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INTERPROFESSIONAL WORK IN THE STRATEGY TEAMS FAMILY HEALTH: CHALLENGES IN BUILDING PRACTICES INTEGRATED

Interprofessional Performance in Family Health Strategy Teams: Challenges in the Construction of Integrated Practices

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SUMMARY:

The Family Health Strategy (FHS) represents the main model of primary health care in Brazil, structured by interprofessional teams. The coexistence between different types of knowledge — doctors, nurses, community health agents, psychologists, physiotherapists and others — presents concrete challenges in the construction of integrated practices.
This article discusses the difficulties and advances of interprofessional action in the context of the FHS, based on a theoretical analysis and empirical evidence from national studies. Communication issues, mutual recognition between categories, care management and continuing education emerge as central to the integration of practices. The article argues that the consolidation of interprofessional work requires not only institutional guidelines, but also cultural and pedagogical changes in the training and performance processes. The methodology adopts a narrative review based on publications indexed until 2022. It is concluded that strengthening interprofessional practice is a necessary path to the effectiveness of comprehensive health care in Brazil.

Keywords: Family Health Strategy. Interprofessional teams. Primary care. Work in health. Integration of knowledge.

ABSTRACT:

The Family Health Strategy (FHS) represents the main model of primary health care in Brazil and is structured around interprofessional teams. The coexistence of diverse areas of expertise—physicians, nurses, community health workers, psychologists, physiotherapists, and others—presents concrete challenges in building integrated practices. This article discusses the difficulties and advances in interprofessional practice within the context of the FHS, based on a theoretical analysis and empirical evidence from national studies. Issues related to communication, mutual recognition among professional categories, care management, and

continuing education emerges as central to the integration of practices. The article argues that the consolidation of interprofessional work requires not only institutional guidelines but also cultural and pedagogical changes in training and practice processes. The methodology is based on a narrative review of publications indexed up to 2022. The study concludes that strengthening interprofessional practice is a necessary path toward the effectiveness of comprehensive health care in Brazil.

Keywords: Family Health Strategy; Interprofessional teams; Primary health care; Health work; Knowledge integration.

1. INTRODUCTION -

The Family Health Strategy (FHS) was established as the main model of primary care in Brazil in the 1990s, with the aim of reorganizing health services in a territorial, comprehensive and continuous logic. The model presupposes interprofessional teams composed of doctors, nurses, nursing technicians, community health agents (CHAs) and, when possible, support professionals such as psychologists, physiotherapists, nutritionists and social workers. This arrangement aims to provide a broader approach to
health, going beyond the biomedical perspective (MENDES, 2002, São Paulo).

However, coexistence and collaboration between professionals from different areas still represent a concrete challenge in the operationalization of health work. The fragmentation of knowledge, hierarchical differences and communication barriers interfere with the quality of care offered and the consolidation of truly interprofessional practices. According to Peduzzi (2001, São Paulo), teamwork requires articulation of objectives, division of
responsibilities and technical and relational interdependence.

Furthermore, the biomedical model still exerts a strong influence on team dynamics, with a central role for the medical figure and undervaluation of other areas of knowledge. In a study conducted by Matta and Pontes (2007, Rio de Janeiro), it was observed that, although the institutional discourse values interprofessionality, in practice there is still a predominance of a hierarchical logic.
This compromises the building of bonds and mutual recognition, fundamental elements for comprehensive care.

In this scenario, it is necessary to critically investigate the main obstacles and possibilities in the daily lives of ESF teams. From a humanized and evidence-based perspective, this article aims to discuss the construction of interprofessional practice and its concrete challenges in the territory. The approach is based on a narrative review based on authors who studied interprofessionality in primary care until 2022.

This is expected to provide theoretical and practical support that will contribute to the formulation of institutional and training strategies aimed at the effective integration of knowledge and the valorization of all categories that make up the ESF. As Ceccim and Feuerwerker (2004, Belo Horizonte) point out, the construction of a new logic of care requires transformation

ethical, political and pedagogical. Thus, interprofessionality is understood here not only as a technique for organizing work, but as a guiding principle for the production of health care, with an emphasis on equity, co-responsibility and comprehensive care.

2. The concept of interprofessionality in public health

The concept of interprofessionality has gained strength in recent decades as a response to the growing complexity of health problems faced by contemporary society.
From the perspective of collective health, interprofessionality refers to the intentional and integrated cooperation between different professions with a view to producing expanded and resolutive care (REIS; SILVA, 2017, Recife). Unlike simple multidisciplinarity, which only brings together specialists around the same case, interprofessional practice requires articulation of knowledge and co-responsibility.

According to Barr et al. (2005, London), interprofessional training is a sine qua non condition for teams to act cooperatively and centered on the user. This training presupposes the deconstruction of professional stereotypes, learning about the role of others and the development of communication skills. However, in Brazil, undergraduate curricula are still marked by strong disciplinary segmentation, making it difficult to build interprofessional skills from initial training (CECCIM; FEUERWERKER, 2004, Belo Horizonte).

The Ministry of Health itself recognized the importance of interprofessional work when it launched the National Program for the Reorientation of Professional Training in Health (Pró-Saúde) and the Education through Work for Health Program (PET-Saúde), with the aim of integrating teaching-service-community. Even so, the effects of these initiatives have been limited, according to an assessment by Oliveira et al. (2018, Salvador), mainly due to a lack of continuity and institutional support. In addition to training, the daily lives of teams are marked by tensions and disputes that hinder cooperation. A study carried out by Silva and Ribeiro (2019, Curitiba) revealed that many professionals do not clearly understand the responsibilities of their colleagues, which leads to overlapping functions or gaps in care. The lack of collective planning moments and work overload also compromise the construction of practices integrated.

Thus, it is necessary to understand interprofessionality as a dynamic, continuous process that is built on a daily basis. The simple allocation of different professional categories in a team does not guarantee, in itself, the integration of their practices. Intentionality, participatory management and spaces for listening are necessary, as proposed by Ayres (2009, São Paulo), so that care can be produced in a shared manner. The consolidation of interprofessional teams therefore requires a paradigm shift, both at the institutional level and in interpersonal relationships. This is an ethical and political challenge that calls into question all subjects involved in the production of care.

3. Challenges of interprofessional action in the Family Health Strategy

Interprofessional work within the scope of the Family Health Strategy (ESF) faces several structural and relational challenges. One of the main obstacles is the persistence of a hierarchical professional culture, in which certain categories, especially doctors, still occupy a position of technical and symbolic command. This structure makes it difficult to share decisions and effectively recognize the contributions of other professionals (PEDUZZI et al., 2006, São Paulo). Overcoming this logic requires continuous training processes, clear combinations of functions and more flexible work environments.
democratic.

Another limiting factor is work overload and lack of time for team meetings and case discussions. The daily routine of basic health units is often marked by urgent demands, waiting lines and lack of human resources, which reduces the possibility of joint construction of care. Research carried out by Ferreira and Pires (2019, Porto Alegre) indicates that, in 65% of the teams evaluated, moments of integration between professionals occurred less than once a week, which compromises the
collective planning.

The absence of facilitative leadership can also represent an obstacle to integrated action. Many local managers do not have specific training in managing interprofessional teams, which makes it difficult to mediate conflicts, establish common goals and build environments of trust. According to a study by Almeida and Campos (2015, Campinas), teams with leaders who value listening, dialogue and collaborative work presented better indicators of integration and satisfaction among professionals.

Furthermore, the lack of knowledge about the role and skills of different professionals of the team is recurrent. Community health agents, for example, are often underutilized or seen only as information transmitters, when in fact they are key players in mediating between the community and the service, with great potential for building bonds and territorialized care (MENDES, 2002, São Paulo). This devaluation compromises the interprofessional potential of the ESF.

Another important challenge concerns the fragmentation between care and management. Many professionals still do not see themselves as political subjects or as co-responsible for the organization of the health system. Interprofessionality demands that all team members are clear about their role in the individual therapeutic project and in the articulation with other levels of care. Without this, there is a risk of reinforcing the verticalization and sectorization of care (CAMPOS, 2000, Rio de Janeiro).

Finally, it is worth highlighting that the COVID-19 pandemic has accentuated some of these weaknesses, but it has also revealed potential for reinvention. In a study carried out by Pinto and Andrade (2021, Recife), it was observed that several ESF teams have expanded internal communication, adopted mutual support practices and developed collaborative protocols, which points to promising paths for the consolidation of interprofessionality as a structuring axis of the SUS.

4. Strategies to strengthen interprofessional practice

To face the challenges identified, it is necessary to invest in multiple and interdependent strategies. One of the most relevant is continuing education in health, provided for in the National Policy for Continuing Education of the SUS (Brazil, 2009). This policy proposes that training processes occur in the workplace itself, based on the real needs of teams and the population. According to Ceccim (2004, Belo Horizonte), continuing education is an essential tool for the development of interprofessionalism, as it allows critical reflection and collective construction of knowledge.

Another fundamental strategy is the construction of institutional spaces for listening and planning. Regular team meetings, discussion groups, workshops and study groups are devices that encourage dialogue between different professionals, promote mutual recognition and enable the agreement of common goals. To this end, it is essential that local management encourages and guarantees protected time for these activities. Studies by Silva and Andrade (2020, Fortaleza) indicate that teams that maintain participatory routines achieve better levels of integration and satisfaction among professionals.

The implementation of tools such as the Singular Therapeutic Project (PTS) can also contribute significantly to interprofessional work. The PTS is a methodology that allows the collective construction of care based on the needs of each user, with the definition of goals, actions, responsibilities and deadlines. According to Campos and Domitti (2007, Campinas), the PTS helps to make the contribution of each professional in the therapeutic process visible, favoring co-responsibility and horizontal dialogue.

Furthermore, it is important that undergraduate health curricula incorporate interprofessional competencies across the board. This includes, for example, shared disciplines between different courses, interdisciplinary internships, and active learning methodologies based on problems and real cases. Initiatives such as PET-Saúde Interprofissionalidade, created in 2018, have sought to foster this integration since initial training (BRASIL, 2019).

Another point to consider is the role of leadership. Managers and coordinators of basic health units must be prepared to exercise collaborative leadership, based on listening, conflict mediation and valuing the collective. Training in participatory management and co-management must be incorporated into the municipalities' training policies. As Franco and Merhy (2013, Rio de Janeiro) argue, health work management is, above all, management of relational and subjective processes.

Finally, it is essential that interprofessional work be recognized and valued in financing and evaluation policies. Remuneration models that consider only individual productivity tend to discourage collaboration. Quality indicators should include dimensions such as bonding, collective resolution and team satisfaction, contributing to a more humane, democratic and efficient SUS.

5. Successful experiences of interprofessionality in the ESF

Despite the numerous challenges, several successful experiences of interprofessional action have been recorded in different regions of Brazil, revealing possible ways to overcome fragmented and hierarchical practices.

A notable example is the municipality of Sobral, in Ceará, which is nationally recognized for adopting a primary care model based on continuing education, co-management and team strengthening (PESSOA et al., 2018, Fortaleza). In Sobral, intersectoral meetings between health, education and social assistance are systematized practices and incorporated into the daily lives of teams, promoting interprofessional and intersectoral articulation.

Another relevant case is that of Belo Horizonte (MG), where the Family Health Support Center (NASF) was structured to offer matrix support to ESF teams. Professionals such as psychologists, occupational therapists and nutritionists work with family health teams, sharing knowledge and developing integrated therapeutic projects. Evaluations of the model demonstrate an increase in the resolution of care and greater user satisfaction (MOURÃO; LIBERALI, 2017, Belo Horizonte). In Florianópolis (SC), the adoption of the Expanded Clinic methodology, based on the collective discussion of cases and the valorization of the user's protagonism, has contributed to the strengthening of interprofessionality.

Teams are encouraged to participate in institutional support groups and develop more horizontal ties between themselves and with users. Research by Campos and Figueiredo (2016, Florianópolis) showed that teams that systematically applied the expanded clinic presented greater integration in decision-making and lower staff turnover. In the city of Arapiraca (AL), the Listening Project was implemented, which promotes active and shared listening of users by different team professionals, focusing on humanized reception and the collective construction of interventions. This practice has shown a positive impact on treatment adherence and on users' perception of the care received (SOUZA; LIMA, 2020, Maceió). The project also increased the autonomy of teams and strengthened continuing education as an axis of service qualification.

The experience of Palmas (TO) is also worth highlighting, where the "Integrar Saúde" program was created, aimed at training ESF teams in interprofessional practices and participatory management. The initiative involved local universities, professional councils and municipal managers, generating positive impacts on communication between categories and on the integrated planning of health actions (VASCONCELOS et al., 2021, Palmas).

These examples demonstrate that, although the challenges are considerable, interprofessionality can be effectively built when there is political will, institutional support and appreciation of teamwork. Successful experiences need to be
made visible, systematized and disseminated, in order to inspire other locations and strengthen the SUS as an integral and interdependent system.

6. Final considerations

The construction of interprofessional action in Family Health Strategy teams is a complex process, marked by advances, setbacks and daily tensions. This article sought to discuss the main challenges faced by these teams, as well as present

strategies and experiences that have contributed to consolidating integrated and humanized practices. Interprofessionality, understood as a conscious and supportive articulation between different knowledge, is an essential condition for the SUS to meet the principles of comprehensiveness, equity and universality.

It was found that the main obstacles to interprofessional practice include the hierarchical culture of the professions, the fragmentation of work, the lack of institutional time for meetings and the lack of adequate training in management and integration of knowledge. However, it was also found that there are multiple possibilities for overcoming these obstacles, as long as there is institutional support, valorization of teams and public policies aimed at qualifying health work.

The most effective strategies identified in the literature include continuing health education, the valorization of the Singular Therapeutic Project, the implementation of participatory management methodologies, the promotion of listening spaces and the inclusion of interprofessional skills in academic training. In addition, it is essential that the evaluation and financing models of services consider the quality of teamwork, co-responsibility and user support as parameters of excellence.

The successful experiences presented in cities such as Sobral, Belo Horizonte, Florianópolis, Arapiraca and Palmas demonstrate that it is possible to build a solid and effective interprofessional practice, even in the face of adversity. These cases show that
investment in human relations, critical education and dialogue between knowledge results in concrete improvements in the quality of health care.

It is therefore concluded that interprofessionality is not just a technical or normative guideline, but an ethical and political choice that should guide all levels of health care. Its strengthening requires commitment from managers, workers, trainers and users. By recognizing the power of different knowledge and promoting listening, respect and collaboration, the SUS advances in the construction of fairer, more effective and dignified care for all people.

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