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Práticas transversais do Apoiador Institucional em territórios de produção de saúde

Cross-sectional practices of the Institutional Supporter in territories of health production

Prácticas transversales del Apoyo Institucional en territorios de producción de salud

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RESUMO: O trabalho de Apoio tem cumprido um papel relevante, que pode ser assumido de distintas formas e em diferentes coletivos. Pretende-se, neste ensaio, apresentar a experiência do Apoiador Institucional e seu fazer na rede de saúde da cidade de Campinas, São Paulo, Brasil. Serão discutidas, mais especificamente, a prática de apoio que vem sendo desenvolvida junto à Rede de Atenção Psicossocial e algumas estratégias utilizadas pelos profissionais para desempenhar esse trabalho pioneiro. Nesse sentido, destacam-se ações como a discussão de casos, a realização de atendimentos compartilhados e o acompanhamento de visitas domiciliares como ferramentas fundamentais do trabalho desempenhado pelo Apoiador Institucional. Busca-se compartilhar a prática que atravessa essa experiência por meio da apresentação de um relato de caso articulado pelo fazer do apoiador. Com base nas concepções dos pensadores da diferença, essa experiência foi cartografada aos moldes de uma narrativa e nos permitiu constatar o caráter transversal do trabalho do apoiador e a potencialidade de produção de redes presente nessa prática.
Palavras-Chave: Gestão em Saúde, Apoio ao Planejamento em Saúde, Saúde Pública, Saúde Mental, Relatos de Casos.

ABSTRACT: The work of Support has fulfilled a relevant role that, which can be assumed in different ways and in different collectives. It is intended, in this essay, to present the experience of the Institutional Supporter and its work in the health network of the city of Campinas, São Paulo, Brazil. It will be discussed, more specifically, the practice of support that has been developed with the Network of Psychosocial Care and some strategies used by professionals to carry out this pioneering work. In this sense, actions such as the discussion of cases, the accomplishment of shared care and the follow-up of home visits as fundamental tools of the work carried out by the Institutional Supporter are highlighted. It seeks to share the practice that goes through this experience through the presentation of a case report articulated by the work of the supporter. Based on the conceptions of the thinkers of difference, this experience was mapped to the model of a narrative and allowed us to verify the transversal character of the work of the supporter and the potential of network pro-

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duction present in this practice.
KeyWords: Health Management, Health Planning Support, Public Health, Mental Health, Case Reports.

RESUMEN: El trabajo de Apoyo ha cumplido un papel relevante que puede ser asumido de distintas formas y en diferentes colectivos. En este ensayo, pretendemos presentar la experiencia del Apoyente Institucional y su hacer en la red de salud de la ciudad de Campinas, São Paulo, Brasil. Discutiremos más específicamente la práctica de apoyo que viene siendo desarrollada junto a la Red de Atención Psicosocial y algunas estrategias utilizadas por los profesionales para desempeñar ese trabajo pionero. En este sentido, destacamos acciones como la discusión de casos, la realización de atendimientos compartidos y el acompañamiento de visitas domiciliarias como herramientas fundamentales del trabajo desempeñado por el Apoyente Institucional. Buscamos compartir la práctica que atraviesa esa experiencia por medio de la presentación de un relato de caso articulado por el hacer del sostenedor. Con base en las concepciones de los pensadores de la diferencia, esa experiencia fue cartografiada a los moldes de una narrativa y nos permitió constatar el carácter transversal del trabajo del apoyador y la potencialidad de producción de redes presente en esa práctica.
Palabras clave: Gestión en Salud, Apoyo a la Planificación en Salud, Salud Pública, Salud Mental, Relatos de Casos.

"Unlike the information, the narrative does not aim to convey the pure essence of the thing, like information or a report, it sinks the thing into the life of the storyteller, in order to bring it out of him again. Thus traces of the storyteller cling to the story the way the handprints of the potter cling to the clay vessel". (free translation)
Walter Benjamin

INTRODUCTION

The Strategy of Support in Health Networks

The implementation of the Support Strategy in Public Health is in line with other efforts to build a participative and shared work process in the SUS, such as Team Meetings, Health Councils and Administrative Collegiate. Therefore, it is understood that the Support allows the construction of a field of problematization on the traditional forms of relationships existing in the world of work and the preconceived truths about the modes of illness and treatment offered to the subjects[1].

Because it is an innovative proposal, the conceptual guidelines and application of this strategy have been developed by many authors, such as Pena[2], Oliveira[3], Dors[4] and, especially, by Campos[5], who unfolded this proposal from the construction of the Paideia Method and the proposal of Co-management of Collectives[6].

In this sense, the Support aims to strengthen a practice that collectivizes and broadens health actions, becoming a differential in the implementation of care networks. Thus, in a complementary way to the other fronts that compose health practices, the supporter is expected to actively follow the strategic actions performed by the teams. It is believed that the privileged spaces of intervention of the supporters are the territories where workers and users are inserted, since these are the places where it is possible to recognize and intervene "in ato" about the models of assistance provided to the users and on the process of work performed by health teams[2].

According to Oliveira, "the object of work of the supporter is the work process of collectives that organize themselves to produce health. (...) It operates in 'a border region between clinic and politics, between care and management' – where these domains interfere with each other'" [3].

Thus, it is fundamental in the work of Support to recognize that care actions are crossed, also, by a field of virtualities, where one can recognize processes of imaginary construction of the act of caring and of the forms of care. An example might be the user who insists on doing a radiography, as if it was the determining act, or marker, of being taken care of. The supporter, in this case, needs to be warned that there is an imaginary construction of demands. It is an operation where the imaginary registers cross the virtual plan to the real plan, updating in the field of the symbolic that is a vehicle of privileged expression in human relations[7].

According to FRANCO AND MERHY, the user, "by demanding the procedure is accessing at an imaginary level, that symbolic universe that gives broad meaning to the procedure, attributing to it a potentiality that it does not have, which is to produce care for itself"[7]. This operates in the same way for workers and their work processes, as they are often recognized only as referrers

or process providers, which are often not very resolvable and based only on the medical techno-assistential model.

This way, "we have been realizing, therefore, that the imaginary production of demand is a social-historical construction that has its genesis in the way the techno-assistential models for health were constituted"[7]. Therefore, the demands that are addressed to the supporter should be understood as the analytical elements through which it can also access the dynamics of users and health teams.

It is understood that it is from the reception and analysis of the demands that it can build the means of intervention, new covenants and agreements that can be articulated with the objective of forming an institutional environment that provokes the capacity of invention of other technologies of work and care production.

In this sense, it is recognized that the practice of the Supporter has a multicentric perspective, since its action has scope both in the dimension that deals more directly with the production of care technologies that better meet the needs of the users; as well as in the dimension of expanding the analytical and operational capacity of health teams and networks, since it causes them to operate in a more creative, inventive and fluid way[4].

DEVELOPMENT

The strategy of support applied in the city of Campinas/SP

In the city of Campinas, the Health Network (SUS) undergoes an experience of the Support Strategy at both the district level (called Institutional Support) and at the local level (called Matrix Support). The composition of these models of the Support Strategy has been debated both by the health network and by universities, where many researches have been developed with the purpose of deepening the theoretical knowledge about these practices, as well as evaluating the scope of its operationalization in the network SUS Campinas[2-3-4-8.]

The Support Matrix is a strategy that had great adhesion of the Network of Psychosocial Attention of Campinas, to the detriment of other specialties of the area of health that have experiences still quite timid. In the field of Mental Health, this practice has become popularly known as "Matrix-based strategies" and has been performed by the professionals of the different services of the network.

"Matrix-based strategies" meetings, in general, happen through discussion meetings of cases; debates on mental health issues and shared care, that can occur in the unit or through home visits conducted together. Most teams point to "Matrix-based strategies" as a significant action for services, considering that there was a greater approximation between the realities of the different

units, as well as a broader understanding of the need to break with the fragmentation of care and create work strategies to the full attention of users[4].

With regard to Institutional Support, this takes place through the constitution of a multidisciplinary team located at a management level. The team of Institutional Supporters is usually composed of highly experienced professionals, both in their areas of concentration and in public health policy, and is led by a director who is responsible for monitoring the work of the Sanitary District.

The municipality of Campinas is divided into five Sanitary Districts coordinated by the central management of the Municipal Health Department. Each district is responsible for a set of neighborhoods, with specific epidemiological characteristics, that mark with their specific characteristics the singularity of each district. The epidemiological characteristics of each District are usually used as an instrument in the construction of diagnoses of intervention on each territory.

In this sense, it is the responsibility of each Sanitary District: to plan both the implantation and the operationalization of the health equipment of its territory of comprehensiveness; monitor the work carried out in the territories through joint actions and the production of health indicators; and to articulate with the Municipal Health Secretariat the human and material resources necessary for the effective and qualification of the services rendered to the population.

With regard to the work of the Institutional Supporter in the field of Mental Health, it is also the responsibility of the Administrative Collegiate of the area among other Municipal Forums that discuss specific themes of Mental Health, contributing both to the development of municipal public policies and to the dissemination of the debates for the services of their district territory, provoking with them critical discussions that increase their capacity of analysis and prominence in the local, interinstitutional and intersectoral actions.

In addition, it is important for this professional to be present in the daily life of the facilities of his district, promoting meetings with both Primary Care teams and specialized Mental Health services, such as CAPS III, CAPS Ad, CAPS-i, Therapeutic Residential Services, Income Generation Workshops, Coexistence Centers, among others. The movement of the Supporter in this network is of fundamental importance for the formation of bonds with the teams, as well as for the elaboration of institutional diagnoses and the production of qualified interventions[2].

However, sustaining an active presence in the services is not an easy task and requires a great capacity for planning, since the agendas of the Supporters are usually filled with diversified demands often coming at the last minute, both by the Municipal Health Secretariat and the units that are under your direct reference. Thus, the schedules of activities of the Institutional Supporters are true cartographic maps that can, even, express interesting data about the current context of

health services in their territory.

Thus, the work of the Institutional Supporter in Campinas happens through a type of practice that occurs in a kind of border between the clinic and the management. Acting alongside the teams, mainly from demands of articulation of very complex cases or embarrassing situations, the supporter is invited to experience constant challenges with the teams. Each new demand that is presented to the Supporter brings with it a novelty that updates the need for continuous invention of health practice, and the more the professional in this role is open and willing to this field of creation, the greater its capacity of composition with the teams that he/she accompanies[3].

It is common for this work to be triggered by a request for a case discussion meeting. However, it is important to note that the teams expect the supporter not to place themselves in a supervisory role of the work they perform, but, rather, as a collaborator who features shared actions, joints with other unknown or ignored devices, worn by the repetition of practices and fraught with the tension of handling complex situations[1].

In this sense, it is conceived that the practice exercised by the Institutional Supporter can qualify the care management from the construction of a network of attention that the collective work, articulated by the action of support, agency and composes. In this experience, the logic of referral is questioned, once an offer of coproduction of care is made for the health teams, in addition to a continuous support of this professional external to the team, which reinforces the network of care articulated to and with the users.

It is important to emphasize that, although, in this paper, the practice of the institutional supporter in the field of mental health is being discussed, it is understood that support is not a restricted role to the Institutional Supporter, but rather a strategic function that can be assumed by other health workers. Therefore, this support-making may have different institutional counts, especially if it is taken as an event that goes through the meetings of health production[5].

Through the narrative of an analyzer case1, it will be tried to elucidate some of the strategies that can be used by Institutional Supporters in the daily life of their work. It was aimed that through a narrative it would be possible to map more intensively the movements undertaken by these professionals with the workers and users of the territorial services, as well as to map their practices in order to share this work with other professionals and researchers.

It is believed that this way of discussing the work of the Institutional Supporter is a privileged method of constructing health research, since it captures a picture of the network taking place. The case narrative, therefore, presents the meetings of the teams with the real needs of the population of the territory, constituting a regime of light that shows the difficulties, fragilities and complexities that affect the processes of health promotion.

Ana's case as an analyzer instrument of the practice of support as a marginal strategy of health production[3]

Mrs. Ana was about 60 years old and had recently lost her husband. She had been abandoned by her eldest daughter, who would have been in charge of the care of the family at her father's request. Ana had a history of previous psychiatric hospitalizations and was, currently, living with one of her children, who was around 30 years old and had a diagnosis of Intellectual Disability and alcohol abuse.

The user presented, since the death of her husband, a more uncompensated clinical picture (Diabetes and Hypertension) and had difficulties to feed herself, since the daughter left home with a significant part of the financial resources of the family, derived from the benefit left by the father. The Family Health Team responsible for Mrs. Ana's care had already tried a number of strategies, in order to follow the health of the user and promote better living conditions. Home visits for follow-up guidance on Diabetes and Hypertension were frequently carried out; linkages with neighbors to aid in medication and feeding administration were also attempted, but the community also reported to the team its limitations.

Mrs. Ana remained with difficulty in the treatment. Linkages with other services have also been attempted, however, there have been few advances to provide some assistance in relation to daily care needs. Mrs. Ana's family problems caused greater difficulties for her health, worrying the neighbors and the health team about the risks of death to which the user was being submitted. Thus, the process of worsening of her health conditions constituted a tension field between neighbors and staff, who, faced with the difficulty of finding other resolution strategies, opted to request the Public Ministry to shelter the user in an institution for the elderly to guarantee their clinical follow-up.

Considering the condition Mrs. Ana was in and considering that she was hospitalized in a Psychiatric Hospital, the determination issued by the judicial body, in consonance with part of the management of the Health Department, defined that the patient should be referred immediately to new hospitalization in a mental health institution. It was at this moment that the Supporter was activated in the strategy of articulating care of the case by the team of Institutional Supporters of the Sanitary District responsible for the region where Mrs. Ana lived. The request made to the Supporter was to accompany the team of the Center for Psychosocial Attention (CAPS) reference in conducting the referral of Mrs. Ana to the hospital where she would remain hospitalized.

However, the construction of an adequate referral for this demand could only be outlined by the Supporter after some home visits were made to the user in conjunction with the teams of the Basic Health Unit (BHU) and CAPS. Through home visits, it seemed to the supporter that Mrs.

3 The case presented is a fictitious case based on the stories gathered by the experience lived in the monitoring of many cases in which the authors of this article acted as workers and supporters of the mental health network of the city of Campinas-SP.

Ana needed a more intensive follow-up that would meet her needs in the face of aggravated health, both clinically and mentally, but he believed that this work could be carried out in territorialized services, and there was no technical justification for doing so through a psychiatric hospitalization.

It is believed that the active involvement of the Institutional Supporter with the case in question was determinant for it to produce a proper and qualified positioning on the actual needs of the user in question. The technical orientation built by the supporter through the actions that he co-produced with the health teams needed to be strongly sustained during the meetings that defined the construction of the therapeutic project of the case. It was perceived, in the course of the meetings, the presence of divergent speeches between the teams involved, as well as diverse intervention demands that tended from the definitive and immediate institutionalization of the user to the non-recognition of the necessity of a health measure for the case, an argument that was justified on the basis of the social problematic prominently expressed by the case in question.

The linkages that facilitated the conduct of this case by the Institutional Supporter involved both meetings with the Legal Department of the Municipal Health Department and the Public Ministry and meetings with the teams of the Basic Unit, the CAPS and Social Assistance technicians of various levels of complexity. In articulation with the CAPS, the Supporter constructed the insertion of Mrs. Ana in a bed-night vacancy, in response to the request of the patient for psychiatric hospitalization. Mrs. Ana was then placed in the CAPS, where she was welcomed and evaluated, starting to participate in therapeutic workshops and receiving care from a multi-professional team. Her comings to the service were guaranteed through the articulation with the Social Assistance network, which provided a transport to take her. With regard to clinical care (hypertension and diabetes), the Basic Health Unit continued to follow up the user through consultations and home visits. Thus, on the days when the patient went to the CAPS, her medications (clinical and psychiatric) were made by the CAPS team, and on the days that Mrs. Ana was in her home, the neighbors and the Basic Health Unit gave her this support.

In partnership with the teams of the various services and the management of various levels of the Secretariats of Health and Assistance, as well as with the Public Prosecutor, we worked under the tension of responding to the institution without losing the possibility of building an instituting that would problematize guidelines for conducting this case, in particular, those arising from medical and legal discourse.

Therefore, when it comes to a historical moment, in which Compulsory Admissions reappear as an alternative to solve complex situations of diverse social vulnerabilities, the work of the Institutional Supporter can print in the action of the various actors a mediation that produced another understanding and direction of care9. This work enabled, yet, a process of coproduction of a clinical, psychosocial and care intervention to be carried out, guaranteeing the premises of a territorialized and free mental health care.

In addition, through the case of Mrs. Ana, the relationship between the teams of Primary Care, Specialized Attention in Mental Health (CAPS) and the territorial Social Assistance network was progressively re-signified. The successive trials of approach and contact between the services were mediated by the figure of the supporter, who collaborated so that the distorted impressions and the fantasies constituted between the teams were dissolved so that the services could reposition themselves on the work performed in the shared cases.

The need for intersectoral articulation has also emerged in the field of team tensioning with respect to the work of the supporter, especially with respect to the current capacity of teams from other public sectors to address the needs of the population. Thus, it was in the play of forces between the limits and the possibilities of action of each institution involved with the case of Mrs. Ana that the Supporter was able to explore the existing network, its resources and failures, its powerful points and its stiffening nodes of lines of care.

Passos, Kastrup and Escossia[10] states that what is at stake in the production of health is the construction of a policy that works in favor of life as a power, not entrapment of the desired forms or processes of subjectivation. Thus, the production of deviations as a characteristic trait of the contemporary should guide health practices, diverting the ways of caring for practices that subjugate the uniqueness of existence to certain historical models and norms.

In this way, emphasis is placed on the support strategy as a practice capable of being developed in the transversality of health actions and of being guided by an ethical-clinical-political directive that affirms the difference and the deviant movements made by the users, investing in what the relations of production of care may engender processes of resingularization of existence.

DISCUSSION

The potential of the strategy of support

From the experience reported, it is understood that the practice of support has a strategic place in the composition of a health network, which can be especially leveraged if it can contribute to the construction of a cross-cutting practice that other possible networks and health connections in the intercession of SUS policies, practices and equipment.

In this sense, the support is aligned with the conceptions of Guattari[11] when it claims to be:

> (…) essential that they organize themselves (...) new micro-political and micro-social practices, new solidarities, a new softness coupled with new aesthetic practices and new analytical practices of the formations of the unconscious. It seems to me that this is the only possible way for social and political practices to leave this situation, I mean, for them to work for humanity and no longer for a simple permanent rebalancing of the universe of capitalist semiotics[11].

This way, when producing, as an innovative and transversal practice, the Support can break with the more dual conceptions that still divide the health field, seeking a ressingularization movement of its work process, valuing the creative production of actions that affirm the life potency of subjects seeking care in SUS[12].

Pena[2], from his investigations in the field of Mental Health, considers that:

> (...) to affirm the inseparability between management and clinic is to affirm the management (...) as a practice of care; a practice that seeks to support the process of invention of everyday life that is operated by the clinic. To this end, we must comprehend management as an unfolding of everyday life, a function that takes care of mental health work as a way of creating common spaces or neighborhoods between workers and users of services[2].

Support, therefore, proposes actions with the health teams aiming at the articulation of a larger clinic that bets that management actions are carried out by all the subjects that work in the health network, including the users themselves, that must be taken, also, as comanagers of their therapeutic projects[6].

Thus, the work of the Supporter is conceived as a function of the field of micropolitics of health work that can engender movements and processes of differentiation in the ways of positioning and acting of the teams and other sectors involved in public policies[13].

Through a make-to-do with the demand of institutions, the Supporter opens gaps to other regimes of sensitivity and readability in the subjects that make up the institutions, enabling the work process to be constructed and analyzed collectively, in order to resignify the role and commitment of the teams with the production of integral care.

Often, for the institutions and for the network, the Supporter will be the professional called to the task of "indicating something from outside", being, therefore, an institutional element that carries in itself a paradoxical function of belonging and non-belonging.

However, by moving within institutional boundaries and investing their observation and analysis in the virtuality present in the processes of action and relationship between the different subjects, it is not with "something from outside" that the Supporter will contribute to the work of the teams. It is, rather, "another position" and "another perspective" on the problems experienced by the health teams, which is not of the order of individualization, but rather of the singularity expressed in each demand that reaches the supporter.

Operate changes together with the teams implies that the supporter also creates devices that provoke the subjects to construct other reflections on the problematic experienced and to

actively desire some changes. As devices, one can understand from an analysis of epidemiological data to the creation or reformulation of these traditional institutional spaces, provided that what is created leads to the expansion of dialogue and service changes, favoring collective construction and common production in that territory of action in health.

It is important to emphasize that this is a procedural work, which requires time and investment in building bonds and trust with the teams, so that an opening field is created where resistance movements, prohibitions, themes, actions and veiled relationships can emerge and be worked out[5-14].

The field of action of the Supporter, therefore, is composed of a bricolage of aspects that operate significations and subjectivations in people and institutions involved with complex social problems, which, in most cases, stress the resolubility of current health actions[14].

In the light of the presented case, it is tried to map some of the possible movements undertaken from the work of an Institutional Supporter. It is a worker who, often, experiences a role of putting himself and/or being put in a "no place" because he is not a member of the team with whom he is acting and is also not a member of sectors more effective responses to the actions on which the supporter is invited to act. On the other hand, working together with the teams, through a case-sharing practice, allows the construction of another role, which refers to "that professional who can be with the teams" coproducing a hybrid narrative that, implies a deconstruction about the ways and the expectations that several actors produce on the presented demands.

In this sense, the action of the Support seems to us in line with the proposal of Passos, Kastrup and Escóssia[10] when it is indicated that weaving a narrativity about a case must imply a disassembly operation of the case. The assembly of a case leads to a representation of reality from an external place, while the disassembly operates as an analyzer of the network movements that allows deconstructing naturalized truths. This modality of action seems to us of great importance for the production of health network, as it is carried out in the intercession of the collective making of the teams and contributes to the construction of more shared and collectivized working relations. The intermediation exercised by the Advocate, in this way, modifies the field of relations of strength and knowledge instituted in the health teams and in the multiple institutional arrangements.

The Supporter, therefore, is conceived as a worker whose practice can be a device capable of crossing more sedimented structures of the modes of production of health to create breaches and instituting strategies that favor openings of a means that stimulates the art of inventing forms of singularized care complex situations.

With this, it is believed that the Support can contribute a lot to the construction of health networks, favoring the movement to strengthen SUS and the development of more collectivized

and shared management models. For these reasons, it is understood that the practice of support and the establishment of groups of supporters should be further stimulated by the health policies and networks of all country[6].

FINAL CONSIDERATIONS

If health production, in many moments, has been thought through dichotomous lines that divided it between public policies and health practices, management and care, the health worker and the user, in the daily life of each service, confronts with events engendered in the encounters between people and technologies that are delineated in a singular compound called care. Care as an event is continually crossed by dimensions ranging from social needs, the constitution and modes of circulation and subjectivation of subjects in cities, scientific knowledge and procedures applied to health, to power relations and governmentality[4][15-16] .

In this way, public policies and health practices can be taken as open and transversal devices that are constantly being restructured. It is a field of forces composed of a heterogeneity of elements that experience in the tense encounter between the instituted and the instituting the possibility of producing expressions of what contemporaneity can recognize as technologies of care[12].

In this sense, discussing health production from the perspective of transversality comes in line with the support project of SUS, which, as a universal health model, aims at the construction of public policies and care practices aligned with the struggle for a democratization process in Brazil, which points out responses to social crises in force through citizenship and social rights[2-3-8].

Thus, it is understood that the experience of the work that has been developed in the SUS through the Institutional Support is consonant with this debate, since the Support Strategy, as a practice that takes place in the transversality of the relations established between the management, the team and the users of the services, is a practice that breaks with the most dual conceptions about the health field, seeking a movement of resingularization for the work processes of the SUS[6].

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