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RESEARCH

COLLABORATIVE PRACTICE IN THE FAMILY HEALTH STRATEGY: EXPRESSIONS, POSSIBILITIES AND CHALLENGES FOR THE PRODUCTION OF CARE

PRÁTICA COLABORATIVA NA ESTRATÉGIA SAÚDE DA FAMÍLIA: EXPRESSÕES, POSSIBILIDADES E DESAFIOS PARA PRODUÇÃO DO CUIDADO

LA PRÁCTICA COLABORATIVA EN LA ESTRATEGIA DE SALUD FAMILIAR: EXPRESIONES, POSIBILIDADES Y DESAFÍOS PARA LA PRODUCCIÓN DE CUIDADOS

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ABSTRACT

Objective: to understand the configuration of collaborative practice in the context of the Family Health Strategy (FHS). **Method:** this is a single case study, of a qualitative nature, carried out with 35 professionals from the family health teams. Data collection took place through interviews guided by a semi-structured script and non-participant observation. Data were analyzed using Thematic Content Analysis. **Results:** the results showed the potential of collaborative practice for the qualification of professional practices and health outcomes in the context of the FHS. However, there was a deficiency of organizational devices to support shared work in the FHS, including with regard to public policies, revealing the call for interprofessional education in the context of health services to encourage collaboration. **Conclusion:** the configuration of interprofessional collaborative practice in the context of the Family Health Strategy is challenging and requires interactional processes and work organization.

Keywords: Professional Practice; Family Health Strategy; Patient Care Team; Cooperative Behavior; Primary Health Care; Intersectoral Collaboration.

RESUMO

Objetivo: *compreender a configuração da prática colaborativa no contexto da Estratégia Saúde da Família (ESF).* ***Método:*** *trata-se de um estudo de caso único, de natureza qualitativa, realizado com 35 profissionais das equipes de saúde da família. A coleta de dados ocorreu por meio de entrevistas guiadas por roteiro semiestruturado e observação não participante. Os dados foram analisados por meio de Análise de Conteúdo Temática.* ***Resultados:*** *os resultados evidenciaram potencialidades da prática colaborativa para a qualificação das práticas profissionais e dos resultados de saúde no contexto da ESF. Entretanto observou-se insuficiência de dispositivos organizacionais para apoiar o trabalho compartilhado na ESF, inclusive no que tange às políticas públicas, revelando o chamamento para a educação interprofissional no contexto dos serviços de saúde para estimular a colaboração.* ***Conclusão:*** *a configuração da prática colaborativa interprofissional no contexto da Estratégica Saúde da Família é desafiadora e requer processos interacionais e de organização do trabalho.*

Palavras-chave: *Prática Profissional; Estratégia Saúde da Família; Equipe de Assistência ao Paciente; Comportamento Cooperativo; Atenção Primária à Saúde; Colaboração Intersetorial.*

RESUMEN

Objetivo: *comprender la configuración de la Práctica Colaborativa en el contexto de la Estrategia de Salud Familiar.* ***Método:*** *se trata de un estudio de caso único, de carácter cualitativo, realizado con treinta y cinco profesionales de equipos de salud familiar. La recogida de datos se realizó mediante entrevistas guiadas por un guión semiestructurado y la observación no participante. Los datos se analizaron mediante un Análisis de Contenido Temático.* ***Resultados:*** *los resultados mostraron el potencial de la práctica colaborativa para la cualificación de las prácticas profesionales y los resultados de salud en el contexto del ESF. Sin embargo, se observaron insuficientes dispositivos organizativos para apoyar el trabajo compartido en los ESF, un reto a superar, incluso en lo que respecta a las políticas públicas, lo que revela la necesidad de una educación interprofesional en el contexto de los servicios de salud para estimular la colaboración.* ***Conclusión:*** *la configuración de la Práctica Colaborativa interprofesional en el contexto de la Estrategia de Salud Familiar es un reto y requiere procesos de interacción y organización del trabajo.*

Palabras clave: *Práctica Profesional; Estrategia de Salud Familiar; Grupo de Atención al Paciente; Conducta Cooperativa; Atención Primaria de Salud; Colaboración Intersectorial.*

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INTRODUCTION

The complexity of the health needs of individuals, families and communities in Primary Health Care (PHC) requires integration of work among team members. This pattern is close to the concept of collaborative practice advocated by the World Health Organization (WHO).[1]

Collaborative practice is considered a strategy to strengthen the health care system and outcomes focused on health needs. It is based on interprofessional action, in which professionals from different categories share the skills necessary for comprehensive and high-quality health care for patients, families, caregivers and communities, creating mutual learning and enabling opportunities for improvement.[1,2]

It should be noted that, in recent decades, the issue of interprofessional collaboration has stood out in the field of health care as a component of a broad political reform in the models of professional training and health care. It was identified as a resource to face the problems of the care model and the workforce.[3]

Therefore, within the scope of PHC, the Family Health Strategy (FHS) has been the *locus* in which collaborative practice presents itself as an operational guideline for work, enabling the effectiveness of PHC and generating positive impacts on the qualification of comprehensive health care and in the organizational change of care.[3,4] Thus, the FHS is configured as a favorable space for the study of the interaction between professionals in practice, verifying the degree of cooperation and the production of care.[5]

It is noteworthy that, in the FHS, collaboration as a form of interprofessional work needs to be approached in a contingent way, relating to aspects of the local reality and to the characteristics of the enrolled people, considering their life contexts and the working conditions of the family health teams. The contingent performance of health care professionals in this context is based on the articulation of knowledge and skills on different professional categories. This articulation leads to a practice that transcends traditional interprofessional work, reaching a performance with other forms of interprofessionality marked by collaboration and interprofessional collaborative practice, in a synergistic way with the user and the community.[3,6]

However, the literature points out that interactional aspects — such as mutual trust, respect, communication and willingness to collaborate — and organizational issues at work express tensions between the hierarchical professional model and the collaboration model, as well as tensions between a procedural and a collaborative logic, focused on the health care needs of people/families and the community.[3,6-8] In this aspect, the forms of communication and interaction between professionals within the team and professionals with users/community can be a significant source of conflicts or interprofessional collaboration. From this perspective and from the growing complexity of health care, the search for understanding aspects related to professional interaction within the FHS is justified, which can help in the identification of potentialities and elements that represent barriers to collaborative practice. From this, subsidies can be offered for the planning of actions in the field of work management in PHC.[6]

Based on the above, it is assumed that the interprofessional collaborative practice is an important form of work organization in the FHS scenario, with influences for the effective practice of the family health team and for an excellent assistance to individuals, families and to the community. Thus, the guiding question of this study arises: how is collaborative practice designed in the context of the Family Health Strategy?

The objective of this study was to understand the configuration of collaborative practice in the context of the Family Health Strategy. The realization of this research can provide subsidies to understand the collaborative practice in the context of the FHS, providing better results with the collaboration of several actors involved in the health care process. Through this exchange, it is possible to achieve quality care and better interpersonal relationships in health care services.

METHOD

This is a single case study, of a qualitative nature. The qualitative approach gives meanings to people's actions and the relationship they establish with their contexts.[9] The case study method enables a holistic understanding of the meanings and situational characteristics of a given phenomenon that involves a real-life context. Thus, a single integrated case study was used, with subunits of analysis. The case of the present study is the collaborative practice in PHC (single case), and the subunits of analysis that make up the case were the practices of the FHS teams that integrate PHC in the studied municipality. Single integrated case studies are representative and seek to capture the circumstances and global conditions of a daily situation or a common place (PHC), considering the particularities

of the subunits of analysis (FHS) through integrated units of analysis.[10]

The study was carried out in FHS units of a medium-sized municipality in the state of Minas Gerais, Brazil, from January to July 2019. The municipality has five administrative regions and 43 FHS teams; thus, a random draw was carried out by administrative region to elect the participating teams.

It should be noted that the number of participants was not indicated *a priori*, and data collection was interrupted when data saturation occurred for each professional category. This happened when the information, after analysis, presented the scope of the participants, valuing the significant contents for the study.[9] In this way, the interviews were carried out in 10 family health care units, with 9 nurses, 9 Nursing technicians, 7 doctors and 10 community health agents (*ACS-Agente Comunitário da Saúde*), totaling 35 professionals.

The inclusion criterion of the participants was working for at least six months in the team. This period was considered necessary so that they could experience the work environment, the interprofessional relationships and the activities that make up the team practice. Professionals who were on sick leave or on vacation during the data collection period were excluded from the study. It is worth mentioning that there was no refusal or withdrawal on the part of professionals from the family health teams to participate in the research.

In order to give consistency to the results and validity to the construct, data triangulation was used through interviews, guided by a semi-structured script, and observation, adopted as sources of evidence.[10] The semi-structured script had questions that sought to elucidate aspects related to the interprofessional and collaborative practice in the daily practices of FHS professionals. The interviews lasted an average of 28 minutes and were carried out by two researchers related to the Nursing Administration Research Center (*NUPAE-Núcleo de Pesquisa Administração em Enfermagem*) and with extensive research experience. The interviews took place in a reserved place, in the FHS unit, individually and according to the availability of professionals. The speeches were recorded and transcribed in full. After the end of the interviews, the participants were able to listen and validate them.

Non-participant observation was carried out during the inclusion of the researchers in the research field and in the moments before and after the interview in places related to the context of the FHS, such as reception, meeting room, clinical offices, home visits and procedure room. During the researchers' time in the field, habits, attitudes, interpersonal relationships, decision-making and communication processes between professionals and between them and the community were observed. Observations were recorded and identified as observation notes (ON).

The ON and the transcripts of the interviews made up the data *corpus*, having been submitted to the content analysis proposed by Bardin,[11] with the aid of the ATLAS.ti software, version 8. The content analysis follows the chronological steps: pre-analysis; material exploration; and treatment of results, inference and interpretation. In the pre-analysis stage, the material was organized for appropriation by means of a floating and exhaustive reading of the content of the interviews and the ON. The exploration of the material consisted of its management for the creation of codes and categorization. In the data exploration stage, the codes were grouped according to their common characteristics or their relevance, composing, in ATLAS.ti, what is called Family. In the inference and interpretation stage, the analysis of the results was in-depth, establishing reflections with the literature.[11] The software used helps in the organization and development of the stages of analysis, being essential the role of the researcher in the manipulation of the software.[12]

Through the analysis of the results, two categories emerged for the understanding of collaborative practice in the context of the FHS: i) "Production of care in the Family Health Strategy from strategies that involve interprofessional collaborative practices"; and ii) "Challenges to the exercise of interprofessional collaborative practice in the work context of the FHS". To make the understanding of the theme effective, it was decided to present the categories in the results as a single category, namely: "Production of care in the Family Health Strategy: possibilities and challenges of collaborative practice".

The study complied with the ethical requirements in research with human beings of Resolution No. 466/2012 of the National Health Council, being approved by the Research Ethics Committee of the Universidade Federal de Minas Gerais under Opinion Report No. 2,285,857. Participants were informed about the study, voluntarily agreed to participate in the research and signed the Free and Informed Consent Term (ICF). It is noteworthy that the results of this study will be disclosed directly to those involved and to the municipal manager, through a technical report. In order to guarantee the anonymity of the participants, they were identified by letters, being M for doctors, E for nurses, ACS for Community Health Agents

and TE for Nursing technicians, followed by the numerical order in which the interviews were carried out.

RESULTS

The configuration of collaborative practice in the daily life of the Family Health team is perceived by the testimonies of M3 and ACS2, who recognize that the joint work of different professionals who make up the team is important for the realization of care.

> *We work as a team. We have the health agents, the Nursing technician, who work here and also in home visits. There's also the nurse. So, it's a whole team working together to solve day-to-day issues, related to the population's health* [...] *each one doing their part, makes it possible to guarantee all the care we should give in primary care* (M3).

> *One helps the other, it's really a matter of teamwork. This is very positive. We bring the people's health needs to the nurse and discuss everything with her, or with the doctor* (ACS2).

Regarding joint work, ACS7, E9 and E1 emphasize their interaction with professionals from the Family Health Support Center (*NASF-Núcleos de Apoio à Saúde da Família*), expressing the sharing and mutual support that professionals from different categories of the FHS and *NASF* team establish. each other.

> *"NASF" is always available to help us. They help the team a lot, they really support us. They help us in different situations. If they didn't exist to help us, we would be with no way to go* [...] (ACS7).

> *Here at the FHS, we rely on matrix support with the "NASF". It is a time when the entire FHS and "NASF" team discuss a specific case in the area and, from all points of view, we set up a program for monitoring this patient in order to improve their treatment and adherence to education practices in health* (E1).

In addition to the joint work between team members, TE2, M2 and M3 consider that harmonious relationships, a pleasant work environment and the relationship of trust between professionals and the community are factors that promote collaborative practice and the production of assertive care and of quality.

> *Care exists for everyone, as I can say, it's a very friendly place, very relaxed to work. There is a lot of dedication, from the health agents, the nurse; it is a pleasant place to provide care, everything is organized, very good, I like it very much* (TE 2).

> *The team is very good, especially the nurse and the Nursing technician. I've worked in other places where the team wasn't good, and the work didn't happen. We depend a lot on the nurse and, thank God, mine* [the one who works with the medical doctor] *is great* (M2).

> *I use a good medical relationship with the patient, a good medical relationship with all employees. I'm worried about everyone's collaboration, otherwise the service can't go on* [...] *this (collaboration) I think is the key point, because whenever I need something that is very difficult to have, my colleagues help me, managers help me, so I think a good relationship with them is paramount* (M3).

Regarding assertive care, E1 and M2 reinforce the importance of health actions being shared not only among team professionals, but also with the community, in order to interact and deal with the decision of the best practice to be adopted.

> *We had a patient who used to come to the unit daily, always feeling sick. I couldn't understand what was happening since she was very well medicated, and her medical follow-up was amazing. But we still hadn't carried out a home visit for her, so I called the health agent, and we went to her house. Arriving there, we asked her to show us all her medication and we found that she was taking it all wrong. What did I have to do then? I had to separate the morning, afternoon, and night medications,* [...] *so, I wrote everything, everything separately. We asked her if that was ok! And, from an action that for us was simple, she started to adhere better to the medication and so we ended up also discovering and seeing there the reality of how she lives, what she had to feed. It's no use staying alone inside the* [*health*] *unit* (E1).

> *I call the nurse and together we think about the best decision to make. Then, we call the patient and decide with her the best option for her treatment* (M2).

In order to favor collaborative practice, E1 and M1 highlight the importance of sharing communication between professionals for the production of quality care. They also highlight the importance of the team getting together and being committed to carrying out the actions.

> [...] *I talk a lot with the team so we can always try to put ourselves in each other's shoes. With that in mind, we will be*

> *able to work ethically, with respect, without criticism among the group. So, in team meetings, we seek to work on the importance of listening to each other and giving voice to our patients. Our desire is to help, always* (E1).

> *Every meeting we set goals, and everyone commits to achieving them. For example, sometimes there is a patient who is* [healthly] *decompensated in a certain area. His blood pressure doesn't go down. We think of a* [treatment] *plan together and try to improve the patient's health. Everyone is committed to helping. The "ACS" accompanies the visits, offers participation in active groups, the technician controls the BP, we offer medical consultation* (M1).

Regarding the importance of communication as a facilitating element of collaborative work, interactions between professionals and between them and the community were observed, which reinforce this finding. The researcher witnessed the interaction between an elderly patient and the *ACS* at the health unit, which took place through attentive listening to her needs. After listening, the *ACS* called the nurse and, together, they solved the issue brought up by the user (ON). Another moment refers to the exchange of information between consultations, in which the doctor and the nurse discuss the case of a pregnant woman in search of the best intervention (ON).

However, some challenges for collaborative practice in the FHS were also identified as barriers to the effectiveness of care production. ACS9 and E7, for example, state the indifference of some team members in relation to working together, making collaboration difficult.

> [...] *not everyone is the same as* ["ACS's" name], *who goes out every day in the morning, and goes to do his homework, run after appointments, get tests, talk to a nurse. Filling the nurse's bag every day to meet what our patient needs, right?* (ACS9)

> *Some employees do not have the profile to work in a team and, to work in the FHS they have to know how to work in a team. If you don't know, it interferes too much with our work.* (E7)

Respondents point to the collection of goals, question their fulfillment and the operationalization of support. In view of the narratives, it appears that the goals are detached from the reality of a shared work based on the social demands present in the territory. Therefore, it is inferred that these challenging situations generate difficulties in carrying out an exchange of knowledge between professionals and, consequently, in implementing collaborative practice — sometimes this occurs not because the professional does not want to, but because it becomes difficult.

> *I have to do everything on the administrative side and on the care side as well, just because of that you can already see how much we are overloaded of work to get done, together with the fact that you have a million goals to meet. Management only cares for the goal to be achieved* (E5).

> [...] *we do not do ESF, because the population is very large and we cannot do prevention; we meet more spontaneous demand, only curative. We estimate that the population is more than 10,000 inhabitants, and we could only serve a maximum of 4,000. So, I just stay in the office, attending, just like in the Emergency Care Unity (UPA-Unidade de Pronto Atendimento)* (M 1).

DISCUSSION

The results of this study reveal that collaborative practice in the context of the FHS in question is arranged by collaboration between health professionals with different professional experiences and, in an intersectoral network, with the *NASF*. It also relies on communication, a harmonious relationship, a pleasant environment and the effective participation of users, with the objective of providing comprehensive, assertive and quality health care.

The practice guided towards collaboration, in addition to providing quality care, awakens the professionals' awareness of their interdependence, which translates into a feeling of belonging, responsibility and mutual trust.[3] Considering the results of the present study, it is perceived that professionals recognize the limitation of individual intervention to meet the complexity imposed by the health needs that the context of the FHS impels to professional practice. The health needs of the population enrolled in the FHS go beyond issues restricted to illness, reallocating the emphasis from team practice to comprehensive care. In this aspect, it is clear that, when there is the articulation of knowledge and actions from different professional areas, the service becomes more problem-solving and efficient, enabling the improvement of health care.[13]

Furthermore, the expanded perspective of health care is emerged with practices that are effectively focused on the users, oriented towards their health needs in a comprehensive way and with high quality.[2] Through the testimonies, it can be seen that professionals recognize that harmonious and respectful relationships are fundamental

to the work of the FHS team. Although each professional has skills and competencies related to their practice, within the scope of the FHS, they share person/family/community-centered care as a common goal, shaping the nature of collaborative practice.

A study on teamwork and collaborative practice in PHC shows that the organizational environment is established as a key element for collaboration. Teams with a better environment in joint work showed more effective participation of their members in decision-making, developed meetings for team reflections and supported new care proposals centered on the user.[3] This allows us to infer that the influence of relationships in the FHS environment goes beyond the objective dimension of work.

In this way, interprofessional collaboration strengthens the health system and comprehensive care, as it recognizes the complex and multifaceted nature of the population's health needs.[14] In this sense, the testimonies of the present study pointed out the importance of interaction between professionals from different categories and the participation of users in the therapeutic process for the rating of care. Regarding the interaction with the user, it is emphasized that it is based on listening and the exchange of knowledge, promoting a relationship of trust and sharing of responsibilities.[15]

Collaborative practice in PHC develops beyond interprofessional issues, referring to interactions and intersubjectivities that include the perspective of the user, the family and the community in the search for "taking care of people, instead of taking care for people". This approach recognizes patient-centered care as a central element of collaborative practice.[4] From this perspective, information sharing and interaction depend on communicative reciprocity, with the synergistic participation of the subjects involved so that care occurs.[3] Thus, the results of the present study corroborate this position in the sense that communication was highlighted as an important device for the realization of collaborative practice.

In addition, interprofessional collaboration appeared in this study as a strategy for the development of forms of communication and interaction between professionals and between them and the user, in response to the problems that arise in everyday life and configure the complexity of health needs in the FHS.

A study that sought to analyze the processes experienced by the Family Health Support Center (NASF) team corroborates the findings of this research by showing that professional interdependence is related to the increase in the complexities of demands in the health area. Interactions between professionals tend to bring better contributions — both theoretical and practical — to the resolution of health problems, enabling an approximation with the principle of integrality.[16]

The proposal of matrix support (part of the *NASF* work process) can be understood as a collaborative practice, since it concerns the attention given to each individual case, with information exchange, bond between professionals and users, collective construction of therapeutic projects singularities, sharing of uncertainties and co-responsibility of users and healthcare professionals. This proposal is carried out through collaborative interprofessional teamwork and communicative action.[4]

It is noteworthy that teamwork in the FHS is not limited to integration for technical intervention; it is a work characterized by the relationships of knowledge, powers and, above all, by interpersonal relationships. This way of working requires that professionals use particular healthcare strategies — evidenced by fleeting and informal interactions, partnerships and team meetings — and recognize the deliberation regarding the assistance to be provided in a shared and negotiated way, as potential for improvement in the quality of care.[17]

Although the results point to the potential of collaborative practice in the context of the FHS, it was possible to identify barriers, such as the indifference of some professionals towards teamwork and the focus on productivity. These impasses are challenges for the development of collaborative practice in the examined context.

The willingness to collaborate is one of the determining principles for the establishment of effective and integrated teams.[3] Researchers[18,19] demonstrated that the lack of commitment and solidarity in the work environment, the high turnover of personnel, the competing demands, the hierarchical culture and the lack of role clarity can provide a conflicting environment between professionals and a fragmented service, affecting team performance. In this way, the change from a fragmented service to a service of shared responsibilities, decisions, visions and practices in the generation of care for users and families remains an important challenge.[6] In this regard, management support and the construction of an adequate environment for professionals, with a culture of care that favors human connections between team members, are mechanisms for the implementation of collaborative practice, and should be strengthened in the institutional space.[2,20]

In addition to these issues, it is noteworthy that, although the NASF teams have been described as important to increase the problem-solving capacity of PHC and to support their integration into health networks, in 2019,

through Ordinance No. program "Previne Brasil". In addition to establishing a new PHC funding model within the scope of the SUS linked to the fulfillment of pre-established goals (which are changed annually), "Previne Brasil" eliminated the *NASF* from the composition of the multidisciplinary teams in this scenario.[21]

From this proposal, the municipal manager becomes autonomous regarding the decision on the composition of their multidisciplinary teams, establishing the professional categories, the workload and the team arrangements. This can compromise the scope of services provided by PHC, as well as release the practice of health promotion and matrix support. In this sense, the health policy itself offers obstacles and challenges for the effectiveness of interprofessional collaborative practice by reconfiguring the health care model and guiding practices to the achievement of goals, disregarding, in part, the health needs perceived by the team in daily life.

Based on the findings presented, it is understood that collaborative practice is an important strategy for the qualification of professional practices and health outcomes, in the context of the FHS. However, there is an insufficiency of organizational devices to support shared work in the FHS, revealing the call for interprofessional education in the context of health services to encourage collaboration. In this regard, a review study[22] pointed out the need to include interprofessional collaborative practice in professional training, through a solid theoretical basis guided by collaboration, leadership and participatory assessment. It should be noted that inserting collaborative practice during the teaching-service articulation can be a beneficial strategy both for the service and for students and teachers.[22,23] However, the authors[22] pointed out that barriers related to organizational structures and the biomedical approach are still perceived to the detriment of the patient-centered approach. These barriers make it difficult to consolidate collaborative practice as a model of educational development.

In a study in the hospital environment, the need for the culture of collaboration to be strengthened since professional training was also highlighted.[18] Therefore, transformational leadership in Nursing has been cited as a means of facing the challenges of collaborative work between different professions.[24] Therefore, collaborative practice involves overcoming hierarchical factors (which involve the occupations) in order to improve service delivery and health outcomes. Nurses are leaders considered indispensable professionals to promote collaborative partnership between healthcare professionals.[24]

Thus, it is suggested that the use of interprofessional education strategies be encouraged to adapt the profile of health workers and build collaborative practice. It is recommended to work from this perspective in order to meet a need beyond the moment of professional training, that is: we propose that interprofessional education be the scope of permanent learning of the health workforce in order to prepare students for collaborative practice throughout the career.

It is worth noting that the expanded perspective of collaborative practice considers the health system as a whole, being a limitation of the study to bring only the reality of PHC. In this sense, it is suggested that new studies take place at different levels of the health system. Another limitation is the inclusion of participants, since there is a predominance of the perspective of the Nursing team in relation to other professions. It should be noted that the choice of inclusion criteria and data saturation by professional category was a way of minimizing such fragility.

CONCLUSION

The configuration of collaborative practice was understood through the recognition of the work among the interdisciplinary team. It is based on trust and sharing between professionals and between them and the user/family, in order to enable negotiation for decision-making on the best practice to be adopted.

The innovation lies in the fact that it explores new paths for collaborative practice in a specific context, arguing that the configuration of collaborative practice is articulated with the values of Primary Health Care. This generates mutual learning and affects the achievement of quality care.

However, the configuration of collaborative practice is still challenging, especially due to the difficulty of interaction between professionals from different categories and the administrative goals imposed in an individualized way. This point requires interactional processes and work organization.

Therefore, teamwork and collaborative work in the Family Health Strategy needs to be elucidated in a unique way, that is, based on the characteristics of users/population, according to context and working conditions. The results presented can contribute to the reflection of new modes of interprofessional education, stimulating interaction between professionals and producing collaborative practice in the contexts of action in the Family Health Strategy.

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