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Collaborative practices in expanded family health and primary health care centers

Práticas colaborativas em núcleos ampliados de saúde da família e atenção básica

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ABSTRACT
The aim of this study was to analyze the collaborative practices developed by the Extended Family Health and Primary Care Nucleus (NASF-AB) in three municipalities in a health region in Northern Paraná. This is an exploratory study, with a qualitative approach. The methodology included the definition of the locations and participants of the research, participant observation and semi-structured interview, carried out from May to August 2019. This research revealed that NASF-AB professionals developed collaborative practices in their daily work. In this practice, elements such as: existence of common objectives, focus on users, establishment of bonds, recognition of interdependence among team members were identified. Management support and the existence of established spaces for discussion were essential for collaboration. The collaborative practices developed by NASF-AB were products of how workers reinterpret the current rules, being protagonists in their work process.

Keywords: Primary health care. Patient care team. Interprofessional relations. Unified health system.

RESUMO
O objetivo deste estudo foi analisar as práticas colaborativas desenvolvidas pelo Núcleo Ampliado de Saúde da Família e Atenção Básica (NASF-AB) em três municípios de uma região de saúde do norte do Paraná. Trata-se de um estudo exploratório, de abordagem qualitativa. A metodologia contemplou a definição dos locais e participantes da pesquisa, observação participante e entrevista semiestruturada, realizadas no período de maio a agosto de 2019. Esta pesquisa revelou que os profissionais do NASF-AB desenvolviam práticas colaborativas em seu cotidiano de trabalho. Nesta prática, identificaram-se elementos como existência de objetivos comuns, foco nos usuários, estabelecimento de vínculo, reconhecimento da interdependência entre os membros da equipe. O apoio da gestão e a existência de espaços instituídos de discussão foram fundamentais para a colaboração. As práticas colaborativas desenvolvidas pelo NASF-AB foram produtos de como os trabalhadores reinterpretam as normas vigentes, sendo protagonistas de seu processo de trabalho.

Palavras-chave: Atenção primária à saúde. Equipe multiprofissional. Relações interprofissionais. Sistema Único de Saúde.

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INTRODUCTION

In the period of time marked by the expansion of the Brazilian Unified Health System (SUS), the Ministry of Health (MS) created, in 2008, the Family Health Support Center (NASF). It aimed to expand the capacity to respond to most healthcare demands of the population in Primary Health Care (PHC) and contribute to the provision of comprehensive care to the population[1,2].

The establishment of the NASF resulted in the expansion and diversification of the PHC workforce, historically centered on the doctor, nurse and dentist. Between 2008 and 2013, some professional categories that basically did not exist in PHC - such as physical education professionals and occupational therapists, or others that already existed, but without great expression, such as physiotherapists, pharmacists and nutritionists - became part of a healthcare team and rates increased by more than 70%[3]. In 2017, the NASF became known as the Expanded Family Health and Primary Care Centers (NASF-AB), supporting, in addition to the Family Health Teams, also the PHC teams[4].

It is recommended that the organization of the NASF-AB work process be guided by the matrix support framework, through a collaborative relationship with the professionals of the Family Health Strategy Team (FHS) and/or primary care, based on communication and collaborative practices and focused on pedagogical and assistance actions. The collaboration foresees the existence of effective communication and the willingness of professionals to contribute to the work of their peers, which can occur both in the teams and can be extended to other services that make up the healthcare network, defined in this article as "a set of health actions and services articulated at levels of increasing complexity, with the aim of guaranteeing comprehensive health care"[5]. Thus, collaborative practice has user-centered attention as a fundamental axis, based on their health needs, in addition to the relationships among professionals[6].

Regarding collaborative practice, this study used as a theoretical reference the contributions of D'Amour et.al.[7] , who developed a model organized in four dimensions that are interrelated and that can be used to analyze collaboration in complex systems, with heterogeneous forms of interaction between different subjects. This model is based on the proposition that professionals work collectively in order to improve the quality of care for users, but, at the same time, they have unique interests and want to maintain a degree of autonomy and independence.

The first two dimensions involve relationships between individuals and refer to: 1) shared goals and vision, which consist of the existence of common goals and their acceptance by the team, the recognition of divergent reasons and partnerships, and the diversity of definitions and expectations regarding collaboration; 2) internalization, which is related to the professionals' awareness of their interdependencies and

the importance of managing them, it translates into a feeling of belonging, knowledge of each other's values and discipline and mutual trust.

The other two dimensions involve the organizational scenario, which influences collective action, as follows: 3) formalization or structuring of care, which refers to the existence and use of documented procedures, which contributes to clarifying expectations and responsibilities; 4) governance that refers to the leadership functions that support collaboration. It guides and supports professionals in carrying out innovations related to interprofessional collaborative practices.

The interaction between these four dimensions is able to integrate the processes inherent to collaboration. It is important to note, however, that these processes are subject to the influence of external and structural factors - such as resources, financial and political restrictions - that must be taken into account as determinants of collaborative processes[8].

Although the matrix support proposal has a collaborative characteristic, based on the logic of co-management and support for interprofessional relations[2], national studies reveal factors that interfere in the integration between these teams, such as the different dynamics and forms of work organization, different productivity requirements, different demands for population care, different action priorities between NASF-AB and FHS, and difficulty in understanding the work of NASF-AB by members of both teams[9,10]. Furthermore, international studies, aimed at investigating interprofessional work, also report challenges related to collaboration between workers, citing communication difficulties, training processes that do not encourage integration with different undergraduate courses and aspects related to the difficulty of sharing workspace[11.12].

Thus, it appears that the studies presented point to challenges and weaknesses in the NASF work process, finding, as a research gap, studies that explore the potential of these teams' work. The analysis of the collaborative practices developed by the teams contributes to the identification of elements to support the planning of actions in the field of healthcare work management, contributing to the strengthening of the NASF-AB, the municipal administrations and the PHC. Therefore, this article aimed to analyze the collaborative practices developed by the NASF-AB teams in municipalities that are part of the 16th Regional Health, in the northern macro-region of Paraná.

METHODOLOGY

This is an exploratory study, with a qualitative approach, carried out in three municipalities of the 16th Regional Health of the northern macro-region of Paraná. All research participants were professionals who were part of the NASF-AB teams in three municipalities, named by the letters A, B and C. The methodological path taken for this study included the definition of the

research sites and participants; participant observation; and semi-structured interview.

For the definition of the locations and participants, questions were asked by a key informant, represented by the coordinator of Primary Health Care of the 16th Regional Health of Apucarana, who had knowledge of the work of the NASF-AB teams in the municipalities integrating this region. We sought to identify NASF-AB teams from the region that, in the coordinator's view, stood out most in their work process for carrying out practices in an integrated manner.

Municipality A, with a population of 2,844 inhabitants[13], had a Basic Health Unit (UBS), a FHS team and a NASF-AB modality 3 team, composed of a nutritionist, a physiotherapist, a psychologist and a social worker. The latter, being on leave at the time of data collection, did not participate in this study. In this UBS, two nurses worked, who also played the role of general coordinator of the unit and coordinator of the NASF-AB.

Municipality B had a population of 10,601 inhabitants[13] and three UBSs, with three FHSs. The Expanded Family Health and Primary Care Center (NASF-AB), classified as modality 2, consisted of a physical education professional, three psychologists, a social worker and a nutritionist.

Municipality C had a population of 134,996 inhabitants[13] and 28 UBSs, six Support Units and 41 FHSs, divided into four quadrants. The municipality had three teams of NASF-AB modality 1, composed of physical education professionals, physiotherapists, nutritionists and psychologists, with four workers, on average, per team, totaling 13 professionals. Each NASF-AB team was responsible for seven to eight UBSs and had an itinerant schedule, rotating between the different units. Questioning was carried out with the NASF-AB coordinator in this municipality to define which NASF-AB team would be part of the research, and the one that, from the manager's perspective, was most prominent in their work process would be selected.

Therefore, ten NASF-AB professionals participated in the study, three from municipality A, four from municipality B and three from municipality C. Then, participant observation of the activities conducted by the selected NASF-AB teams was carried out from June to July 2019, during one week of operation of each NASF-AB team, totaling 52 hours and 30 minutes of observation. The observation was made by one of the authors who works as a tutor for the family health residency and, therefore, knows the daily work processes of the FHS and NASF-AB. In addition, she was guided by a semi-structured script, contemplating the observation about the use of technological tools by NASF-AB professionals for support; whether health education actions are carried out; team meetings among NASF-AB professionals, and between these and the FHS; whether the actions developed by NASF-AB are discussed with the FHS and whether there is co-responsibility for

care; whether there is evaluation and monitoring of the actions taken; the professionals' attitude towards teamwork and whether there are innovative strategies in planning or conducting clinical-care and technical-pedagogical actions. The elaboration of the script was guided by ministerial documents[1] and references of collaborative practices[2,6,7]. Observation data, including statements and expressions by other professionals and users, were organized in a field diary, thus favoring the description of facts, impressions and informal conversations.

An individual interview was also conducted with each of the ten NASF-AB professionals selected, guided by a semi-structured script containing the following questions: How is the relationship among the NASF-AB professionals and between them and the FHS? How is the NASF-AB team's work agendas elaborated? How are activities planned and carried out by NASF-AB? How is the relationship between management and NASF-AB (coordination, secretary, mayor)? What tools are used in an attempt to offer comprehensive care to users and families? Is there collaboration in the work of NASF? How does it manifest?

The script was previously tested with NASF-AB professionals who were not part of the analyzed teams. The interviews were conducted from July to August 2019, and the interviewees were identified as E1, E2, E3 ... E10.

For data analysis, the discourse analysis method proposed by Martins and Bicudo[14] was used, covering two moments. The first consisted of an individual or ideographic analysis, carried out in each of the statements. The units of meaning were extracted, interpreted and, then, the convergences of those having the same interpretation in the interviewee's discourse were carried out. The second moment corresponded to the nomothetic analysis, which consisted of understanding and articulating the various individual cases in something more general, looking for present divergences, convergences and individualities. Thus, it was based on general interpretations for the construction of the analysis categories[14].

This research complied with the precepts contained in resolution 466/2012 of the National Health Council[15], and was submitted to and approved by the Ethics Committee in Research with Human Beings of the institution to which the authors are linked, under No. 3,093,051.

RESULTS

Of the ten NASF-AB professionals who took part in the study, three participants were nutritionists, a social worker, two physiotherapists, two psychologists and two physical education professionals. As for professional training, seven workers had graduate degrees, six of whom participated in a course to work in public health and/or NASF-AB.

This study revealed that NASF-AB professionals were able to develop collaborative practices in their daily work, which were manifested in the context of

individual care, home visits, in the planning and execution of collective activities and in articulation with the intra and inter-sectoral care network, which constitute categories of analysis, detailed below.

INDIVIDUAL ACTIVITIES AND HOME VISITS

The workers of the three municipalities analyzed had a relationship of interaction and collaboration, both with each other and with the FHS, triggering other professionals to discuss cases, whenever they realized this need.

> *Yesterday I saw a patient, but I identified another problem with another family member. So I told the social worker what was going on, and he suggested what could be done to help this person (E7).*

> *I have a lot of contact with people here at this UBS. So when they need you to make an appointment or visit, they talk in advance (E8).*

The excerpts above indicate the existence of a bond established between the professionals and the recognition of the interdependence between the team members in the management of certain cases. This implies that workers are aware of the performance of each professional category and establish a relationship of trust that allows them to share the responsibilities inherent to users, as evidenced in the participant observation of the activities performed by NASF-AB professionals.

> *I followed a home visit by the nutritionist, based on a case discussed with the CHA (Community Health Agent). After delivering assistance, the professional returned to the UBS and talked to the nursing assistant about the need to change the urethral catheter, and also requested the monitoring of this case by the NASF psychologist. In a second moment, already in the NASF room, the nutritionist commented with the social worker about a case, and the two professionals arranged a shared home visit for the afternoon. [...] The team's CHA and the physical education professional arrived at the NASF room. The two then started a conversation about the need for dental treatment for a user, and commented that, according to the nutritionist, this same child needed to gain weight (Observation note - municipality B).*

In the daily work, there are problems, situations and variability that exceed the protocols, norms, techniques and that need to be managed by the worker in order to fulfill his/her objectives. In municipality B, most NASF-AB professionals had exclusive physical workspace, moving to the territory whenever necessary. Thus, in order to cope with the demands imposed by daily life and ensure integration between both teams, the

workers positioned themselves, made micro choices and established alternatives for maintaining effective communication and more collaborative work. Considering this reality, in order to facilitate the exchange of information, increase interaction between workers and reduce the fragmentation of care, communication mechanisms were agreed between supporters and FHS teams, via cell phone (call and WhatsApp).

> *It [communication with the FHS] does not have an hour to happen. So when we need it, we get in touch by cell phone, or go there, or they come to us (E6).*

In this same municipality, NASF-AB professionals felt as an integral part of the FHS, accessing them whenever they needed to. Likewise, according to the interviewees, FHS workers had free access to supporting professionals and to the NASF-AB's installed structure.

> *We look for them [FHS] regularly when there is a need, and they also look for us. [...] I am happy when they arrive, they sit, because I always say that the space is ours, in the same way that we arrive at the UBS and want to sit down. It is not because I "am visiting your unit": it is my unit too! We are also part of that (E4).*

The statements indicate the presence of a feeling of belonging on the part of NASF-AB professionals in relation to the FHS, translated by the perception of fluid communication, free access and interaction between both teams, despite the NASF-AB being allocated in an exclusive physical structure.

In municipalities A and B, NASF-AB professionals reported that they were able to carry out shared activities in their work routine and recognized the importance of this element, since *"this technique strengthens the team, providing the patient with the best result (E4)"*.

The consultations took place both among NASF-AB professionals and between them and the FHS. Generally, decision-making regarding the performance of shared activities was agreed upon within the framework of the matrix meeting, but it also occurred in the work routine, whenever this need was identified by the team members.

> *We have already agreed in the matrix that when it is a patient who needs nutrition as well as when it is a social problem, then we already arrange it and the nutritionist and I make this visit together (E4).*

> *I also go to the visit with the nurse when we realize that we need it, I go with the nursing technician who will sometimes make a dressing... (E7).*

The use of the matrix meeting to discuss the demands and jointly define the need to carry out shared activities is an important formalization tool. It allows for the exchange of information, the establishment of agreements and the

negotiation of how responsibilities will be shared.

The performance of shared activities among NASF-AB professionals in municipality C was hampered by the fact that they have different working hours in each UBS.

> *We are unable to make a shared visit because we are not together at the unit at the same time, due to lack of room, lack of space (E8).*

Even with conditions that did not favor interprofessional work, the professionals of the same team agreed in their daily evaluations of the evolution of users referred to specific collective activities, allowing to verify if the objectives initially set were being achieved, monitor the resolution of cases, as well as rethink other forms of intervention.

> *Whenever she [physiotherapist] refers [users to the physical activity group], she asks how the evolution is going, how the patient is feeling. Their evaluation is monthly, they do their anamnesis right and if there are any unsolved problems, I talk to the physiotherapist again and then she refers them to a Clinic or medical consultation if necessary (E10)*

Thus, the physical education professional performed an individual monthly assessment of the participants in the physical activity group, later discussing the results with the physiotherapist.

COLLECTIVE ACTIVITIES

In general, NASF-AB professionals from the three municipalities analyzed reported the development of collective activities shared with the FHS, which were planned together during team meetings. Most of these initiatives were manifested in the actions and campaigns proposed by the positive agenda of the Ministry of Health.

> *Always on dates like pink October (The Breast Cancer Awareness Month), blue November (prevention of prostate cancer), yellow September (suicide prevention campaign), we always do something together [NASF-AB and FHS]. It is always done in the vaccination campaign as well. We always have Bolsa Família weighing. The PSE [Health in School Program] we always do together too (E7).*

> *Together with the teams, within the events, we do some actions. So we discuss, depending on the topic, how it will work, so we can work together (E10).*

Although such collective activities involve the interaction of NASF-AB and FHS professionals in their planning and execution, during the observation of a matrix meeting, in which there was a discussion to carry out one of these actions,

it was found that they were guided by an agenda established by the federal level, in a vertical manner and often unrelated to the needs of the population.

It is important to highlight, in municipality B, the initiative of NASF-AB professionals to develop alternatives to the specific groups generally required by management.

> *So we worked with specific groups: diabetic group, hypertensive meetings, weight loss group or overweight and obesity group. And then, I especially have to give credit to a nutritionist, she said: "oh, but aren't we focusing too much on the disease, instead of thinking about health"? And then we challenged each other at the matrix meetings, discussing with the teams, we said: let's unify some groups in the units. But let's work on what: quality of life group. Are there particularities within the collective activity? There are, there will be the diabetic patient, the hypertensive patient, the obese patient. But then their treatment, their care, their monitoring, will be differentiated. So we changed the logic and in that logic the discussion was with the teams (E4).*

When professionals took the initiative to make changes in the configuration of collective practices, they were able to change the logic of care, previously focused on the disease, to the model with a focus on users' needs.

ARTICULATION WITH THE INTRA AND INTERSECTORIAL NETWORK

The existence of interprofessional collaboration was also manifested through the articulation between NASF-AB and the intra and intersectoral network. In some moments, this interaction was mediated by the reference team: *Here in the city, we can articulate very well* [with the network]. *Especially with Education staff and Social Assistance staff (E4).*

In the context of municipality A, the development of an intersectoral project between the NASF-AB nutritionists and education, entitled "Healthy growth", stands out. The project is based on the high demand for children with overweight and malnutrition identified in the Municipal Centers of Early Childhood Education (CMEI) and schools in the municipality.

During the field observation, a meeting was held to agree on these interventions, in which the two nutritionists, the NASF-AB coordination and the municipal education and health secretaries participated. It was noted, on this occasion, that the agreements involved the formalization of the collaboration processes through the registration and clarification of the responsibilities of each actor involved in the project.

It was also noticed that the managers present supported and helped in directing the activities to be developed - contributing, for example, to the definition of the period and duration of each intervention, the establishment of alternative work schedules

for professionals, since one of the axes requires them to work at night, and how this could be inserted in the political pedagogical project of the school.

In municipality A, the existence of periodic meetings involving the NASF-AB and the intersectoral network was evidenced.

> *We do it once a month, between social assistance, the tutelary council, healthcare professionals, and we invite the people from the other unit as well. And the schools: the nursery, the municipal school and the high school (E2).*

Generally, the presence of NASF-AB occurred through the representation of the professional category that has a greater affinity with the topics to be addressed in the discussions. According to the interviewees, these meetings contribute to the integration between the services and with the possibility of responding in a timely manner to the demands presented by the territory, in addition to enabling the planning of actions articulated between the services.

DISCUSSION

This study demonstrated the development of collaborative practices by NASF-AB professionals. They permeated the four dimensions of collaboration proposed by the model of D'Amour et.al.[7], in different contexts of performance of the analyzed teams.

The results showed the presence of a bond and interdependence between NASF-AB workers and between them and the FHS, through the discussion of cases among professionals, especially when the performance was related to individual activities and home visits. These elements are essential for collaborative work and are included in the "internalization" collaboration dimension, proposed by D'Amour et.al.[7].

Studies reveal that the bond, commitment, interest and welcoming attitude towards the team's requests contributed to the NASF-AB[9,10] work process. A systematic review study showed that collaborative practices are favored in teams whose professionals have a shared vision and objectives and feel part of it[16].

This was also pointed out in a survey carried out by Bispo Júnior and Moreira[17], in which the FHS, as they did not feel supported by NASF-AB professionals, disregarded them as belonging to the team. The way in which the relationship between the FHS and NASF-AB occurs, both in individual and collective activities carried out in a shared way, has the ability to interfere in the feelings of interdependence and belonging inherent to the dimension of internalization[7].

The existence of formal and periodic spaces for discussion between the NASF-AB and the FHS is related to governance as a dimension of collaboration, since it favors dialogue, the participation of professionals

and the building of a link between them, providing the opportunity to list the best conduct to solve each case[7]. The possibility of discussing cases among the supporting professionals and between these and the FHS in the daily work process is consistent with the matrix support logic, which is the basis of NASF-AB's work. For Barros et.al.[8], the matrix strategy requires the exchange of knowledge and information, making it possible to adjust expectations and make decisions. The appropriation of this proposal implies availability, trust and collaboration, in addition to the establishment of horizontal relations between professionals, elements that could be observed in the teams analyzed by this study.

In municipality B, where NASF-AB professionals had exclusive physical workspace, communication mechanisms with the FHS were agreed. This initiative is related to the "Governance" collaboration dimension, since it supports innovation in order to guarantee dialogue and the bond between professionals[7].

Similarly, the study by Silva et.al.[18] pointed out that devices capable of guaranteeing the FHS's access to the NASF facilitated the organization of work, the workers' personal telephone being the main means by which the FHS activated these professionals in unforeseen events. In this way, such technological resources can facilitate the interaction between both teams and contribute to a more collaborative work[19].

The ministerial guidelines recommend the performance of shared activities as part of the NASF-AB[1] work process, promoting the exchange of knowledge and practices, in an attempt to break with the model centered on disciplinary and fragmented actions. Respondents from municipalities A and B reported the development of shared activities in their work routine. However, in municipality C, professionals reported difficulties in carrying out shared activities, with a gap between the work provided for in the norms that guide NASF-AB and the work actually carried out, influenced by the context in which NASF-AB professionals in municipality C are inserted.

A review study on the macro and micropolitical factors that influenced the work of the NASF points out that the lack of adequate infrastructure, related to the availability of physical space for the work of NASF professionals, as well as the insufficient supply of material resources, interfere negatively for the interprofessional work[20], a reality found especially in municipality C.

Seaton et. al.[11] highlight that the performance of PHC professionals in the same physical space can offer greater opportunities for interprofessional collaboration. According to D'Amour et.al.[7], the increasing complexity of health problems requires knowledge, contributions and participation from each of the team's professionals.

Thus, collaboration requires healthcare workers to be interdependent at

the expense of autonomous action, based on a common desire to meet the user's needs. This brings us to the concept of expanded clinic, insofar as it points to the perspective of the transformation of individual care, which allows other aspects of the subject to be understood and worked by healthcare professionals[21], demonstrated in this study by the use of matrix meetings for the joint discussion of the demands and conducts to be carried out based on the users' needs, as well as by carrying out activities shared between NASF-AB professionals and these with the FHS.

The interaction between professionals, focusing on user care, points to an expanded perspective of health care, which refers to the integration of promotion, prevention, health recovery and rehabilitation actions, encompassing the inter-professional articulations and between the various actors in the healthcare network. Thus, collaborative practice has user-centered attention as its fundamental axis, based on their health needs, without reducing the dimensions of pathology and physiology[22].

In municipality C, periodic assessments of the evolution of users referred to specific collective activities were made. In this sense, the importance of establishing evaluation as a specific activity in a process of critical reflection, with the capacity to promote the reorientation of practices, insofar as it helps in decision-making based on its results, supporting the negotiation for the renegotiation of conducts or their maintenance[1] is evidenced. These results can be associated with the collaborative processes in the dimension "vision and shared goals"[7], related to the existence of common goals between these two NASF-AB professionals (physiotherapist and physical education professional), with the establishment of partnerships between them, focusing on guidelines and care centered on users.

Systematic review study, produced by Mulvale et. al.[16], suggests that interprofessional PHC teams that have a shared vision and objectives have greater opportunities to improve collaboration, regardless of the organizational or political context in which they operate.

The interviewees of the present study referred to the development of collective activities planned and carried out jointly with the FHS in the framework of the matrix meeting. Most of these activities are associated with campaigns proposed by the federal level and are often different from local demands. For the development of collaborative work, the promotion of care centered on the needs of users must be the primary objective among team members[7].

Still in relation to collective activities, this study identified, in municipality B, the reorganization of these actions by NASF-AB in conjunction with the FHS, shifting the focus of attention to the needs of the user. Thus, when taking the initiative to make changes in the logic of care, previously focused on the disease, to a user-centered model, they played a collaborative leadership role, shared among team members, involving the participation

of all in the dialogues and making decisions about the new configuration of groups[7].

This study pointed out the existence of articulation between NASF-AB and the other services that integrate the intra and intersectoral network. Similarly, the study by Sousa et.al.[23] revealed that the networking meetings helped the interpersonal knowledge of professionals from different teams, improving integration between workers from different services, creating spaces for communication and favoring information exchange and the adjustment and sharing of therapeutic strategies.

Reeves et. al.[24] highlighted that, although teamwork has been the dominant concept in the last two decades to designate effective interprofessional practice, networking is an important additional concept for this practice. In this sense, collaborative network can be very effective for users, especially in the context of primary health care in which clinical work is, in general, predictable, relatively non-complex and not urgent.

Other authors also emphasize that the presence of effective communication - between NASF-AB, FHS professionals and other workers in the intra and intersectoral network - proved to be an important factor for the work process and the planning of joint actions between these actors[8,9,18].

Studies show that interprofessional collaboration results in organizational improvements and benefits to patient care in different health services[25], particularly those with complex needs[16], contributing to a more collaborative work based on the needs of users.

In municipality A, during a meeting to agree on the development of an intersectoral project - between the NASF-AB nutritionists and education, the NASF-AB coordination and the municipality's education and health secretaries - the management support for action planning and organization, which defines the dimension of collaboration related to governance[7] was observed.

The commitment of the local manager in relation to matrix support and the NASF is decisive for the interprofessional work of the teams[9,26], which was confirmed in the results of this research, regarding the articulation between NASF-AB and the intersectoral network involving health and education managers in municipality A. In this sense, directionality and support by local management is essential for the development of collaborative activities based on the demands of each territory, since managers must negotiate priority activities and evaluate interaction between NASF-AB and FHS[27].

CONCLUSION

Analyzing the collaborative practices developed by the NASF-AB teams in municipalities that are part of the 16th Regional Health, it was found that they occur in the daily work of the NASF-AB teams, both among themselves and with the FHS. Such practices were expressed in

individual care, home visits, in the planning and execution of collective activities developed within and between sectors.

The interpretation of the practices performed by NASF-AB allowed to analyze that the collaborative practices are manifested in the four dimensions proposed by D'Amour: shared objectives and vision, internalization, formalization and governance. The existence of shared goals and visions with a focus on users was evidenced in practices involving joint decision-making among professionals, focusing on guidance and care centered on users. At the time when case discussions were held, it was possible to identify the presence of bond and the appropriation of matrix support by workers, linked to availability, trust, collaboration, establishment of horizontal relationships and interdependence between NASF-AB professionals and these with the reference team, characterizing the internalization dimension.

The governance dimension was verified by the support and direction of the management, as well as the existence of instituted spaces for discussion, elements that proved to be fundamental for interprofessional collaboration. The dimension of formalization, on the other hand, was expressed by the operationalization of matrix meetings, allowing the exchange of information, the establishment of negotiations and the registration and clarification of the responsibilities of each actor involved in a given action.

It is pointed out that the development of collaborative practices was shown to be more favored in small municipalities, which integrate NASF-AB teams, modality 2 and 3. This is probably due to the fact that they support a smaller number of FHS and that the supporting professionals are allocated daily in the same physical space, contributing to the interaction between workers and strengthening the bond. In the large municipality, the performance of collaborative practices proved to be difficult for NASF-AB professionals to have different working hours in each UBS.

It is noteworthy that this study explored the power of the worker, in order to develop collaborative practices considering their singularities and the context in which they are inserted. It was possible to verify that, in certain situations, the collaborative practices developed by NASF-AB professionals were renormalized, according to the context and the available infrastructure, with workers being protagonists in their work process.

It is concluded that this study elucidates determinant elements so that the collaborative practice occurs between professionals of NASF-AB and FHS in the context of PHC. It is noteworthy that collaborative practice is an important condition for PHC to fulfill its role of fully serving users and the population of the territory, articulating actions for the promotion, prevention, treatment and recovery of health.

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