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FOR TRANSFORMATIVE PRIMARY CARE: TRAINING AND PROFESSIONAL TRAINING TO STRENGTHEN THE WORK IN FAMILY HEALTH CARE

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Revista ARACÊ
ISSN: 2358-2472

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ABSTRACT

Primary Health Care (PHC) plays a central role in structuring fair and effective health systems, being considered the main gateway to comprehensive care for populations. In Brazil, the Family Health Strategy (FHS) is the main public policy focused on PHC, structured to promote prevention, promotion, early diagnosis, and continuous care actions. However, the effectiveness of this strategy depends directly on the education and qualification of professionals who work at this level of care, since health work demands not only technical knowledge but also relational and cultural skills to deal with the complexity of territories and social demands. The challenge of professional training in PHC involves overcoming fragmented biomedical models, which have historically prioritized a curative approach to the detriment of comprehensive and community care practices. Thus, the ways to structure health education that not only trains professionals to work in PHC but also sensitizes them to humanized, transformative, and socially engaged practices are questioned. That said, we ask: How can the training and qualification of Primary Health Care professionals contribute to the construction of comprehensive and transformative care in Family Health? Theoretically, we are anchored in the works of Illich (1975), Giovanella et. al. (2008; 2012; 2013), Starfield (2002), Mendes (2011; 2012; 2018), Werner et. al. (2009), Freeman (2018), among others. Methodologically, we used the qualitative approach according to Minayo (2007), descriptive and bibliographic from Gil (2008), and with comprehensive analytical bias according to Weber (1969). The findings showed that the education and qualification of Primary Health Care (PHC) professionals play a fundamental role in the construction of comprehensive and transformative care. It was found that the qualification of workers has a direct impact on the problem-solving capacity of care, the humanization of practices, and the expansion of access to health, especially in vulnerable communities. In addition, it was identified that PHC, when structured in an intersectoral and participatory way, promotes better clinical outcomes and reduces inequalities in the health system. The implementation of permanent education strategies and active teaching methodologies was pointed out as essential to ensure the preparation of professionals for the challenges of PHC. Finally, it was concluded that valuing PHC as a structuring axis of the Unified Health System (SUS) requires public policies that prioritize

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Revista ARACÊ
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adequate financing, the retention of professionals, and the expansion of multi-professional teams.

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Revista ARACÊ
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INTRODUCTION

HEALTH AND PHC EDUCATION: CHALLENGES AND POSSIBILITIES FOR TRANSFORMATIVE PRIMARY CARE

Primary Health Care (PHC)[16] plays a central role in the organization of health systems, ensuring equitable access, comprehensiveness, and continuity[17] of care. However, it is also necessary to recognize that, historically, the construction of this model of care has faced challenges related to the fragmentation of services and the predominance of the biomedical paradigm[18]. According to Starfield (2002, p. 19), "[...] PHC should be understood as a set of essential functions for the proper functioning of a health system, ensuring not only entry into the system but the continuity of care". Thus, a health system guided by a strong and structured PHC promotes greater equity in access to services and reduces socioeconomic inequalities in care. According to Mendes (2012, p. 47), "[...] The reorganization of care must prioritize territorialization and longitudinality, allowing services

[16] Primary Health Care (PHC) is the first level of care in the health system, being responsible for ensuring universal, continuous and comprehensive access to health services. And its importance transcends the simple provision of basic care, as it is based on health promotion, disease prevention and care coordination, ensuring articulation between the different levels of care. According to Starfield (2002, p. 10), "[...] in its most highly developed form, primary care is the gateway to the health service system and the locus of responsibility for the care of patients and populations over time". Thus, PHC represents an essential pillar for the implementation of the principles of the Unified Health System (SUS), promoting equity, accessibility, and efficiency in meeting the needs of the population. See: Starfield, B. *Primary care: balance between health needs, services and technology*. Brasília: UNESCO, Ministry of Health, 2002.

[17] The principles of equity, comprehensiveness, and continuity of care are fundamental for the organization of a health system that meets the needs of the population in a fair and efficient manner. And, in this sense, equity seeks to reduce inequalities in access to services, ensuring that those in greater social vulnerability receive the necessary assistance. Comprehensiveness, in turn, refers to the provision of comprehensive care, considering not only the disease, but also the social determinants of health and the individual needs of users. Continuity of care, on the other hand, is related to the coordination of health actions over time, avoiding the fragmentation of services and promoting adequate patient follow-up. As Starfield (2002, p. 12) points out, "[...] A strong primary care system improves health outcomes, reduces inequalities, and promotes more efficient care by ensuring that services are accessible and coordinated over time to meet the needs of individuals and populations." In this way, ensuring equity, integrality, and continuity in Primary Health Care (PHC) strengthens the Unified Health System (SUS) and contributes to a more problem-solving and humanized care. See: Starfield, B. *Primary care: balance between health needs, services and technology*. Brasília: UNESCO, Ministry of Health, 2002.

[18] The biomedical paradigm, historically predominant in the training and practice of health professionals, is characterized by an approach centered on the disease, on the human body as an object of intervention and on the medicalization of health problems. And this reductionist perspective emphasizes diagnosis and curative treatment, often disregarding the social determinants of health and the subjectivity of patients. According to Illich (1975, p. 15), "[...] excessive medicalization transforms natural life experiences, such as birth, pain, and aging, into medical problems, promoting an increasing dependence of individuals on health institutions and medical professionals." However, overcoming this model requires a transition to more holistic and integrative approaches, such as Primary Health Care (PHC), which values health promotion, disease prevention, and the active participation of individuals in their own care. See: Illich, I. *The expropriation of health: nemesis of medicine*. Rio de Janeiro: Nova Fronteira, 1975.

Revista ARACÊ
ISSN: 2358-2472

to be structured to ensure continuous and humanized monitoring of the populations served".

> Primary care is the entry point to individual health care, the locus of continued responsibility for patients in populations, and the level of care in the best position to interpret problems presented in the patient's historical context and social environment. Thus, how it is formulated to deliver services and how to do it appropriately are key components of a strategy to improve the effectiveness and equity of health services. However, primary care is only one component (although it is the fundamental component) of health systems. Its role is to directly provide all services for common needs and to act as an agent for the provision of services for needs that must be met elsewhere (Starfield, 2002, p. 315).

In Brazil, the Family Health Strategy (FHS)[19] is the main public policy aimed at PHC and has been responsible for expanding access to health in recent decades. However, it is necessary to understand that the FHS is not only an organizational model but also a device for transforming care practices. According to Giovanella et al. (2012, p. 89), "[...] the ESF represented an advance in the decentralization of health services, promoting a closer look at the social and epidemiological conditions of the territories". However, the effectiveness of this model depends directly on the training and involvement of the professionals who work in PHC, because, as Mendes (2011, p. 218) states, "[...] Comprehensive care presupposes not only technical knowledge but also relational skills and an expanded understanding of the social and cultural needs of the population served".

> The FHS should be expanded from the current 51.6% coverage to reach 75% coverage of the Brazilian population in the coming years. [...] However, when the coverage of the FHS is analyzed, it is found that it is not homogeneous, due to its ideological conception of selective primary care, which concentrates it, relatively, in poorer municipalities and regions. [...] Thus, the expansion of the FHS should be carried out to complete the coverage of municipalities with up to 50 thousand inhabitants, in which it has expanded the most, in all regions of the country, but has a special focus on medium and large municipalities, also in all states of the federation (Mendes, 2012, p. 109).

[19] The Family Health Strategy (FHS) represents a central model for the reorganization of Primary Health Care (PHC) in Brazil, being responsible for expanding access to services, strengthening the bond between professionals and the community, and promoting health promotion, prevention, and recovery actions. And its implementation has been fundamental to ensure the decentralization of services and the integrality of care, considering the particularities of each territory. According to Giovanella et al. (2012, p. 539), "[...] when assumed as a strategy, Family Health disseminates an innovative perspective for primary care in the country, focused on the family and the community, which has the potential to trigger changes in the care model, making the right to health effective in the daily lives of citizens". In this way, the ESF strengthens the structure of the Unified Health System (SUS), ensuring more equitable and problem-solving care, especially for populations in situations of social vulnerability. See: Giovanella, L., Mendonça, M. H. M., Almeida, P. F., & Escorel, S. *Políticas e sistema de saúde no Brasil*. Rio de Janeiro: Fiocruz, 2012.

Revista ARACÊ
ISSN: 2358-2472

And if the FHS has been an essential tool in expanding PHC coverage, there are still important challenges regarding its effective implementation. Health professionals are not always trained to work with a broader view of the health-disease process, which ends up reproducing fragmented and poorly resolutive practices. For Starfield (2002, p. 43), "[...] PHC is not limited to the provision of basic services, but needs to be understood as a structuring axis of health care, promoting preventive and articulated practices between the different levels of care". Now, if PHC must fulfill this role, professionals must receive adequate training, ensuring the construction of more humanized and socially engaged practices. As Mendes (2012, p. 109) points out, "[...] the strengthening of PHC necessarily involves the qualification of professionals, as they are the ones who guarantee the effectiveness of care and the continuity of care".

Therefore, the training and qualification of PHC professionals must overcome the traditional biomedical model, which has historically prioritized curative interventions to the detriment of health promotion and disease prevention. But it is also necessary to consider that this paradigm shift requires not only new curricular content but a transformation in the logic of teaching and the very organization of health work. According to Illich (1975, p. 85), "[...] the excessive medicalization of daily life leads to the loss of autonomy of individuals and the strengthening of a system that prioritizes profit over well-being." Therefore, Mendes (2018, p. 63) emphasizes that "[...] PHC should act as a space for social emancipation, strengthening the protagonism of users and promoting more equitable and participatory health".

> From an ideological point of view, the logic of PHC confronts some principles of Flexnerian medicine that are largely hegemonic, such as the negative view of health (health as the absence of disease), individualism, biologism, specialism, and the emphasis on the curative [emphasis added]. Heroic medicine, inherent to certain procedures of greater technological density, is not the field of PHC, which means that its daily action, even if it adds more health to the population, does not frequent the headlines of the mainstream media and is not positive health news. The ideology of scientific medicine seduces the population that sees PHC as low-quality medicine and eagerly seeks the care of specialists (Mendes, 2012, p. 68).

However, traditional health education remains mostly centered on the hospital and excessive specialization, distancing professionals from the community reality. Whether it is undergraduate or continuing education, training strategies need to incorporate methodologies that value comprehensive care and interdisciplinary teamwork. According to Giovanella et al. (2013, p. 312), "[...] health training must be aligned with the principles of

Revista ARACÊ
ISSN: 2358-2472

PHC, ensuring that professionals are prepared to work in comprehensive care, with an emphasis on promotion and prevention". However, as Starfield (2002, p. 71) argues, "[...] well-structured PHC requires professionals who understand the complexity of social and territorial relations that influence illness and the quality of life of the populations served".

Thus, the big question that arises in this research is: How can the education and qualification of PHC professionals contribute to the construction of comprehensive and transformative care in Family Health? The answer to this question involves the need for a training model that articulates technical knowledge and social sensitivity. For Mendes (2012, p. 177), "[...] PHC training should be based on the problematization of local realities, ensuring that professionals develop skills to work in diverse and challenging contexts". Giovanella et al. (2012, p. 523) point out that "[...] interprofessional education is a promising way to strengthen PHC, as it allows professionals to learn to work collaboratively, respecting the knowledge of each category".

Therefore, the construction of a more efficient and humanized PHC model depends on the adoption of policies that prioritize the qualification of professionals and the valorization of innovative practices. However, it is also essential that educational institutions incorporate active learning methodologies, promoting more critical and reflective teaching. According to Mendes (2011, p. 245), "[...] the training of PHC professionals must go beyond the transmission of technical knowledge, and an approach that encourages critical thinking and humanized practice is necessary". Likewise, Starfield (2002, p. 313) argues that "[...] efficient PHC requires professionals who can establish links with the community and understand the social dynamics that affect collective health".

If PHC must guarantee equitable access and integrality of care, then its professionals must be trained to deal with the complexity of territories and social demands. Whether at the undergraduate level or in continuing education, it is necessary to invest in pedagogical strategies that prepare professionals to face the challenges of family health care. Mendes (2012, p. 218) points out that "[...] the strengthening of PHC involves the commitment of universities and training institutions to offer curricula aligned with the needs of the SUS". Giovanella et al. (2013, p. 412) point out that "[...] continuing education in health should be a structuring axis of PHC, ensuring that professionals are always up to date and committed to the continuous improvement of care".

Thus, the relevance of this study lies in the need to strengthen PHC as a problem-solving, equitable, and humanized care model. Neither the fragmentation of services nor

Revista ARACÊ
ISSN: 2358-2472

the absence of critical and reflective training can continue to be barriers to the effectiveness of PHC in Brazil. Mendes (2018, p. 287) summarizes this challenge by stating that "[...] the future of PHC depends on the ability to train professionals prepared to act in a transformative way, breaking with welfare and technicist models". Thus, as Starfield (2002, p. 365) concludes, "[...] efficient PHC is not built only with investments in infrastructure, but, above all, with qualified, committed professionals capable of promoting significant changes in the health of the population".

QUALITATIVE RESEARCH IN HEALTH: APPROACHES, METHODS AND RELEVANCE TO PHC

Qualitative health research was an essential instrument for understanding the complex phenomena that involve care and the organization of health services. And, in this sense, Minayo (2007, p. 23) points out that "[...] Qualitative research is an interdisciplinary, transdisciplinary, and sometimes interdisciplinary field. Its focus is the interpretation of phenomena and the attribution of meanings from social interactions". Therefore, this type of approach allowed for capturing the nuances of the subjects' experience, their perceptions about Primary Health Care (PHC), and the challenges faced in the daily routine of the services. As Gil (2008, p. 50) argues, "[...] Bibliographic research allows the identification of fundamental theories and concepts for the understanding of the object of study, constituting an essential support for qualitative investigations".

> [...] Qualitative research is concerned with the meaning of actions and events. There are no empirical tests to measure the establishment of meaning. [...] We can find meaning if we start a dialogue with people about their feelings, we can do so by studying the context of gesture in a range of people, and we can understand meaning intuitively because this act of communication is part of our language, or we can use all these ways of understanding gesture. After verifying the meaning of this mode, we made a valuable contribution to knowledge, although it does not apply to all human beings (Manual de Medicina de Família e Comunidade, 2012, p. 1).

But it was also essential to consider that qualitative research, by focusing on subjective and contextual aspects, required an interpretative approach to the data collected. According to Weber (1969, p. 110), "[...] every social action must be understood from the subjective meaning attributed to it by the actor". Thus, the interpretation of the discourses and interactions made it possible to apprehend not only the operational challenges of PHC but also how professionals and users signified their experiences in the health system. As Minayo (2007, p. 28) emphasizes, "[...] qualitative research does not

Revista ARACÊ
ISSN: 2358-2472

seek statistical generalizations, but rather an analytical deepening of the social relations that structure the phenomena investigated".

However, to ensure the validity and reliability of the analyses, it was essential to resort to a methodological strategy that integrated different sources and perspectives. The bibliographic research, by critically reviewing the existing literature, provided a theoretical framework to support the findings. According to Gil (2008, p. 72), "[...] Bibliographic research must follow a set of steps, which include the formulation of the problem, the identification of sources, critical reading and the organization of fundamental concepts". Thus, the review of the literature on PHC allowed us to situate the challenges faced in the context of public health policies and strategies to strengthen Primary Care.

> [...] The formulation of the problem and the literature review are essential steps for the construction of any scientific research. The literature review enables the identification of gaps in knowledge, contributes to the delimitation of the theme, and offers theoretical support for the analysis of the findings. In addition, it allows the researcher to situate his investigation in the context of academic discussions and to identify the main theoretical currents that guide the field of study (Gil, 2008, p. 73).

Now, descriptive research, by emphasizing the characterization of the phenomena, also played a crucial role in the systematization of the findings. According to Gil (2008, p. 55), "[...] Descriptive research has as its main objective the detailed study of the characteristics of a given population, institution or problem". Therefore, by adopting this approach, it was possible to draw an overview of the practices and challenges faced by PHC professionals, based on the reports obtained through qualitative research. As Minayo (2007, p. 34) argues, "[...] the triangulation of methods and sources is a fundamental resource to ensure a broader understanding of the social phenomena investigated".

Consequently, Weber's comprehensive analysis guided the interpretation of the results, considering the subjective meaning attributed by the subjects to their experiences. Weber (1949, p. 90) states that "[...] the ideal type is an analytical instrument that allows ordering and understanding social reality from its most essential characteristics". Thus, the reports of PHC professionals and users were analyzed taking into account the social representations of health care, the links established with the services, and the challenges faced in the daily work. As Minayo (2007, p. 37) points out, "[...] understanding the meaning of social action is the first step towards the construction of critical and transformative knowledge".

Revista ARACÊ
ISSN: 2358-2472

However, the use of these approaches was not limited to data analysis but also guided the structuring of the research from its initial phases. According to Gil (2008, p. 77), "[...] The logical construction of a research must integrate the theoretical foundation, the definition of methods and the analysis of findings in a coherent and articulated way". Thus, the combination of bibliographic research, comprehensive analysis, and qualitative approach allowed us to deepen the understanding of PHC and its implications for the Unified Health System (SUS).

> [...] The presentation consists of organizing the selected data to enable the systematic analysis of similarities and differences and their interrelationship. This presentation can consist of texts, diagrams, maps, or matrices that allow a new way of organizing and analyzing information. In this stage, other categories of analysis are usually defined that go beyond those discovered in the data reduction stage (Gil, 2008, p. 176).

But it is also necessary to emphasize that qualitative research, by valuing subjectivity and meanings, provided a more sensitive look at the challenges faced by PHC professionals and users. As Minayo (2007, p. 41) argues, "[...] qualitative research must be committed to social transformation, contributing to the formulation of more inclusive and equitable public policies". This perspective was essential to situate PHC within a broader context, which considered social inequalities and structural limitations that impact the supply of services.

Finally, the integration between these different methodological approaches allowed not only a deeper understanding of PHC but also the construction of critical and reflective knowledge on the subject. According to Weber (1969, p. 112), "[...] understanding social action implies capturing its intentionality and motivations, situating it within a historical and cultural context". Thus, qualitative research, comprehensive analysis, and literature review complemented each other in the structuring of this study, reinforcing the importance of these strategies for the advancement of scientific production in health.

FOR TRANSFORMATIVE PRIMARY CARE: PROFESSIONAL EDUCATION AND TRAINING

Primary Health Care (PHC) is the basis of an equitable health system, ensuring universal and continuous access to health services. And, in this sense, PHC plays a structuring role in the organization of health systems, as it seeks to meet the needs of the population through a comprehensive and coordinated approach. According to Starfield

Revista ARACÊ
ISSN: 2358-2472

(2002, p. 10), "[...] in its most highly developed form, primary care is the gateway to the health service system and the locus of responsibility for the care of patients and populations over time". Thus, a health system based on PHC not only expands access but also improves efficiency and reduces costs. Mendes (2012, p. 24) complements this view by stating that "[...] primary health care, to position itself as a reorganizer of the SUS and as a coordinator of health care networks, has to undergo profound reforms that allow for the solution of the present problems".

> Healthcare systems based on a strong orientation towards PHC presented better and more equitable results, were more efficient, had lower costs, and produced more satisfaction for users when compared to systems with a weak orientation towards PHC. These systems have made it possible to free up resources to meet the needs of the excluded; improved equity because they were less costly for individuals and more cost-effective for society; ensured greater efficiency of services because they saved time in consultations, reduced the use of laboratory tests and reduced health expenses (Mendes, 2012, p. 94).

As we can see, Primary Health Care (PHC) has proven to be the most equitable and efficient approach to ensure access to quality health. And this efficiency is not only reflected in the reduction of costs, but mainly in the expansion of user satisfaction and the promotion of more problem-solving care. According to Starfield (2002, p. 420), "[...] The quality of primary care should be measured not only by the satisfaction of users but also by their ability to coordinate care, minimize unnecessary hospitalizations, and avoid the fragmentation of services".

This premise materializes in the daily lives of PHC health professionals, who work on the front line, dealing with various demands and ensuring the continuous monitoring of patients. As Mendes (2012, p. 94) points out, "[...] health care systems based on a strong orientation towards PHC presented better and more equitable results, were more efficient, had lower costs and produced more satisfaction for users". But it is also necessary to consider that this efficiency does not simply mean cutting expenses but allocating resources more rationally and strategically.

In the daily life of the Basic Health Units (UBS),[20] this translates into the prioritization of preventive care and the strengthening of the bond between professionals and patients.

[20] The Basic Health Units (UBS) play an essential role in the structuring of Primary Health Care (PHC), being the main gateway to the Unified Health System (SUS). And its function goes beyond the provision of individual care, covering health promotion actions, disease prevention, monitoring of chronic conditions and articulation with other sectors to ensure comprehensive care. In addition, the UBS are responsible for coordinating care, ensuring continuity of care and avoiding the fragmentation of health services. According to Mendes (2012, p.

Revista ARACÊ
ISSN: 2358-2472

As we endorse the statement of Mendes (2012, p. 106), "[...] countries with strong PHC have lower rates of avoidable hospitalization and better public health indicators." In this way, a family doctor who follows a hypertensive patient over the years can avoid emergency episodes, unnecessary hospitalizations, and serious complications. In addition, Starfield (2002, p. 683) points out that "[...] Identification with a primary care physician and continuous follow-up result in better clinical outcomes, reduced mortality, and greater patient satisfaction."

Therefore, PHC also plays a crucial role in mitigating health inequalities, as it ensures that vulnerable populations have continuous and qualified access to the system. And this equity is reflected in the prioritization of peripheral territories and in family health strategies that bring care to people's homes. According to Giovanella et al. (2012, p. 540), "[...] Family Health has been fundamental for expanding access in the most vulnerable territories, ensuring the presence of multiprofessional teams and intersectoral actions". However, Mendes (2012, p. 126) warns that "[...] despite the progress of the ESF, the consolidation of PHC requires overcoming challenges such as the precariousness of work and the insufficiency of professionals".

> SUS resources are not enough to fulfill the constitutional mandate of a universal and free public system. But if there is political will, there are enough to make a revolution in PHC. This would add enormous value to the health of the Brazilian population. Overcoming the problems of the FHS in the SUS involves a wide range of changes, as presented. This is imposed because the FHS is a complex problem and, as such, its problems cannot be solved by a restricted agenda. The institution of the FHS as a strategy for the organization of the SUS and the consolidation of the evolutionary cycle of primary health care in the SUS imply an action that involves all the interventions mentioned above, taken as a whole. This is not a simple question, nor a quick one, nor a cheap one (Mendes, 2012, p. 135).

However, the challenges of PHC are not limited to the structuring of the model, but also to the need for continuous qualification of professionals. And adequate training has a direct impact on the problem-solving capacity of care. As the Pan American Health Organization[21] (2005, p. 94) points out: "[...] The expansion of primary services may not

100), "[...] it is not possible to have a quality PHC, fulfilling the functions of problem-solving, communication center and accountability in the Health Care Networks (RAS), with a PHC that is installed in rented houses, that offers services of low technological density, that has a restricted portfolio of medicines and that works based on professional care provided by doctors and nurses". Thus, the strengthening of the UBS is essential to ensure a qualified, accessible PHC capable of meeting the real needs of the population. See: Mendes, E. V. *The care of chronic conditions in primary health care: the imperative of consolidating the family health strategy*. Brasilia: Pan American Health Organization, 2012.

[21] The Pan American Health Organization (PAHO) is an international organization dedicated to promoting health and strengthening health systems in the countries of the Americas. And its work is focused on the

Revista ARACÊ
ISSN: 2358-2472

always reduce costs because it identifies unmet needs of the population, improves access and expands the use of services". A practical example of this occurs in the UBSs where there are professionals trained for humanized mental health care, reducing unnecessary referrals to specialists and improving patient adherence to treatment. Starfield (2002, p. 421) adds that "[...] The quality of primary care must be evaluated by the capacity to respond to the real needs of the population and by the efficiency in articulation with other levels of the system".

And if PHC is recognized for its effectiveness, it also needs strengthening policies to expand its performance. Whether in the expansion of multiprofessional teams or in the improvement of infrastructure, the changes should ensure that the services are increasingly resolute. According to Mendes (2012, p. 61): "[...] the traditional PHC model, centered only on medical consultations, does not adequately respond to contemporary public health demands". An example of this is the need to expand the role of community health agents, who are often the first to identify problems and refer complex cases to other professionals. As highlighted by Giovanella et al. (2012, p. 505), "[...] the performance of PHC teams must consider population diversity and ensure strategies for reception and qualified listening".

> It is not possible to have a quality PHC, fulfilling the functions of problem-solving, communication and accountability in the RASs, with a PHC that is installed in rented houses, that offers services of low technological density, that has a restricted portfolio of medicines, that works based on professional care provided by doctors and nurses, that it cannot offer supported self-care due to the lack of multiprofessional teams, that it has precarious systems for hiring professionals and that, in general, it does not have a professionalized management. [...] This paradigmatic change will mean a more qualified, technologically dense PHC, with more resources, with a multiprofessional team and, for this, it should be taken as an effective priority by SUS managers (Mendes, 2012, p. 100).

Therefore, the benefits of PHC are reflected at different levels of the health system, reducing the burden of emergency services and ensuring greater coordination of care.

development of public policies that guarantee equitable and universal access to health, in line with the principles of the World Health Organization (WHO). In addition, PAHO has played a key role in supporting the implementation and qualification of Primary Health Care (PHC) in Latin America, including strengthening the Family Health Strategy (FHS) in Brazil. According to PAHO (2005, p. 94), "[...] The expansion of primary services may not always reduce costs because it identifies unmet needs of the population, improves access and expands the use of services". In this way, PAHO contributes significantly to the formulation of strategies and guidelines that seek to improve health indicators and reduce inequalities among countries in the region. See: Pan American Health Organization (PAHO). (2005). *Renewal of primary health care in the Americas: Position paper of the Pan American Health Organization/World Health Organization (PAHO/WHO).* Brasília: PAHO, 2005.

Revista ARACÊ
ISSN: 2358-2472

However, one of the main challenges is still to overcome the fragmentation of public policies and consolidate adequate funding for PHC. Mendes (2012, p. 137) points out that "[...] a joint effort is needed to ensure that PHC occupies the central place in the organization of health systems, articulating with the care network in an effective way". In addition, Starfield (2002, p. 527) points out that "[...] the evaluation of PHC systems must consider not only clinical indicators, but also the experience of patients and the responsiveness of services".

Thus, PHC should be understood as the basis for a fairer and more efficient health system, ensuring qualified access, continuity of care, and reduction of inequalities. But this requires continuous investments in the qualification of professionals, in the expansion of financing and in overcoming structural barriers. As Mendes (2012, p. 540) summarizes: "[...] PHC should be seen as the structuring axis of the SUS, ensuring that health actions are organized based on the real needs of the population". Thus, Starfield (2002, p. 36) concludes that "[...] countries that structure their health systems with a strong base on PHC have better health indicators and greater population satisfaction". But it is also essential to highlight the Family Health Strategy (FHS) as the central model of PHC in Brazil, representing a significant advance in the organization of care.

Created to decentralize and humanize care, the ESF strengthens the relationship between health professionals and the community, promoting continuous monitoring focused on prevention. According to Giovanella et al. (2012, p. 539), "[...] when assumed as a strategy, Family Health disseminates an innovative perspective for primary care in the country, focused on the family and the community, which has the potential to trigger changes in the care model, making the right to health effective in the daily lives of citizens". However, the effectiveness of the FHS depends on the existence of adequate professional training and training policies, as pointed out by Mendonça et al. (2010, p. 540), when they state that "[...] human resources in health are, admittedly, one of the main challenges to the process of implementation of the Brazilian SUS".

> At the end of the first decade of the twenty-first century, the National Primary Care Policy expanded the scope and conception of Brazilian primary care, incorporating the attributes of comprehensive primary health care. [...] Family Health becomes the priority and permanent strategy for the organization of primary care and the local health system; thus, the Brazilian model of primary care incorporates the other elements of comprehensive primary health care, family-centric and community-oriented (Giovanella et. al., 2012, p. 541).

Revista ARACÊ
ISSN: 2358-2472

Therefore, the challenges faced by PHC in Brazil include the precariousness of work, the insufficiency of qualified professionals, and the fragmentation of public policies. And, in this context, the lack of stable employment relationships and adverse working conditions directly impact the continuity and quality of health care. According to Pierantoni, Varella and França (2006, p. 273), "[...] the SUS spent the decade of its implementation without worrying about its workers, without elaborating an effective human resources policy compatible with its universalist conception. This allowed [...] the creation of an army of workers without social and labor rights." Machado (2005, p. 274) points out that "[...] the expansion of the teams with the entry of new professions and occupations took place in an anarchic way, without regulation and little committed to the precepts of the SUS".

In addition, the turnover of professionals, especially physicians, compromises the continuity of care, which is one of the main weaknesses of PHC. But, to face this issue, some strategies have been adopted, such as holding public exams and valuing the process of qualification of workers. As Mendonça et al. (2010, p. 540) point out: "[...] the retention of professionals in the Family Health Strategy teams is a challenge to be faced, even though recent studies indicate a higher retention rate in relation to the beginning of the strategy".

However, the precariousness of labor relations still prevails, as Mendes (2012, p. 99) points out: "[...] in the PSF, the vast majority of higher education professionals have precarious contracts, especially through temporary contracts. This not only cuts the possibility of stability but also favors layoffs and political hiring." In Brazil, it was found that 77.7% of the physicians and 46.7% of the nurses had precarious contracts in which labor rights were not ensured.

> [...] In Brazil, 41.7% of physicians and 35.4% of nurses have worked for up to 1 year, which indicates the high professional viewing hours. [...] This is facilitated by the precariousness of the bonds that allows a municipality to replace, many times, almost all the members of the teams for purely political reasons. In addition, it means that there are no plans for positions and salaries (Mendes, 2012, p. 99).

Now, if PHC is the gateway to the SUS and should be the organizing axis of health services, it is essential to overcome the structural challenges that limit its effectiveness. But this implies significant changes in the training of professionals, the strengthening of work management and the expansion of PHC funding. According to Mendes (2012, p. 106), "[...] the conception of the ESF, truly as the strategy for the reorganization of the SUS and as a communication center for the RASs, is fundamental for the other problems to be overcome

Revista ARACÊ
ISSN: 2358-2472

because it will allow giving priority to PHC in the SUS". Starfield (2002, p. 20) also endorses the need for a PHC model based on principles of equity and solidarity: "[...] health care systems should be guided by values of human dignity, equity, solidarity and professional ethics".

Therefore, the strengthening of PHC requires a political and institutional commitment that guarantees its structuring as a model of priority care in Brazil. Neither the fragmentation of public policies nor the devaluation of professionals can continue to be barriers to the consolidation of PHC. And, as Mendes (2012, p. 120) points out, "[...] it is essential to strengthen the ESF units managerially to meet the challenges of a structured PHC as a SUS organization strategy". Starfield (2002, p. 21) argues that "[...] Specialization directed to the treatment of illness cannot maximize health because prevention and the promotion of well-being transcend specific illnesses."

That said, PHC and ESF are fundamental for building a fairer and more accessible health system. However, challenges persist and require an integrated approach that involves professional qualification, adequate funding and strengthening of management. As Giovanella et al. (2012, p. 493) points out: "[...] primary care refers to a set of comprehensive health practices, aimed at responding to individual and collective needs, which, in Brazil, during the process of implementation of the Unified Health System (SUS), came to be called primary health care". And, according to Mendes (2012, p. 126), "[...] the expansion of the ESF should be done in order to complete the coverage of municipalities of up to 50 thousand inhabitants, in which it has expanded the most, in all regions of the country".

Consequently, professional training in Primary Health Care (PHC) has historically been influenced by the biomedical model, which prioritizes the diagnosis and treatment of diseases to the detriment of health promotion and prevention. And this reductionist approach limits the understanding of the health-disease process and distances professionals from a broader and interdisciplinary view. According to Gillies (2005, p. 2), "[...] The biomedical model was very successful and continues to be within the walls of the teaching hospital. Outside these walls, however, everything is very different." For this reason, Mendes (2012, p. 100) emphasizes that "[...] it is not possible to have a quality PHC, fulfilling the functions of problem-solving and communication center in the Health

Revista ARACÊ
ISSN: 2358-2472

Care Networks (RAS),[22] with a PHC that works based on professional care provided only by doctors and nurses".

> Historically, professional training in health has been oriented towards disease and not towards health. Medical education was deeply influenced by the Flexnerian model, which favored hospital teaching and the fragmentation of knowledge into specialties. [...] This curricular structure reinforces the training of professionals who are poorly prepared to deal with the complexity of primary care, making it difficult to transition to more integrative and person-centered models (Teixeira & Solla, 2006, p. 469).

But it is also necessary to consider that this traditional model of medical education, centered on the disease and the hospital, reinforces the fragmentation of care and hinders the implementation of more comprehensive approaches. And this fragmentation is reflected in the practice of PHC professionals, who often reproduce specialized care without taking into account the social determinants of health. According to Teixeira and Solla (2006, p. 469), "[...] medical education separates the disciplines of the basic and professional cycle, which is carried out in teaching hospitals, which reinforces the hospital-centric view of care". Illich (1975, p. 150) criticizes this reductionist formation by stating that "[...] serious illnesses, with no apparent symptoms, which only these diagnostic equipment can detect, are, in general, incurable diseases, in which early treatment aggravates the patient's psychic state".

Therefore, the training of PHC professionals needs to be rethought to overcome this fragmented and hospital-centric logic[23]. And this means integrating different disciplines and

[22] The Health Care Networks (RASs) are organizational structures that aim to integrate the different levels of care in the health system, ensuring continuity of care and efficiency in the provision of services. And its implementation in the context of the Unified Health System (SUS) seeks to overcome the fragmentation of care, promoting coordination between Primary Health Care (PHC), medium and high complexity. In addition, RASs allow for a better allocation of resources, reducing waste and optimizing the response to the needs of the population. According to Mendes (2012, p. 67), "[...] the Health Care Networks are polyarchic organizations that combine common horizons and high connectivity between their components, and it is essential that PHC assumes the role of care coordinator to ensure the integrality and problem-solving capacity of care". Thus, strengthening the RASs is essential to ensure a more equitable, accessible, and user-centered health system. See: Mendes, E. V. *The care of chronic conditions in primary health care: the imperative of consolidating the family health strategy*. Brasilia: Pan American Health Organization, 2012.

[23] The health care model historically adopted in many countries, including Brazil, has been marked by a strong emphasis on hospital care, reinforcing the hospital-centric view of care. And this perspective favors curative care to the detriment of health promotion and prevention actions, resulting in a fragmented and high-cost system. In addition, the predominance of this model compromises the problem-solving capacity of Primary Health Care (PHC), which should be the structuring axis of the Unified Health System (SUS). According to Teixeira and Solla (2006, p. 469), "[...] medical education separates the disciplines of the basic and professional cycle, which is carried out in teaching hospitals, which reinforces the hospital-centric view of care". Thus, overcoming this paradigm requires valuing PHC as a coordinator of care, ensuring greater comprehensiveness and accessibility to health services. See: Teixeira, C. F., & Solla, J. P. *Health care model: promotion, surveillance and family health*. Salvador: EDUFBA, 2006.

Revista ARACÊ
ISSN: 2358-2472

promoting learning that is closer to the reality of primary care, valuing the work in a multiprofessional team. According to Mendes (2012, p. 263), "[...] Educational reform must have some important elements: the adoption of competency approaches in instructional design, the promotion of inter- and trans-professional education, and the institutionalization of a new professionalism that develops the values of comprehensive care." In addition, as Gillies (2005, p. 2) points out, "[...] Balint's teachings[24] marked the beginning of a departure from the purely biomedical model of medical practice prevalent at that time." For Mendes (2012: 308):

> Multiprofessional care is not just a group of different people with different professions working together in the FHS for a certain time. A team spirit must be created, which implies that different professionals must establish and share a common vision and learn to solve problems through communication, in order to maximize the unique skills of each one. The tasks of care should be distributed according to the competencies and areas of interest of each team member. Some elements are fundamental in teamwork: long-term strategy, focus on the mission and vision, and orientation to overcome resistance to the changes that teamwork requires.

However, the implementation of a more integrated education faces challenges, as the biomedical model is still deeply rooted in medical education and professional practice. And this resistance makes it difficult to adopt a more humanized and person-centered model. According to Mendes (2012, p. 245), "[...] the collaborative and person-centered clinic marks, in an important way, the differences of PHC provided by the traditional model and by the Family Health Strategy (ESF)". The Pan American Health Organization[25] (2005,

[24] Michael Balint's teachings were fundamental for the reformulation of the doctor-patient relationship, introducing a more humanized approach centered on the patient's subjectivity. And his main contribution was to highlight the importance of qualified listening and consideration of emotional aspects in clinical practice, as opposed to the rigidity of the traditional biomedical model. Balint emphasized that the physician should not limit himself to the role of treatment technician, but rather act as a facilitator of the understanding of the patient's suffering. According to Gillies (2005, p. 2), "[...] Balint's teachings marked the beginning of a departure from the purely biomedical model of medical practice prevalent at that time." In this way, its approach influenced Primary Health Care (PHC), reinforcing the need for lasting bonds between professionals and patients and promoting more comprehensive and problem-solving care. See: Gillies, J. C. (2005). *Family doctors and the future of medicine*. Porto Alegre: Artmed.

[25] The Pan American Health Organization (PAHO) is an international organization linked to the World Health Organization (WHO), responsible for promoting cooperation among the countries of the Americas to strengthen health systems and improve health indicators in the region. And its work ranges from supporting the formulation of public policies to the implementation of disease prevention and control strategies, always focusing on equity and universal access to health services. In addition, PAHO has been one of the main agents in the dissemination and strengthening of Primary Health Care (PHC) as the organizing axis of health systems. According to PAHO (2005, p. 94), "[...] PHC must be structured to respond to the needs of the population, ensuring universal access and equity, promoting comprehensive and continuous care over time". In this way, PAHO plays an essential role in building more accessible, responsive, and sustainable health systems in the Americas. See: Pan American Health Organization (PAHO). *Renewal of primary health care in the Americas:*

Revista ARACÊ
ISSN: 2358-2472

p. 865) emphasizes that "[...] there are methodologies that allow the evaluation of cooperation among the members of a health team, promoting an interdisciplinary and integrative approach".

Now, if PHC should be the structuring axis of the health system, the training of professionals needs to be aligned with its principles. And this implies the need to incorporate active teaching methodologies, which encourage the problematization of reality and the collective construction of knowledge. According to Mendes (2012, p. 540), "[...] the National Program for the Reorientation of Professional Training in Health (Pró-Saúde)[26] was created to integrate teaching and service, aiming at the reorientation of professional training in health and promoting transformations in the health care of the population". In addition, Starfield (2002, p. 421) points out that "[...] The quality of primary care must be evaluated by the capacity to respond to the real needs of the population and by the efficiency in articulation with other levels of the system".

> Health care systems that structured PHC based on short-term medical consultations failed to respond to chronic conditions. The common sense solution, including the proposal of the Brazilians in the IPEA survey, is to increase the number of doctors in PHC. This may be necessary in places where there is a strong supply constraint on doctors. But, in general, the true solution involves the formation of a multi-professional work team that distributes the tasks, according to the comparative advantages of each professional (Mendes, 2012, p. 94).

And if PHC must guarantee comprehensive and longitudinal care, then the training of professionals needs to contemplate an interdisciplinary and humanized approach. Whether in undergraduate or continuing education, it is essential to stimulate collaborative practice and teamwork. According to Mendes (2012, p. 126), "[...] the consolidation of PHC requires overcoming challenges such as the precariousness of work and the insufficiency

Position paper of the Pan American Health Organization/World Health Organization (PAHO/WHO). Brasília: PAHO, 2005.

[26] The National Program for the Reorientation of Professional Training in Health (Pró-Saúde) was created with the objective of integrating teaching and service, promoting changes in the training of health professionals to meet the needs of the Unified Health System (SUS). And its implementation aimed to overcome the fragmentation of traditional teaching, bringing students closer to the reality of Primary Health Care (PHC) and strengthening the link between theory and practice. In addition, the program encouraged active teaching methodologies, fostering a more critical, reflective and oriented training for health promotion and disease prevention. According to Mendes (2012, p. 540), "[...] the National Program for the Reorientation of Professional Training in Health (Pró-Saúde) was created to integrate teaching and service, aiming at the reorientation of professional training in health and promoting transformations in the health care of the population". In this way, Pró-Saúde represented a significant advance in the qualification of professionals, contributing to a health system that is more resolute and aligned with the needs of the population. See: Mendes, E. V. *The care of chronic conditions in primary health care: the imperative of consolidating the family health strategy*. Brasilia: Pan American Health Organization, 2012.

Revista ARACÊ
ISSN: 2358-2472

of professionals, which will only be possible through effective investment in training and qualification". In addition, Giovanella et al. (2012, p. 540) point out that "[...] Family Health has been fundamental for expanding access in the most vulnerable territories, ensuring the presence of multiprofessional teams and intersectoral actions".

That said, it is essential that the training of PHC professionals breaks with the reductionist paradigm of the biomedical model and incorporates more comprehensive and humanized practices. But this requires structural changes in medical education, in the organization of work and in the management of health services. According to Mendes (2012, p. 99), "[...] in the Family Health Program, the vast majority of higher education professionals have precarious contracts, especially through temporary contracts, which impacts the continuity of care and the qualification of professionals". Starfield (2002, p. 683) concludes that "[...] Identification with a primary care physician and continuous follow-up result in better clinical outcomes, reduced mortality, and greater patient satisfaction."

Thus, continuing education and continuing education in health play a fundamental role in the qualification of Primary Health Care (PHC) professionals, ensuring that they are prepared to respond to community needs. And this qualification goes beyond simple technical updating, being essential to consolidate humanized and integrated practices in the territory. According to Mendes (2012, p. 263), "[...] continuing education must be focused on the transformation of professional practices, ensuring that training takes place in service and dialogues directly with the demands of the population". In addition, the World Health Organization (2008, p. 96) highlights that "[...] reforms in the provision of health services must build a people-centered system, reorganizing PHC based on the needs and expectations of the population".

> The continuing education of health professionals must evolve from traditional education to contemporary continuing education processes. [...] The overcoming of the traditional processes of education of health professionals is based on major trends: education as a permanent process; the articulation of continuing education with the improvement of professional practices; the adoption of fundamentals from scientific research in the areas of cognitive psychology and professional education; and the evidence-based education movement (Pan American Health Organization, 2008, p. 390).

But it is also necessary to rethink traditional training models, which are still based on passive methodologies that are decontextualized from the reality of PHC. And this disconnect between teaching and practice compromises the quality of care and hinders the adoption of interdisciplinary approaches. According to Mamede (2005, p. 394), "[...] The

Revista ARACÊ
ISSN: 2358-2472

traditional education of health professionals is based on isolated and punctual interventions, disconnected from professional practices, which leads to fragmented and ineffective learning". For this reason, Mendes (2012, p. 391) reinforces that "[...] permanent education must evolve towards contemporary educational processes, based on meaningful learning and active methodologies".

Consequently, the adoption of innovative models, such as problem-based learning (PBL)[27] and teaching-service integration, has shown greater effectiveness in the training of PHC professionals. And this approach allows learning to take place in real scenarios, strengthening the articulation between theory and practice. According to the National Policy for Permanent Education in Health, "[...] health education should start from reflection on the work process and seek the transformation of professional practices". In addition, Giovanella et al. (2012, p. 901) point out that "[...] continuing education must be integrated with health policies, promoting training that values the protagonism of professionals and their ability to respond to the challenges of PHC".

> To overcome the limits of Flexnerian didactics, there is a worldwide trend in the diffusion of innovative methodologies, such as 'problem-based learning' (PBL). This method, initially experimented in Canada and the Netherlands, has spread to several countries in medical courses, and is generally well evaluated in relation to traditional methods. PBL is based on the study of cases and the active search for solutions to related problems after reading them. The study is done individually and in groups, with the guidance of a tutor. Among some advantages attributed to the method is greater integration between the disciplines and greater student motivation (Giovanella et. al., 2012, p. 901).

However, the effectiveness of these innovative training models depends on an institutional commitment that ensures their large-scale implementation. And this means investing in the training of teachers, in the infrastructure of health units and in the creation of spaces for the exchange of experiences among professionals. As Mamede (2005, p.

[27] Problem-Based Learning (PBL) is an active teaching methodology that seeks to develop students' critical thinking, autonomy, and problem-solving skills through the investigation of real situations. And its application in health education has been fundamental to bring students closer to the reality of the services, allowing them to acquire knowledge in an integrated and contextualized way. In addition, PBL encourages teamwork, interdisciplinarity, and the active search for solutions, making learning more dynamic and meaningful. According to Giovanella et al. (2012, p. 901), "[...] to overcome the limits of Flexnerian didactics, there is a worldwide trend in the diffusion of innovative methodologies, such as 'problem-based learning' (PBL), which integrates the disciplines and motivates students to seek solutions in an autonomous and collaborative way". Thus, the adoption of PBL in medical education and in other health fields represents a promising strategy to train professionals who are more prepared to work in Primary Health Care (PHC) and in the Unified Health System (SUS). See: Giovanella, L., Mendonça, M. H. M., Almeida, P. F., & Escorel, S. *Políticas e sistema de saúde no Brasil*. Rio de Janeiro: Fiocruz, 2012.

Revista ARACÊ
ISSN: 2358-2472

394) points out: "[...] the articulation between education and service is still a challenge, as many training processes are disconnected from the real needs of PHC". Mendes (2012, p. 391) emphasizes that "[...] continuing education must be aligned with the guidelines of PHC, ensuring that professionals are prepared to act in a problem-solving and humanized way".

Now, if PHC should be a space for health promotion and not just for the treatment of diseases, the training of professionals needs to incorporate intersectoral and community approaches. And this requires a constant dialogue between health services, the community and other public policies. According to Mendes (2012, p. 391), "[...] intersectoriality is a fundamental principle of PHC, as it allows health to be worked together with other areas, such as education, social assistance and culture". In addition, Mamede (2005, p. 394) reinforces that "[...] The integration between sectors should be a structuring axis of permanent education, ensuring that professionals understand the complexity of the social determinants of health". Intersectoriality is crucial for health promotion and supposes the joint action of social practices and institutions to intervene in the needs of individuals and the community. Although widely disseminated as a proposal, the effectiveness of intersectoriality is not simple. This is because, in general, the systems responsible for the various social areas are very rigid and have their own institutional and professional logics, which makes it difficult to adhere to intersectoral work.

> [...] Intersectoriality requires establishing intersectoral and interinstitutional partnerships with non-governmental and civil society entities, aiming to: foster and monitor the establishment of integrated public policies in favor of quality of life; encourage social participation in the decision-making process and management of public health policies; and to strengthen processes of co-responsibility and autonomy of subjects and collectives in the production of health (Campos, Barros & Castro, 2004, p. 747).

Therefore, successful experiences of PHC training have demonstrated the importance of valuing popular knowledge and the active participation of the community in the educational process. Whether in the organization of health education groups or in the construction of spaces for qualified listening, these initiatives strengthen the bond between professionals and users. According to Mendes (2012, p. 127), "[...] the National Program for the Reorientation of Professional Training in Health (Pró-Saúde) has been an important experience to integrate teaching and service, promoting training aligned with the needs of PHC". The World Health Organization (2008, p. 96) points out that "[...] reforms in PHC

Revista ARACÊ
ISSN: 2358-2472

must ensure that vocational training is aligned with the principles of equity, social justice and community participation."

Therefore, popular health education stands out as an essential strategy to qualify PHC professionals, valuing local knowledge and collectively constructed care practices. And this approach strengthens the autonomy of users, promoting protagonism in the management of their own care. According to Mamede (2005, p. 394), "[...] Permanent education should be a dialogical process, in which professionals learn from the community and recognize the importance of popular knowledge". In addition, Mendes (2012, p. 391) reinforces that "[...] health education practices must be carried out together with the population, ensuring that interventions are culturally appropriate and effective".

> The strengthening of PHC goes through a struggle that will be neither brief nor easy, in the political, economic and ideological spheres. The favorable factor is that the current model of the fragmented, reactive, episodic system, focused on the disease and organized based on the strengthening of specialized care units, often sustained through spectacle health policies, is not sustainable in the long term. Health care systems that are organized with fragile PHC are like buildings without foundations. In the long run, they will collapse, causing disastrous economic and health results (Mendes, 2012, p. 71).

Therefore, strengthening continuing education and continuing education in PHC requires a paradigm shift, overcoming traditional models and incorporating active, interdisciplinary, and socially engaged methodologies. But this will only be possible with a continuous investment in the qualification of professionals and in the articulation between teaching, service and community. As Mendes (2012, p. 127) summarizes: "[...] the challenge of PHC is to train professionals who not only master technical knowledge, but who are also sensitive to social needs and committed to the transformation of reality". Thus, Mamede (2005, p. 394) concludes that "[...] continuing education must be a continuous process of reflection and action, ensuring that professionals are always prepared to face the challenges of PHC".

That said, humanization in Primary Health Care (PHC) emerges as a fundamental principle for the construction of a more democratic health system. And, in this context, health professionals play an essential role in promoting practices that consider the subjectivities of users and their sociocultural realities. Thus, PHC cannot be reduced to a mechanized and fragmented service, because "[...] there is robust evidence that health care systems based on a strong orientation towards PHC have better health outcomes and greater equity" (Pan American Health Organization, 2012, p. 62).

Revista ARACÊ
ISSN: 2358-2472

Therefore, it is essential that health workers assume a commitment to sensitive action, centered on the real needs of the population. But it is also essential to recognize that the social engagement of PHC professionals must be based on a broader understanding of health, which goes beyond the traditional biomedical model. Now, PHC is strengthened to the extent that its professionals get closer to the communities, understanding their specificities and developing participatory actions. As emphasized, "[...] health care systems in low-income countries with strong PHC tend to be more equitable and accessible, ensuring a fairer distribution of resources" (Mendes, 2012, p. 61). Thus, the construction of solid bonds with users becomes essential to ensure continuity of care.

> An important characteristic of comprehensive primary health care, which differentiates it from other conceptions, is the understanding of health as inseparable from economic and social development, as discussed in Alma-Ata; This implies action directed to the community – orientation to the community – to face the social determinants of the health-disease processes and encourage social participation. Recognizing the social determination of the health-disease processes requires articulation with other public policy sectors, triggering and mediating intersectoral actions for integrated social development and health promotion (Políticas e Sistema de Saúde no Brasil, 2012, p. 506).

Consequently, valuing the relational skills of PHC professionals becomes an essential pillar for strengthening these bonds. And this implies the need to develop communicative, empathetic and cultural skills, which favor the approximation between professionals and users. As highlighted, "[...] the interpretation of PHC as a strategy for organizing the health care system understands it as a unique way of recombining and reordering all the resources of the system to meet the needs of the population" (Pan American Health Organization, 2012, p. 58).

> Therefore, active listening and valuing patients' experiences are fundamental aspects for the quality of care. Person-centered care summons unique communication skills of users and health teams because working with people and families presupposes a relational clinic. On the part of the users, it implies the structuring of the narrative process, reflection on their life condition, the reconstruction of their history and identification with health; in relation to the health teams, the development of listening and communicative skills, the search for empathy towards the other, the reflection on the practice mediated by individual knowledge and interdisciplinary experience, the incorporation of the user's perspective, the ability to understand the user's preferences, the ability to share decisions about prevention and treatment, the ability to provide support for self-care, the ability to work in multi-professional teams, the ability to use new technologies to make the user more engaged in the production of their health, and the ability to manage time to make all this possible (Pan American Health Organization, 2012, p. 253).

Revista ARACÊ
ISSN: 2358-2472

However, the impact of cultural sensitivity on the implementation of a more inclusive and accessible PHC cannot be ignored. The ethnic and social diversity of the Brazilian population demands that health professionals be prepared to deal with different ways of conceiving the process of illness and cure. "Systems with strong PHC were associated with greater user satisfaction and lower aggregate spending on health care" (Mendes, 2012, p. 62). Therefore, the participatory approach should be a structuring axis of comprehensive care in PHC. But the construction of this participatory approach requires an institutional effort to implement strategies that consolidate a transformative practice in PHC. In this sense, it is essential to overcome the fragmented and technicist view that still predominates in many health services. "The structuring of health care networks depends on a strong PHC, because without it, the systems become ineffective" (Pan American Health Organization, 2012, p. 55). Like this

> [...] The active participation of the community in the planning and evaluation of health actions should be encouraged. Overcoming the problems of the FHS in the SUS involves a wide range of changes, as presented. This is imposed because the FHS is a complex problem and, as such, its problems cannot be solved by a restricted agenda. The institution of the FHS as a strategy for the organization of the SUS and the consolidation of the evolutionary cycle of primary health care in the SUS imply an action that involves all the interventions mentioned above, taken as a whole. This is not a simple question, nor a quick one, nor a cheap one (Pan American Health Organization, 2012, p. 136).

Therefore, strategies aimed at consolidating PHC must be aligned with the principles of the Unified Health System (SUS), ensuring universality, comprehensiveness, and equity. Now, the humanization and social engagement of health professionals are fundamental so that these principles do not become just abstract guidelines, but concrete practices in the daily routine of the services. "PHC should occupy the driver's seat to run the health care system" (Pan American Health Organization, 2012, p. 65). Thus, it is necessary to continuously invest in professional qualification and in the expansion of spaces for social participation. However, for PHC to be, in fact, transformative, it is necessary to have a political and institutional commitment that guarantees its valorization. The dismantling of public policies and the devaluation of health professionals[28] weaken this level of care,

[28] The dismantling of public policies and the devaluation of health professionals represent significant challenges for the consolidation of the Unified Health System (SUS) and for the effectiveness of Primary Health Care (PHC) as a structuring axis of care. And this process manifests itself through underfunding, precarious work and the instability of employment relationships, which compromise the quality of services offered to the population. In addition, the lack of investments in infrastructure and professional training makes it difficult to implement comprehensive and problem-solving actions in PHC. According to Mendes (2012, p. 225), "[...] the

Revista ARACÊ
ISSN: 2358-2472

compromising its problem-solving capacity and its ability to respond to the needs of the population. "Adequate funding for PHC is essential to ensure its effectiveness and its ability to respond to the needs of the population" (Mendes, 2012, p. 107).

Therefore, it is urgent to reverse this scenario, strengthening PHC as the central axis of the SUS. The low political, economic, and social valuation of the PSF results, in large part, from the ideological issue, but also, as has been shown, from the small economic value that PHC adds to social actors of great weight in the health arena: the pharmaceutical industry, the biomedical equipment industry, the most prestigious service providers, and opinion makers. Added to this is the low symbolic value that the PSF represents for politicians, managers and the population itself, whose perception, captured in opinion polls, is fundamentally linked to specialized and rapid medical care (Mendes, 2012, p. 225).

Therefore, the training of PHC professionals needs to be in line with a humanized perspective and committed to the promotion of equity in health. This means that technical training must be accompanied by a deep ethical and relational development, which allows professionals to establish meaningful connections with users. "Health care systems based on strong PHC have shown better health outcomes and more equity" (Pan American Health Organization, 2012, p. 62). Thus, investment in the qualification of health teams must be continuous and based on the concrete reality of the territories served.

> The training of health professionals is a process of essential importance in the development and maintenance of a public health system. This importance lies in the fact that health work is necessarily based on the human element – that is, on its ability to act, reflect, put itself in the place of the people who receive its care and understand the determinants of the health-disease process in its dynamism and complexity. [...] However, the process of training university-level health professionals faces problems that cause direct and indirect impacts on health systems, both in Brazil and abroad (Campos, Aguiar & Belisário, 2012, p. 885).

Thus, humanization and social engagement in PHC cannot be treated as mere complements to professional practice, but rather as structuring elements of a care model that prioritizes the life and well-being of the population. And, for this, it is essential that the

low political, economic and social valuation of the Family Health Strategy (FHS) results, in large part, from the ideological issue, but also from the small economic value that PHC adds to social actors of great weight in the health arena: the pharmaceutical industry, the biomedical equipment industry, more prestigious service providers and opinion makers". Thus, facing this scenario requires a governmental and social commitment that guarantees decent working conditions for health professionals and strengthens public policies aimed at equity and universality of the SUS. See: Mendes, E. V. *The care of chronic conditions in primary health care: the imperative of consolidating the family health strategy*. Brasilia: Pan American Health Organization, 2012.

Revista ARACÊ
ISSN: 2358-2472

management of the SUS strengthens policies that encourage the protagonism of health teams and the involvement of communities in the planning of actions. "PHC must be structured to respond to the needs of the population, ensuring universal access and equity" (Pan American Health Organization, 2012, p. 66). Therefore, the construction of a strong and transformative PHC depends on a collective commitment to justice and human dignity.

CONCLUSION

The education and qualification of Primary Health Care (PHC) professionals are fundamental for the construction of a comprehensive and transformative care model in Family Health. The strengthening of PHC in Brazil requires overcoming historical challenges, such as the fragmentation of services, the predominance of the biomedical paradigm, and the precariousness of health work. To this end, the qualification of professionals must go beyond the transmission of technical knowledge, incorporating pedagogical practices that promote critical reflection, interdisciplinarity and the appreciation of the users' experience.

The Family Health Strategy (FHS) has proven to be an effective model in expanding access to health services and promoting care that is closer to the needs of the population. However, its effectiveness depends directly on the qualification of the teams, as it is the professionals who guarantee the problem-solving capacity of PHC and the continuity of care. As demonstrated throughout the study, training based on active methodologies, such as Problem-Based Learning (PBL), and the valorization of continuing education are essential to enable professionals to deal with the complexity of public health practice.

In addition, PHC should be understood as the structuring axis of the Unified Health System (SUS), requiring a careful look at territorialization, the longitudinality of care, and the intersectoriality of actions. The involvement of the community and the appreciation of popular knowledge are essential aspects to consolidate a humanized and problem-solving PHC. For this, it is essential that professionals are prepared to act collaboratively, recognizing the social determinants of health and promoting inclusive and equitable practices.

The hospital-centered model, still predominant in traditional medical education, needs to be overcome in favor of a strengthened PHC, capable of offering comprehensive and continuous care. The engagement of health professionals in the construction of care centered on the user and the community depends on training that goes beyond reductionist

Revista ARACÊ
ISSN: 2358-2472

biomedicine, incorporating elements of communication, qualified listening and humanization of care. The approach advocated by Balint, for example, emphasizes the importance of the bond between doctor and patient, promoting a more empathetic and problem-solving service.

In this sense, the implementation of public policies aimed at the qualification of PHC professionals should be a priority. The expansion of the FHS, together with the appreciation of health workers and the guarantee of adequate working conditions, are determining factors for the effectiveness of this care model. The National Program for the Reorientation of Professional Training in Health (Pró-Saúde) is an example of an initiative that aims to integrate teaching and service, promoting transformations in professional training aligned with the needs of PHC.

Thus, valuing PHC as a central model of the SUS involves the construction of a health policy that prioritizes equity, comprehensiveness, and continuity of care. The training of professionals should be directed towards the transformation of social reality, ensuring that PHC is a space for health promotion and strengthening of citizenship. As demonstrated, the adoption of innovative strategies in the training of PHC professionals can contribute significantly to the consolidation of a more efficient, accessible, and fair health system for the entire population.

Revista ARACÊ
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