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Atuação do Núcleo de Apoio à Saúde da Família: o entendimento de profissionais da estratégia de saúde da família de um município catarinense.

Activities of the family health support core: the understanding of the family health strategy professionals of a municipality of santa catarina.

Actividades del núcleo de apoyo a la salud de la familia: el entendimiento de profesionales de la estrategia de salud de la familia de un municipio catarinense.

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RESUMO: A pesquisa teve comoobjetivo investigar o entendimento de profissionais da Estratégia em Saúde da Família (ESF) sobre a atuação do Núcleo de Apoio à Saúde da Família (NASF). Configurou-se como um estudo qualitativo descritivo, realizado em um município da região serrana deSanta Catarina, em 2 unidades de saúde da família. Foram realizadas entrevistas semiestruturadas com 12 profissionais com formação em nível superior (medicina, odontologia e enfermagem), das quatro equipes de ESF, pertencentes às 2 Unidades de Saúde da Família. Os dados coletados foram tratados por meio da análise de conteúdo, decompondo-se as falas e construindo categorias temáticas por meio da semelhança dos conteúdos. Percebeu-se que os profissionais entendem a atuação do NASF afastada das práticas realizadas pelos profissionais da ESF, resultando no trabalho em equipe como algo desafiador para as equipes multiprofissionais. Observou-se que as práticas em saúde se mostram fragmentadas e restritas à prática clínica, dificultando o cuidado integral. Entretanto, a

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atuação do NASF se mostra relevante para a transformação dos processos e das práticas de trabalho nos serviços de saúde.
Palavras-chave: Estratégia Saúde da Família, Pessoal de Saúde, Sistema Único de Saúde.

ABSTRACT: The current research aimed to investigate the level of understanding of the Family Health Strategy (ESF – initials in Portuguese) professionals on the activities of the Family Health Support Center (NASF – initials in Portuguese). Set up as a descriptive qualitative study, it was conducted in a municipality of the highland region of Santa Catarina, in 2 family health units. Semi-structured interviews were conducted with 12 professionals with superior education degrees (medicine, dentistry and nursing), of the four teams of the ESF (initials in Portuguese), belonging to the 2 family health units. The collected data was subjected to content analysis, decomposing the interviews and constructing thematic categories through the similarity of contents. It has been observed that the professionals understand the activities of the NASF (initials in Portuguese) as being separate and apart from the practices that they carry out in the ESF (initials in Portuguese), resulting in challenges to achieve teamwork in multiprofessional teams. The health practices were deemed fragmented and restricted to the clinical practice, hindering the comprehensive care. However, the NASF's (initials in Portuguese) activities are shown to be relevant to the processes and the work practice transformations in the health services.
Keywords: Family Health Strategy, Health Personnel, Unified Health System.

RESUMEN: La investigación tuvo como objetivo averiguar el nivel de entendimiento de profesionales de la Estrategia de Salud Familiar (ESF) acerca de las actividades del Núcleo de Apoyo a la Salud de la Familia (NASF). Configurado como un estudio descriptivo cualitativo, se llevó a cabo en un municipio de la región serrana de Santa Catarina, en 2 unidades de salud de la familia. Se realizaron entrevistas semi-estructuradas con 12 profesionales con formación de nivel superior (medicina, odontología y enfermería), de los cuatro equipos de ESF, pertenecientes a las 2 unidades de salud de la familia. Los datos obtenidos fueron tratados mediante análisis de contenido, descomponiendo las entrevistas y construyendo categorías temáticas a través de semejanza de contenidos. Se observó que los profesionales entienden las acciones de la NASF como distanciadas de las prácticas realizadas por profesionales de la ESF, dando como resultado dificultades para conciliar el trabajo en equipo en los equipos multiprofesionales. Se observó fragmentación en las prácticas de salud, que parecen estar restringidas a la práctica clínica, lo que dificulta la atención integral. Sin embargo, las acciones de la NASF muestran relevancia en los procesos de transformación y en las prácticas de trabajo en los servicios de salud.
Palabras clave: Estrategia de Salud de la Familia, Personal de Salud, Sistema Único de Salud.

INTRODUCTION

The Unified Health System (SUS) is a product of the Brazilian Health Reform, originated in the 1960s and 1970s, and of the political process that mobilized the Brazilian society to propose new models of system organization, services and practices in health and regulated by the Organic Laws of Health nº 8080/90 and nº 8,142/90[1].

From the 8th National Health Conference (1986), with the theme "Health for all, a duty of the State", and the Brazilian Constitution of 1988, the concept of health was expanded, assuming the conception of social determination in health, where health is not only the absence of disease[2].

Considering that the Basic Healthcare, one of the levels of attention to healthcare of the SUS, is the main door of entry and the first contact of users with the health services, the Family Health Strategy was instituted. The FHS seeks to legitimize the SUS and the comprehensive care to the subjects through the work of the family health teams committed to the comprehensiveness of the healthcare focused on the family unit and close to the context of the communities[3].

The Family Health Strategy (FHS) teams are composed of different professional categories, thus forming a multiprofessional team for integral healthcare. In the country, until February of 2016, there were 40,307 FHS teams, which is equivalent to 63.9% of national coverage[4].

In this sense, in view of the implementation of the FHS and the reorientation of the healthcare model, the Ministry of Health, based on municipal experiences and national debates, creates the Family Health Support Center (FHSC) as a to support the FHS teams and increase the scope of service.

The FHSC is a National Policy, through the GM Resolution No. 154, of January 24, 2008. Constituted by a multiprofessional team, it must work together with the professionals of the Family Health teams and support the health practices. However, in order to allow any Brazilian municipality to be contemplated with such policy, and to encourage the improvement of the work of the FHSCs already implemented as of 2008, new regulations were elaborated. Thus, through the Resolution No. 3,244, dated from December 28, 2012, the parameters for linking the modalities 1 and 2 were redefined, as well as creating modality 3, giving support to the Primary Care teams for specific populations (Offices in the Street, and river teams)[5 6].

From the reformulations, the FHSC teams in modality 1 are linked from 5 to 9 family health teams and/or Primary Care teams to specific populations. The FHSC teams in modality 2 are linked from 3 to 4 family health teams and/or Primary Care teams to specific populations. Finally, the FHSC teams in modality 3 are linked from 1 to 2 family health and/or Primary Care teams to specific populations[6].

Regarding the implementation of FHSC teams in Brazil, from 2008 to 2016 there is a

significant increase. In all the Brazilian territory, in January 2016, there were 4,462 FHSC teams in their three types of modality. Thus, the composition possibilities of the FHSC teams in their different modalities may include: social worker; physical education professional; pharmaceutical; physiotherapist; speech therapist; professional with training in art and education (art educator); nutritionist; psychologist; occupational therapist; gynecologist/obstetrician; homeopathic physician; pediatrician; veterinarian; psychiatric doctor; geriatric doctor; outpatient doctor (medical clinic); work physician; acupuncturist; and sanitary health professional, that is, a professional with a degree in the health area with a post-graduation degree in public or collective health, or graduated directly in one of these areas[7 6].

The implantation of the FHSC implies the need to establish routine spaces for meeting, planning and discussion of cases for the definition of the therapeutic projects shared by the teams of health professionals. Thus, it is believed the importance of the insertion and support of the FHSC teams to promote health practices in the FHS, increasing collective and individual care[8].

In order for changes to happen in hegemonic models in the health services, especially in the FHS, it is necessary to work in a multidisciplinary and intersectorial team, as well as the knowledge of the practices carried out by the teams, causing them to be rethought and innovated to improve conditions and access to health.

Therefore, the research had the objective of investigating the understanding of the Family Health Strategy (FHS) professionals about the Family Health Support Center (FHSC). The interest for the theme of this research was perceived during the practice of the Multiprofessional Residency in Family and Community Health. Sometimes the work of the FHSC teams generates unfamiliarity among the professionals of the FHS teams, and it may result in fragmented health practices and difficulties in the comprehensive and multiprofessional work.

Thus, this research can provide health professionals, users and the academic community with the recognition of different professional practices, the valorization of the work of FHSC teams in Primary Care, as well as the approximation and linking of health professionals, practices and users, resulting in the fulfillment of the comprehensive service of the users.

METHODOLOGY

The present research is configured as qualitative descriptive, since it contemplates aspects of the social reality[7]. The research project was approved by the Ethics and Research Committee (CEP) of the Universidade do Planalto Catarinense - (UNIPLAC), through the Opinion No. 1,536,139. The research was carried out in a municipality of Santa Catarina, in 2 Family Health Units (FHU), with Sunflower and Violet pseudonyms. The choice of these FHUs was due to the fact that there was no professional or academic involvement of the researcher, who did not know the professionals who were part of the 4 teams of FHS and the FHSC team.

Both family health units had 2 FHS and oral health teams linked to the same FHSC team. Each team served approximately 6 thousand people and had 22 health professionals. Twelve professionals with higher education from the 4 FHS teams belonging to the 2 Family Health Units, who worked for at least 6 months in the FHS teams, participated in the survey. Being: 4 doctors, 4 nurses, and 4 dentists. It should be highlighted that the profession of the participants, the name and Health Units in which they worked were not described in the data analysis, being represented by P (participant), numbering (1 to 12) and FHU as Violet Health Unit (Violet HU) and Sunflower Health Unit (Sunflower HU), to preserve the identity of the professionals.

For the data collection, contact was made with the managers of the study sites, who mobilized the participants of the research. The technique used for the collection was the semi structured interview, with a script built by the researchers, and the recording of the speech was done through audio recording[9]. The data collection took place from July to September 2016.

The interviews took place individually, by prior appointment, at the participants' work place and at comfortable times for the participants. The participants received, read and signed the Free and Informed Consent Form in two copies, in compliance with the Resolution No. 466/2012 of the National Health Council.

The collected data were treated through the content analysis, decomposing the answers through the construction of categories a *posteriori*, where the contents found in the speeches of the participants were grouped by their similarities[9]. Subsequently, the data with the available literature were articulated, thus seeking the interpretation and the production of new knowledge on the subject.

RESULTS AND DISCUSSION

Participants were aged between 26 and 54 years old, with an average of 34 years old. Of the 12 interviewees, 9 are female. This fact becomes relevant because it shows that even with the cultural and social changes and reconfigurations in the roles of women nowadays; we can see their predominance in the healthcare role.

The notion of care, as an action conceived as feminine, is a product of the "natural qualities" of women, a notion that is built historically, providing attributes and coherence to its exercise in the formal space of health work relations[10].

The average academic time of interviewees ranged from 1 to 22 years, but most of them graduated 10 years ago. 10 participants had a post-graduate level of specialization. Regarding the time of performance in the Family Health Strategy, it presented in average from 9 months to 18 years, and most of the subjects of the research had been working for about 6 years. It is believed that, even with the variation in the time of performance at the FHS, the professionals interviewed were able to speak about their reality.

It was observed that among the participants, 9 interviewees had other work activities besides the FHS, being in private clinics, hospital environment or teaching in higher education and technical courses. The issue of double employment is an issue that calls attention, because it is the reality of many public health professionals.

This data can be related to the precarious physical and material conditions of the workspaces, absence of guarantee of safety for work and health of the worker, distribution of workload, weekly working day, wage and career differences, and organizational fragility of the workers' policy[11].

Thus, from the analysis of the data, three categories were emerged: The FHSC in the FHS; FHSC Professional Practices; and Teamwork: Difficulties and Potentialities, presented and discussed below.

The FHSC in the FHS

The interviews with the professionals indicated differences in the understanding and knowledge of the practices performed by the same FHSC team that accompanies the Sunflower Health Unit and the Violet Health Unit. The professionals of the Sunflower Health Unit mentioned that they understand the FHSC as a multiprofessional group to support the FHS teams in health practices. However, it was observed that the professionals of the FHSC team focused on the main objective of interventions for the cases considered to be "most vulnerable" socioeconomically of the territory, demonstrating that this type of demand is the responsibility of Psychology and Social Work professionals.

> *I understand the FHSC as a team that comes to assist our work here in the health unit, it is the support of the psychologist, social worker [...]. (P1 – Sunflower HU)*

> *Their competence is all the evaluation, and what they can help in relation to the social part, regarding the family that is not structured, that has social problems. What is not our responsibility [...]It is more a legal and social support, a psychological assessment, a more thorough investigation of the family [...]. (P5 – Sunflower HU)*

The data indicate that the Sunflower HU professionals understand that the FHSC's job is a team that performs health interventions separately from the practices performed by the FHS professionals, with a focus on professional specialties. It is believed that understanding the health performance model in this way contributes to the strengthening of the biomedical model, resulting in fragmentation and prescription in healthcare. The non-interaction of the professionals makes it difficult to exchange knowledge and practices, imprisoning the work processes in rigid ways.

Thus, it is seen that the Sunflower HU professionals do not see the FHSC as a specialized back up for Family Health teams. The work should be shared and collaborative in at least two dimensions: clinical-assistance, in direct contact with users and technical-pedagogical teams, producing actions

of educational support with and for the teams[6].

For most Violet HU professionals, understanding the work of the FHSC team is to support, collaborate, and develop health practices, in a multiprofessional manner in the health unit, and aiming to carry out the activities together, in addition to the other FHS professionals, and not the individual work or focused on individual specialties/services.

> *The team will collaborate with the work of the BHU, they will not develop actions alone, but together with the other professionals, they will add and help to coordinate the groups [...]They are joint actions with the Unit, not isolated [...]". (P11 – Violet HU)*

> *The FHSC is another complement, it is to strengthen, it is to direct us the cases that have a difficulty resolution [...]We always refer cases to them and try a shared solution [...]. (P9 – Violet HU)*

It is understood by the speeches of the professionals of the Violet Health Unit that they approach the objective of the FHSC team, having the vision of teamwork and the exchange of knowledge present in the practices carried out by the professionals. This way of perceiving the work together goes towards the organization of the work processes of the FHSC, which should focus on the territory under their responsibility and be structured prioritizing shared and interdisciplinary care with training and mutual responsibilities. Generating experience for all the professionals involved[6].

The FHSC, as a National Policy implemented in 2008, was officially inserted in the new edition of the National Policy of Basic Care on October 21, 2011, by the Ordinance No. 2488 of the Ministry of Health, with a fundamental role in the care networks[12]. Through the speeches of the participants of the research it was evident that even the policy of the FHSC having its attributions and objectives consolidated, the perception of this policy differs in the diverse realities in the FHS.

The FHSC Professional Practices

In relation to the practices carried out by the FHSC team, the Sunflower HU and the Violet HU participants also perceive in different ways the performance models of the same FHSC team offered in their respective realities. It is assumed that this distinction is related to the (non) understanding of the work of the FHSC according to the Policy, and the lack of integration of practices between the FHS and the FHSC.

The Sunflower HU participants mentioned that they realize that the work of the FHSC team is about monitoring "vulnerable" families through home visits, individual consultations (mainly from Psychology and Social Work professionals), referrals to other services of the health network, conducting matricity meetings and participation in groups.

> *[...] The realization of groups, I would like to have individual consultations [...] Here there is a large demand for patients who need a psychologist [...]. (P1 – Sunflower HU)*

> *The work of the FHSC is more matricity, it does not have the follow up [...]If you have a psychological problem, go there, guide and refer, do not follow up, only when it is really necessary [...]It is not individual care, it is not therapy, it is matricity. (P3 – Sunflower HU)*

It can be observed from the statements that, in addition to the practices performed, most professionals interviewed mention the psychological counseling and individual care as interventions that should be performed by the FHSC team in order to meet the demand and problems in the community served.

However, the work of the FHSC is not just a methodology, which refers to individualized and fragmented health. The performance of the FHSC is guided by the theoretical-methodological framework of the matrix support, which happens from the integration of the Family Health teams involved in the attention of the common situations/problems of a given territory, with teams or professionals from other knowledge centers - in addition to the professionals of the Primary Care teams[6].

Regarding the interviewees of the Violet HU, they also mentioned referrals and individual consultations as practices carried out by the FHSC team. However, they point out that the interventions are based on health promotion and disease prevention through the groups in which the FHSC professionals participate and perform in the Family Health Unit.

> *The FHSC makes the referral and the counter referral to the network, referral of the most vulnerable cases, groups, it does health promotion, disease prevention. The issue that I think tht is very important of the FHSC is the matricity [...]. (P7 – Violet HU)*

> *It would be the cases, always do the matricity with the FHS, regarding the social problems, the psychologist intervening, collaborating with the Unit in relation to physical activity, it has our strong groups. But the main one is the matricity of the cases [...]. (P11 – Violet HU)*

The performance of the FHSC teams stands out by the matricity. It is verified that the professionals interviewed mention the holding of biweekly meetings of matricity, a fundamental part in health work. The respondents stated that through these meetings they were able to approach and reflect together with the FHSC team on possible interventions and solutions to the demands of the Family Health Unit.

The matricity is a tool that can foster the knowledge of the reality, the approximation between health teams, and the joint responsibility for the cases or situations to be faced. Aiming at the problem-solving, planning, scheduling and execution of collaborative actions between the FHSC and the FHS, agreeing on healthcare actions among the teams[5 6].

It is believed that another resource to approach the FHSC and FHS teams, as well as to potentiate these problematizations and joint planning is to consider the applicability of Permanent

Health Education. Since it allows professionals - in a team - to focus on their work process and, from this and the problems experienced, to reflect, build and transform everyday situations in learning and alternative actions.

The Permanent Education in Health is an educational process that puts the daily work or health training under analysis, permeated by concrete relationships that operate realities and that makes it possible to construct collective spaces for the reflection and evaluation of the meaning of the attitude produced in daily life[13].

The Permanent Education should also be seen as a tool of the FHSC teams and as an emancipatory process of health professionals and, consequently, of service users. After all, through this it is possible to build a moment beyond the immediate care of the users, during which it proposes the collective discussion and the problematization of what it involves to get sick. It is a step in the management of the healthcare.[14]

Thus, through the matricity and multiprofessional interventions, the importance of doing of the FHSC is believed when it seeks to collaborate for qualified action practices, increasing the resolving capacity of the teams and problematizing the work processes for a shared and integrated logic between the teams.

In this sense, despite the different professional backgrounds, a high degree of articulation and sharing of actions within the health unit (between FHS and FHSC) is necessary. Emphasizing the interdisciplinarity in the work process and in the capacity of care of the teams, both in terms of FHS professionals and FHSC[15].

Teamwork: Difficulties and Potentialities

It is known that in health practices, teamwork and multiprofessional work is a constant challenge for professionals. It was evidenced that there are obstacles in the integration and the teamwork between the professionals of the FHS and the FHSC. Some professionals have reported that the FHS professionals do not see the FHSC team as part of the health team. In addition, highlighting characteristics of the work dynamics of the professional categories interviewed (Medicine, Dentistry and Nursing) in the Family Health Units. These aspects of lack of approach and interaction between the FHSC and FHS teams are observed in the following statements.

> *In fact, the team does not receive the FHSC as if it were part of the team, they (FHSC professionals) come once a week, it's very little right? (P1 – Sunflower HU)*

> *They (FHSC professionals) do not know much, do not get involved, do not stay a lot here [...]. (P4 – Sunflower HU)*

> *I think they (FHSC professionals) create a lot of trouble [...]So, they make it very difficult to return*

with us [...] In fact, they are here to give support, so they would have to come and advise us, and we do not suit ourselves according to their routine. (P5 – Sunflower HU)

[...]I cannot see the practice of all the professionals because I do not have much contact with them, usually we stay here in the office, locked, attending and we cannot see the rest [...]. (P2 – Sunflower HU)

Faced with the interviewees' positioning, it is observed that the professionals of the health teams distanced their practices of care, restricting them to the referrals of individual cases and clinical care.

Therefore, it is possible to reflect that for teamwork to happen, one should have the detachment of looking only at his professional doing. In addition, it is essential the availability to approach the other areas, so that there can be interaction between workers. Otherwise, without the exchange of knowledge and articulation in the production of care, it cannot be said that there is teamwork[16].

The results of the research indicate that health professionals face difficulties to reinvent their practices and detach themselves from the traditional model of healthcare, losing the perspective of health promotion and prevention and collective actions. It is emphasized that the absence of teamwork can compromise the quality and efficiency of healthcare, in this way, the process of teamwork is related to the reflection about the sense of team[17].

The health teams often organize themselves without communicative action, marked by the hierarchical relationships of subordination, a common value attributed to the traditional biomedical model of health. The multidisciplinary team, whose purpose is to constitute a space for dialogue and exchange of knowledge, has often been used to establish the division of labor and roles, strengthening the individualization of the professionals to the detriment of horizontal and collective relations[18].

On the other hand, some professionals interviewed stated that teamwork happens in partnership with the FHSC.

It is a complement to the other, because we have to work together for supporting other professionals [...] There is no way to work apart, they will not be able to have greater contact with the community if we do not work together, and we cannot do a more complete job without them. (P8 – Violet HU)

We work a lot together, we do not work alone, the FHSC will take care of this case or just the nurse, make the calls together so everyone has the same vision of the case. (P7 – Violet HU)

This work organization carried out by the professionals results in the approach of the teams, a broader knowledge of the work of the FHSC and the possibility of multiprofessional work. Because the health-disease process is complex, it depends on the interrelationship between health professionals, users and the community. It is believed that the partnership between the FHSC and

the FHS team has the potential to improve the work together and the quality of the practices, modifying the interaction of those involved and the planning of health actions.

Most of the professionals from the two health units (Sunflower and Violet) mentioned aspects that hinder the work relations, the interventions in the team and the continuity of the work accomplished by the FHSC. Among these difficulties, they report the lack of space in the physical structure of the health units, for both teams (FHS/FHSC), the presence of the FHSC in only once a week, the lack of some professional categories, and the rotation of the members of the FHSC.

> *They (FHSC professionals) do not come every day, once a week, it's kind of complicated. Sometimes I give them my office [...] that's a bad thing about our meetings too. [...]. (P1 - Sunflower HU)*

> *[...]They changed teams often, because they had a very large turnover [...]. (P5 – Sunflower HU)*

> *The FHSC is improvised in the meeting room, which is the room of the Health Agents, when there is a group they have to leave, when they need to attend they have no room. (P7 - Violet HU)*

> *I think there's a lack of a personal environment for the FHSC, [...] So that's a little disruptive to the team's relationship [...]. (P9 - Violet HU)*

To be a health professional, it is important to have scientific and technological knowledge, but it is also necessary to have humanistic and social knowledge in the care process. Knowledge acquired through the contact with people and by revisiting personal and professional needs at the moment that difficulties appear in the work environment[19].

Therefore, it should be emphasized that the multiprofessional and interdisciplinary practice can be an association of disciplines, knowledge and actions; they are called as specialized technicians, on account of a project or objective that are common to them, to solve this or that problem, with exchanges and cooperation between the subjects involved[20].

In this way, teamwork and the integration of health practices must be based on the needs, difficulties or limits of the health teams. Seeking to contribute to the increase of the capacity of care of the supported teams, in order to expand the scope of offerings (range of actions) of the Family Health Units, helping the articulation of/with other points of attention of the network, when this is necessary, in order to guarantee continuity of care[6].

FINAL CONSIDERATIONS

The FHSC, as a National Policy consolidated in the model of Primary Healthcare, has its important role in the FHS, aiming at a remodeling the SUS work processes and health practices. Its mission is to develop planning and strategies for the multiprofessional work, strengthening the articulation and qualification of the service network that makes up the health system.

Through the research data, it was observed that for most FHS professionals, the understanding of the FHSC is embodied in a multiprofessional team that supports them in relation to the social demands and vulnerabilities existing in the territories covered by the Family Health Units researched. In addition, it was evidenced that the presence of a FHSC team in the FHS causes changes (not always positive) in the work processes and in the dynamics of the health units functioning - often processes that are rooted in the traditional and hegemonic patterns of the biomedical model.

It is important to emphasize that in order to transform the work processes, the health professionals need to understand the importance of reformulating their traditional practices and being willing to work in a multiprofessional way. Thus, through the data, we can observe the differentiation of the vision of the two FHS teams on the same FHSC team, where one FHS team resists the attempts of changes of the health practices, while the other team welcomes and realizes the importance of the FHSC team in their health production space.

Thus, in relation to teamwork, it is believed that this practice remains a challenge among health professionals, because it is perceived that the professionals have difficulty in reflecting on their actions and on the possibility of approaching the collective work. Therefore, it is considered that collective health work spaces are governed by the interaction and integration between the subjects, professionals from different areas and users. Otherwise, there will be difficulties in promoting and qualifying health practices and relationships.

It is believed that the FHSC has possibilities and potentialities for the development of multiprofessional work, favoring with its diverse knowledges the organization of the health pathways that facilitate the coordination and continuity of care with the other FHS specialties, thus forming a shared knowledge.

Even believing that the FHS is a model of reorientation for health, as indicated by the research data, it can be stated that the practices and interventions are still focused on specialties and isolated interventions, aiming at healing and immediate results, remnants of the biomedical model focused on the biological. However, it is perceived, based on the speeches of the professionals interviewed (even in short steps), a movement towards the intersectoral approach, articulating knowledge and experiences in the planning and implementation of actions, aiming at achieving integrated results in the most diverse situations and raising a positive impact on the living conditions of the subjects.

In this way, it is believed that even if health teams face daily challenges in health and teamwork – as some professionals interviewed mentioned, there are difficulties in relation to the physical structure of health units and the interaction between teams and scientific knowledge – the FHS teams perceive the relevance of a scientific, material, and human complement to the health interventions, such as the relevance that a FHSC team can provide.

With this research, it is possible to broaden the perception of the FHSC and its practices at the FHS, and to understand how the FHS professionals understand and integrate with that team. Thus, it is possible to reflect that it is necessary to revisit the professional practices of both teams, since the work in Primary Healthcare requires multiprofessional work. In addition, it is necessary to think about spaces for reflection and discussion about the various processes, scenarios and actors of the health work, in order to consolidate a comprehensive and emancipatory care.

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