REFACS

Original Article
Rev. Fam., Ciclos Vida Saúde Contexto Soc.
http://seer.uftm.edu.br/revistaeletronica/index.php/refacs/index
ISSN: 2318-8413 DOI: 10.18554/refacs.v10i2.5414

Collaborative practices in basic health units and the role of management

Práticas colaborativas em unidades básicas de saúde e o papel da gerência

Prácticas colaborativas en las unidades básicas de salud y la función de la gerencia

Wellington Pereira Lopes[1], **Brigida Gimenez Carvalho**[1]

Received: 15/04/2021 **Approved:** 11/02/2022 **Published:** 29/06/2022

Objective: to analyze the collaborative practices and strategies used by management in primary health care. **Methods:** qualitative study, carried out in 2019, through interviews with managers in a municipality in the northern region of the state of Paraná, Brazil. Data were interpreted by discourse analysis and discussed based on the theoretical framework of Collaborative Practice. **Results:** Five managers participated, one from each region of the city, and four categories were organized: *Collaborative practices in primary care*; *Role of the manager in promoting collaborative practices*; *Incipient user participation in the construction of collaborative practices*; and *Situations that interfere in the consolidation of collaborative practices*. **Conclusion:** the presence of collaborative practices was demonstrated, so that the managers mainly used the strategies: release of professional agenda, articulation of spaces for matrix support and debates of the work process, individual feedbacks and organization of logistics.
Descriptors: Health Services Administration; Patient Care Team; Primary Health Care; Cooperative behavior.

Objetivo: analisar as práticas colaborativas e estratégias utilizadas pela gerência na atenção primária à saúde. **Método:** estudo qualitativo, realizado em 2019, por meio de entrevistas com gerentes em um município do norte do Paraná. Os dados foram interpretados pela análise de discurso e discutidos com base no referencial teórico da Prática Colaborativa. **Resultados:** Participaram cinco gerentes uma de cada região da cidade e organizou-se quatro categorias: *Práticas colaborativas na atenção básica*; *Papel do gerente na promoção de práticas colaborativas*; *Incipiente participação do usuário na construção de práticas colaborativas;* e *Situações que interferem na consolidação das práticas colaborativas*. **Conclusão:** demonstrou-se a presença das práticas colaborativas, de modo que as gerentes utilizavam principalmente as estratégias: liberação de agenda profissional, articulação de espaços para matriciamento e debates do processo de trabalho, *feedbacks* individuais e organização da logística.
Descritores: Administração de Serviços de Saúde; Equipe de Assistência ao Paciente; Atenção Primária à Saúde; Comportamento cooperativo.

Objetivo: analizar las prácticas colaborativas y estrategias utilizadas por la gerencia en la atención primaria a la salud. **Método:** estudio cualitativo, realizado en 2019, a través de entrevistas con gerentes de un municipio del norte de Paraná, Brasil. Los datos se interpretaron mediante el análisis del discurso y se discutieron a partir del marco teórico de la Práctica Colaborativa. **Resultados:** Participaron cinco gerentes de cada región de la ciudad y se organizaron cuatro categorías: *Prácticas colaborativas en la atención básica; Función del gerente en la promoción de prácticas colaborativas; Participación incipiente del usuario en la construcción de prácticas colaborativas;* y *Situaciones que interfieren en la consolidación de las prácticas colaborativas*. **Conclusión:** se demostró la presencia de las prácticas colaborativas, de modo que los gerentes utilizaron principalmente las estrategias: liberación de la agenda profesional, articulación de espacios para el soporte matricial y debates del proceso de trabajo, *feedbacks* individuales y organización de la logística.
Descriptores: Administración de los Servicios de Salud; Grupo de Atención al Pacient; Atención Primaria de Salud; Conducta cooperativa.

Corresponding Author: Wellington Pereira Lopes – E-mail: wellingtonp43@gmail.com

1. Postgraduate Program in Public Health at the Universidade Estadual de Londrina, Londrina/PR, Brazil.

INTRODUCTION

With the demographic and epidemiological transition that took place in recent decades in Brazil, there was a drop in birth rates and a reduction in mortality from infectious and parasitic diseases; with a concomitant increase in non-communicable chronic diseases, due to aging of the population and increase in obesity and sedentary lifestyle[1].

Such changes have intensified the population's demands for health services and brought to light the need to adopt methods and strategies that can fully and resolutely meet this new epidemiological profile. Some of the relevant strategies are team activities and collaborative practices[2].

Teamwork is characterized by the involvement of several professionals who, together, recognize their place as members and integrate to meet the demands of their users. However, such practice requires integration among workers, knowledge of roles and functions of each professional nucleus, planning and the expanded construction of collective therapeutic projects aimed at meeting more urgent and complex situations. Teamwork can be seen as a practice of deep sharing of values and reciprocity in collective actions[2].

The collaborative practice consists of work between two or more professionals and the user and aims at the welfare of the assisted, reducing the old model of hierarchy and competition between those involved, creating a partnership network during this process, while maintaining decision-making autonomy regarding of the case. Unlike teamwork, collaborative practice is more flexible and requires a lower level of reciprocity, interdependence and interprofessional sharing, without underestimating networking in care[3].

Collaborative practice brings the idea of ensuring care with the person and not for the person as a spectator of the entire process. In this way, there is a change from the need for the service and the professionals to the needs of the user. Thus, collaborative practice is not only linked between professionals, but also encompasses user participation[2].

In Primary Health Care (PHC), organized through the Family Health Strategy (FHS), the managements of the units must provide a more favorable environment for collaborative practices. These must be integrated, according to the complexity of the case, ensuring the involvement of professionals and users in care, reducing the fragmentation of actions and seeking greater comprehensiveness[3].

In this way, the manager of the Basic Health Unit (UBS) has the role not only of managing conflicts, but of seeking comprehensiveness in the health actions of users, through the organization of the work process with a view to collaborative work. For this to happen, user

inclusion is important in formulating strategies to articulate and integrate professionals, as well as encouraging collaborative practices to integrate the work process[2-4]. From this point, the question is: *What strategies are adopted in your daily work for collaborative practices among workers in UBS?* Thus, this study aims to analyze the collaborative practices and strategies used by management in primary health care.

METHODS

This is a qualitative, analytical study that was carried out in a large municipality located in the northern region of the state of Paraná, with a territorial area of 1,652,596 km^2 and an estimated population of 575,377 inhabitants[5]. The PHC network consists of 54 UBS, 42 in the urban region, 12 in the rural region and, in 2016, it had an average of 92 FHS teams, which covered 57.9% of the population, in addition to 10 teams from the Expanded Nucleus of Family Health (NASF)[5].

The study subjects were UBS managers, one from each region of the city, namely: north, south, east, west and center. To define the research subjects, the following inclusion criteria were used: units that constitute a field of practice of the multiprofessional residency or action of the NASF, signaled by the regional coordinator, thus considered as a key informant of the units that developed collaborative practices in their work process.

An interview was used, guided by a semi-structured script, containing questions that were about: *how do you see the development of the work process in the unit, if there are collaborative practices and how they manifest themselves, how you organize the work process so that such practices happen, how it is the users' participation in this process and if there is any factor that interferes in the development of collaborative practices.*

In the first moment, a pilot test was carried out (with a manager who did not participate in the research) and, only after verifying the applicability of the script, the interview stage was started. This process took place between May and August 2019. The interviews were carried out at the managers' workplace and were digitally recorded and transcribed in full. For the presentation of the results, the speeches were coded with the letter G, followed by a number in the order in which the interviews were carried out, namely: G1, G2...

The interpretation of the interviews was carried out through the discourse analysis proposed by Martins and Bicudo[6]. It comprised two moments: the ideographic analysis and the nomothetic analysis. At first, we looked for units of meaning and, for that, a floating reading of the transcripts of each interview was carried out, aiming to take ownership of the phenomenon, which allowed us to know the central ideas of the social actors. After that, the

nomothetic analysis was carried out, in which, after a new reading of the interviews, approximations were carried out and convergences and divergences were identified, which allowed the construction of categories for the structuring of the phenomenon studied[6].

This work adopted collaborative practice[3] as a theoretical framework, to analyze collaboration in complex systems that present heterogeneous forms of interaction between different subjects, as is the work process in PHC.

The theoretical model proposed by D'Amour *et al*[3] suggests that collaboration can be analyzed in four interrelated dimensions. The first two dimensions involve relationships between individuals, and refer to: 1) Shared goals and vision that consist of the existence of common perspectives and their appropriation by the team, the recognition of divergent motives and partnerships, and the diversity of definitions and expectations in relation to the collaboration. 2) Internalization that is related to the awareness of professionals about their interdependencies and the importance of managing them. It translates into a feeling of belonging, knowledge of each person's values and discipline, and mutual trust[3].

The other two dimensions involve the organizational scenario, which influences the action among professionals: 3) Formalization or structuring of care, which refers to the existence and use of documented procedures, which helps to clarify expectations and responsibilities and 4) Governance that refers to the leadership roles that support collaboration; it encompasses the role played by the authority in a clear direction for the development of collaborative actions, as well as favoring dialogic relations between workers and favoring their participation with a view to solving problems. Also noteworthy is the role of the leader in promoting adjustments in professional practice and in providing guidance and support for carrying out innovative interprofessional actions in the work environment[3].

Data collection with managers began with the explanation and subsequent signing of the Free and Informed Consent form. This work is linked to the research project entitled: "Performance of the Multiprofessional Residency in Family Health in Basic Health Units in the Municipality of Londrina", approved by the Research Ethics Committee of the Universidade Estadual de Londrina (CEP/UEL), under opinion No. 1,154,455/2015, CAAE: 46699415900005231.

RESULTS

Five managers participated, one from each region of the city. From the analysis of the results, four analytical categories were constituted: *Collaborative practices in primary care*; *Role of the manager in promoting collaborative practices*; *Incipient user participation in the construction of collaborative practices*; and *Situations that interfere in the consolidation of collaborative practices*.

Collaborative practices in primary care

For the managers, the work developed at the unit *is seen as a serious collaborative work, committed and very resolutive within its governance* (G5) among all the UBS servers, including the NASF. It was affirmed the development of a differentiated work and that, despite the divergences of ideas, a consensus is obtained, which is reflected in the integrated work.

There was an observation that the work process was different before the insertion of the NASF in the service, *each one of us worked more within their own sector* [...] *it was not multidisciplinary* (G3). This interviewee also mentioned that, from the moment the NASF was inserted in the UBS and the Family Health Program had the insertion of dentistry, there was a radical change in the work process, being transformed from a uniprofessional model to an interprofessional model.

On the other hand, there were reports that there is still individualized work at times, although there is a need to change this situation. They highlight *that the training of professionals tends to* [make] *the work like this* (G4), which favors the creation of this scenario.

Regarding the organization of work and collaborative practices, professionals implement such practices in working together, in moments of discussion of more complex cases and in the construction of a unique therapeutic project.

There was also reference to the development of planning among the team to face problems related to health indicators and the achievement of agreed goals. And even that *NASF is a necessary support for the primary care team to conduct and develop actions together with the community and even for matrix support* (G1).

Although collaborative work is more visible in the groups, *it also occurs in daily care, they always exchange information* (G2). There is the sharing of *activities, doubts, questions with each other* [to] *complement the service* (G2) and enhancing their actions.

In terms of access to NASF professionals, it was mentioned that it is easier on the day they are in the unit. This facility is more noticeable in units where there are residents, as they remain in the unit every day of the week. For the interviewee, the insertion of the residence

in the unit made the multiprofessional work more comprehensive.

Despite the manifestation of progress in the work process in the units studied towards collaborative practices, there is still a feeling of difficulty, especially on the part of *older employees; they have greater resistance, you call them to a meeting, they look at you with a frown* (G4).

According to this interviewee, in addition to collaborative practices occurring in groups, they also occur in shared consultations. He mentions the existence of a great sensitization among colleagues and that when someone is on sick leave or there is a need of some kind of help, there is a mutual collaboration between professionals, as they maintain all the assistance to the population in the best way possible, through coverage of scales and shared care.

The nursing team is the category that most performs collaborative practices in the unit; *I see that this team is more collaborative and goes in search and has, let's say, a potential for that* (G1). This interviewee mentions that, because the staff is not complete and there is no Community Health Agent (CHA) at the UBS, this team is even organized to supply the work that should be developed by other professional categories such as the CHA.

In addition to the nursing team, the NASF was another group mentioned among those who develop collaborative practices. And, among the professionals who are members of the NASF, there was no special emphasis on any specific category, *because you suddenly need a psychologist, a physical educator, a nutritionist who, in this way, contributes with their knowledge, I think there is no category that stands out in that sense* (G3).

In turn, it was mentioned that, even on the part of the NASF, there is difficulty in defining its attributions in the UBS and the resistance of several professional nuclei in the construction of collaborative work. Despite this finding, this has been minimized with the support of the NASF. *I think this is a construction that has improved a lot on a daily basis* (G4).

Role of the manager in promoting collaborative practices

There was unanimity that the work of the UBS management positively interferes with the occurrence of collaborative practices in the units, because they organize the team's work process, when they open space for discussion of various topics in general meetings, in addition to being open to suggestions and ideas that help in the work in a democratic way.

As a strategy, the organization of meetings was mentioned, which ensure greater integration between the workers of the unit, *I always try to mix the categories in the groups, like a NASF professional, a technician, a CHA, dentist, with a medical professional, a nurse to mix the teams up with this exchange of experience and bond strengthening* (G2).

The manager's interference occurs not only by opening spaces in meetings, but mainly by making the professionals' schedules more flexible. This allows the participation of different professionals in the actions that take place on a daily basis and so that they can organize matrix support and integration workshops: *by making the professional available to the groups, we collaborate in this sense, to enable the professionals' agendas and organize integration workshops* (G3).

They also contribute by promoting the articulation, organization and feasibility of infrastructure for the development of activities by the team with community groups: *I believe that I interfere more in the sense of facilitating these things to happen, not only technically, but logistically, to facilitate and to make it happen* (G4).

Also, through feedback to the team, or, especially, individually to a professional when necessary, in order to sensitize the worker about the importance of collaborative practices and teamwork, and also to break prejudices and paradigms created throughout the professional practice: *depending on the situation, it can be a direct action, I ask the person to talk, I exemplify how it has to happen, I often give advice to the person,* [especially when it is a person] *who is more sensitive* (G5).

The mental health of the team was brought up, in the search for ways to help them when possible and to be available to listen to them in case of emotional suffering: *we invest in our mental health and that of the employees. Here you have this time to ask are you not well today? how can I help you?, in general, one helps the other* (G5).

Incipient user participation in the construction of collaborative practices

In collaborative practices, it was mentioned: *very little participation. Sometimes we try to take from them what they need, what they want, but they don't express it very much. I even think it's something cultural, which comes from something already solid* (G2). One form of participation mentioned was the suggestion box left at the reception of the unit. The box is periodically opened, and the demands left there are read and put in practice, whenever possible.

And there was still a report that there is no direct popular participation in the formulation of collaborative practice, but it reinforces the respect that the population has for the team in moments of workshops, general meetings of the UBS and training in which it is necessary to close the unit for a period of the day. *On the day that we stay in heretrain the team, you notice that few approach at the door. So, it is already a way to help a lot* (G5).

Situations that interfere in the consolidation of collaborative practices

It was pointed out the lack of sensitivity of some team members in providing support when necessary to the other, which on a different scale ends up generating an uncomfortable situation between workers. This hinders the development of collaborative practices, as demonstrated in the excerpt: *I still notice a certain resistance from some professionals, not all of them, but there are still some who do not have this sensitivity, perhaps a lack of interest* (G1).

Also, the occurrence of unforeseen events, the lack of a professional without prior notice and the need for immediate coverage negatively interfere in the process of implementing collaborative practices: *today, for example, there would be a lack of a professional to lead a group, so before that I already have to have a replacement, if the day comes and that professional doesn't come, even if the person is going to take over the group, it's stressful to find out so suddenly* (G2).

The fact that the NASF always works together, not being at the UBS every day and not being an effective member of the team, ends up making it difficult to create a bond with the other members: *the NASF has more activity among them. The CHA sometimes ends up putting themself in another position, like the NASF is a higher level, it's different, it's not every day that they're here, so when they arrive it's like a foreign body, right? Hence, the CHA has that idea that 'I studied less, I am less, I am discriminated against'* (G2).

On the other hand, there was a report of an interviewee who does not see difficulties with her team due to familiarization with NASF professionals and with the Multiprofessional Residency in Women's Health that works in her unit; she also reinforces that collaborative practice is part of everyday life at her UBS and denies any type of hierarchy among professionals.

It was also mentioned the lack of: salary stimulus, replacement of the professional staff, and the ideal structure of the UBS, interfering in a negative way in the work process, consequently discouraging the team to perform a better job: *there are many people discouraged because of salary, because of a car they don't have, because of a physical structure that isn't cool, because of a human resource that hasn't been replaced for years* (G4).

It was also reported that uniprofessional training is something that negatively interferes in the process of building collaborative practices, which interferes with daily working life, for irrelevant reasons, when compared to the complexity of users' problems. Resistance to changes in the organization of work by older professionals and the lack of understanding about the importance of meetings were cited as factors that hinder the construction of collaborative practices in the work environment. The non-validation of spaces for collective

discussion about work: *when it's time for the meeting, they go to the bathroom, they drink coffee, they do everything, but they don't show up at the meeting, so I feel that in all categories we have some resistance* (G4) .

It is also difficult to involve dentistry in collaborative practices. One interviewee stated that she had doubts whether this is just the professionals' fault, or even factors such as the isolated construction of the physical space of these professionals: *we see that there are many professionals trained to develop a lot, but when comes the time to sit down and talk and put stuff in action, there is no progress* (G4).

Inflexible opinions and professional corporatism hinder the creation of new activities for the population, as well as harm collaborative practices, especially when these are contrary to the interest of some professional category: *this is very difficult because you cannot implement a group, an outpatient clinic, and also the class concepts, which we know we have, you know, in general, doctors are more united in one class, nurses in another* (G5).

DISCUSSION

There was integrated work and collaborative practices among professionals in the studied UBS. This advance is certainly a reflection of an expanded concept of health in the Unified Health System (SUS), and an also expanded apprehension of users' needs, through the articulation of promotion, prevention and recovery actions[6]. In Brazil, since 2006, Family Health has been the strategy chosen to implement a broader and more qualified approach to PHC[7].

Subsequently, to support the family health teams and expand the scope and resolution of their actions, through integrated practices and sharing of multiple knowledge to offer comprehensive care, the NASF[8] was created.

The insertion of these new professionals caused changes in the work process towards collaborative work, with the implementation of new arrangements. In this study, the development of unique therapeutic projects for the most complex cases, shared consultations, assistance to groups of users with common problems, joint planning for the proposition of strategies to face problems in the territory, in addition to the development of actions with the community, results that corroborate research on the performance of NASF in three municipalities in the northern region of Paraná[9].

In collaborative practices, nursing professionals were highlighted. An investigation reports that teamwork and collaborative practices have been discussed in nursing since 1950 in order to overcome the lack of human resources, revealing the importance of integration

between the members of the nursing team, as a means of providing comprehensive care, humanized and effective[10].

Although the term team is used to designate the body of nursing members, there are studies that point out that nursing work is still hierarchical and fragmented, making it difficult to resolve actions and preventing the development of collaborative practices in the work process[11]. However, this reality of hierarchy and fragmentation of work processes was not verified in the units surveyed in this study.

On the contrary, the nursing teams stood out in the development of collaborative practices, as they showed greater involvement with the work, greater sharing of the activities developed, and commitment to the execution of the work of professionals lacking in the unit and even of other categories. These characteristics presented refer to dimensions that involve the relationships between professionals: shared goals and vision and internalization, highlighting the feeling of belonging, mutual trust, as well as the awareness of their interdependencies. These two dimensions point to the existence of effective communication and willingness of professionals to contribute to the work of their peers, fundamental in collaborative practice[3].

In the work of nursing professionals and NASF, the existence of trust and recognition of the other at work was pointed out. These characteristics strengthen the bond between the team, in addition to opening spaces for the formulation of agreements and pacts between the different professional categories[10-11]; It is essential that each professional feels like a member of the team, understanding their importance and their role in the service[11].

Although most workers feel like an integrated member, the dentistry team appears in the reports in isolation, as if they were not part of the team. Several reasons can justify such isolation. One of them is the technical training of the dental surgeon, considered traditional, segmented, aimed at entering the private market, with a focus on curative and individualized care. Another reason could be the location of the dental space, since, in most units, it is in a separate space from the unit, making it difficult to create a bond with other professionals[12].

The role of unit managers for collaborative practices among workers was also addressed, highlighting the positive influence. This influence is due both to the way they organized the work process, as well as to providing more democratic spaces in the meetings, incorporating suggestions and ideas from the workers for new activities and projects, and also for making the agendas more flexible, with a view to: shared consultation, participation of different professionals in activities with groups of users[2].

A review study points out that management support is essential to ensure the

participation of professionals in team meetings, for matrix meetings between NASF and FHS, and that the lack of support represented an obstacle to the performance of multidisciplinary activities[13].

For managerial action that favors collaborative practices and comprehensive care in PC, there is a need to contemplate the articulation of different knowledge, and communication skills, qualified listening, conflict management strategies, creativity, ability to articulate new proposed ideas and team development. In addition, care management requires the construction of a new organizational reality and often the deconstruction of old concepts and paradigms that interfere in a negative way[14].

When analyzing such managerial practices under the framework of collaborative practice[3], there is the governance dimension, with emphasis on the role of leadership in promoting adjustments in professional practice, as well as favoring dialogic relationships between workers and guidance and support for carrying out innovative interprofessional actions in the work environment.

Another recognized management action was the organization and feasibility of infrastructure, both within the unit and in other areas of the community, for the development of activities with groups by the team. The performance of the managers interviewed in this aspect refers to the leadership roles that support collaboration, and encompasses the role played for a clear direction aimed at the development of collaborative actions, in addition to favoring the participation of professionals with a view to solving users' problems[3].

Studies have identified that the lack of adequate infrastructure, related to the availability of physical space, as well as the insufficient supply of material resources to carry out activities, interfere negatively in the daily work practices of professionals in AB[15-16]. An integrative review study pointed out that the favorable configuration of the physical space and the possibility of brief and frequent meetings between professionals in the workplace were facilitators for interprofessional collaboration[17].

In democratic and communicative management, participants build agreements together. That is, the manager is the one who leads their team through communication, and can be a facilitator in the work process, enhancing collaborative work, ensuring the opening of space for horizontal communication and favoring the sharing of power with his team[2].

Despite the various activities developed by the managers, actions that involved the user more actively in this process were not mentioned, which is one of the reasons for the incipient participation in the construction of care. The low participation of users in the formulation of collaborative practices and in self-care, as was also observed in this research, makes it difficult

to create patient autonomy, in addition to relieving them of the leading role in this process. This has been considered a throwback to user-centered care. The non-active participation of the user reduces care to a prescriptive and transversal action, harming the principles of equity and integrality[18].

Some negative aspects in the way the NASF works were mentioned: presence on sporadic days, working in several units, which hinders the development of comprehensive care[19]; context in which some workers find it difficult to recognize them as part of the team and their real role in providing care to users.

A similar result was found in a study[13] in which they point to the existence of conflicting understandings between NASF professionals and the FHS regarding the role of matrix support, which makes it difficult to carry out collaborative practices. This context makes it difficult to create an awareness of the interdependence between FHS and NASF, being a critical node in building mutual trust between both teams[3].

Another difficulty referred to the non-openness of some professionals to work in integrated and collaborative work processes, as well as professional corporatism. There is a big difference between the logic of traditional care and the logic of collaborative care with shared goals. The work in collaborative logic calls into question vertical care based on differentiation, hierarchy and the power of one category over the other, and brings the discussion of work with shared interests among professionals, breaking barriers, prejudices and paradigms in favor of the user[20].

It is considered that uniprofessional training places the student within their professional core, with no internalization of shared practice and the potential of collaborative practices[21]. Added to this is the lack of preparation to work in PHC and, despite this being included in the National Curriculum Guidelines for undergraduate courses in the health area, there is insufficiency in this training[22].

The reduced preparation for interprofessional practice is defended as related to the different cultural structures and centrism in the profession that permeate training environments in the health area; this context demands the construction of new curricula that allow interprofessional cultural competence[23].

In Brazil, the driving strategy for interprofessional practice is the multiprofessional residency. A study revealed that the multiprofessional residency in family health caused changes in the micropolitics, reflection and practices of the work process[24].

It is believed that interprofessional training is the best option to prepare the health professional, by understanding the roles of each professional nucleus, the interdependence of

the areas and, consequently, in the reduction of hierarchy, competition and fragmentation in the work processes, which enables comprehensive care[2].

CONCLUSION

Collaborative practices in PHC are carried out mainly by the nursing team and the NASF, and take place during case discussions, in group work, on a daily basis through the exchange of information and, in more complex cases, by through the formulation of unique therapeutic projects.

The manager has a fundamental governance role in encouraging collaborative practices at the UBS and uses different strategies: freeing up spaces for general meetings and matrix support in the team, articulating agendas for collective work, organizing logistics for the development of groups and carrying out integration activities together with the NASF.

This study was limited by the fact that the UBS interviewed were identified as the most advanced in collaborative practices by the key informant, which does not allow the generalization of the results to the entire PHC health services.

Considering that the result of this research points to the incipient participation of users in the formulation of collaborative practices, as well as the recent changes that have taken place in the National Policy of Primary Care and its funding; it is recommended that future studies be carried out to articulate care strategies involving the user, as well as studies that evaluate the possible repercussions of the new financing model on collaborative practices in PHC.

REFERENCES

1. Duarte EC, Barreto SM. Transição demográfica e epidemiológica: a epidemiologia e serviços de saúde revisita e atualiza o tema. Epidemiol Serv Saúde [Internet]. 2012 [cited in 29 Apr 2021]; 21(4):529-32. DOI: http://dx.doi.org/10.5123/S1679-49742012000400001
2. Peduzzi M, Agreli HF. Trabalho em equipe e prática colaborativa na atenção primária à saúde. Interface (Botucatu) [Internet]. 2018 [cited in 29 Apr 2021]; 22(Suppl 2):1525-34. DOI: https://doi.org/10.1590/1807-57622017.0827
3. D'Amour D, Goulet L, Labadie JF, Rodriguez MLS, Pineault R. A model and typology of collaboration between professionals in healthcare organizations. BMC Health Serv Res. [Internet]. 2008 [cited in 19 Apr 2021]; 8(188):1-14. Available from: https://bmchealthservres.biomedcentral.com/track/pdf/10.1186/1472-6963-8-188.pdf
4. Carvalho BG. Coordenação de Unidade na Atenção Básica no SUS: Trabalho, Interação e Conflitos. [tese]. Sao Paulo, SP: Escola de Enfermagem da Universidade de São Paulo, São Paulo; 2012. 300p.
5. IBGE | Cidades@ | Paraná | Londrina | Panorama [Internet]. 2021 .[cited in 4 May 2021]. Available from: https://cidades.ibge.gov.br/brasil/pr/londrina/panorama
6. Martins J, Bicudo M. A pesquisa qualitativa em Psicologia: fundamento e recursos básicos. 5. ed. São Paulo: Centauro, 2005. 110p.
7. Brasil. Ministério da Saúde. Política Nacional de Atenção Básica. Portaria nº. 648, de 28 de março de 2006. Brasilia, v. 143, n. 61, 2006. Seção 1: 71-76.
8. Araujo Neto, Albuquerque JD, Napoleao IM, Vasconcelos LG, Magalhães ML. Aspectos restritivos à integralidade nos Núcleos de Apoio à Saúde da Família: o olhar dos stakeholders. Physis [Internet]. 2018 [cited in 30 Apr 2021]; 28(4):e280417. DOI: https://doi.org/10.1590/s0103-73312018280417
9. Mazza DAA, Carvalho BG, Carvalho MN, Mendonça FF. Práticas colaborativas em núcleos ampliados de saúde da família e atenção básica. Saude e Pesqui. [Internet]. 2022 [cited in 14 Apr 2021]; 15(1):e-9566. DOI: 10.17765/2176-9206.2022v15n1.e9566
10. Souza GC, Peduzzi M, Silva JAlM, Carvalho BG. Teamwork in nursing: restricted to nursing professionals or an interprofessional collaboration? Rev Esc Enferm USP [Internet]. 2016 [cited in 30 Apr 2021]; 50(4):642-9. DOI: https://doi.org/10.1590/S0080623420160000500015
11. Laccort AA, Oliveira GB. A importância do trabalho em equipe no contexto da enfermagem. Uningá Review Journal [Internet]. 2017 [cited in 14 Apr 2021]; 29(3):6-10. Available from: http://revista.uninga.br/index.php/uningareviews/article/view/1976/1572
12. Mello ALSF, Andrade SR, Moyses SJ, Erdmann AL. Saúde bucal na rede de atenção e processo de regionalização. Ciência & Saúde Coletiva [Internet]. 2014 [cited in 30 Apr 2021]: 205-14. DOI: https://doi.org/10.1590/1413-81232014191.1748
13. Mazza DAA, Carvalho BG, Carvalho MN, Mendonça FF. Aspectos macro e micropolíticos na organização do trabalho no NASF: o que a produção científica revela?. Physis [Internet]. 2020 [cited in 30 Apr 2021]; 30(4):e300405. DOI: https://doi.org/10.1590/s0103-73312020300405
14. Pena Júnior JB, Curcio F, Borges N. A relevância dos saberes gerenciais do enfermeiro na estratégia saúde da família: uma revisão de literatura. Múltiplos Acessos [Internet]. 2021; [cited in 28 Apr 2021]; 5(2):152-66. Available from: :http://www.multiplosacessos.com/multaccess/index.php/multaccess/article/view/166
15. Bispo Júnior JP, Moreira DC. Núcleos de Apoio à Saúde da Família: concepções, implicações e desafios para o apoio matricial. Trab Educ Saúde. [internet]. 2018; [cited in 05 May 2021]:683-702. DOI: https://doi.org/10.1590/1981-7746-sol00122
16. Oliveira IF, AMO, Paiva RA, Oliveira KSA, Nascimento MNC, Araújo RL. The role of the psychologist in NASF: challenges and perspectives in primary health care. Temas Psicol. [Internet]. 2017 [citado em 30 Apr 2021]; 25(1):291-304. DOI:

http://dx.doi.org/10.9788/TP2017.1-17Pt
17. Morgan S, Pullon S, McKinlay E. Observation of interprofessional collaborative practice in primary care teams: an integrative literature review. Int J Nurs Stud. [Internet]. 2015 [cited in 30 Apr 2021]; 0452(7):1217-30. DOI: https://doi.org/10.1016/j.ijnurstu.2015.03.008
18. Agreli HF, Peduzzi M, Silva MC. Atenção centrada no paciente na prática interprofissional colaborativa. Interface (Botucatu) [Internet]. 2016 [cited in 01 May 2021]; 20(59):905-16. DOI: https://doi.org/10.1590/1807-57622015.0511
19. Araújo EMD, Galimbertti PA. A colaboração interprofissional na estratégia saúde da família. Psicol Soc. [Internet]. 2013 [cited in 11 Apr 2021]; *25*(2):461-8. Available from: https://www.scielo.br/j/psoc/a/vFKZFXT58XWLj6sdKXhDP3w/?format=pdf&lang=pt
20. Matuda CG, Pinto NRS, Martins CL, Frazão P. Colaboração interprofissional na Estratégia Saúde da Família: implicações para a produção do cuidado e a gestão do trabalho. Ciênc Saúde Colet. [Internet]. 2015. [cited in 01 May 2021]; 20(8):2511-21. DOI: https://doi.org/10.1590/1413-81232015208.11652014
21. Costa DAS, Silva RF, Lima VV, Ribeiro ECO. Diretrizes curriculares nacionais das profissões da Saúde 2001-2004: análise à luz das teorias de desenvolvimento curricular. Interface. [Internet]. 2018 [cited in 01 May 2021]; 22(67):1183-95. DOI: https://doi.org/10.1590/1807-57622017.0376
22. Souza GC, Peduzzi MS, Alcântara JM, Carvalho BG. Teamwork in nursing: restricted to nursing professionals or an interprofessional collaboration?. Rev Esc Enferm USP [Internet]. 2016. [cited in 01 May 2021]; 50(4):642. DOI: https://doi.org/10.1590/S0080-623420160000500015
23. Costa MV, Freire Filho JR, Brandão C, Silva JAM. A Educação e o trabalho interprofissional alinhados ao compromisso histórico de fortalecimento e consolidação do Sistema Único de Saúde (SUS). Interface (Botucatu, Online) [Internet]. 2018 [cited in 01 May 2021]; 22(Suppl 2):1507-10 DOI: https://doi.org/10.1590/1807-57622018.0636
24. Domingos CM, Nunes EFPA, Carvalho BG. Potencialidades da Residência Multiprofissional em Saúde da Família: o olhar do trabalhador de saúde. Interface (Botucatu, Online) [Internet]. 2015 [cited in 01 May 2021]; 19(55):1221-32. DOI: https://doi.org/10.1590/1807-57622014.0653

Associated Publisher: Rafael Gomes Ditterich.

Conflict of Interest: The authors declared that there is no conflict of interest.

Financing: none.

CONTRIBUTIONS
Wellington Pereira Lopes and **Brigida Gimenez Carvalho** contributed to the design, collection and analysis of data, writing and review.

How to cite this article (Vancouver)
Lopes WP, Carvalho BG. Collaborative practices in basic health units and the role of management. Rev. Fam., Ciclos Vida Saúde Contexto Soc. [Internet]. 2022 [cited in *insert day, month and year of access*]; 10(2):253-68. Available from: *insert access link*. DOI: *insert DOI link*.

How to cite this article (ABNT)
LOPES, W. P.; CARVALHO, B. G. Collaborative practices in basic health units and the role of management. **Rev. Fam., Ciclos Vida Saúde Contexto Soc.**, Uberaba, MG, v. 10, n. 2, p. 253-268, 2022. Available from: *insert access link*. DOI: *insert DOI link*.

How to cite this article (APA)
Lopes, W.P., & Carvalho, B.G. (2022). Collaborative practices in basic health units and the role of management. *Rev. Fam., Ciclos Vida Saúde Contexto Soc., 10*(2), 253-268. Retrieved in *insert day, month and year of access* from *insert access link*. DOI: *insert DOI link*.