

Network transversality: matrix support in the decentralization of counseling and rapid testing for HIV, syphilis, and hepatitis

Transversalizando a rede: o matriciamento na descentralização do aconselhamento e teste rápido para HIV, sífilis e hepatites

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ABSTRACT The aim of this research was to investigate how the decentralization of counseling and rapid testing for HIV (Human Immunodeficiency Virus), syphilis, and hepatitis B and C have been implemented in the city of Porto Alegre, Brazil, using matrix support with Primary Health Care teams. It is a qualitative study, in which eight matrix supporters were interviewed. Positive aspects include training of Primary Health Care professionals, interconsultation, supervision, and visits. Such experiences point out the potentiality of more horizontal work between primary and specialized levels of care. Negative aspects include the emphasis on the technical aspect of the test and the discontinuity of matrix support.

KEYWORDS Primary Health Care; Counseling; HIV; Public policies.

RESUMO *Objetivou-se investigar como a política de descentralização do aconselhamento e teste rápido de HIV (Vírus da Imunodeficiência Humana), sífilis e hepatites foi implementada a partir do matriciamento das equipes de Atenção Básica em Porto Alegre. É um estudo qualitativo, no qual foram realizadas oito entrevistas com matriciadoras. Entre os aspectos positivos, estão a realização da capacitação dos profissionais da Atenção Básica, de interconsultas, supervisões e visitas. Essas experiências destacam a potencialidade de um trabalho mais horizontal entre os níveis de atenção especializado e básico. Entre os aspectos considerados negativos, destacam-se a ênfase na parte técnica do teste e a descontinuidade do matriciamento.*

PALAVRAS-CHAVE *Atenção Primária à Saúde; Aconselhamento; HIV; Políticas públicas.*

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Introduction

The Brazilian National Health System (SUS) has been instituted as public policy in the Federal Constitution of 1988 in a context of historic resumption of citizen's rights. The SUS seeks to comply with the population's health demands, considering every subject, territory and team as singular and unique, and aiming at the universal, equitable and integral access to health by all users residing within the national territory.

In the last decades, the Primary Health Care (PC) has been receiving incentives and seeking to occupy a central position in health care in Brazil by means of the National Policy for Primary Health Care (Política Nacional de Atenção Básica – PNAB) (BRASIL, 2012). The Family Health Strategy (FHS) plays a central role in the coordination and ordination of care and access to health, with the characteristic of being the central point and entrance door to the SUS care network. The main objective of the PC is the decentralization of examination, thus amplifying the population's access to services, and aiming to create bonds between users and professionals. Therefore, it seeks to offer care relationships that are more efficient, profound and coherent regarding the reality of communities and users' families (BRASIL, 2012; CONILL, 2008).

With the strengthening of SUS, resulting from the consolidation of the primary level of health care, the creation of the SUS Humanization program (HumanizaSUS) and the achievements and connections of practices of the Mental Health System Reform (Reforma Psiquiátrica), new responsibilities and service demands on the primary level of health care took place, and the matrix support was created as a new device of operational management of health services (CAMPOS; DOMITTI, 2007). Campos (1998) used Baremlitt's (1992) concept of device to define matrix support as a political tool for institutional intervention. The concept refers to

the insertion of external resources (such as the matrix support) into an institution, intervening in the daily reality for changes in its basis, principles and operation.

The matrix support was introduced in 2007 in the sphere of mental health. Its purpose is to alter the health care organizational logic based on specialization, by relativizing the principle of hierarchy among professionals as well as among distinct levels of care services (proposed in the theory of health systems), and considering all knowledge (team and community) as being important for the work process (CAMPOS, 1988; CAMPOS; DOMITTI, 2007). From theoretical and practical exchanges between the reference team (primary care team) and the matrix support team (professionals' team of specialized care level), the proposal of the matrix support is to rethink the public health policies present in the health network in a longitudinal way in the three levels of care. According to Campos and Domitti (2007), the matrix support offers a singular care, which respects the different cultures and necessities of each territory and its reference team.

Studies exploring the matrix support strategy especially in mental health have been published, as highlighted in the literature review carried out by Bonfim *et al.* (2003). Nevertheless, there is a lack of studies on the matrix support for rapid testing for HIV (Human Immunodeficiency Virus), syphilis, and viral hepatitis (HAAG; GONÇALVES; BARCELLOS, 2013).

Regarding the National Policy for STD/AIDS, since the year 2000 the Ministry of Health has publicized three manuals with the directives for HIV/AIDS care. The manuals highlight the insertion of counseling and the incentive to the offering of HIV diagnosis in the Primary Care network (BRASIL, 2003, 2005). The idea is that besides being offered by the Testing and Counseling Centers (TCC), the testing is also offered by the primary care and that people can be followed-up by the primary health units within the logic of

co-responsibility. It is noteworthy that Rio Grande do Sul is the state with the highest rate of HIV in Brazil, with 41.3 cases per 100 thousand inhabitants in 2013. In the capital Porto Alegre the situation is even more alarming, with 95.6 cases per 100 thousand inhabitants in that same year (BRASIL, 2014).

In this context, the objective of this study is to investigate how the policy for the decentralization of rapid testing for HIV, syphilis, and hepatitis is being implemented, since the introduction of the matrix support for Primary Care teams in the city of Porto Alegre and Rio Grande do Sul state. It must be stressed that Porto Alegre is one of the pioneer cities in the process of decentralization of rapid testing for HIV, syphilis and hepatitis in the primary care network.

Method

This is a qualitative and exploratory study carried out with professionals who acted as matrix supporters for the realization of counseling and rapid testing of HIV, syphilis and viral hepatitis in Primary Care. The participants were selected according to the snow ball technique, in which the interviewed indicated other matrix supporter professionals. Eight professionals took part; five were responsible for the matrix support in the municipality of Porto Alegre and three were involved in the process of matrix support in the state of Rio Grande do Sul. They were invited for the position due to their professional experience and identification with the HIV/AIDS theme. The participants were identified as P1, P2, and so on.

Data were collected from October to December 2014 by means of semi-structured interviews of 45 minutes medium length. All interviews have been recorded, transcribed and analyzed using Atlas.ti software.

Data interpretation was made using Thematic Analysis (TA) (BARDIN, 2011). To carry out the TA, the steps suggested by Braun

and Clarke (2006) were followed: careful transcription of interviews; generating initial codes of themes that arose from the examination of the entire material as more relevant, and considered as coherent, consistent and distinct from one another; after the selection of themes, the interviews were read once again and recodified; the data from the interviews were interpreted and organized; the data analysis sought to consider a good balance between the analytical narrative and the illustrative extracts provided in the text. For this study, three researchers independently codified the interviews using the Atlas.ti, whereas a fourth researcher acted as judge. When distinctions in the codification were found, they were discussed by all the researchers, aiming at a consensus.

This study was financed by the National Counsel of Scientific and Technological Development (CNPq) (Edital Universal nr. 482051/2013-2) and was approved by the Research Ethics Committee of PUC-RS and the Municipal Health Secretariat of Porto Alegre, via Plataforma Brasil (nr. 779.500).

Results

Regarding the respondents, five were trained in psychology and three in nursing, having different employment status: two respondents had a temporary contract of 20 hours per week during 13 months to carry out the matrix support in six (of eight) municipal district health units; three respondents were state civil servants in charge of the matrix support in the other two municipal district health units; and the other three respondents were state civil servants in charge of the matrix support in state regional health units. Only two of the respondents were still conducting the matrix support in the region that they had been assigned to.

The thematic axes that arose from reading the material collected during the interviews were: 1) Training; 2) Matrix support; 3)

Counseling; 4) Resistances and possibilities; and 5) Matrix support: interior versus capital. The thematic axes sought to give visibility to elements for the analysis of the matrix support carried out for the implementation of counseling and rapid testing for HIV, syphilis and hepatitis.

Training

One of the first aspects pointed out by the respondents was the differentiation between training and matrix support. Training can be one of the activities performed within matrix support. By means of the interviews, it was noticed that most of the actions related to the matrix support for rapid testing and counseling in the city and in the state presented a training characteristic. Thus, lectures and specific workshops occurred in central places in the city, with large number of participants, with no distinction between professionals according to territory or service to which each one was related. One respondent synthesized that the training sessions had three objectives: *“There was a knowledge part, a technical part, and a sensibilization part”* (P1).

Another participant stated that training consisted of:

A theoretical part and also a practical part. Practice and theory, explaining the entire test and how it [test] works and, thus, helping them [primary care professionals] to be trained and to learn more from the technique, how easy it is, but also difficult, in the sense of the huge responsibility. (P2).

Besides the operationalization of the testing, another respondent referred to the opportunity of exchanging experiences:

To give instruments to the professional about the legislation on rapid testing, how the process is; the practical part, how the test is done; we tried

to inform about everything, how to prepare the report, how to organize the physical area; we had already implemented [the rapid testing in the TCCs], so we told about our experience... the difficulties we faced, but also what were the benefits, for us personally and professionally, right? (P3).

Another respondent mentioned the importance of training as a differentiated space that provided an opportunity for the teams to have more proximity that, at times, was stronger in the training sessions than during visits. In this sense, she reported:

Because we have used that methodology of the Ministry [of Health] to problematize... using practical cases and situations, and at the end one sees the theory, and one integrates the cases with the theoretical aspects, not only because they begin to work better, but also because we managed to have more proximity with the unities thru the training sessions than during the visits, because sometimes during visits one gets there and it is the practice, you see? (P4).

In the same direction, some matrix supporters mentioned that the training sessions are used as a device to sensitize and as a way to discommode the teams: *“The proposal was to discommode, you see, to be able to help that professional to think about those issues and see him/herself in it”* (P5).

All respondents stated that the professionals who participated more actively in the training sessions for testing and counseling were nurses and in some cases physicians. On the other hand, the matrix supporters stressed the importance of having more than one professional of the team taking part in the training sessions. One of the respondents pointed out:

So, as much as possible, one tries to sensitize the unity in the sense that other members share this task, so that two or three members take the training, and only one is in charge... [if] there is

one on leave for being ill or quitting... nobody else is in charge, nobody does the testing. (P4).

Another limitation highlighted by the matrix supporters is the high turnover of professionals in primary care, often associated with the precariousness of the employment contracts. The respondents reported:

It caught people in high turnover, I think that from those people that we trained in 2012, I don't know if there is still anyone in the network, because soon after there was none. (P6).

The respondents also discussed the specific characteristic of the training sessions in this context of high turnover. One respondent stated:

Often it was that professional who made him/herself available to take part in the training with us, and that professional quitted and, well, the teams didn't manage to get reorganized, the teams were dismantling, you see? I think that these were serious difficulties that we faced. (P5).

Training was referred to as a starter and that the process of knowledge production should be done in a concerted and continuous way:

I think that training is a starter. It is a device to know basic things to be done. Now, when do you feel apt to do counseling with confidence and calm, it is from doing it a lot, having supervision, having conversation, having someone to discuss your doubts with, what shall you do with this. (P1).

Matrix support

Besides the training, there were other actions in the matrix support process, such as interconsultation, visits to unities, and exchanges via e-mail and telephone. The

frequency and continuity of those activities varied according to the matrix supporters' employment status. The respondents presented discussions and criticism on the development and characteristics of the matrix support in the city and in the state.

I think that those who went for the matrix support didn't know what it was about. They had no idea. They thought it was about taking a course. (P1).

The respondents referred to having carried out interconsultation with PC professionals at the TCC where they worked:

We also began to do interconsultation in the unity, with complicated situations regarding the testing, the patient's difficulty to deal with the diagnosis. There are also interventions when we work together with the team dealing with a specific user, other situations when we discuss it with the team and the team acts, and situations when the team acts together with us, which are the interconsultations. (P4).

Some matrix support teams also reported having made visits to some units:

We were five or six technicians here. We planned to visit all units. We visited the services, right? (P1).

Another aspect brought up by the respondents was that the matrix support was not structured as a longitudinal practice. The supporters reported:

The ideal situation would be to give continuity to this and be able to provide this follow-up so that it would actually become part of people's routine, to be able to think about sexuality, about rapid testing, also regarding the possibility that the user could leave the unity having already received a diagnosis. (P5).

I understood it as a longitudinal process, right? In which we would continue to have this partnership. This is how I understand the matrix support; I think this is the way it works. (P1).

The lack of continuity was also associated to the fact that the work of matrix support professionals was discontinued, because some of them were hired for a limited period of time.

These regions have received the matrix support and have implemented the rapid testing, but this ended after the changes in the teams, it was reduced, so what happens today is that the region is the one that does more testing. (P7).

When we left, there was no more matrix support team... so I don't know what happened since... I think that the visits are no longer being made... (P8).

The statements highlight the association between the continued realization of matrix support and the increase in the quantity of testing being done.

The issue of the employment contract and working conditions concerning both matrix supporters and primary care teams seems to be a transversal element having an impact on the programmatic response to epidemics.

Counseling

Counseling is a tool that aims at the promotion and prevention of health by means of a moment of conversation before doing the test and another moment in the post-test, when giving the result. It is planned to be singular, contemplating the integrality of the subjects who have access to it.

The respondents have stressed that when discussing counseling during the training sessions, they sought to bring up the more experiential aspects by doing workshops. The matrix supporters stated:

One has been talking in a very theoretical way about the principles of counseling, but also we always try to have a more experiential moment, as a workshop. (P6).

So, yes, we used the theory of counseling but in a practical way. How would it be to approach someone, to listen, to have the feeling to listen, and feel oneself within the scene to be able to evaluate. (P2).

The perception that a large part of the training would be centered on the practical testing in detriment of counseling, which despite being considered more complex would not always be favored within the decentralization policy, presented a paradox:

[...] or only the issue of counseling itself, which the professionals ended up by saying they had more difficulty with, because the technique in itself is simple. (P8).

All respondents mentioned that the aspect they considered to be less dealt with during the training sessions and in the entire process of decentralization of the test is the counseling.

There was a time to discuss only aspects of counseling, how to talk, what is important, very much structured. (P3).

To talk about the counseling itself, for people to understand that it is not about giving advice, right? But we couldn't do much of this... it was one of the things that gave me a sense of frustration; that I could have achieved more [...]. (P8).

[...] training on technology and counseling, we were always trying to accomplish all of it, but it seemed that we were always running after something that we would not be able to complete. (P5).

The respondents also criticized the aspects that are being prioritized in the implantation of the policy:

The testing policy was very much focused on actually making diagnosis and treating the serum positives and thus having a decrease in the circulation of the virus; this is why I say it is somewhat Americanized... that if it would be possible to identify everyone who has HIV and treat them all and have a decrease in our rates... Well, it is an important thing, right, but I think that this tool was not very much enhanced... finding the serum positives and dealing with the epidemic. (P6).

In this sense, the same professional has reported:

The issue of counseling appears seemingly as a gift for those who will learn the technique of using the needle to extract the blood sample from the finger for the testing. (P6).

Resistances and possibilities

The relationship between the teams was another issue raised in the interviews. The matrix supporters mentioned difficulties in the work between the basic and specialized levels, besides the resistances of some professionals and teams:

Not everyone who we were investing in was actually keen; there was a whole issue of sensibilization, and it is not just the training that will accomplish it, independently of the amount of time available. (P5).

When it comes to the practical point, one knows that not everyone will have the profile and will ever have...(P4).

Other respondents have stressed that communication between the different levels of care continues to be a challenge:

It is a challenge to have a conversation with the primary care, and for the primary care to talk to us. (P3).

And so my colleagues [matrix supporters] would say: 'Oh, but you see? Those people can't learn how to do it [primary care professionals]'. And I said: 'how could they learn?' [...] They started two weeks ago, or two months ago! 'Oh, but she is a nurse!' But she is a nurse who has never worked with AIDS. It is different, right? The unwillingness and misunderstanding was present in both sides [matrix supporters and primary care professionals]. (P1).

The teams [primary care] do not always receive us the way we would like them to, right? (P4).

The logic and hierarchy between the different levels of care appear as a challenge for the development of an integrated work. On the other hand, the respondents have mentioned positive aspects both for the primary care and for the specialized care, with the creation of a longitudinal bond of exchange between the two levels.

If there would be a matrix support, it would make the work at the TCC easier. It would maintain the two-way lane that we had; at the same time you bring us new cases and we give you back cases of people that we have lost. (P1).

Matrix support: interior versus capital

In the process of training for the rapid testing and counseling, some territorial inequalities were observed in the way that the training has been and still is carried out for the interior of the state. While in the capital the matrix supporters report that the average length of the training is of 20 hours with possible follow-ups at the unities, in the rest of

the state this could happen in one day or in one week:

We have been to many municipalities to train professionals so that they would become trainers for the testing in their regional unity. (P2).

My participation is always very specific: going to the municipality, training the person, but not doing a follow-up, not knowing what happened afterwards... there was a moment of rush, when we said 'oh, let's do it, let's train everybody', and then we look at the numbers, which should say that all the municipalities must have someone who has been trained. I think that this serves to say, but if the person is actually doing it, is still in the municipality, and is doing it properly, we have not been able to follow it, and I think it gives way to plenty of doubts, right? (P6).

Discussion

A first aspect to be highlighted is that the participants that were interviewed clearly understood the difference between training and matrix support. In most of the actions that were approached, what had been named as matrix support was actually limited to specific training, with no longitudinal follow-up of teams and services in their singularity and specificity.

Regarding the training sessions that were performed, the respondents highlighted the importance that they would not only offer the transmission of technical and theoretical knowledge, but would also be a space for experience exchange, sensibilization and creation of bonds between the teams, provided by the use of participation and problematizing methodologies. Therefore, the matrix supporters sought to get away from the dichotomist logic between theory and practice present in their work, and that these two fields would operate in an integrated

manner in the training sessions (CAMPOS, 2011).

As highlighted in the Introduction, Baremlitt's (1992) concept of device refers to the insertion of external resources (in the case of the matrix support of a team) within an institution, intervening in the daily reality and producing movement, altering the logics of management and work processes. In this sense, one of the respondents referred to the training as an important starter. Nevertheless, in order that the primary care teams would be sufficiently prepared, it would be necessary to have a longitudinal follow-up of those teams, with supervision and discussion of cases in the daily practices of their unities.

In this direction, Franco (2011) stresses that the practices developed by the FHS must progress towards the integrality and focus on actions less directed at the disease and the logic of risk groups. Another aspect pointed out was the participation of only one professional of each team, usually one with nursing training. In this sense, Campos and Domitti (2007) point out the importance that the matrix support process should have an interdisciplinary characteristic in both teams. In order that this tool may be characterized as a device, it should involve the entire team in the work process and in the reception of the new technology, instead of training only one professional of each team. The matrix support aims to reduce the referral logic starting from the primary unity team, having no hierarchy and not determining knowledge due to training, resulting in a transversal circulation of knowledge and practice among the professionals. In order to achieve this level of transversality, the training process of the team should also occur in the territory of the insertion of the new policy, enabling the matrix support to integrate the routine and dynamics of the professionals' work, rather than breaking it.

Another difficulty that the matrix supporters' teams have highlighted was the high turnover of primary care professionals

that hindered the continuity of the work carried out. The precariousness of the employment contracts could also be noticed regarding some of the respondents who had worked under a temporary contract of only 20 hours per week and who were responsible for the matrix support in most of the district health units of Porto Alegre. Among the respondents, only two continued to do matrix support in one of the eight district health units of the assigned city. In this sense, the response to the epidemics requires a programmatic response from the state administration, by setting up a longitudinal program with greater investment in human resources, both in primary care and in specialized care.

Despite the criticism on the predominance of the very specific characteristic of the training sessions, during the period when the teams were receiving the matrix support there were different activities going on, such as visiting the teams, giving supervision and the interconsultations. According to Campos and Domitti (2007), matrix support implies the construction of an integrated therapeutic project, in which the connection between the reference team and the supporters may develop in three fundamental spheres: a) interconsultation: joint examination and interventions by the matrix specialist and some professionals of the reference team; 2) in situations that require specific care by the knowledge nucleus of the specialized team, it may program specialized examinations or interventions, keeping contact with the reference team, that would take active part in the decisions regarding the user and would not disengage from the case; c) the support may be limited to the exchange of knowledge and directions between the reference team and the matrix support team, as well as supervisions and dialog about changes in the evaluation of the case and even reorientation of conducts; in this sphere, also lectures and workshop are carried out, directed to the community of the specific territory.

The importance of having specialized health professionals in proximity to the territory is highlighted, according to Campos, Barros and Castro (2004), because they build up knowledge, languages and ways of doing that are different from those experienced by primary care professionals. The two levels of care can dialog and establish bonds of co-responsibility and co-management, aiming to improve the users' health (CAMPOS; BARROS; CASTRO, 2004).

In this sense, a parallel is drawn with a matrix support experience studied by Arona (2009) about a process carried out in four unities of Primary Health Care by a Nucleus of Family Health Support in a small municipality in São Paulo state. Though the studies had different objectives, it was observed that a matrix support that includes the entire basic team and multiple policies (as in this case being mentioned) tends to construct an action that is more horizontal, interdisciplinary and intersectoral and, consequently, co-management practices.

The respondents also mentioned the issue of inequalities among training sessions and matrix support carried out in the capital and the interior of the state. Outside the capital, what was named matrix support was kept within the limits of very specific training with a reduced amount of time. As has been discussed earlier, training can be one of the activities of matrix support; but having only very specific training does not constitute matrix support, considering that this should have a longitudinal follow-up. The logic of the numbers and coverage of the teams that were matrix supported was questioned in a broader sense, in terms of effectiveness of the intervention. Territorial inequalities have, according to Assis and Jesus (2012), a multidimensional characteristic, with social and political aspects that are present in the way health policies are implemented.

A paradox highlighted by the respondents is that although the technical part, meaning the rapid testing, received greater emphasis

in the training, it was the counseling that they actually considered to be more complex to be carried out by the primary care professionals. Counseling on HIV and AIDS is understood as a process of active listening, individualized and user-centered. It is based on the establishment of a relationship of confidence between the health professional and the user, making use of the user's own resources so that he/she is capable to recognize him/herself as the subject of his/her own health and transformation. In the sphere of HIV/AIDS, counseling is based on three components: 1) emotional support; 2) educational support, in which there is the exchange of information on Sexually Transmitted Disease (STD) and HIV/AIDS, and its ways of transmission, prevention and treatment; and 3) risk evaluation, by which a reflection is carried out on values, attitudes and conducts, including a strategy for the reduction of risks (BRASIL, 2003, 2005). Regarding HIV/AIDS, counseling should comprise the subject's singularities, including his/her practices, and should not have a prescriptive characteristic.

The respondents mentioned a feeling of frustration regarding the time given to counseling in the training sessions and also in the matrix support in general. One of them spoke about counseling as a 'gift'. The notion of 'gift' clarifies the prioritization of the technologies considered hard in detriment of the technologies considered light. According to Mehry (2002), hard technologies in health can be considered as the working tools associated to technology, as for example a diagnosis test. Light technologies allow for the construction of bonds of confidence, enabling the perception of each user's singularity and ways of life. For the author, it is in the relation of the encounter, in the living work, that the user can act and interact. By the way in which the logics of power (political, technical and administrative) operate there is still a tendency to prioritize the harder and light-hard, more structured technologies.

The centrality of the diagnosis, despite its importance within the current context of the epidemics, responds to a model of biomedical health centered on the disease, in which prevention and promotion are put into a second level in favor of strategies of care denominated 'Americanized' by one of the respondents. Those strategies aim to reach the population massively, standardizing or, sometimes, disregarding interventions like counseling, resulting in disrespect for the subject's singularity. This logic of action and management of the rapid testing policy with emphasis on the diagnosis contradicts the principle of integrality in care of SUS.

Campos, Barros and Castro (2004) refer that the model of health promotion should make a shift in the way health professionals see and listen only to the disease, seeking to produce autonomy during the process of health care. In this sense, counseling as relational and light technology becomes a space for health promotion and prevention, in which the user him/herself may evaluate the risks and seek strategies of self-care, becoming a potent tool for autonomy production.

The respondents also talked about the difficulty of the work among the different levels of care: specialized and primary. As highlighted by Campos and Domitti (2007), one of the challenges of matrix support is to break with the logic of hierarchy among the different levels of care within SUS, seeking to develop the logic of co-responsibility and horizontality in the relations. In order to reach this setting and work relationship, the author stresses the importance that the relationship thus established becomes continuous and systematic, enabling the creation of bonds between the teams and establishing a transversal and longitudinal partnership between the levels of hierarchy of the network.

The matrix support can be considered as an important device because it ensures a specialized care rearguard and gives technical support to the teams, enabling that

barriers are broken and connections are made. Campos and Domitti (2007) affirm that in order to broaden the possibility of carrying out expanded clinics and dialogic integration between distinct specializations and professions, one should make use of the matrix support. According to Campos (2011), matrix support is praxis, rather than being only technology or a tool. It is a dialectic method, a constellation of concepts that can be combined in several ways according to the objective and the specificity of the case.

Another aspect to be highlighted is that the respondents demonstrated deep knowledge about SUS and about the matrix support technology, and appeared as very much politicized regarding their practices. Therefore, they were able to make an evaluation both of the positive and of the negative aspects regarding the matrix support, situating themselves as social actors and political agents who not only carried out actions and policies, but also evaluated the macro- and micro-political improvements and developments. Granjeiro, Silva and Teixeira (2009) stress that among the positive aspects of the Brazilian response to HIV/AIDS epidemics there is the politicized characteristic and the participation and social control, by grassroots movement as well as health workers, and these potentialities should be recognized and legitimated.

Among the limitations of this study, there is the fact that the matrix support has been analyzed only in one state of the country. Future studies should expand the analysis to other regions, and also assess the impact of matrix support carried out in a longitudinal

way in counseling and rapid testing in the context of primary care.

Final considerations

Porto Alegre is one of the pioneer cities in Brazil regarding the decentralization of rapid testing and counseling within the Primary Health Care network. Therefore, the results and experiences presented in this research may serve as a starter to other contexts in which decentralization is being implemented.

From the interviews with the matrix supporters, one observes a series of improvements associated to the use of matrix support as a trigger for new logics of care. Many of the aspects presented as relevant in the matrix support, such as training, interconsultation, supervision and team follow-up, were put into practice at the initial moment of the implementation of the test in the network. The narratives and strategies used by the matrix support teams permit to observe how to develop strategies of permanent education in health in the daily work and how to construct logics of work that are more horizontal between specialized teams and primary care teams.

Among the negative aspects, it has been stressed that often the matrix support was limited to very specific training sessions. From these statements, stands out the importance that the matrix support with all its potentialities should be used in a transversal and longitudinal way in the follow-up of primary care teams, to ensure qualified counseling and diagnosis to users. ■

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Received for publication in: October, 2015

Final version: February, 2016

Conflict of interests: non-existent

Financial support: Conselho Nacional de Desenvolvimento Científico e Tecnológico (CNPq). Edital Universal nº 482051/2013-2