DEMANDS, CONSTRUCTIONS AND CHALLENGES EXPERIENCED BY OCCUPATIONAL THERAPISTS IN PRIMARY HEALTH CARE

Demandas, construções e desafios vivenciados por terapeutas ocupacionais na atenção primária à saúde

Demandas, construcciones y desafíos vividos por terapeutas ocupacionales en la atención primaria de salud

Original Article

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ABSTRACT

Objective: To understand the demands, constructions and challenges experienced by occupational therapists in primary health care in Fortaleza city, Ceará, Brazil. **Methods:** This is a qualitative study conducted with 13 occupational therapists of the Support Centers for Family Health. It used the focus group method in March 2011 at the headquarters of the Regional Council of Physiotherapy and Occupational Therapy – 6th Region. After the thematic analysis of the material, with theoritical contributions of occupational therapy and collective health, the following categories emerged: construction of work processes; demand and assisted population; contributions and challenges of the occupational therapists. **Results:** It could be observed that occupational therapists encouraged teams to perform joint actions through health promotion activities for priority groups and created room for planning the construction of comprehensive care between healthcare teams and users, highlighting the challenges of the territory as a space for interdisciplinary achievements, where the problem resolution requires sensitivity and recognition by the professional categories in field. **Conclusion:** It is understood that diversities and specificities inherent to the territory relate to the needs, and the community daily routine, in addition to the field stresses, counters the team work logic, implying fragility in the actions of supporters.

Descriptors: Occupational Therapy; Primary Health Care; Family Health Program; Health Promotion.

RESUMO

Objetivo: *Compreender as demandas, construções e desafios vivenciados por terapeutas ocupacionais na atenção primária à saúde, no município de Fortaleza-CE.* ***Métodos:*** *Trata-se de um estudo de caso com abordagem qualitativa, do qual participaram 13 terapeutas ocupacionais dos Núcleos de Apoio à Saúde da Família. Utilizou-se a técnica de grupo focal, em março de 2011, na sede do Conselho Regional de Fisioterapia e Terapia Ocupacional - 6ª Região. Após a análise temática do material com aportes teóricos em terapia ocupacional e saúde coletiva, emergiram as seguintes categorias: construção dos processos de trabalho; demandas e população assistida; contribuições e desafios dos terapeutas ocupacionais.* ***Resultados:*** *Pode-se afirmar que os terapeutas ocupacionais sensibilizaram as equipes para ações conjuntas mediante atividades de promoção da saúde a grupos prioritários e criaram espaços de planejamento para a construção da integralidade da atenção entre equipes de saúde e usuários, explicitando os desafios do território enquanto espaço de conquistas interdisciplinares, quando as resoluções dos problemas exigem sensibilidade e reconhecimento das categorias profissionais em campo.* ***Conclusão:*** *Entende-se que diversidades e especificidades inerentes ao território estão relacionadas às necessidades, e o cotidiano comunitário, juntamente com os tensionamentos no campo, contrapõe-se à lógica do trabalho em equipe, implicando em fragilidade das ações dos apoiadores.*

Descritores: *Terapia Ocupacional; Atenção Primária à Saúde; Programa Saúde da Família; Promoção da Saúde.*

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RESUMEN

Objetivo: *Comprender las demandas, construcciones y desafíos vividos por terapeutas ocupacionales en la atención primaria de salud en el municipio de Fortaleza-CE.* **Métodos:** *Se trata de un estudio de caso con abordaje cualitativo en el cual participaron 13 terapeutas ocupacionales de los Núcleos de Apoyo a la Salud Familiar. Se utilizó la técnica de grupo focal en marzo de 2011 en la sede del Consejo Regional de Fisioterapia e Terapia Ocupacional – 6ª región. Después del análisis temático del material con aportes teóricos de terapia ocupacional y salud colectiva, emergieron las siguientes categorías: construcción de procesos de trabajo; demandas y población asistida; contribuciones y desafíos de los terapeutas ocupacionales.* **Resultados:** *Se puede afirmar que los terapeutas ocupacionales sensibilizaron los grupos para las acciones conjuntas mediante actividades de promoción de la salud para grupos prioritarios y crearon espacios de planeamiento para la construcción de la integralidad de la atención de los equipos de salud y usuarios, destacando los desafíos del territorio en cuanto espacio de conquistas interdisciplinares cuando las resoluciones de los problemas exigen sensibilidad y reconocimiento de las categorías profesionales en campo.* **Conclusión:** *Se entiende que las diversidades y especificidades inherentes al territorio están relacionadas a las necesidades y el cotidiano comunitario, en conjunto con los problemas en el campo, se contrapone a la lógica de trabajo en equipo, contribuyendo para las fragilidades de las acciones de los que apoyan.*

Descriptores: *Terapia Ocupacional; Atención Primaria de Salud; Programa de Salud Familiar; Promoción de la Salud*

INTRODUCTION

The Family Health Strategy (FHS) was implemented in 1994 aiming to strengthen the Brazilian primary health care (PHC). Originally named as a program, such initiative became the main tool for the reorganization of the Brazilian National Health Care System, also known as the Unified Health System (*Sistema Único de Saúde – SUS*) [1].

The concentration of efforts and investments on the implementation of the FHS resulted in the establishment of the main health care program for the Brazilian population, currently present in 5,325 of the 5,560 municipalities of the country with a total of 32,930 Family Health Care teams[2,3]

Despite the successful expansion, the FHS faces some difficulties in the implementation of integrated care, accountability and the bond between professionals and users in certain situations. Studies point out obstacles that may be hindering the consolidation of the FHS. They are: the lack of professionals, input and structure; the poor training of professionals; prejudice against simple technology; excessive demand, especially in urban areas; problems in other levels of complexity, such as infrastructure, etc[4-6].

This scenario pointed to the need to reorganize the work of the FHS and enabled the introduction of new methodologies, technologies and professional categories. The Family Health Support Centers (*Núcleos de Apoio à Saúde da Família – NASF*) were instituted by the Ministry of Health in 2008 through the Governmental Order No. 154[7]. They aimed to support the insertion of the FHS in the health care system and expand its coverage, problem-solving capacity, territorialization and regionalization, and the PHC actions in Brazil. NASF became the first public health policy to include the occupational therapist in primary health care. At that time, the work of such professionals was mostly performed in tertiary health care[8].

In PHC, the occupational therapy has the challenge to face the specific core of action (activity, occupation) in the setting in which it is inserted, according to social and health determinants that interfere with their work and routine, in order to solve problems concerning such aspects. The object of the professional specificity – human activity – needs to be in line with non-traditional therapeutic practices that have been experienced by the country's occupational therapists after their inclusion in NASF[9].

NASF professionals should offer matrix support to Family Health Care Teams in order to provide them with specialized backup (care and technical/pedagogical). Matrix support is one of the tools for the implementation of the work processes of the NASF, along with the Extended Clinic program (*Clínica Ampliada*), Singular Therapeutic Project (*Projeto Terapêutico Singular - PTS*), Territory Health Care Program (*Projeto de Saúde no Território – PST*) and the Support Agreement.

The first experiences from NASF performance have started arising slowly in the literature[10-12] and they already point to questions, contributions and limitations concerning the implementation of this new policy, such as: difficulties in the integration between the NASF and the Family Health Care teams; adjustments in the coordination of work processes; questions concerning the existence of individual care provided by the NASF teams; prevalence of collective practices, among others.

In Fortaleza, considering they were inserted in the Family Health Multiprofessional Residency Program from 2009 to 2011, it was possible to follow up the process of inclusion of NASF occupational therapists in health care units. After that, many questions emerged: How did therapists approach the Family Health Strategy teams? What has the occupational therapist done? Which activities have been performed? Which demands are referred? How do occupational therapists cooperate within this context?

Thus, this research aimed to understand the demands, constructions and challenges experienced by occupational therapists in PHC in the City of Fortaleza, Ceará.

METHODS

This is a qualitative case study[13,14] conducted in the city of Fortaleza, Ceará. Fortaleza is administratively divided into six Regional Executive Secretariats (*Secretarias Executivas Regionais – SERs*) and has approximately 2,447,409 inhabitants[3] assisted by 265 Family Health Care teams and 22 NASF teams[2].

Initially, the professionals in charge of continuing education of each SER were contacted to talk to NASF occupational therapists. However, only 13 out of 22 therapists agreed to participate in the study.

Data were collected using the focus group technique. First, the participants answered a questionnaire with open and closed-ended questions that enabled the characterization of the subjects[15]. After that, a script containing guiding questions[16] was used to facilitate the focus group and promote discussion on the issue, and, through group interaction, produce data and insights that would be more difficult to access outside an interactional context[17]. The focus group was held in the headquarters of the Regional Council of Physiotherapy and Occupational Therapy – 6th Region (*Conselho Regional de Fisioterapia e Terapia Ocupacional da 6ª Região*) in 2011 and included the researcher as the facilitator and two observers for the conduction of the research.

Focus group was planned according to the following phases: a) first, a meeting with the facilitator and observers was conducted in order to present the observation guide and divide tasks; b) a script with guiding questions was used for the facilitation of the focus group; c) after the meeting and participation of individuals, they received a certificate and a letter thanking them for their contribution[18].

The content of the recorded and transcribed reports focus on NASF professionals' perceptions and their relationship as a team, the needs and demands concerning the work, the field requests, the most assisted population groups and the most common activities carried out.

The reading material was skimmed and organized according to the registration units and context. This helped to meet – through a pre-analysis – the validity norms such as the exhaustiveness, relevance for the research proposal and homogeneity. After that, the material underwent a detailed reading, and the units of meaning that popped up in this process were removed[15] and then grouped according to the dialogue between the theoretical presuppositions and the empirical content in a central category entitled "occupational therapists interventions at the Family Health Care Support Centers".

The research is in compliance with the Code of Ethics for Research Involving Human Subjects of the National Health Council and Resolution 196/96. Data collection started after approval from the Research Ethics Committee of the University of Fortaleza (*Universidade de Fortaleza – UNIFOR*) through Process No. 342/2010.

RESULTS AND DISCUSSION

The group of 13 occupational therapists participating in the research had previously worked in private institutions, the public health care system or in the tertiary health care level. Time of graduation ranged from 2-6 years, and only two professionals had more than 15 years of experience. Regarding professional qualification, only one participant had not attended a specialization program, i.e., such professionals were specialized in gerontology, psychomotricity and fields relating to collective health.

The findings revealed three thematic categories: (1) construction of work processes; (2) demands and assisted population; and (3) occupational therapists' contributions and challenges in NASF.

Construction of work processes

The National Primary Health Care Policy[19] draws upon the principles of universality, integrality and equity in order to clarify and regulate the work processes, the accountability, professional attributions and the characterization of the work of FHS teams in an interdisciplinary way so that both individual and collective demands are met.

To do so, occupational therapists used strategies to approach Family Health Care teams and support their work without being the service gateway for the user[20]. Some of these strategies were the creation of actuation instruments and protocols, tools for requesting specific categories, folders containing a summary of their jobs, among others. Supporters tried to encourage the teams and raise awareness of joint-actions through health-promoting activities for priority groups. They also provided the teams with an opportunity for planning and invited them to develop joint-visit programs that were performed by Community Health Agents (CHA). This is illustrated with the following reports:

> *"We've had four meetings [...]. We created a folder explaining the NASF." (OT 13)*
>
> *"We explained the NASF in each and every unit; we talked about the Governmental Order, all the professionals, what each professional would do. Twice, we've done this twice." (OT 1)*
>
> *"We need to have the FHS requesting us because we cannot be the gateway. Therefore, if the FHS does not know about our work, we get stuck. (...) And I think NASF - the way it was developed – fails to do so (...)." (OT 7)*

This reality highlights a power relationship that contrasts with the findings of a study on matrix support[21] that showed that the relationship between supporter and supported one must take place horizontally so that they can work together on problem-solving. Regarding the interaction with the Family Health Care teams, the professionals observed that some teams feel threatened by the changes in a space that has already been established. In this case, they refer to practices limited to programs focusing on health care. In their opinion, a support program is considered "more work", as it can be drawn from the following reports:

> *I see that, many times, some teams feel threatened (...) by us. We come around proposing something and all we hear is 'No... it won't work. No, we're not gonna do that. No, we're not gonna work with that.'" (OT 2).*

The opposition grows when NASF teams include, in the integrated care, demands that are not usually inserted by the Family Health Care teams like mental health care. Therefore, it was noticed that part of the users do not receive this type of care because they are not referred to the Psychosocial Care Centers (*Centros de Atenção Psicosocial – CAPS*).

> *"Concerning mental health, there is a big opposition to the provision of care for this population. But they are there, and they are not referred to the CAPS, and they are in the territory; they are many times neglected and many times abandoned or left out with medication only, and it's really complicated." (OT 7)*

A research on matrix support in mental health care[22] has also found a similar scenario in which supporters reported that the reference teams used to avoid the contact with psychological pain. They explained that this omission was caused by the insecurity resulting from the lack of qualification in mental health and the difficulty to intervene outside the objective field of procedures and medication therapy.

According to NASF professionals, a joint intervention only occurs when one proposes some action for priority groups that are already defined by programs of the Ministry of Health. Thus, team's adherence to these actions is more likely to happen, as it can be observed through the following reports:

> *"There is a demand involving the Bolsa Família [Brazil Anti-Poverty Program – Family Allowance]. Therefore, the professional in charge of it asks for help with that group of people because he has to meet the demand. (...) Since its his duty, (...) he wants help, because there are a lot people to take care of." (OT 4)*
>
> *"(...) Something nice was that the FHS team in charge of this demand [leprosy] surprisingly embraced the NASF team. The request comes straight from the doctor." (OT 12)*
>
> *"When the team already has a program, we are well accepted. But when we see that there are other demands and (...) they are not met, (...) they are not followed up, then there's rejection." (OT 7)*

Due to the difficulties to perform this teamwork, the relationship between supporter and supported one is hindered by the conflicts. Thus, due to the initial barriers, NASF teams tend to define their work priorities according to the positive response of each team, as it is highlighted in the following report:

> *"The unit that was more difficult to work in was less receptive, therefore, people used to go to that unit less often. (...) The ones with a better user's embracement received more people, so the professional and the category were more devoted to it" (OT 4)*

This scenario reflects an interdependence between the work of both teams (FHS and NASF teams) in such a way that the work process in NASF can be stopped because of this relationship. Attitudes like those go against the logic of teamwork, shared accountability and qualified listening – practices that are essential for the employment of the matrix support proposal[23].

Demands and assisted population

According to the occupational therapists assessed by this research, the professionals who mostly requested support by NASF teams and were more open to work collaboratively were the CHA and nurses. Besides them, professionals of the Medical Residency and the Family Health Care Multiprofessional Residency programs along with FHC coordinators and professionals from community health services also requested help from NASF.

Thus, one must understand, *a priori*, that the demand for NASF occupational therapists has somehow been elected by the service, taking into account the condition that it should not become a gateway[20]. Thus, before analyzing the daily actions of NASF professionals, it is important to understand that the demand is also socially constructed, and it is – in one way or another – related to the health care service profile and the way knowledge production and the relationships between workers and users occur[24].

According to the professionals assessed by this research, there are different demands depending on the work shift: in the morning, there is a predominance of individual care and in the afternoon, there is a higher demand for group and collective actions. This is a result of users' will to take up actions and the diversities of territories that influence the changes in the community profile.

In this research, the populations assisted by NASF occupational therapists are mainly those that have been historically established by the FHS within its care program, i.e., they are enrolled in primary health care priority programs such as diabetes, hypertension, leprosy, childcare and the new proposals like the Evaluation for Quality Improvement (*Avaliação por Melhoria de Qualidade – AMQ*) and the Health at School Program (*Programa Saúde na Escola – PSE*), besides home visits and actions performed outside the FHC, like the extramural campaigns.

Regarding the performance, the professionals assessed also reported the tension between practices focused on clinic expansion and light technologies and the reductionist practices focused on the biomedical model and hard technologies. When NASF professionals start to deal with demands in a different way, some professionals and the community – who trust and reproduce the curative and biomedical model – show resistance.

> *"(...) Our country has been used to a curative model for a long time. [...] Then, you come up with a different proposal, people frown... There is also that thought: it's the medicine, it's the medicine..." (OT 2)*
>
> *"The professional wanted to give her some antidepressant because she was really weepy, didn't know what to do, and we kept inviting the lady to participate in the group Cuidando do Cuidador (Taking Care of the Caregiver). But the professional insisted on giving her the antidepressant." (OT 4)*

The professionals assessed by this research reported that the work tended to focus on the doctor and the technologies. This means that the care is still using the resources from machinery and medicines, i.e., the hard technologies[24].

This finding has also been observed in another study[25] on NASF practices which highlighted the need to discuss with users and their family the request for medicalization and hence strengthen autonomy and shared accountability.

With regard to the high demands for occupational therapists, one should consider the historicity of building the profession; however, other demands have emerged in this scenario. There is a predominance of the following fields: childcare (child development follow-up, children considered "hyperactive" – a term that is widely used to characterize a child who is agitated or badly behaved, most of the times without a diagnosis – and impaired children); people with motor impairments; cerebrovascular accident sequelae; users with leprosy, dementia, depression and other psychic sufferings; elders; actions relating to worker's health, drugs and violence.

> *"At the units, we are often requested to follow up childcare [psychomotor development]." (OT 9)*
>
> *"Groups of elders always think of the NASF, especially the occupational therapist (...) well trained, well prepared during college years" (OT 10)*
>
> *"(...) We follow childcare and patients with dementia very often. (...) We give them support, a very good support (...)." (OT 1)*
>
> *"Children, many children with motor impairments, CVA sequelae". (OT 4)*

In general, the responses given to users are centered on matrix support (medical appointments and joint home visits), the planning of collective actions with the Family Health Care teams, development of therapeutic groups (relating to mental health and worker's health), the *Hiperdia* program (collective actions conducted with people with diabetes and hypertension), the *Cuidando do Cuidador* program (directed to community caregivers, elders and smokers) and the workshops (production, memory and functional conditioning); in addition, other actions are conducted in the waiting room focusing on health promotion, autonomy, integrality and equity.

It can be noticed a tendency to advance within this community perspective. The professionals interviewed in this research characterized their relationship with the community based on a live territory, with identity, beliefs, costumes, potentialities and its own dynamics. The work of the occupational therapist meets the population needs and requires an understanding of a work that discloses the social determinations experienced, tries to discover revolutionary forms and shows the contradiction and the conflict of health in a class society[9].

Contradictions and territories of conflict are also part of the daily routine at NASF. Violence and the negative impact on work processes were mentioned. The professionals participating in this research reported that violence and illegal drug trade in the communities where they work hinder extramural activities, such as home visits, and even the access to the FHC. Moreover, in places where the situation is more critical, the community rejects professionals and care provided by the Family Health Care team.

> *"[...] There are communities there that can't go to the health care center because they can't cross that zone." (OT 5)*

Although violence is acknowledged as a factor that prevents the access to the territory, this issue was little explored as a public health concern that involves social determinants in the communities.

Contributions and challenges of occupational therapists in NASF

The professionals assessed in this research believe that the biggest contribution of occupational therapists to NASF is the broader view of the concept of health, since they correlate historical, occupational, social and cultural elements to the daily routine established by families, taking into account the contexts, but respecting individuals' singularities. Thus, they are able to help the team with technical and scientific aspects of the profession in the care and matrix support, keeping identity aspects of the community.

> *"We don't look at that person with the disease only. We see leisure, what she's doing. When we make these observations, the other professionals, in the other visits, in the matrix support meetings, naturally start to notice such things, and we get to know what is best for the patient." (OT 11)*

Other important factors are the abilities required in the group work, including knowledge of planning, operationalization and group assessment, which are set as an essential strategy in primary care. Additionally, the professionals demonstrate empathy with the multiprofessional team because they realize they are subjects of the same process and able to perform intersectoral actions in the daily routine.

> *And I see (...) that the greatest advantage of occupational therapy in primary care is that we know how to work in group, [...] but also (...) develop groups in the health care center and the community. (OT 7)*

A work that shares knowledge becomes an essential action of the expanded clinic, for it is an intermediation of sociopolitical, cultural and economic vectors in the same plane of immanence[25].

However, individual care appeared as a major challenge, since the category receives complex clienteles for which the guidelines are not enough and therefore require a long-term therapeutic follow-up. Thus, professionals must have abilities and competences to properly refer the user to other complexity levels of SUS.

This issue has become controversial in the first studies published about NASF. The program guidelines recommend that direct and individualized care should be performed only in extremely necessary situations[20]. Researchers[12] question and interrogate about the creation of the normative statement that allows the professional to bond with users and become their care reference.

Such matters have already started to settle disagreements concerning policy-making in the country, since the direct interventions performed by NASF run the risk to become a specialty outpatient facility and, on the other hand, be distant from the user and out of context, addressing the problems collectively only, without acknowledging and responding the singularities and needs of each user. The last problem can be as serious as the first one since integrality, set as the primary guideline to be followed by NASF[20], assumes the bond between professionals, users and the community.

In Fortaleza, according to the professionals assessed by this research, the consultations occur in a focal manner. Generally, initial assessments are carried out and then the patient is referred to a specialized service if necessary. Many factors prevent consultations from happening within this framework, such as absence/lack/deficiency of material, proper setting for specific consultations, and time, as there are high demands in all FHC.

It is important to note that, in addition to the reflection of the historicity of the category in the demands and activities received, there is also a targeting of actions and views according to the experience of each professional, who bring previous experiences of their professional practices to the universe of primary care.

However, it is interesting to think that every work activity is always a "meeting" that brings together the history of technical devices, the life history of the subject who performs the activity, the protocols, and a particular way of utilization, whether personal or collective, referring to the combination of natural individuals with unique histories[26].

This multiplicity of experiences can positively influence the care practice setting in primary health care. However, it will only be considered a contribution when placed in the context of the needs of users and teams. It is clear that the reproduction of alienated and limited practices that are out of the context of the local reality jeopardize the FHS.

Still, with regard to the work performed by the occupational therapist of NASF, attention can be drawn to the way the service is provided and the social reproduction of the service – a factor that may have impelled the creation of NASF – which had not been made explicit until then and refers to a possible rationalizing nature of the policy.

> *"Since the beginning, when there was the preparation course, (...) it was highlighted that the NASF proposal is*

not to work individually, it's not to bring demands to the center. Moreover, we stay in four, five centers. So, if you start performing individual consultations in the center, the demand is going to increase, and you won't manage it. What's gonna happen next? They're going to say that the center is not providing care, that there are professionals but things don't work. The proposal is to work in groups, with the community... so this demand does not need to come to the center." (OT 6)

It is believed that guidelines are interpreted in a reductionist way, implying on issues that can undermine the real actions performed by the support teams. Thus, elements need to be clarified. First, the individual (user) must be the object of care of NASF and Family Health Care teams; individual follow-up of the case is suggested by the guidelines as long as its need is discussed and the implementation agreed. In more complex cases, it is suggested the development of the singular therapeutic project for both individual and collective subjects. Secondly, it is believed that the need to work collectively in order to meet the demands found in the FHS results from the fact that they are considered collective health problems[9]. Therefore, the groups and the understanding of collective demands cannot be seen as "rationalizing procedures of cost-effectiveness" for a population lacking access to health care. Thirdly, the NASF and FHS teams share the accountability concerning users and territories. These teams should, together, recognize the great variety of health-related needs and provide resources to address them[20]. Thus, the demands cannot be neglected by the teams; they should rather be met taking into account the health-related needs of the population of the territory where they work in.

It is also necessary to understand that the needs are individually felt but biologically and socially determined. Its attention is a sign of its recognition[27]. Therefore, it is necessary to identify the professional action of the occupational therapist in the group work, especially based on a materialist conception of history, which understands that group work may be the means by which, through practice (praxis), one can move from a level of social adaptation – through the development of potential skills – to a level of possibilities of social network, transgressing the boundaries of what is considered possible towards a possible exercise of what is right[9].

Based on this need, if the team realizes that the quantity of professionals working in the service is too small to meet the big existing demand, this need should be made visible so that it can be met through public policies. The minimum number of teams linked to a NASF team was questioned by the professionals who alleged the difficulty to bond and give proper answers in the few moments of joint construction.

FINAL CONSIDERATIONS

This investigation enabled the approximation to the constructions and challenges experienced by occupational therapists in the PHC in the city of Fortaleza, Ceará.

The reports helped understand that the construction of the work process of this professional category in the NASF was complex, mainly because of the need for an approximation with Family Health Care teams. Within this context, the attempt to perform a joint work faced some resistance since the areas of practices and power were already constituted. Adaptive strategies and dialogue were used in order to soften the tensions established and find new possibilities of performance.

Since then, the occupational therapists started being requested to help with certain demands that sometimes reproduced the profile of users assisted by FHS programs and constantly replicated the historical demand of patients assisted by this profession. The expansion of such demand has become necessary just like the intimate relationship between social contexts and health.

Regarding the contributions and challenges, it could be observed that the broader concept of health – when correlated to historical, occupational, social and cultural elements of life build by families inherent to the contexts but preserving the singularities of the subject – provides occupational therapists with differential features to work in primary health care in an interdisciplinary way. Besides the skills required for group work, the group planning, operationalization and assessment facilitate the communication between teams and health care users.

It is believed that the biggest challenge for NASF and occupational therapists is the reductionist interpretation of the guidelines, implying matters that can undermine the real actions developed by the support teams, such as the development of the singular therapeutic project for both individual and collective subjects. Another point is the work with groups and the understanding of collective demands that cannot be seen as "rationalizing procedures of cost-effectiveness" for a population lacking access to health care. Health care teams should recognize the shared accountability concerning users and territories, and the variety of health-related needs in order to provide resources to address them.

Given that, based on the solicitudes of a complex field such as collective health, there is a need to think about the changes imposed by the training process of occupational therapists, showing the importance of changes made in their curriculum so that they can promote integral care and professional action in NASF. In this context, the role of continuing education in the service is indispensable to the construction of knowledge along with those who are already inserted in the program.

Finally, the limitations of this research should be highlighted. Since it is a case-study conducted with a professional category in a municipality setting, it is impossible to make generalizations about the theme. However, there is a need to carry out investigations aimed at assessing the NASF from the team's point of view, including perceptions of other settings, in order to broaden the understanding of this recent proposal.

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