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Teamwork in the implementation of a group in the Family Health Strategy

O trabalho em equipe na implementação de um grupo na Estratégia Saúde da Família

El trabajo en Equipo en la Implementación de un grupo en la Estrategia Salud Familiar

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ABSTRACT

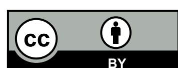
Objective: To understand how the implementation of a therapeutic group influences the teamwork process in the Family Health Strategy (*Estratégia Saúde da Família – ESF*). **Methods:** This is a single case study of a qualitative and exploratory nature carried out between November 2018 and February 2019 in a Family Health Center belonging to the VII Health District of the city of Recife, Pernambuco, Brazil. Eight professionals from the family health team and the extended family health and primary care center participated. These were involved in the construction of a therapeutic group. Data were collected from a focus group and content analysis was used based on a theoretical framework of health education, matrix support and interprofessionality for data analysis. **Results:** With the construction of three thematic categories – the group experience as a health promotion tool; health training and group work; the group and the influence of matrix support on teamwork – the interviewees said the therapeutic group encouraged self-care as it shared alternative forms of care, expanded the field of professional action and the team's potential for intervention in the reality of users' health. **Conclusion:** The construction of a therapeutic group presents professionals with a powerful health education strategy to create spaces for learning, sharing and user embracement within the primary care service. While enhancing self-care and encouraging users' autonomy, this construction process promotes health by influencing the way teamwork is organized.

Descriptors: Family Health Strategy; Health Promotion; Group Processes; Interprofessional Relations.

RESUMO

Objetivo: *Compreender como a implementação de um grupo terapêutico influencia no processo de trabalho em equipe na Estratégia Saúde da Família (ESF).* ***Métodos:*** *Trata-se de um estudo de caso único, de natureza qualitativa e exploratória, realizado entre novembro de 2018 e fevereiro de 2019 em uma Unidade de Saúde da Família pertencente ao Distrito Sanitário VII da cidade do Recife, Pernambuco, Brasil. Participaram oito profissionais da equipe de saúde da família e do núcleo ampliado de saúde da família e atenção básica, que se envolveram na construção de um grupo terapêutico. A coleta de dados aconteceu a partir de um grupo focal e utilizou-se a técnica de análise de conteúdo com referencial teórico da educação em saúde, do apoio matricial e da interprofissionalidade para a análise dos dados.* ***Resultados:*** *Com a construção das três categorias temáticas – a experiência do grupo como dispositivo de promoção da saúde; a formação em saúde e o trabalho com grupos; o grupo e a influência do apoio matricial no trabalho em equipe, para os entrevistados –, o grupo terapêutico incentivou o autocuidado, à medida que compartilhou formas alternativas de cuidado, ampliou o campo de atuação profissional e o potencial de intervenção da equipe na realidade de saúde dos usuários.* ***Conclusão:*** *A construção de um grupo terapêutico apresenta, aos profissionais, uma estratégia de educação em saúde potente para criar espaços de aprendizado, compartilhamento e acolhimento dentro do serviço de atenção primária. À medida que potencializa o autocuidado e estimula a autonomia dos usuários, esse processo de construção promove saúde por influenciar na forma como está organizado o trabalho em equipe.*

Descritores: *Estratégia Saúde da Família; Promoção da Saúde; Processos Grupais; Relações Interprofissionais.*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RESUMEN

Objetivo: *Comprender cómo la implementación de un grupo terapéutico influencia en el proceso de trabajo en equipo en la Estrategia Salud Familiar (ESF).* ***Métodos:*** *Se trata de un estudio de caso único, de naturaleza cualitativa y exploratoria, realizado entre noviembre de 2018 y febrero de 2019 en una Unidad de Salud Familiar perteneciente al Distrito Sanitario VII de la ciudad de Recife, Pernambuco, Brasil. Participaron ocho profesionales del equipo de salud familiar y del núcleo ampliado de salud familiar y atención primaria, que se comprometieron en la construcción de un grupo terapéutico. La recogida de datos ocurrió a partir de un grupo focal y utilizó la técnica de análisis de contenido con referencial teórico de la educación en salud, del apoyo matricial y de la interprofesionalidad para el análisis de datos.* ***Resultados:*** *Con la construcción de las tres categorías temáticas – la experiencia del grupo como dispositivo de promoción de la salud; la formación en salud y el trabajo con grupos; el grupo y la influencia del apoyo matricial en el trabajo en equipo, para los entrevistados –, el grupo terapéutico incentivó el autocuidado, a la en que compartió formas alternativas de cuidado, amplió el campo de actuación profesional y el potencial de intervención del equipo en la realidad de salud de los usuarios.* ***Conclusión:*** *La construcción de un grupo terapéutico presenta, a los profesionales, una estrategia de educación en salud potente para crear espacios de aprendizaje, intercambio y acogida dentro del servicio de atención primaria. Al paso que potencializa el autocuidado y estimula la autonomía de los usuarios, este proceso de construcción promueve salud por influenciar en la forma como está organizado el trabajo en equipo.*

Descriptores: *Estrategia de Salud Familiar; Promoción de la Salud; Procesos de Grupo; Relaciones Interprofesionales.*

INTRODUCTION

Primary Health Care (PHC) represents the first contact of users with the health care network and presents itself as an alternative to the predominant health care model historically influenced by the biomedical model of care and curative practice focused on biological and individual aspects[1-3].

The increase in noncommunicable diseases and the sociocultural impact on the population's living conditions demanded profound changes in the way services were organized[4]. In that regard, the Family Health Strategy (*Estratégia Saúde da Família – ESF*) was adopted as a way to organize PHC by developing health promotion, disease prevention, diagnosis and treatment, rehabilitation and harm reduction actions through the Family Health Teams (*Equipes de Saúde da Família – eSF*)[2,4].

The work process of the eSF occurs in a multiprofessional way and considers the singularities of people, the family and community context in which they live, articulating the knowledge of physicians, nurses, nursing technicians, dentists and community health workers (CHW)[2,4-6]. This work dynamics made it possible to identify new health needs that justified the creation of the Expanded Center for Family Health and Primary Care (*Núcleo Ampliado de Saúde da Família e Atenção Básica – NASF-AB*) in 2008 with the aim of expanding the scope and problem-solving capacity of the actions developed by eSF[7].

One of the working tools of NASF-AB is the construction of collective spaces for health education as a way to encourage the autonomy of individuals and develop health promotion actions[5]. Health education represents an axis of support for the National Health Promotion Policy (*Política Nacional de Promoção da Saúde – PNPS*), which understands health as an expression of objective living conditions (housing, work, income, food, environment, education, transport, leisure, land ownership), which are subject to action and transformation[8].

The construction of groups represents one of the ways to promote health education activities and maximize the care offered by ESF teams. These groups can be open, closed, thematic, social or therapeutic and should guide care based on the concepts of health education and health promotion[9-11].

For an effective development of groups, teamwork is essential where professionals can interact, dialog and problematize the multiple factors that influence the lives of users. However, as a result of the daily demand, the work process of eSF may reproduce fragmented care practices where there is a shortage of spaces that integrate professionals[3,12].

To understand the organization of teamwork within ESF, the implementation of a group was chosen as a tracer condition. In this study, it is believed that the organization of professionals around an activity common to ESF, as is the case of groups, reflects the difficulties, potentialities and challenges experienced in daily teamwork. Thus, this study aimed to understand how the implementation of a therapeutic group (TG) influences the teamwork process within the Family Health Strategy.

METHODS

A qualitative and exploratory single case study was carried out between November 2018 and February 2019 in a Family Health Center (FHC) belonging to the VII Health District of the city of Recife, Pernambuco, Brazil.

This FHC had two eSF, each composed of one physician, one nurse, one nursing technician, one pharmacist and five community health workers (CHW) in addition to one oral health team and a professional responsible for regulation. The FHC had the support from professionals linked to a Multiprofessional Family Health Residency (*Residência Multiprofissional em Saúde da Família – RMSF*), but the NASF-AB team responsible for the territory was represented exclusively by the residents and composed of physical therapist, occupational therapist, psychologist, speech therapist, nutritionist, physical education professional, social worker and health worker. In addition to the receptionist, security guard and general services assistant, the FHC had 34 workers from the Unified Health System (*Sistema Único de Saúde – SUS*).

The implementation of a TG was proposed by the physician of one of the eSF after observing the high dispensing of analgesic drugs in the Family Health Center (FHC). According to the eSF professionals, this demand for analgesics was directed at users with chronic pain, whose medication was the form used to relieve symptoms. In an attempt to interfere in this context and act on the dimensions that permeate care for chronic conditions, a multiprofessional and interdisciplinary working group on chronic pain was created at the FHC composed of professionals from eSF and NASF-AB professionals.

This working group was intended to define the TG objectives, plan the meetings and build moments of matrix support and permanent education. Working group participants were the physician of one of the teams, one physiotherapist, one physical education professional, one psychologist, one nutritionist, one pharmacist, one sanitarian and one CHW. After six meetings, the working group presented the action proposal to the FHC and began the implementation of the TG, which was developed at the FHC itself and which aimed to encourage users' self-care by sharing knowledge and presenting non-drug therapy alternatives to deal with chronic pain.

The TG meetings took place weekly over three months (June, July and August 2018), totaling ten meetings. Each meeting consisted of thematic dialogs with participatory methodologies and guided and supervised practical activities. In addition, all FHC professionals were invited to participate and contribute to the activities.

The selection of topics was initially carried out by the working group based on topics of interest to users in the first meeting. Thus, the TG addressed the following topics: self-medication; Phytotherapy; psychological aspects of pain; physical exercise and activity for pain control; integrative and complementary practices; relaxation; joint protection and spinal care; and food education.

After the completion of the TG, the professionals involved participated, upon invitation, in a Focus Group (FG) [13] with the aim of discussing aspects related to the construction of the TG and teamwork. eSF and NASF-AB professionals who were involved in the working group and/or in the TG activities, except those who were away from the work environment due to holidays, medical leave or unavailability, were also invited to participate in the FG.

Eight professionals participated in the FG, two from the eSF (dental surgeon and nursing technician) and six members from the RMSF in the areas of Dentistry, Nursing, Pharmacy, Physical Education, Nutrition and Public Health. The other professionals could not participate due to unavailability of time.

Table 1 - Characteristics of the professionals who participated in the Focus Group, 2018

ID	Professional category	Type of team	Graduate year	Time working in PHC
01	Physical Education Profession	Resident	2017	3 years
02	Dental surgeon	eSB	2002	15 years
03	Sanitarian	Resident	2016	*
04	Nursing technician	eSF	2001	20 years
05	Nurse	Resident	2016	*
06	Dental surgeon	Resident	2012	1 year and 7 months
07	Pharmacist	Resident	2017	*
08	Nutritionist	Resident	2016	*

ID: Identification; eSF: *Equipe de Saúde da Família* (Family Health Team); eSB: *Equipe de Saúde Bucal* (Oral Health Team); * Professionals who joined the RMSF shortly after completing their undergraduate studies and had no previous work experience in PHC besides those provided by the undergraduate program

The FG lasted one hour and forty minutes (1h40min) and was held at the FHC in December 2018 on a date and time agreed with the participating professionals. In conducting the FG, a script was used with guiding questions organized around thematic axes (Table I). Each professional was able to present their ideas and listen and respond to others aiming at synergy between people and not consensus. Audio recording was performed using the application RecForge II Proe. During the transcription of the interviews, professionals were identified as numbers from 01 to 08 respecting the order of appearance of their reports during the transcription.

Chart I - Thematic axes guiding the focus group and the respective thematic categories that emerged from the reports, Recife, 2019

Thematic Axis 1: Knowledge about the therapeutic group in the Family Health Strategy
1. What's your understanding of groups within ESF?
2. In your opinion, how does the demand for the construction of a group at the FHC arise?
3. In which environment(s)/space(s) did you learn to work with groups?
4. Did your professional training enable you to work with groups?
5. Do you feel able to strategically plan the construction of groups in the Family Health Center?
Thematic axis 2: Matrix support in the construction of a therapeutic group.
6. In which spaces does matrix support occur at this FHC?
7. What is the influence of matrix support in your daily work? And in the creation of the therapeutic group?
8. What is your opinion about the chronic pain working group?
9. Do you think the presence of other professionals during group activities is important? For what reason?
10 How did building the group influence your team's work process?
Thematic axis 3: Difficulties and potentialities observed in the construction of a therapeutic group.
11. What factors hindered the construction of the group and the elaboration of thematic workshops?
12. What factors potentiated the construction of the group?
13. In your opinion, what did the therapeutic group leave as positive for the FHC, for users and for professionals?
14. What incentives did you receive to form the group? What form of incentive would you like to receive?

Thematic content analysis was used to analyze the data since it fits the objective of this study to understand the professionals' narratives about aspects related to the teamwork process developed from the construction of a TG. In content analysis, a set of techniques allows understanding, interpreting, analyzing and inferring about the manifest content of communications in a given context[13,14].

Maxqda 2020 for Windows 2010 was used to store and transcribe the interviews which were later subjected to successive readings in order to understand the whole of the data, organizing them and determine the main recording units. The exploration of the material allowed the grouping of common themes and resulted in the construction of thematic categories – significant expressions that organized the content present in the interviews[13,14] – allowing the interviews to be divided into main thematic categories and the extraction of meanings associated with the experience of building a TG as a team[13]. Thus, it enabled the construction of three thematic categories: the group experience as a health promotion tool; health training and group work; the group and the influence of matrix support on teamwork.

This study was approved by the Research Ethics Committee under Approval No. 3.064.700 and represents the product of an RMSF completion work.

RESULTS AND DISCUSSION

The theoretical framework used to analyze the professionals' perceptions was based on authors whose scientific production permeated the concepts of health education and aspects of the teamwork process in Primary Health Care (PHC). The concept of Popular Health Education[15] was adopted and influenced by other ideas in order to complement the concept of Health Education[16]. The reflections on the aspects inherent to teamwork were based on the concept of teamwork, the concept of Permanent Education[17], the concepts of field and core of knowledge and matrix support[18] and interprofessionality[19].

The group experience as a health promotion tool

The professionals interviewed understood the TG as a common health promotion tool in PHC that breaks with the biomedical view of care and offers alternative forms of care by using health education as an enhancer of self-care. The identification of the demand for the construction of the TG was pointed out as a factor defined from the daily work and the sensitivity of the professionals who work at the FHC.

Health education integrates pedagogical methods in order to transform behaviors from the sharing of scientific knowledge capable of intervening on health conditions[15]. Complementarily, popular health education values individual experiences, popular knowledge and the daily thinking of the population, permeating dialog, love, problematization and emancipation[16,20].

Based on health education, groups in the ESF provide users with tools to understand their health condition and incorporate self-care strategies[9]. These groups also represent spaces for interaction, sharing and recognition based on the particularities and experiences of the others[9,10,21]:

> *"I see the group as a space for exchange between the participants in this care process, for the inclusion of the user in this place of taking care of themselves as well." (Professional 03)*
>
> *"Recognizing that my problem is also in the other causes empathy. You see that you are not alone, that there are other people in the community with the same difficulty." (Professional 04)*

The professionals interviewed understood that the sharing provided by the TG transformed the group into a welcoming space where there is space to talk about difficulties. During this exchange of experiences, the user establishes bonds of companionship and recognizes that their problem may be similar to the problem of the others, thereby expanding networks of solidarity in the territory[9,10]. Thus, while learning from the experience of the others, users also teach, triggering a therapeutic effect even if this is not the group's objective[22].

Understanding the role of users emerged as an important aspect to optimize self-care in health. Thus, in order to encourage users to take a leading role in their health care, it is important to transform the traditional, vertical and hierarchical form of knowledge transmission, which uses only lectures focused on health problems, and focus on active and participatory methodologies that foster dialogs that embrace subjectivities and individual experiences[9,10]. In doing so, the group also becomes a space for collective listening, motivating users to adopt an active stance in the face of the problems presented[11,23]:

> *"In the case of this group, one thing that stood out was letting the user be the protagonist, offering, directing and equipping them to make their own decisions." (Professional 01)*
>
> *"It's impossible for you to have autonomy over something you don't understand. With the meetings, we tried to pass this on. Demystifying, talking about things they might not even understand that would interfere with the pain process." (Professional 07)*

Understanding that the solution to health problems is not limited to the use of biomedical technology or changing individual behaviors, ESF presents itself as a fertile territory for building this type of shared care based on groups[9,10,24]. These spaces promote the bond with the service, expand the user's understanding of their health and, consequently, favor changes in life habits that echo throughout the territory[9,10]. Thus, it is necessary to embrace therapeutic strategies aimed at quality of life and not at the normalization of behaviors and lifestyles[10,11,22].

Despite being highlighted as a challenge to be overcome, professionals understood that there was a link between users, staff and service. The choice of themes together with the users had a positive outcome among the interviewees – an important factor for establishing a bond and encouraging protagonism and co-responsibility by the TG and generating quick responses to the proposed activities.

User dropout was also considered a difficulty to be faced. This issue may be associated with the predominance of the biomedical model in the imagination of users, who seek clinical and individualized care even in collective spaces, even with the pedagogical strategies adopted and the ability to promote dialog based on experiences[9,10].

Active and creative methodologies encourage co-responsibility for the group and expand participation, thus preventing that measures such as the distribution of medicines, snacks, prizes or essentially assistance practices from becoming the only ways to attract and maintain attendance in the group[9,11].

For changes in behavior and lifestyle to be achieved, the needs of professionals and users need to be aligned. It is essential to understand that users are guided by their culture, knowledge, experiences, desires, expectations, limitations and needs. Professionals need to be able to recognize these dimensions and act according to what

they represent in order to enhance the ability of subjects to translate the information obtained into practical and transformative issues. Valuing users' knowledge opens space for questioning, promotes dialog and produces bonds and the collective construction of therapeutic projects[20,22].

With collective listening, group activities can also be important tools in monitoring the health situation of users, allowing the monitoring of needs, the identification of new demands and, consequently, the rationalization of work, as it can reduce demand for individual consultations[7,11]. The use of epidemiology, local health diagnosis and integration with experiences from other territories help to define the best group format to be implemented[5,9,11,23].

In this study, the professionals interviewed understood that the TG expanded the offer of care and the service's problem-solving capacity. However, it is essential that professionals identify the TG as part of the care line for chronic conditions at the FHC and be trained to use this tool in order to contribute to health care.

Health training and group work

The influence of training on qualification for working with groups was presented as one of the themes provoked in the FG. This reflection took into consideration both academic experiences and experiences developed in the daily life at the health service.

In the present study, the professionals reported a lack of subjects on public health and a short period of internship in PHC during their undergraduate studies, which, added to a clinical practice guided by specialties, made it difficult to develop competences for developing collective activities in PHC.

As shown in Table I, professionals 02 and 04 had worked in PHC for more than 10 years. Of the residents, only Professional 01 and Professional 06 had worked in PHC before joining RMSF. Professional 06 had already completed a residency in Public Health and Professional 01, despite having graduated in 2017, had a second degree in the health field. These characteristics provided opportunities for their performance in PHC. The other residents joined the program as soon as they completed their degrees; therefore, RMSF was these professionals' gateway to the health work market:

> *"[...] So, in my training I had no idea what a group was. 16 years ago it was very clinic-centered. Totally centered on the clinic. And Dentistry is kind of separate, you see it anyway, you arrive at any health center and Dentistry is kind of separate. It's a little box. I see that there has currently been a change in the curriculum and this has brought it closer together, but even so it is very focused on the clinic [...]." (Professional 02)*

The literature shows that health education is still heavily influenced by the Flexnerian model based on a biomedical and clinical and individualistic logic. The fragmentation of knowledge and the focus on biological conditions resulting from this approach stimulate little reflection on the contexts that determine and condition people's health[24,25].

Thus, the experience with groups was approached in different ways. Three professionals stated that they had no relationship with this approach in their training, two professionals mentioned specific experiences and three reported training aimed at learning scenarios in PHC through groups, with two of them happening in higher education and one in technical education:

> *"Public health people have training very focused on management. We have an axis that is health care and that is where we learn to think about activities with users." (Professional 03)*
>
> *"We work a lot with health education. In college we also always discussed group work, but sometimes they were very specific groups. When we did talk about it, it was about a group of pregnant women, a group of children, but we never addressed the possibility that groups can address any theme." (Professional 05)*

The practical experience with groups also emerged in the reports of extension and research projects and the experiences with social and student movements, which qualified the work with groups in the ESF. In understanding the first contact with the SUS, the longitudinality of care and the coordination of care as essential attributes of PHC, it is necessary that this level of care represents a structuring axis of higher education in the health field in Brazil[1,24].

A milestone to support these initiatives was presented by the publication of the National Curriculum Guidelines (*Diretrizes Curriculares Nacionais – DCN*) for undergraduate health courses in 2001 with the aim of directing and guiding curricular changes that would enable contextualized training that would allow responding to health needs of the population and the work process in PHC[24,25].

In this scenario, PHC services have become preferred places to diversify practices in health education and, based on the strengthening of teaching-service integration, qualify the teamwork process[24,26]. In terms of services,

the National Policy for Permanent Education in Health (2004) sought to overcome traditional training models using learning at work and for work:

> *"I was trained as a health worker to do group work. So, there was a specific training for group building. As a nursing technician, I sought to do pro-technical public health training, which is also not available on the market. It was done because of the civil servant exam and then there we discussed a lot of group formation." (Professional 04)*

Continuing health education actions incorporated into the daily practice of services amplify the ability to intervene and build transformative practices[26]. Thus, the interviewees refer to the presence of RMSF in the FHC as essential to encourage work with groups. RMSF has the potential to encourage teamwork, propose alternative paths and guide changes in the work process at the FHC, sensitizing professionals and building ongoing education processes on a daily basis[27]:

> *"When I left college, I went to a Family Health Center, but the group I participated in was a group related to oral health. The place where I was able to actually know the concept of group was the residency. It was there that I began to know that I could insert myself anywhere." (Professional 02)*

In this research, it was identified that the interaction between FHC workers and residents potentiated training on groups and reaffirmed the importance of teamwork. However, residents tend to be overwhelmed by the demand for assistance from the service, especially when the FHC does not have the coverage of a NASF-AB.

The interviewees defend that the matrix support, carried out among the professionals during the working group, enabled them to build the TG, but they recognize the need to adopt a more integrated teamwork concept that can provide effective responses to the health needs of the population. In this process, as the ESF incorporates the educational process into the daily routine of the service, joint mobilizations are necessary in order to integrate training and health work[17,26].

The group and the influence of matrix support on teamwork

The interviewees in the present study understood that teamwork expands their field of action and the potential to interfere in reality as long as there is a sharing of responsibilities. The adequate understanding of teamwork in ESF allows articulating the knowledge and practices necessary for comprehensive care, which are guaranteed only when the perception of the need for the other's work is valued[23,28].

According to Professional 03 "if you know what the other professional does, you start to reflect on what you can do too". Thus, cooperation between different areas of knowledge and recognition of different positions in relation to the same object is essential[29,30].

It is supported by this perspective that matrix support emerges as a strategic tool to overcome the fragmentation of care and redefine the way of working as a team, creating networks of interdisciplinary dialog[18,20,27,30]. Through matrix support, the interviewees saw that, in addition to the characteristics that demarcate their core of knowledge, there is a field of common attributions, where new knowledge is supported in the performance of activities:

> *"As primary care, we have this support and this ability to work together and each one can be a pillar in one thing. As we, academically, are not prepared for this intersectoral work, the matrix support comes to provide the basis that we did not have in our undergraduate studies." (Professional 04)*

Matrix support is a powerful theoretical-methodological framework in the qualification of teams, in the definition of flows and, mainly, in the promotion of comprehensive and shared care. Through horizontal relationships, matrix support spaces allow the construction of multi, inter and transdisciplinary perspectives[18].

Based on the matrix support, the professionals interviewed in the current study understood the numerous possibilities of building groups at the FHC. However, some aspects were pointed out as factors that limited the effectiveness of the TG. The low participation of the CHW in the TG activities was presented as an aggravating factor to materialize the bond between the users and the group. The biomedical nature of the training, the daily demands of the service and the disbelief that the group is a care tool were presented as justifications for the resistance and low adherence of professionals in collective activities:

> *"[...] one thing that is commonly not valued for several reasons is the idea that group work is not a form of treatment." (Professional 01)*

As they are in permanent contact with the families, the CHW are the professionals most qualified to identify the real demands of the population, acting as a link between the FHC and the community, facilitating the surveillance work carried out by the entire team[29].

Thus, despite being highlighted as a challenge to be overcome, the professionals interviewed in the present study understood that there was a link between users, staff and service. The choice of themes together with the users had a positive outcome among them and was an important factor for the establishment of a bond, also encouraging the protagonism of the users and generating quick responses to the proposed activities. Valuing users' knowledge opens space for questioning, promotes dialog, produces bonds and the collective construction of therapeutic projects[20,22].

The difficulty in communication between professionals and between teams was pointed out as a problem, since not all of them added efforts in the construction of the group:

> *"We should have had a moment to talk only with the CHW about the group's objectives to mobilize them and for them to mobilize the other CHW and the patients, because we depend on them, they have a primordial, essential role in establishing this bond with the user." (Professional 08)*

Communication is essential for the planning of actions, and failures in this interaction create an environment conducive to fragmented care, harming the integrality of health care[23,30]. Understanding that the relationships between team members are dynamic, it is important to align the work process, recognizing the personal characteristics and technical specificities of each team member[20,28]. In that regard, teamwork based on interprofessionality makes it possible to create spaces for co-management, interaction, communication and reflection within the teams.

Interprofessional teamwork involves different professionals who share a team identity, recognize the roles of each profession and work together in an integrated, interdependent and collaborative way, establishing partnership relationships and sharing responsibility for the care provided[18].

The sustainability of the group proved to be a frequent concern among professionals. Despite the multiprofessional nature assumed in the construction of the TG, the residents became the professionals who were most responsible for the coordination, planning and organization of activities. However, the need for teamwork is reinforced by the residents:

> *"The group is not just one head, it is not just one view. We need a collective to build the group because when the group starts it is even easy, but to continue it is more difficult. When I say continue, it's not just about attractiveness, it's about keeping the ball rolling no matter what comes next and, often, we need to deviate from the planned path. So, even to direct a group we need to think about the collective." (Professional 01)*

Even with longer working time in the PHC, Professionals 02 and 04 did not feel capable enough to take responsibility for the group when the residents completed their in-service training at that FHC. However, there was a belief that the users themselves could reproduce this collective space of care in the community autonomously and independent of the FHC:

> *"[...] because the residents were leaving, it looked like the house was going to fall apart. What I saw was a group that was ready, I saw that the group existed. If they said: 'Well, since we don't have the group at the health center anymore, let's do it at home'. The idea I had was that the force was in them [...]." (Professional 04)*

Initially, this process may require the monitoring of professionals until the group consolidates itself as a self-managed space. Thus, assuming that the user must be co-responsible for the TG means enabling the construction of social spaces of care driven by the leadership potential existing in each person. The report from professional 04 presents a very frequent reality in teamwork involving residents. If there is no integration between the needs of the service, professionals and residents, the interprofessional dialog, which could be built, is weakened and the tendency to focus work on clinical and individual activities is strengthened[3,19,27].

In that regard, the TG becomes one more instrument of permanent education and motivation of professionals. Continuing health education activities, which use active methodologies and encourage discussion about the interprofessional teamwork process, qualify the work process developed by all teams in ESF[12,19]:

> *"[...] if we could motivate a greater number of professionals, whoever they are, we could have formation and continuity of groups. Of course, I know, everyday life is a tractor, there are many demands, but we change people's perception from a clinic-centered health to an expanded view of health [...]." (Professional 02)*

An important aspect highlighted by the professionals refers to the lack of training spaces to work with groups. In this context, it is necessary to maximize meetings between management and health workers, creating strategies

based on continuing education on educational practices with groups and, mainly, consolidating and equipping professionals for the importance of continuing education and matrix support to strengthen the teamwork necessary for the construction of groups based on the problems and practical experiences of daily life[12].

Regarding teamwork, the statements above registered that the experience of implementing the group encouraged the professionals' co-responsibility for the TG, expanded the understanding of the role played by each team member and of other possibilities of health care. Therefore, as it demands collaborative action from all team professionals, the TG becomes an interesting way to experience interprofessionality[5,9,19].

This study points to fundamental questions that permeate the implementation of a group in the daily life of ESF. The literature points out that several professional categories can promote health in the territories, as well as expand their intervention potential, based on the development of collective health education actions[5,6,9,19,22]. The creation of the NASF-AB was crucial for the consolidation of this perspective. And, although the literature permeates the theme and suggests commonalities, this study contributes to the field of health promotion by focusing on teamwork relationships for the development of groups with an educational content, with the interprofessional work process being essential for the effectiveness of actions in ESF[12,20,27,28,30].

Despite focusing on the implementation of a TG, the reflections present in this study can serve as support for the construction of groups in PHC services. However, it should be noted that the small number of participants and the fact that these professionals work in the same FHC limit the generalization of the findings of this study. Therefore, it is important to carry out further research on the organization of teamwork and its contribution to the strengthening of collective practices, such as groups, in health promotion actions within the scope of PHC.

FINAL CONSIDERATIONS

The construction of a TG is, according to the investigated professionals, a powerful health education strategy for the creation of spaces for learning, sharing and user embracement within the primary care service. There are challenges to be faced in the meetings produced between professionals and in the relationship they establish with users and their particularities.

Thus, the importance of RMSF in strengthening health promotion is highlighted through the construction of collective activities, such as therapeutic groups, and the encouragement of interprofessional teamwork, especially with regard to co-responsibility for these collective activities.

While enhancing self-care and encouraging users' autonomy, this construction process also promotes health by influencing the organization of teamwork. The TG is influenced by the professional experiences lived by each team member and challenges professionals to expand their horizon of knowledge and possibilities when it comes to offering non-drug therapy alternatives.

Access to training processes that encourage the integration of PHC professionals proves to be important in training to work with groups. Therefore, the construction of an interprofessional working group, based on permanent education and matrix support, can expand the intervention potential of the teams through the TG.

CONFLICTS OF INTEREST

The authors declare there are no conflicts of interest.

CONTRIBUTIONS

Josemar Ramos Nunes Junior and **Evelyn Siqueira da Silva** contributed to the conception and design of the study; acquisition, analysis and interpretation of data and the writing and revision of the manuscript. **Fabiana de Oliveira Silva Sousa** contributed to the acquisition, analysis and interpretation of data and the writing and revision of the manuscript. **Diego Francisco da Silva** contributed to the revision of the manuscript. All authors have approved the version of the manuscript to be published and are responsible for its content and integrity.

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