutional performance of professionals strongly linked to the specialist center.

More than 30 years after the creation of SUS, we are still far from overcoming the model centered on disease and hospital care, especially in the current moment of crisis in the System. There are fundamental challenges from the training of professionals still predominantly centered on the biomedical model, but also from the recent financial and political cuts that go back concerning the promotion of health-promoting actions, with significant consequences in the ways of organizing and implementing health guidelines and principles of the FHS, which is the main strategy for reorienting the care model in Brazil.

The actions developed by Nasf-AB, converging with other studies in collective health, do not seem consolidated to the point of significantly altering the way of producing health in the territories and facing the social determinants of the health-disease process. In this perspective, we highlight the need for the different actors to know and engage effectively in the implementation of structural policies and other documents since the creation of SUS, they have been built as consistent instruments and guiding the organization of health actions and services in Brazil. PNPS is one of these instruments, constituting a transversal and inspiring policy for the translation of the

expanded concept into effective practices in the daily activities of the Nasf-AB and FS teams in favor of health and quality of life.

As a limitation of this study, we found that the interviews were conducted in five municipalities in the state knowing the reality of a limited number of professionals and locations. Another limitation in the discussion of the findings is the small number of studies on the topic.

AÇÕES DE PROMOÇÃO DA SAÚDE DOS NÚCLEOS AMPLIADOS DE SAÚDE DA FAMÍLIA E ATENÇÃO BÁSICA

RESUMO

Objetivo: analisar ações dos Núcleos Ampliados de Saúde da Família e Atenção Básica (Nasf-AB) em Santa Catarina, na perspectiva da promoção da saúde. **Método:** pesquisa qualitativa mediante entrevistas realizadas em grupo com 43 profissionais de cinco equipes do Nasf-AB, entre setembro e novembro de 2017. As informações foram tratadas por meio de análise temática de conteúdo. **Resultados**: os profissionais demonstram relacionar suas ações aos determinantes sociais tendo por base a realidade do território, embora com pouca utilização de indicadores para planejamento das ações. Eles dialogam com outros núcleos de conhecimento no próprio Nasf e com profissionais da equipe de referência, nesse caso, priorizando a atuação compartilhada. Há pouca participação em conselhos representativos ou, mesmo, iniciativas intersetoriais no território, apesar de os dados indicarem iniciativas interdisciplinares ou com outros serviços da Rede de Atenção à Saúde. **Conclusão**: há ações de promoção da saúde, em seu sentido coletivo e social, desenvolvidas pelos profissionais do Nasf-AB, prevalecendo práticas educativas sem grupos com usuários. Destacam-se a aspiração em promover o empoderamento individual e comunitário, com vistas ao aumento da autonomia dos sujeitos e, por conseguinte, da resolutividade da Atenção Primária à Saúde.

Palavras-chave: Atenção primária à saúde; Promoção da saúde; Saúde da família; Equipe multiprofissional; Colaboração intersetorial.

ACCIONES DE PROMOCIÓN DE LA SALUD DE LOS NÚCLEOS AMPLIADOS DE SALUD DE LA FAMILIA Y ATENCIÓN BÁSICA

RESUMEN

Objetivo: analizar las acciones de los Núcleos Ampliados de Salud de la Familia y Atención Básica (Nasf-AB) en Santa Catarina-Brasil, en la perspectiva de la promoción de la salud. **Método:** investigación cualitativa a través de entrevistas realizadas en grupo con43 profesionales de cinco equipos de Nasf-AB, entre septiembre y noviembre de 2017. Las informaciones fueron tratadas por medio de análisis temático de contenido. **Resultados**: los profesionales demuestran relacionar sus acciones a los determinantes sociales teniendo por base la realidad del territorio, pero con poca utilización de indicadores para la planificación de las acciones. Ellos dialogan con otros núcleos de conocimiento en el propio Nasfy con profesionales del equipo de referencia, e neste caso, priorizando la actuación compartida. Hay poca participación en consejos representativos o, incluso, iniciativas intersectoriales en el territorio, pese a que los datos indiquen iniciativas interdisciplinarias con otros servicios de la Red de Atención a la Salud. **Conclusión**: hay acciones de promoción de la salud, en su sentido colectivo y social, desarrolladas por los profesionales de Nasf-AB, prevaleciendo las prácticas educativas sin grupos con usuarios. Se destaca el anhelo en fomentar e l empoderamiento individual y comunitario, con el fin de aumentar la autonomía de los sujetos y, por consiguiente, de la resolución de la Atención Primaria de la Salud.

Palabras clave: Atención primaria de la salud; Promoción de lasalud; Salud de la familia; Equipo Multiprofesional; Colaboración Intersectorial.

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Corresponding author: Carine Vendruscolo. Rua Mato Grosso, 545-E, Apartamento 302, Jardim Itália, Chapecó, SC, Brasil, CEP: 89814-080. E-mail: E-mail: carine.vendruscolo@udesc.br

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