DOI: 10.1590/1413-81232022279.01472022EN

Construction of the historical-regulatory standard of the Expanded Family Health Center

Mauricio Pereira de Mattos (https://orcid.org/0000-0002-3644-6114) [1]
Adriana Coser Gutiérrez (https://orcid.org/0000-0002-7305-5841) [1]
Gastão Wagner de Sousa Campos (https://orcid.org/0000-0001-5195-0215) [2]

Abstract *This paper discusses the historical construction of the Expanded Family Health Center (NASF, in Portuguese), based on the analysis of 17 documents edited by the Ministry of Health (MH) between 2005 and 2021. This is a qualitative study of documental review that seeks to understand how the regulations and official instructive manuals have been shaping the way NASF teams operate. It proposes to divide the NASF construction process into five periods: previous movements (2003 to 2007); support guidelines (2008 to 2011); the universalization of nasf (2012 to 2015); expansion of support (2016 to 2018); and the dismantling of NASF? (2019 to 2021). The results show changes in guidelines over the years of the team's existence, especially in relation to the matrix support concept and its two dimensions: technical-pedagogical and clinical care. This study also demonstrates the effects of the Previne Brasil Program on the NASF, which resulted in the reduction of 379 teams in 2020 and 2021. Added to this scenario is the SARS-CoV-2 pandemic, which may be repositioning NASF interventions in the Brazilian Unified Health System (SUS, in Portuguese).*

Key words *Matrix support, Expanded Family Health Center, Primary health care, Qualitative research, COVID-19*

[1] Escola Nacional de Saúde Pública Sérgio Arouca, Fundação Oswaldo Cruz. R. Leopoldo Bulhões 1480, Manguinhos. 21041-210 Rio de Janeiro RJ Brasil. mauriciomattos@gmail.com
[2] Faculdade de Ciências Médicas, Universidade Estadual de Campinas. Campinas SP Brasil.

Introduction

Due to the different experiences of the Family Health Program, which have been in place since 1994, the Ministry of Health (MH) has been gradually leading municipalities toward the adoption of this model[1]. The National Primary HealthCare policy (PNAB, in Portuguese) from 2006 has been advancing in the reorganization of health care within the Brazilian Unified Health System (SUS, in Portuguese), formalizing the traditional name of the Family Health Strategy (FHS). The consequent increase in the importance of Primary Care as the coordinator of health care, with the respective allocation of financing for this level of care, has forced municipalities to face the challenge of the reorganization of its healthcare networks. With the FHS, the teams have the task of guaranteeing health care to users in a different way. It is hoped that this, over time, will be implemented throughout the country to meet all needs, which requires the intervention of more professional categories beyond the FHS teams

The Expanded Family Health Center (NASF, in Portuguese) was created in 2008 as a Family Health Support Center, aimed at increasing the resolutive capacity of the FHS and expanding the care provided to users of the territories in question[2]. It is organized as a specialized backup interdisciplinary team that operates by means of the matrix support methodology and of its two dimensions: technical-pedagogical and clinical-care. The refers to the methodology though which the support teams and the NASF have been constructing their interventions will engender different arrangements and configurations of the support function, with impacts on the production of health care.

Matrix support has proposed other means through which to organize work and clinical process management, which seeks to surpass rationales that produce a fragmented health care-focused on one single physician. It is intended to join NASF specialists from the support groups with users, aimed at increasing the capacity of analysis and intervention concerning the health problems within a given territory[3].

Method

This study selected 17 regulations and publications written by the MH, edited in 2005 and 2021. These documents were accessed in the official websites of the federal government and were produced to regulate the public health policies of SUS throughout the first two decades of the twenty-first century. These contain the regulatory theoretical references and the referent guidelines to the NASF work processes and outlines, and defines how the professionals of this team should work.

Two objectives were the guiding principles of this documental analysis[4,5]: identify the NASF's organizational proposal and their main changes throughout their implementation, as well as to reflect on the guidelines defined in these documents regarding the work process and the matrix support concept.

For the purpose of understanding, the period of analysis was divided according to Chart 1. These periods were produced and marked as the expression of sociohistorical time, and were driven by a wide range of interests that were often distinct and contradictory to SUS itself.

The initial period had the characteristics of core demands from different subjects, in addition to the first designs of the arrangement of the interdisciplinary team. In the second period, after the creation of the team, one can see an effort on the part of the MH to disclose and disseminate the matrix support and the other support devices, with the inclusion of the NASF in the first review of the PNAB. In the third movement, new organizational parameters were established and the work tools were improved, aimed at universalizing support. In the fourth period, it

Chart 1. NASF's historical-regulatory path of construction.

Periods	Highlights
Previous movements 2003 to 2007	Municipal claims Corporate demands Municipal experiences Total Family Health Care Center – NAISF
Support guidelines 2008 to 2011	Decree154/2008 Basic Health Notebooks (BCN) 27 PNAB 2011
Universalization of NASF 2012 to 2015	NASF 1, NASF 2, NASF 3 Basic Health Notebooks (BCN) 39
Expansion of support 2016 to 2018	Congenital syndrome caused by Zika virus PNAB 2017
The dismantling of NASF? 2019 to 2021	*Previne Brasil Program* SARS-CoV-2 Pandemic

Source: Authors.

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is possible to verify the increase in the number of NASF teams nationally, and the changes in how the team is managed. In the fifth and final period, other cost parameters are defined and a pandemic of catastrophic proportions ravages the country, imposing adaptations in NASF's organization and work.

A survey was conducted to determine the number of NASF teams registered in the System of the National Health Facility Registry (SCNES, in Portuguese) – a historical series conducted from 2008 to 2021 – with the intention of numerically illustrating the repercussions of the analyzed documents, if they favor the implementation of new teams or if they represent a reduction in these.

Chart 2 presents 17 analyzed documents, as well as the subsequent results. The second column lists the main incorporations, changes, and alterations identified in the regulations and publications, movements that shaped the NASF work process.

Results

1st period: 2003 to 2007 – previous movements

In the construction of a public policy, aspects of technical order share space with ideological and corporate interests form professional catego-

Chart 2. Synthesis chart of NASF's historical-regulatory construction.

Previous movements – 2003 to 2007	
	- Municipal claims - Corporate pressures - Successful municipal experiences
Decree 1,065, July 4, 2005 Created the NAISF	- Had the purpose of expanding the integrality and resoluteness of health care. - Decree repealed two days after its publication. - Comprised of four modalities of action: diet/nutrition and physical activity; physical activity; mental health; and rehabilitation. For each modality, a specific team arrangement, within the following professions: professions, nutritionist, professional of physical education, phonologist, and instructor of body practices. - MH would finance municipalities with a population equal to or more than 40,000 inhabitants, except in the Legal Amazon region, equal to or more than 30,000 inhabitants.
Support guidelines – 2008 to 2011	
Decree 154, January 24, 2008 Created the NASF	- Created to expand the coverage, scope, and resoluteness of PHC through the actions of continued education and clinical care for specific cases. - Works in collaboration with the health services network, reviewing the practice of referrals. - NASF 1: 8 to 20 associated FHS teams or 5 to 20 (Municipalities with less than 100,00 inhabitants from the states in the North Region of the country); 5 professionals of non-coinciding occupations: acupuncturist, social worker, physical education professional, pharmacist, physical therapist, phonologist, gynecologist, homeopathic doctor, nutritionist, pediatrician, psychologist, psychiatrist, and occupational therapist. - NASF 2: minimum of 3 associated FHS teams; a minimum of 3 professionals of non-coinciding occupations: social worker, physical education professional, pharmacist, physical therapist, phonologist, nutritionist, psychologist, and occupational therapist. - Federal incentives for implementation and monthly financing. - Workload of 40 hours for the professionals with some exceptions. - Nine strategic areas of work: physical activity/body practice; integrative and complementary practices; rehabilitation; diet and nutrition; mental health, social service; child health; women's health; pharmacist care.

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Chart 2. Synthesis chart of NASF's historical-regulatory construction.

Basic Care Notebooks (BCN) 27 NASF's guidelines	- Instruction manual that defines the technological tools of work: matrix support, expanded clinical care, Singular Therapeutic Project and Health Project in the Territory. - Emphasis on the technical-pedagogical dimension, with the care provided directly to the users "only in extremely necessary situations".
Decree 2,843, September 20, 2010 Created NASF 3	- Priority in the prevention of disease and promotion of health, the treatment and reduction of risks and damages caused by alcohol and drug abuse, especially crack. - Municipalities with a population of less than 20,000 inhabitants. - 4 to 7 associated FHS teams
Decree 2,488, October 21, 2011 1st review of the National Primary Health Care Policy	- Incorporates the NASF and the concept of matrix support in the PNAB text Increase in the number of professionals to 19 categories with the inclusion of: geriatrician, internal doctor (medical clinic), occupational physician, veterinarian, professional with a degree in art and education (art educator). - Expand the work to the following teams: Street Doctor's Office, Riverside Family Health, and Fluvial Family Health. - Manager begins to take part in the team together with the professionals that he/she prefers. - Define the minimal workload for the teams: NASF 1 – minimum 200 hours; NASF 2 – minimum 120 hours. - Reduce the number of associated teams: NASF 1 – 8 to 15 (Municipalities that have less than 100,000 inhabitants from the States of the Legal Amazon Region and the Pantanal Region of Mato Grosso do Sul – 5 to 9); NASF 2 – 3 to 7; Minimum workload of 80 hours for the teams. - Repeals NASF 3, with the teams converted to NASF 2.
Universalization of NASF – 2012 to 2015	
Decree 978, May 16, 2012 Review of the Variable PAB	- 1/3 increase in the values of incentives for the NASF 2 teams, maintenance of the same values for the NASF 1.
Decree 3,124, December 28, 2012 Redefines the association parameters of NASF 1 and 2 and creates NASF 3.	- Recreates the NASF 3, without focusing on the questions of drug use or drug abuse; 1 or 2 associated teams; 80 minimum work hours for the teams; - Reduces the number of associated teams: NASF 1 – 5 to 9; NASF 2 – 3 to 4.
Decree 548, April 4, 2013 Defines the financing value of the variable PAB	- 50% increase in the values for NASF 2, defines the incentive for NASF 3, and maintains the same values to be transferred to NASF 1.
Decree 562, April 4, 2013 Defines the monthly value of the financial incentive from the 3rd cycle of PMAQ-AB	- Allowed the inclusion of all of the PHC teams, including the NASF.
Basic Care Notebooks (BCN) 39 Volume 1: tools for management and daily routine	- Discusses the matrix support as of the structural elements that comprise the professionals' agendas, reflecting on the necessary infrastructure and the conditions for these activities to occur. - Advances in the discussion regarding the tension between individual care and matrix support and concerning the main crossings in the operationalization of the matrix support.

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ries, often generating a clash between power and knowledge[5]. NASF can be understood as an organizational arrangement that arose due to this power play, city hall requesting financial incentives and the professional boards seeking greater insertion in SUS[6].

Another factor that contributes to the construction of SUS policies are the successful mu-

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Chart 2. Synthesis chart of NASF's historical-regulatory construction.

Expansion of support – 2016 to 2018	
Decree 1,171, June 16, 2016 Accreditation of municipalities referent to the NASF/congenital zika syndrome	- Aims to instrumentalize the accredited municipalities to conduct early stimulation actions and provide psychosocial support to the families undergoing follow-up. - At least one physical therapy professional in each team, as well as recommending the inclusion of an occupational therapist, a phonologist, or a psychologist. - Emphasis on the clinical care dimension of the matrix support and on individual care, which "does not contradict the logic of the matrix support". - Publication of the instruction manual "Early stimulation in primary care: guide for the neuropsychomotor development approach through the PHC, FHS, and NASF, in the context of the congenital zika syndrome".
Decree 2,436, September 21, 2017 2nd review of the PNAB	- Changes the name to Expanded Family Health and Basic Health Center (NASF-AB). - Removes the matrix support concept from the text, with the loss of the focus on the technical-pedagogical dimension. Despite the removal of the concept, it is still reaffirmed in 3 specific competencies: a – co-management / collaborative planning with the follow-up teams; b – expansion of the clinic and increase in the capacity of analysis and intervention; c – discussion of the case, individual care, collaborative construction of therapeutic projects, permanent education, discussion of the work process.
The dismantling of NASF? – 2019 to 2021	
Decree 2,979, November 12, 2019 Implemented the *Previne Brasil Program* – new financing model to cover PHC costs	- Changes the way PHC is financed, which becomes a mixture of weighted capitation, incentive for strategic actions, and payments per performance. - End of discretionary financing for the NASF. - Repeals Section II of the Consolidation Decree in the 2/GM/MS, from September 28, 2017, which includes the decree for NASF parameterization.
Decree 3.222, December 20, 2019 Treats the performance payment indicators in the scope of the *Previne Brasil Program*	- Establishes the financing of interdisciplinary actions within the scope of PHC, with the arrangement and formulation of teams according to the criteria defined by the manager.
Technical Note 03/2020 NASF-AB and *Previne Brasil Program*	- Reaffirms the changes brought by the *Previne Brasil Program*, such as the termination of discretionary financing and the extinction of the parameters for the creation of NASF.
Decree 99, February 7, 2020	- Redefines the registration of the PHC teams in the SCNES. - Creates a new code for the team, which includes the three typologies of NASF: team72 – Expanded Family Health and Basic Health Center teams (NASF-AP teams).
Decree 37, Janurary 18, 2021	

Source: Authors, based on the documents cited in the chart.

nicipal experiences, which are projected as good practices. In the process of the creation of NASF, it is possible to identify some pioneering incentives in key municipalities, such as Betim/MG; Brumadinho/MG; Campinas/SP; Camaragibe/PE; Contagem/MG; Florianópolis/SC; Niterói/RJ; Santos/SP; and Sobral/CE[6,7].

In 2003, the MH began the initial discussions concerning the Full Health Center, a project for the inclusion of an interdisciplinary team in Primary Care. The studies did not advance. However, in 2005, the proposal began to take shape as the Total Family Health Care Center (NAISF, in Portuguese)[8]. Suggested with the purpose of ex-

panding the resolutive capacity of the FHS, promoting comprehensive health care and actions of health promotion, the decree to create the NAISF was revoked two days after publication, with the justification of the non-definition of the financial contributions allocated to the municipalities[6]. Despite its short lifespan, it is possible to find articles that mention the implementation of some types of NAISF[9,10].

The proposal for interdisciplinary support was brought back in 2007, with the debates being led by a working group proposed by the MH. After intense discussions, the control group understood that the said team model and specialized back-up, focused on the support function and on thematrix support would enable a broader scope of care[6]. In the following year,Decree 154/2008 was published, which created the NASF[2].

2nd period: 2008 to 2011 – support guidelines

With the creation of the NASF, the MH was able to create the NASF according to its main interests; to define the values to be allocated to the municipalities for the implementation and maintenance of the teams; to make it possible to expand the scope of the intervention in the Basic Health Units (BHU), through the co-management[3] and interaction of the interdisciplinary team with the FHS professionals; and to enable the expansion of the work market for 13 professional units in the health area.

Even though it was derived from the Paidéia theory set forth by Gastão Wagner de Sousa Campos, the key concept of the matrix support, which defines the means of interaction between a support group – NASF – and the reference teams – FHS – is not mentioned in Decree 154. It is believed that this fact may well have been the authors' strategy to diminish the resistance to the proposal in this format, which had resulted from the prior discussions concerning the NAISF. At this time, two groups politically disputed the goals of the team to be created – as a support team (matrix) or as a group of specialists to provide direct care to the users[6]. Despite the omission of the concept, continued education and clinical care for specific cases appeared as actions to be carried out by the NASF, joining the two forces in the same proposal.

As of the expansion of the number of NASFs, the MH began the qualification process of the professionals' work processes. The increase in the scale of the teams in the National Health Facility Registry (CNES) shed light on the need to discuss how these practices had been developed, in part due to the difficulty of operating within the logic of the matrix support[11].

In 2009, the Basic Care Notebook (BCN), number 27 – NASF guidelines was launched. The BCN 27 was presented with the expectation that the publication *can truly strengthen Primary Health Care (PHC) in Brazil, by increasing the knowledge of the teams that work in this area, be they FHS teams, NASF teams, or general management teams*[12] (p. 8). The text seeks to mark the action primarily in a perspective of shared and interdisciplinary work, making it explicit that the individual approach conducted directly with the users should occur *only in extremely necessary situations* (p. 8), seeking to move away from the outpatient model that the inclusion of FHS specialists might suggest.

The BCN 27 points to integrality as the main guideline of the team, as it is of full care provided to users and collectives that it is possible to plan a less fragmented care, anchored in the specific needs of each territory. In addition, it presents and discusses the agreement concerning support functions, the matrix support, the expanded clinic, the single therapy project, and the health project in the territory, defined as necessary technological tools for the organization and development of actions.

In the previous chapters, the publication presented the nine strategic areas of NASF action, with reflections regarding the context of these areas in the national scenario, the policies in place, and their main challenges. Debated were the means of the formulation and agreement on collaborative work within the FHS, integration strategies, and other means through which to insert specialties within BHUs.

In 2010, the country registered an increase in the number of crack users. The "crack epidemic", as it was called by the media, forced the MH to institute diverse measures to tackle the problem[13]. One of these was the creation of another modality of the NASF – NASF 3 – geared toward full care in mental health, focused on crack, alcohol, and other drug users in municipalities with less than 20,000 inhabitants[14]. The typology was revoked in the first revision of the PNAB in 2011[15], with the teams being converted into NASF 2. The NASF 3 returned in 2012, with a different arrangement.

The PNAB of 2011incorporated important changes that were being implemented in SUS, as is the case of NASF. The text included the matrix

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support concept, which appears in four key moments, not necessarily associated with the NASF practice. On the first occasion, the text was based on permanent education and the processes of institutional support, as in one of the "provisions for support and horizontal cooperation"[15] (p. 7). After, the text mentioned the item about the formulation of the workload of the FHS professionals, who can use part of the work shift with permanent education activities and the matrix support. Regarding the attributions of the NASF, the supporter should work by sharing knowledge and health practices, through actions of the matrix support, together with associated teams. Moreover, upon ascribing some functions to the public health official – category recently inserted in the team – the matrix support concept is cited for the 4th time in the PNAB. The text indicates that these professionals "can reinforce the institutional support and/or the matrix support, so long as these are exclusive to them"[15] (p. 16).

Other changes are related to the formulation and work shifts of the centers. New professional categories were included – totaling 19 professions – which became part of both of the NASF typologies. In addition to having new specialties available to them, the municipalities had the freedom to define their arrangement through the choice of the manager. They also established the minimum work shift for the teams and the reduction in the number of associated teams.

Much like the BCN 27, the PNAB reinforced the collective and educational character of the NASF actions. In one excerpt where the activities to be developed are pointed out, the "collaborative care or not" is cited, avoiding the use of the expression "individual care". Once again, the commitment is that of not "outpatienting" the conduct of the specialists, providing a type of action geared toward the pedagogical dimension of the matrix support.

3rd period: 2012 to 2015 – universalization of NASF

In 2012, two decrees were edited with effects concerning the NASF. The 1st updated the variable Basic Healthcare package (PAB, in Portuguese), giving a 1/3 increase in pay for the NASF 2 teams, but maintaining the same values for the NASF 1 team[16]. The 2nd redefined the parameters of the connection of the two modalities of already existing teams and recreated the NASF 3, this time with no connection to the questions linked to drug use and drug abuse[17].

As in the other modalities, the NASF 3 can contain any one of the 19 professional categories established in the last version of the PNAB. However, it should accompany one or two teams, which enables a closer relationship than in other arrangements, "configuring as an expanded team"[17] (p. 3). For the already existing modalities, the decree led to the reduction in the number associated teams: NASF 1, from five to nine teams, and NASF 2, from three to four teams. This reduction was an important movement of the MH in the sense of qualifying the support provided by the NASF, which began to dedicate itself to the follow-up of less teams and users. In addition, the creation of the NASF 3 enabled the universalization of the support to all Brazilian municipalities with FHS or BHU teams for specific populations, regardless of its territorial or populational extension.

In the first semester of 2013, the MH published two decrees on the same day. One increased the valued transferred to NASF 2 by 50%, in addition to allocating the rest to the NASF 3. The other defined the incentive of the 2nd cycle of evaluation of the National Program for Access and Quality Improvement in Primary Care (PMAQ-AB)[19]. This cycle allowed for the adherence of all of the teams to Primary Care and the performance, for the first time, linked to the evaluative processes of the NASF teams throughout the country[20,21].

After having defined the new parameters, the MH once again began to qualify the work process, and in 2014, it published the BCN 39 – NASF – Volume 1: Tools for management and daily routines. If in the BCN 27 the objective was to debate the support guidelines, this second volume presented the "how to do". Its having been launched five years after the implementation of the NASF allowed for the accumulation of experiences necessary to draft the technical material that would dialogue with the practice and that could reflect on the main overlappings in the operationalization of the matrix support[22].

The publication of part of the actions that comprised the agenda of the professionals to contemplate the matrix support, reflecting on the necessary infrastructure and condition for these activities to take place. The structuring elements of the interventions were defined as follows: the meeting of the matrix support; the meeting of the NASF team; the shared and specific individual care; the shared and specific home care; the shared and specific collective activity; and the creation of support materials, routines, proto-

cols, among other actions of permanent education.

The BCN 39 also debates other tools and word strategies, such as work in groups, the genogram, and the ecomap. These are all part of the menu of activities that the technicians can make use of, but these should not be limiting or restrictive in relation to the other possibilities and paths that may arise, such as work by means of addressed demands and with offers from supporters, based on singular situations.

The publication lists some challenges for shared work, such as the lack of training to work under the logic of the matrix support, the multiplicity of demands that are addressed to the supporters, and the lack of knowledge about the different possibilities of NASF actions. It points out suggestions to tackle these questions, be it through meetings and rounds of conversation to reflect on the daily challenges, or as of the direct intervention of the managers to mediate conflicts and impasses.

4th period: 2016 to 2018 – expansion of support

In 2015, an outbreak of cases of newborn children with microcephaly and other genetic malformations attributed to the Zika virus were identified, especially in the Northeast region. Faced the sanitary emergency, the MH authorized Brazilian municipalities to implement NASF teams[23]. The decree required that each team had at least one physical therapist and recommended that it also include an occupational therapist, a phonologist, or a psychologist, relevant professionals in the area of rehabilitation. With these strategies, the decree sought to instrumentalize the FHS to carry out actions of early stimulation and psychosocial support to the families undergoing follow-up.

To subsidize the work of the teams, the MH published the "Early Stimulation in Primary Care" in 2016. The guide affirms that it is up to the NASF to follow-up on family and children, as it is "very important that it also offer, in addition to shared care, specific individual care, according to the agreed therapeutic project"[24] (p. 16-17). The manual illustrates the clinical dimension of health care within the matrix support, which can be understood as a change in the direction regarding the action of the NASF up to that moment. In the final considerations, the publication reiterates the guidelines, signaling the importance of the individual approach in early stimulation, and points out that this type of direct action would not contradict the precepts of the matrix support. In the second semester of 2017, the last review of the PNAB was published. One update accompanied many criticisms, both in relation to the process of construction without social participation, as well as the changes approved and their possible impacts on the weakening of SUS and the privatization of primary care[26,27].

Regarding the NASF, the text contains important changes. The team takes on the name of Expanded Family Health and Basic Health Center (NASF-AB). The concept of "support" was removed, and the adjective "expanded" was added. With the change, the NASF-AB began to provide support to all teams, including the more recently created Primary Health team, a model concurrent with the Family Health.

In yet another careful reading, one can see that in addition to the change of the noun "support", the matrix support concept is also removed from the Primary Health policy. Nonetheless, at the same time in which it is omitted as a concept, the principles of the matrix support are affirmed in the three specific competencies defined in the law. In item "a", co-management appears through collaborative planning together with follow-up teams. Item "b" points to the expansion of the clinic and is able to synthesize the purpose of the action of the support team together with the reference team in order to contribute to the increase in the capacity of analysis and intervention and, consequently, to produce greater coefficients of autonomy. Item "c" lists the different possibilities and types of action, such as case discussions, individual care, the collaborative construction of therapeutic projects, permanent education, and the discussion of the work process, types of intervention that are directly linked to the two dimensions of the matrix support – clinical care and pedagogical.

5th period: 2019 to 2021 – the dismantling of the NASF?

The four previous periods can be characterized as those in which the core aim was the institutionalization of a policy. All of the claims, clashes, and achievements were fruits of a long process of worker, user, and manager disputes, which materialized into the consolidation of the NASF. The 5th and final period, marked by another position taken by the MH in relation to the team, coupled with the thousands of deaths

caused by the SARS-CoV-2 pandemic, brings some uncertainties, which explain the reason for the subtitle in the form of a pessimistic question.

The *Previne Brasil Program*[28], edited in November 2019, established the new model of financing the cost for the PHC, a mixture comprised of weighted capitation, payment per performance, and incentives for strategic actions. The payment per performance is measured through the defined indicators in a specific decree, and for the years of 2021 and 2022, the interdisciplinary actions in the scope of PHC, among others, would be monitored[29].

Regarding the incentives to strategic actions, the program does not include the NASF, which, in practice, extinguishes discretionary financing. In addition, it revokes diverse regulations, among which are Section II of the Consolidation Decree 2/GM/MS, from September 28, 2017, which defined NASF association parameters, such as workloads of the professionals and teams, and the minimum and maximum number of associated teams.

In response to the criticisms, the MH edited the Technical Note 03/2020[30,31], in which it assumed the extinction of the parameters of conformation and financing. It also informed that, according to that set forth in Decree 3.222/19, interdisciplinary team arrangements can be financed through the payment per performance in 2021, as interdisciplinary actions in the scope of PHC. The note indicates that the specialists can be registered together with the FHS team of the PHC team, becoming a fixed and organic member of these collectives.

The final regulation is Decree 37/2021, edited to substitute Decree 99/2020, which redefined the types of PHC teams in the SCNES, including team 72 – Expanded Family Health and Primary Care Center Team (NASF teams-AP)[32,33]. Code72 joins the three NASF modalities, defines another name for the nucleus, and again allows new NASF teams to be registered in the CNES, which had been forbidden by *Previne Brasil*. As of the month of May 2020, the municipalities began their migration to the new code, a process that is still ongoing.

Table 1. The historical-regulatory periods and those of the NASF team.

Periods	Year	NASF team
1st Previous movements	2003 - 2007	
2nd Support guidelines	2008	464
	2009	1,058
	2010	1,415
	2011	1,661
3rd Universalization of NASF	2012	2,046
	2013	3,123
	2014	4,110
	2015	4,559
4th Expansion of support	2016	4,672
	2017	5,266
	2018	5,797
5th The dismantling of NASF?	2019	5,886
	2020	5,592
	2021	5,525

Source: Authors, based on SCNES, accessed on January 20, 2022.

Reflection of the policies concerning the number of teams registered in Brazil

The data from Table 1 were grouped according to the five construction periods of this study. They enable the visualization of the historical-political construction of the team, showing the effects of the policies adopted by the MH since the implementation of the NASF, whether by leading to the creation of more centers – with the creation of NASF 3 – or by producing a reduction in the number of teams, as can be seen in the final period. The months of December of each year were used as the reference.

The numbers show a small growth in the four first years, during a period in which the NASF work proposal was still being presented. The publication of the CNB 27, the courses offered by the MH, and the inclusion of the team in the 1st review of the PNAB of 2011, defined the guidelines for the matrix support and affirmed the NASF as an important Primary Care policy introduced by the MH.

The teams present a more expressive increase as of 2012, the year in which a wide range of relevant decrees were approved, such as Decree 3.124, which changed the NASF 1 and 2 association parameters, and recreated NASF 3; there was a new definition of team financing values in 2012 and 2013; a new BCN was edited in 2014, advancing in the discussion about the challenges and power of the NASF modes of operation.

The onset of the Zika virus and the publication of the PNAB of 2017, which in addition to the change in the name, brought about the expansion of the reach to all PHC teams and maintained the paths of growth and the consolidation of the interdisciplinarity, as of the specific NASF arrangement.

The scenario of expansion and gamble of the MH was interrupted in 2020, after having reached it highest number ever in January 2020, with 5,904 NASFs. The beginning of the fall in the number of teams registered in the SCNES happened together with the changes implemented by *Previne Brasil* and the arrival of COVID-19 in the country.

To analyze the reflections of the two years in place of the new model of financing of PHC, Table 2 and Graph 1 show the monthly variations of the number of NASF teams in 2020 and 2021.

It is possible to observe the gradual reduction in the registration as of February 2020, with oscillations in some months. The biggest drop was seen in May 2020, with the beginning of the migration to the new code – NASF-AP, with 111 teams unregistered. In December 2021, there were 5,525 NASF teams in the SCNES. Considering the two years of operation of the *Previne Brasil*, 379 NASF teams lost their accreditation.

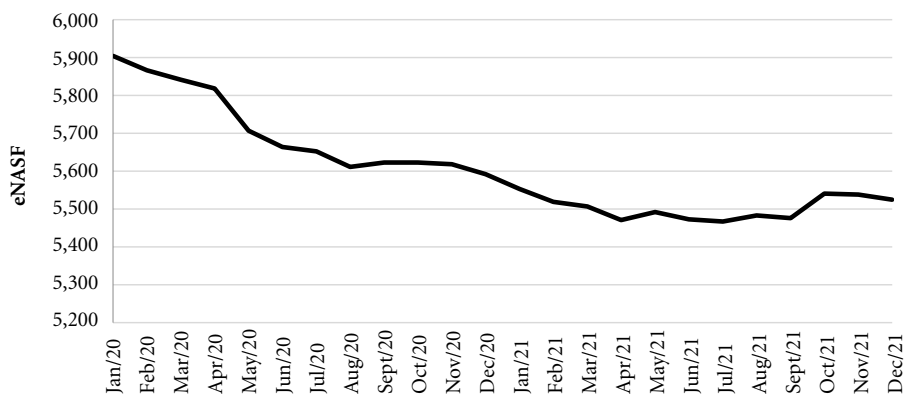
It is important to highlight that Table 2, in addition to the validity of the new model of financing, reflects, as of March 2020, the effects of the COVID-19 pandemic. Measuring the influence of the pandemic and the economic questions that such a scenario involves, such as the reduction in the investments and need for the reallocation of financial resources to other sectors, produces a scenario of a differentiated analysis of other periods.

The supplementary material of this article is available from: https://doi.org/10.48331/scielodata.8PCFOH

Table 2. NASF teams registered in 2020 and 2021.

	NASF1	NASF2	NASF3	NASF-AP	Total
Jan/2020	3,526	1,077	1,275		5,904
Feb/2020	3,526	1,073	1,267		5,866
Mar/2020	3,516	1,067	1,258		5,841
Apr/2020	3,507	1,065	1,246		5,818
May/2020	1,103	392	488	3,724	5,707
Jun/2020	632	234	262	4,536	5,664
Jul/2020	401	166	173	4,912	5,652
Aug/2020	153	47	45	5,366	5,611
Sept/2020	138	37	36	5,412	5,623
Oct/2020	135	33	30	5,425	5,623
Nov/2020	128	30	25	5,435	5,618
Dec/2020	124	28	23	5,417	5,592
Jan/2021	120	26	20	5,387	5,553
Feb/2021	117	24	18	5,360	5,519
Mar/2021	117	24	18	5,348	5,507
Apr/2021	116	24	18	5,313	5,471
May/2021	115	24	18	5,335	5,492
Jun/2021	115	24	18	5,316	5,473
Jul/2021	114	23	13	5,317	5,467
Aug/2021	111	23	13	5,336	5,483
Sept/2021	111	23	13	5,329	5,476
Oct/2021	109	23	13	5,396	5,541
Nov/2021	109	22	13	5,394	5,538
Dec/2021	109	22	13	5,381	5,525

Source: Authors, based on SCNES, accessed on January 20, 2022.



Graph 1. NASF teams registered in the SCNES in 2020 and 2021.

Source: Authors, based on SCNES, accessed on January 20, 2022.

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Discussion

Through the results in the first four periods, it is possible to observe the construction and strengthening of the interdisciplinary arrangement proposed by the NASF. This process began in the expansion of the number of implemented teams, engendering the increase in the scope of the primary care interventions and contributing with the integrality of care provided to the users and the collective groups.

Since the publication of Decree 154 in 2008 until the last review of the PNAB, it was observed that the NASF was expanded to more health professionals; the parameters of association were reduced, bringing supporter and the supported closer together; all municipalities were able to implement their teams with financial backing from the MH, which also was also gradually increased; the managers gained higher degrees of autonomy so that they could shape the teams according to their demands, so long as they observed some key criteria of parameterization.

The BCN 27 guidelines, the first guiding document of the NASF, sought to establish a work directed toward technical-pedagogical actions, providing a new means of interdisciplinary collaboration. However, the resistance of some supporters in attending to care demands may have contributed to a list of questions criticizing the teams[34,35].

The BCN 39 was able to advance in relation to the tension between the individual care and the matrix support. In the entire text, the individual approaches are placed as one of the support dimensions, always connected to a shared care plan, without the use of provisos such as "only in extremely necessary situations", as seen in BCN 27. It is understood that the justification for the use of these expressions was meant to establish a mode of operation that was different from the NASF, especially as regards the traditional forms of referrals. Such movements were guided by pedagogical actions, based on the sharing of knowledge and of permanent education, strategies used to produce the expansion of knowledge and the autonomy of the professionals that participate in them.

In the manual of Early Stimulation in Primary Care, the clinical care dimension becomes a protagonist in the interventions, ever-increasingly demonstrating that clinical actions geared directly to the user are not only part of the scope of actions, but they are also essential and complementary to the matrix support.

Considering the new configurations of the NASF teams-AP, where the manager has total freedom to define the arrangements and formulations, it is understood that these changes can bring risks to the continuity of this interdisciplinary team model, be it related to the criteria to be used in more flexible formulations, or even through the termination of discretionary financing[36,37].

Furthermore, some questions need to be asked: How can high-quality follow-up be offered without minimal parameterization? In the case of professionals being registered directly as members of the FHS team or of the PHC team, would this not be returning to the model prior to the Family Health Strategy, in the molds of outpatient or health centers? What actions of matrix support would these professionals be able to sustain in their daily routines, or do they intend to centralize the interventions only in direct care?

By contrast, the strengthening of the clinical care dimension at the expense of the pedagogical dimension can weaken the processes of clinical reformulation and management, which NASF's mode of operation proposed. The omission of the matrix support concept from the PNAB, the removal of the substantial support of the name of the team, and the termination of discretionary financing incentives suggest an intentional maneuver and coordination toward its dismantling. To achieve more democratic, autonomous, and participative spaces within SUS, the matrix support has lost ground in the health policies of the Bolsonaro government.

Final considerations

This study concludes that in its first two years in place, the *Previne Brasil Program* promoted the dismantling of the NASF, with the reduction of 379 teams, representing a setback to the approximate number of NASF teams that were registered in February 2018. It is believed that the decrees that have been issued since 2019, such as those that modified the means of financing primary care and that changed the registration of the SCNES teams sought, among other purposes, to substitute the NASF for other types of interdisciplinary teams. It is important to note that one of the indicators of the payment per performance, set forth in Decree 3.222/2019are the interdisciplinary actions of the PHC. While the NASF loses funding and the teams are discontinued, other arrangements are encouraged by the MH.

Few active teams have a direct impact on the number of professionals in activity, reducing the capacity of SUS actions when faced with accumulated scenario of millions of people infected by COVID-19, in addition to producing the non-care for those people undergoing follow-up by NASF teams that have lost their accreditation. In the context of a long-lasting pandemic, with the large number of diseases and sequelae resulting from the disease[38], Primary Care will need to create mechanisms of identification and clinical care for these cases[39], many of which will demand interventions from different professional centers, renewing the potential of teamwork. In this light, the NASF represents the strategic arrangement for the multifactorial approach to these diseases – together with the PHC teams – given that the participation of specialists from the social services, physical therapy, nutrition, psychology, phonology, among other categories that can participate in the team, expand the capacity of health units to respond to the new and traditional demands from the many territories within the country.

Regarding the termination of discretionary funding, such initiatives as the Primary Health Care Financing Program of the State of Rio de Janeiro (PREFAPS)[40], which included the NASF in the list of teams financed at the end of 2019, has been contributing in an attempt to maintain the centers, thereby strengthening the FHS teams in the pandemic scenario. In the PREFAPS, the NASF 1 and NASF 2 teams of the municipalities of the Fluminense region of Rio de Janeiro receive monthly financial incentives, referred to as sustainability in the component program. Another incentive – the expansion component – is paid in one single payment for newly implemented teams, functioning in the same molds adopted by the MH before *Previne Brasil*.

Since its creation in 2008, NASF's mode of operation was constantly adapting to the prerogatives of SUS. If in the beginning it was primarily geared toward actions of the matrix support, it was observed that direct care was not contradictory to that set forth in the matrix support. The search for a balance between the two dimensions – pedagogical and clinical care – taking as the starting and ending points the needs from the users and collective groups, produces interventions geared toward expanded and shared clinics, as well as the co-management of health care. Being able to shape the diverse possibilities of intervention is the result of daily construction, conducted through the micro-policy of interdisciplinary work. To achieve this, both teams, supporters and the supported, need to be open to interaction and to new possibilities.

Collaborations

MP Mattos: responsible for the study's creation, analysis, data interpretation, write-up of the article, and approval of the final version for publication. AC Gutiérrez and GWS Campos: responsible for the study's critical review and approval of the final version for publication.

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Article submitted 29/09/2021
Approved 16/05/2022
Final version submitted 18/05/2022

Chief editors: Romeu Gomes, Antônio Augusto Moura da Silva