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DEVELOPMENT OF MULTIPROFESSIONAL WORK IN MULTIPROFESSIONAL RESIDENCY PROGRAMS IN FAMILY HEALTH

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ABSTRACT

Introduction: The qualified training for work in the Unified Health System has in the Multiprofessional Residency Programs in Family Health (PRMSF) an in-service training strategy with multiprofessional and interdisciplinary characteristics. Objective: to identify actions developed in a multiprofessional way by professionals and residents of the PRMSF. Methodology: This is an exploratory study with a qualitative approach, with data from the five Brazilian regions, collected by an online questionnaire sent by email to the coordinators

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of the PRMSF, from October 2022 to March 2023, submitted to thematic content analysis. Results: The following themes emerged: Actions that promote multiprofessional and interdisciplinary work; Relationship between residents and health team professionals; Factors that hinder the development and implementation of PRMSF; Planning and organization of multiprofessional activities between programs; Difficulties with management; Lack of appreciation of the program's professionals; Lack of financial resources for the development of the program's activities; Absence of training processes and Guarantee of conditions for the coordination of the PRMSF. Final considerations: Multiprofessional actions were evidenced in the realization of shared visits and consultations, matrix support, meetings with health teams and conversation circles. Thus, the PRMSF should enable the association between theory and practices, carrying out technical and academic activities, research and dialogue with other areas of knowledge, conditions to work in the SUS in a multiprofessional and interdisciplinary way.

Keywords: Primary Health Care, Multiprofessional Team, In-Service Training, Family Health Strategy.

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INTRODUCTION

Professional training has been the subject of discussion due to its centrality in the transformation of work in health (ARAÚJO *et al*., 2021). It stood out after the development of partnership policies and programs between the Ministry of Health (MS) and the Ministry of Education (MEC) directing experiences, financed or not, by these Ministries, to generate new ways of thinking and organizing the training process (Teófilo; Saints; Baduy, 2016), so that what is established by the Federal Constitution of 1988 regarding the role of the Unified Health System (SUS) in the organization of the training of human resources is complied with.

The Ministry of Health has been supporting Multiprofessional Health Residencies (RMS) since 2002 as one of the professional qualification strategies for the SUS. In 2003, with the creation of the Secretariat for Work Management and Health Education (SGTES) in the structure of the Ministry of Health, the National Policy for Permanent Education in Health (PNEPS) was instituted, expressed in Ordinance No. 198/2004 and its complementary amendments, as a milestone for training and work in health in the country. Residency programs emerged as a result of struggles and efforts promoted by defenders of the theme of education of health professionals, as a way to promote the transformation of health work practices (Brasil, 2018).

Thus, according to Mioto *et al*. (2012), the specialization courses developed in the format of Multiprofessional Residency Programs in Family Health (PRMSF) were designed to provide theoretical and practical support to professionals already inserted in the ESF teams; to offer training focused on Primary Care (PHC) to recent graduates of professional courses in the area of health, within what is proposed by the Family Health Strategy (ESF) and to insert the theme of the reorientation of the health model in the *lato sensu* specialization courses offered by educational institutions and schools of public health.

From this perspective, the trajectory of the construction of the SUS, over the years, demonstrates the expansion of its actions with the purpose of encompassing interventions capable of guaranteeing the integrality of health care. Thus, in order to obtain this guarantee, it would be necessary to include the different types of services and levels of health care for the most varied professionals, from an interdisciplinary perspective; articulate the different knowledge and practices with the objective of producing a common good, without devaluing the knowledge and attribution of each profession (Cezar *et al.,* 2015). In this sense, health residency programs are considered as a strategy for reorienting

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PHC, for the implementation/reorganization of public services based on the logic of the principles and guidelines of the SUS.

In recent years, *lato sensu training initiatives* in the Multiprofessional Residency in Family Health (RMSF) modality have been developed with the support of State and Municipal Secretariats and the Ministry of Health. This training modality aims to bring professional training in health closer to the social reality and work in the SUS, qualifying professionals to work in the system (Melo, 2012), based on the foundations of multiprofessional work.

From this perspective, the PRMSF represents an opportunity to review the processes of professional training, with the aim of an integrated and multiprofessional work, with the exchange of knowledge and, above all, with greater possibilities of insertion in the world of work of professionals able to offer qualified health care (Melo, 2012).

To this end, multiprofessional teamwork in Primary Health Care (PHC) is an important assumption for the reorganization of the work process, and also as an important tool for expanding health care, valuing and recognizing the exchange of knowledge among professionals, in order to enable a broader view of the health-disease process, with a view to a comprehensive and problem-solving approach (Assunção; Martins, 2019).

To meet the characteristics of multiprofessionality and interdisciplinarity, the PRMSF was structured with a minimum duration of two years, with a workload of 5,760 hours, with 20% of the total workload in the form of theoretical educational strategies and 80% in the form of practical and theoretical-practical educational strategies. The teaching-learning process is developed by educational strategies guided by the development of multidisciplinary and interdisciplinary practices in the field of knowledge and by the integration between the nuclei of knowledge and practices inherent to the professions involved (Brasil, 2014), distributed in the standard week of residents consisting of 48 practical hours and 12 theoretical and theoretical-practical hours. The theoretical activities consist of 12 hours per week that take place with face-to-face and/or distance classes and as self-directed learning (AAD) activities.

Thus, the guiding question of the study is: how does the development of multiprofessional work take place within the scope of the residency program in family health? Therefore, the objective of this study was to identify the actions developed in a multiprofessional way by the professionals and residents of the PRMSF.

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METHODOLOGY

This is an exploratory study with a qualitative approach, developed in the five regions of Brazil, with the participation of PRMSF coordinators. Data were collected through an *online* questionnaire, made available by *Google Forms*, and sent by e-mail to the Program Coordinators. In the stages of production, systematization and analysis of qualitative data, the guidelines of the Consolidated *Criteria for Reporting Qualitative Research (COREQ) guide*, translated and validated into Portuguese spoken in Brazil by Souza *et al.* (2021).

Its construction was based on a script structured in 6 dimensions, with Dimension 5) Development of multiprofessional work within the scope of the residency program in family health being the one addressed in this study. In it, they were asked if there are activities included in the residents' standard week, to be developed in a multiprofessional way? Did they consider that the development of multiprofessional work occurred in the practice scenarios of the residency? Were there difficulties for the residents to carry out multiprofessional work? What were the factors that hindered the development and implementation of the institution's residency program? Was there planning and/or organization of multiprofessional activities seeking integration with other residency programs of the institution or the city?

The instrument was sent by email to 36 experts, for content validation in the period from June to July 2022 and nine responses were returned. The suggestions were analyzed and accepted, according to their pertinence, as the general evaluation of the instrument resulted in a Content Validity Index (CVI) of 0.98, obtained by the sum of all questions that had CVI above 0.78 divided by the total number of questions in the questionnaire (Coluci; Alexander; Milani, 2015).

Access to the Program Coordinators was possible from a database provided by the Ministry of Education, through the National Commission for Multiprofessional Residency in Health (CNRMS). All PRMSF, which were active and registered with the MEC until 2018, whose coordinators had been working for at least one year in the management of the program, were eligible. Data collection took place from October 12, 2022 to March 31, 2023. There were 46 PRMSF registered and active, five (10.87%) in the Midwest region, 13 (28.26%) in the Northeast, five (10.87%) in the North, 12 (26.08%) in the Southeast, and 11 (23.92%) in the South (Brasil, 2022).

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The analysis was of content in the thematic modality, in three stages: the pre-analysis of the material; the exploration of the material and the treatment of the data, which are interpreted, reflections and inferences are made (Minayo, 2013).

The study was received by the Certificate of Presentation for Ethical Appreciation n. 58463322.5.0000.0107 and approved by Opinion n. 5,436,484, in compliance with the scientific research standards contained in the Resolution of the National Health Council No. 466/2012 and No. 510/2016 (Brasil, 2012; 2016). The guidelines of the General Data Protection Law No. 13709/2018 (Brazil, 2018), which regulates the protection of personal data, and the guidelines for research in a virtual environment provided for in Circular Letter No. 2/2021/CONEP/SECNS/MS (Brazil, 2021) were also complied with. To this end, the data was stored through download on the researchers' local device, through a report issued by *Google Forms* and deleted from the virtual environment.

In order to guarantee and ensure the confidentiality of the information, codifications were assigned by means of the abbreviation C01, C02, successively, up to C24, according to the order in which the responses were received.

RESULTS and DISCUSSION

The activities included in the residents' standard week, developed in a multiprofessional and interdisciplinary way, take place for the 24 (100%) coordinators.

The reality found in this research corroborates the SUS guidelines for training human resources who can develop a multiprofessional and interdisciplinary work. These characteristics of the PRMSF allow for the strengthening of teamwork through the exchange of knowledge between the different professional categories and can contribute to the training of professionals inserted in the practice scenarios in which the activities are carried out, which allows for the exercise of multidisciplinarity and interprofessionality through the organization of services and the learning process.

A study carried out by Farias (2023) pointed out that 82.3% of the participants, who graduated from a PRMSF, indicated that the residency provided multiprofessional training, not only as a training strategy, but as a professional instrumentalization for the labor market. This understanding enables the construction of expanded care, supported by interdisciplinary understanding, which is a subsidy for comprehensiveness.

The analysis of the coordinators' answers allowed us to list the following themes: Actions that promote multiprofessional and interdisciplinary work; Relationship between

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residents and health team professionals; Factors that hinder the development and implementation of PRMSFs; Planning and organization of multiprofessional activities between programs; Difficulties with management; Lack of appreciation of the program's professionals; Lack of financial resources for the development of the program's activities; Absence of training processes and Guarantee of conditions for the coordination of the PRMSF.

The actions that promote multiprofessional and interdisciplinary work are manifested in the collective work that takes place in the PRMSF in the spaces of training and care, as expressed in the answers: "Program seminars" (C01; C08); "Coremu's inter-program meeting, and inter-resident meeting [...] (C02). "[...] There are shared visits, shared consultations, interconsultation, matrix support, weekly team meetings, case discussion, continuing education" (C04; C05; C07; C09; C10; C11; C12; C13; C14; C15; C16; C18; C19; C20; C21; C22; C23).

It is known that the teaching-service-community integration influences the teaching and learning of residents, professionals in training. Thus, the importance of agreements in the planning of residents' activities with those involved in the training (managers, preceptors, users and/or residents) is highlighted, since the activities developed by residents are carried out in health services (Mello, 2019) and, therefore, all actors need to participate in this educational context.

According to Salvador (2011), the multiprofessional residency uses several active methodologies that aim to contribute to an education that aggregates the knowledge of all professional centers, showing that the use of these methodologies in the training processes articulates the different professionals involved with educational actions in the SUS and for the SUS.

In view of this scenario, activities related to the search for operationalizing actions from the perspective of interdisciplinary teams in the health area stand out, such as multiprofessional meetings in which residents present cases of their patients and exchange experiences, Singular Therapeutic Project (STP), multiprofessional consultations, welcoming of residents, collective multiprofessional rounds and conversation circles, theoretical disciplines, and collective meetings (Arnemann *et al.,* 2018).

In this sense, the study developed by Araújo *et al.* (2021) points to shared consultations, team discussions of cases considered complex, multiprofessional home visits, intersectoral work, activities planned together with the health unit, social equipment

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and residents, as a relevant strategy for professional training and improvement of the quality of care, based on the shared planning of user-centered care, multiprofessional learning and exchange of knowledge among those involved in the assistance.

In this sense, it points to the development of the Interprofessional Health Education (IPE) axis in health residency programs, a strategy that enables the realization of practices aimed at multiprofessional actions, and that respond to local and regional needs (Lewgoy *et al.,* 2019).

The World Health Organization describes IPE as: "[...] the learning that occurs when students from two or more professions learn about each other, with each other and with each other in order to enable effective collaboration and improve the problem-solving capacity of health services" (WHO, 2010, p. 7). To achieve collaborative practice, health professionals need to learn how to work as effective members of interprofessional teams. Thus, *The Center for the Advancement of IPE* (Caipe), created in 1987 in the United Kingdom, defines interprofessional education as a teaching and learning process that promotes collaboration at work and improves the quality of care through collaborative practice (Caipe, 2002).

To this end, interprofessional education is an initiative aimed at changing the profile of professionals in the health area, focusing on teamwork, involving different professions, with the purpose of active participation, exchange of knowledge between areas of knowledge to expand the comprehensiveness of care.

Thus, in order to carry out multiprofessional and interdisciplinary work, it is necessary to establish a relationship of partnerships between residents and health professionals in practice scenarios, which is evidenced in a harmonious way and characterized as good, integrated and cooperative, and thus, providing opportunities for integration between residents and the health team. Stamping the theme **of the relationship between residents and health team professionals** perceived in the coordinators' answers: "[...] positive" (C01); "Good relationship [...] (C04; C06; C09; C11; C20; C23); "Integrated" (C07; C12; C16); "Cooperative relationship" (C14; C17; C21). “[...] the residents are welcomed and create important bonds, [...] the entire team involved in the unit" (C24).

However, this reality is not perceived in all scenarios, as pointed out in the coordinators' answers showing that there is "[...] Tensions; since there is an initial difficulty about the resident's work process and what his role is in the unit" (C02), evidencing a lack

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of knowledge about the PRMSF, as well as "[...] there are difficulties in the integration of all professionals in the practice scenario for the development of interdisciplinary work" (C05). “[...] some sporadic conflicts arise [...]" (C10). "Sometimes conflicting" (C19). "Complex and tense [...] conflict mediation is necessary" (C22).

In this sense, the importance of the relationship between residents and health workers is highlighted so that they can contribute to improving the quality of care provided, favoring the integrality of care and enabling the inclusion of various professional categories that did not previously work in health services (Manho; Soares; Nicolau, 2013; Lacy; Silva; Batista, 2012; Casanova; Baptist; Ruiz-moreno, 2015; Sundays; Nunes; Carvalho, 2015).

Among the coordinators, 14 (58.3%) indicated difficulties for the residents to carry out multiprofessional work and 10 (41.7%) do not experience them, allowing the systematization of the theme **of actors who hinder the development and implementation of the PRMSFs**, revealing the fragmentation of interdisciplinary work, as observed in the statement: "Care model that does not prioritize interdisciplinary work [...]" (C05). Another aspect evidenced was the characteristic of the training offered in the undergraduate course, as stated in C07, "Professional training prior to residency". In this scenario, the infrastructure of the services is a factor that hinders multiprofessionality, as C10 says, "Physical space, availability of vehicles for visits, some materials and equipment". And, thus, interdisciplinary actions do not occur and, in "Some nuclei, training is in the office" (C15). And, C18 attributes this difficulty to the fact that "The work process instituted in the practice scenarios has made this type of work difficult". They also highlight the way in which the professionals who conduct the training activities of residents in the practice scenarios act, "Insertion in the team, autonomy and differences in performance between scenarios and preceptors who conduct the activities in their own way" (C19).

Another point presented as a difficulty for carrying out multiprofessional and interdisciplinary work was "The frequent changes in management [that] directly impact the way the teams act" (C21).

The difficulties reported by the participants are in line with the problems found in other realities in which residencies were implemented in PHC, such as difficulties in partnerships between educational institutions and the local health network, lack of interaction between tutors and preceptors, lack of preceptors prepared for the function and lack of preparation of the other professionals in the units for absorption and joint work with

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residents (Brasil, 2006; Pine; Garcia; Nogueira-Martins, 2017). The perceived barriers to teaching-service integration are shown in the lack of integration among health professionals, absence of planning to solve the community's demands, labor issues, high turnover, lack of training and infrastructure (Pareira *et al.,* 2015).

The study by Costa and Azevedo (2016) revealed precarious situations in relation to the physical structure of the UBS; lack of material to do cytology, rooms with infiltration and electrical problems and the non-functioning of the dental service due to lack of material. Situations evidenced in Bof (2019), which reports the difficulty of support to develop the program's actions by managers, institutions, and also in training processes and infrastructure of the units.

In this sense, the complexity of planning practices developed in central, district, and local spaces of health management necessarily demands the acquisition of new knowledge, skills, attitudes, and values (Soares, 2018).

These similarities alert to the main critical points of the implementation of Residency Programs in PHC, especially within the scope of the ESF, which can hinder the training process of these professionals.

Regarding the planning and/or organization of multiprofessional activities seeking integration with other residency programs in the institution or city, 19 (79.2%) of the participants answered affirmatively and 5 (20.8%) said there was none.

It is necessary to have the participation of various actors in the planning and/or organization of the multiprofessional activities of the PMRF, seeking the integration of those involved (tutor, preceptor, coordinator, service professionals, manager, users) in the management of teaching-service-community integration; and, in this way, to integrate these various actors and their institutions, so that they can share opinions and decisions. Thus, collegiate management is an important strategy in the construction of sustainable partnerships (Ferreira; Forster; Santos, 2012).

It is important that the forms of inclusion of residents are built together with the professionals of the services according to the needs of users, residents, tutors and preceptors, according to the guidelines established by the MEC and the Ministry of Health.

It is characteristic of institutions to offer different programs in the same scenario, however, as much as the legislation is different, there is a need to develop integration between them, for the effectiveness of multiprofessional actions, **glimpsed in the theme of planning and organization of multiprofessional activities between programs**, but

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according to C01's statement, there is no **"**Integration between programs", this **absence of integration**, corroborates the study by Lucena *et al.* (2018), which reports the difficulty of integration between RMS Programs and Medical Residency. In this sense, it is pointed to the elaboration of strategies that stimulate such integration, since the discussions are aimed at overcoming the current hegemonic model, thus, it is understood that integrative actions should reach all professionals involved in the health work processes.

The distant relationship between medical residents and other professional categories was evidenced in a study carried out by Carneiro; Teixeira; Pedrosa (2021) verifying practices concentrated on the figure of the medical professional, reinforcing the medical-centered view. Also found in Baquião *et al*. (2019), which revealed problems in the dialogue with medical professionals that would result, at least in part, from the existing separation between the Medical and Multiprofessional Residency Programs, which presents itself as a hindrance to interdisciplinarity.

In this sense, it is essential to adopt measures that can improve the relationships established between the different existing programs and their professional categories, in the search to value the different knowledge, so that they can act in a way that complements each other, with a view to making interdisciplinarity effective.

The theme **difficulties with management** revealed the lack of knowledge and resistance of managers about the PRMSF, as expressed by C02 "Management resistance". “[...] the first difficulty is the articulation with the municipal management" (C09). Another situation is the choice of practice scenarios for the insertion of residents, which are defined based on management, as reported by C12 "The choice of Health Units and the capacity of residents (and division of professional categories) are sometimes defined by management based on criteria for staffing and approval of teams, not necessarily contemplating the need for teaching-learning".

These barriers are found in other realities studied, such as in the study developed by Pereira *et al.* (2022), which evidenced dissatisfaction with the management spheres, especially the municipal one, a strong perception of the lack of management support, the fragility of work relationships, when comparing the medical category with other health professionals, divergences in financial recognition, work overload, which can generate professional and personal conflicts. A management biased towards a professional or category.

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Also in the study carried out by Mendes *et al.* (2018) contradictions were perceived in the management of teaching-service integration by some health unit managers because they were unaware of or still not committed to the activities of the programs and the lack of clarity in the agreement established between the University and the Health Department, pointing to the need to institutionalize the relationships.

Some weaknesses were pointed out by the coordinators in relation to the devaluation of the professionals who work in the PRMSF, evidencing in the theme the **lack of appreciation of the professionals in the programs**, as shown in the following statements: "Lack of a policy to value the preceptors, inexistence of federal financial resources for residents who are not part of the minimum family health team (nursing, dentistry and medicine), little workload available for preceptors, tutors and program coordination [...]" (C05). Another factor of fragility reported is the absence of financial aid for professionals, as reported "Work team of teachers, tutors and preceptors. We have few professors involved in programs without bonuses, without a reduction in the workload for other activities at the University" (C08), "[...] lack of financial bonus for professionals to act as preceptors" (C17). Also reinforced by C10 who points out that this recognition could be due to "Valuing the professors involved with the allocation of adequate workload, expansion of the number of scholarships for expansion and vacancies", which is reaffirmed by C24, when pointing out "Few hours assigned to the professors involved".

Such answers show that as much as the SUS is legally responsible for training, as well as the professionals who work in it, the difficulties limit the teaching-learning process of the resident (Antunes, 2016).

In addition to the financing of residents' scholarships, the need for financial resources is pointed out to promote the implementation of the residency policy, including structural improvements in services and appreciation of professionals (Santos; Santos Neto, 2023).

In this same context, in a study carried out by Silva and Natal (2019) and Miolo and Fedosse (2020), the non-availability of a specific workload for tutors and preceptors was identified as a limitation. Even if the institution assigns a workload to the coordinator, there is no release of this workload from his work environment so that he can dedicate himself to the organizational and administrative demands of the residency program, which generates overload and a feeling of powerlessness on the part of the professionals who assume the position and strengthens chronic obstacles in the process of consolidation of residency.

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These difficulties presented by the coordinators of the PRMSF are justified by the absence of regulation at the national level or in the decision-making spaces of the PRMSF, through Resolutions, Ordinances, Regulations or Laws, on the allocation of an exclusive workload for the performance of the specific demands of the position.

The unavailability of financial resources to fund the actions developed by the PRMSF, led to the theme **of lack of financial resources for the development of the program's activities** present in the answers: "Financing of resources for the practices, in addition to the residents' scholarship (C04). " Difficulty in accessing financial resources to fund health education actions in the territories (C16), "The precariousness of the bond of SUS workers and the financial difficulty, due to the current form of health financing" (C23).

The availability of financial resources is placed as a difficulty in the daily life of the program, with materials necessary for the maintenance and conduct of activities, as well as the absence of resources for residents' didactic activities, participation in scientific events and expenses of possible speakers (Silva, 2018).

Another obstacle that is presented is the absence of **courses and training** aimed at professionals, more specifically the preceptors who receive the residents, was also a point highlighted in the theme **absence of training processes**, reported by C21, "The lack of training of preceptors with regard to acting as preceptors".

The point made by the participant reflects the importance and need for articulation and alignment of the University and for the proposal of training processes with a view to involving the professionals working in the residency programs.

According to Silva, Lopes and Petribú (2020), the preceptor, when placing himself in the position of conductor of the possibilities of action in the scenarios, needs to be equipped with pedagogical skills that broaden his horizons. In addition, it is necessary that this professional integrates the objectives of the PRMSF within the academy to his or her competencies, so that the training of residents meets the course plan effectively with regard to coherence between theory and practice.

Therefore, the absence of training that deals with basic and necessary issues such as those mentioned above, ends up compromising the harmonious process of training. Thus, it is essential that the management of the residency program promotes qualification and training spaces for these actors, so that they are equipped and sure of their role in this context (Carvalho; Gutiérres, 2021).

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Continuing education strategies, through the modalities of professional master's degrees and specialization courses, with an emphasis on public health, are possibilities to qualify the professionals who accompany the residents, in order to guarantee subsidies aimed at overcoming the challenges imposed by the complex role of tutors and preceptors in the public service (Wanderley *et al.,* 2015).

The participants highlight the need **to guarantee conditions directed to the coordination of the PRMSF** so that it is possible to develop quality work, as described by C03 "The lack of an administrative structure, such as a program secretary or administrative assistant, also makes it very difficult, because the coordinator accumulates all the activities that would be the responsibility of this administrative assistant", and also when referring to "Little workload available [...] [for] program coordination [...]" (C05). As can be seen in the answers, the help of human resources to assist in administrative activities and the determination of the workload for coordination is an urgent demand, since unstable management makes all its managers vulnerable.

In this context, Milanesi, Caregnato and Canabarro (2019), state that the non-guarantee of workload also contributes to disarticulation and discouragement on the part of professionals. Thus, it is worth mentioning that it is essential to ensure that the coordination has the means to act within its attributions with the release of a specific workload to enable the effectiveness of the program's regulations and the provisions of the Pedagogical Project.

FINAL CONSIDERATIONS

The articulation between educational institutions, with a view to teaching-service-community integration, through multiprofessional actions that seek comprehensive care is the way to promote effective changes in the care model.

To this end, the importance of the PRMSF is highlighted, they developed actions that promote multiprofessional and interdisciplinary work, in this sense, it is pointed out the relevance of integration between health teams and residents to strengthen the SUS and public health policies. It is necessary to implement planning and organization of practices that are contemplated in the standard week and that enable the dissemination of knowledge about the implementation of projects that expand the search for interdisciplinary care, articulated in a network aiming at its integrality.

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In this study, the multiprofessionality of the PRMSF was evidenced in shared visits and consultations, matrix support, meetings with health teams and conversation circles, and points to the development of the IPE axis in health residency programs.

It should be noted that in order to achieve interdisciplinarity, it is necessary to establish links and relationships between the PRMSF; health teams, the community so that they can strengthen the construction of new knowledge in the interaction with the various occupational fields, and also, articulation between other residency programs, regardless of different legislation and their particularities; thus, The residents build a training process with a view to comprehensive health care for the population, the organization of the networking process.

However, the participants pointed out weaknesses in the teaching-service-community integration process of the Programs, the object of this study, such as: difficulties with managers; lack of appreciation of the professionals who work in the programs, scarcity of financial resources to implement the actions carried out by the PRMSF; deficiencies in the training processes for members and the guarantee of infrastructure and human resources conditions for the coordination of the PRMSF. These deficiencies influence the quality of the development of activities, and may compromise the training of residents and, consequently, the service provided to the population.

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