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Original Article

Nurses' management role in the Family Health Strategy: impacts on nursing care

Função gerencial do enfermeiro na Estratégia Saúde da Família: impactos no cuidado de enfermagem

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Lidiane de Fátima Felipe Lourenço[1]
Vitória Cristina Silva[1]
Mirelle Inácio Soares[2]
Fábio de Souza Terra[1]
Roberta Seron Sanches[1]
Tábatta Renata Pereira de Brito[1]
Zélia Marilda Rodrigues Resck[1]

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[1]Universidade Federal de Alfenas.
Alfenas, MG, Brazil.
[2]Centro Universitário de Lavras.
Lavras, MG, Brazil.

Corresponding author:
Vitória Cristina Silva
Rua Gabriel Monteiro da Silva, 700 - Centro
CEP: 37130-001. Alfenas, MG, Brazil.
E-mail: vitoria.cristina@sou.unifal-mg.edu.br

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ABSTRACT
Objective: to uncover the management role of nurses in the Family Health Strategy and its impact on nursing care. **Methods:** qualitative research was carried out with 11 nurses from the Family Health Strategy, selected using the Snowball sampling technique, in a virtual environment, with a single interview. A script was used for personal and professional characterization and a guiding question related to the topic. Descriptive analysis and content analysis were used in the light of dialectical hermeneutics. **Results:** the majority were women with between 10 and 20 years in management. Two categories were identified: lack of understanding of the managerial and care role and the impact on nursing care, and nurses' perception of their role as managers of the Family Health Strategy. **Conclusion:** there was confusion about the role of nurses, work overload, poor management skills for these professionals, and feelings of dissatisfaction and frustration that reflected on their health and the resolvability of the service. The multi-professional team presents challenges for interprofessional, with a view to collaborative practice to achieve comprehensive care. **Contributions to practice:** rethinking the management role of nurses in Primary Health Care, proposing and implementing strategies to guide their daily work.
Descriptors: Organization and Administration; Nurses, Male; Nursing Care; National Health Strategies.

RESUMO
Objetivo: desvelar a função gerencial do enfermeiro na Estratégia Saúde da Família e seu impacto no cuidado de enfermagem. **Métodos:** pesquisa qualitativa, realizada com 11 enfermeiros da Estratégia Saúde da Família, selecionados por meio da técnica de amostragem *Snowball*, em ambiente virtual, com uma única entrevista. Utilizou-se um roteiro, para caracterização pessoal e profissional e uma questão norteadora relacionada ao tema. Empregou-se análise descritiva e a análise de conteúdo, à luz da hermenêutica dialética. **Resultados:** maioria mulheres com tempo na função gerencial entre 10 a 20 anos. Identificou-se duas categorias: incompreensão do papel gestor e assistencial e os impactos no cuidado de enfermagem e, percepção do enfermeiro sobre sua atuação enquanto gestor da Estratégia Saúde da Família. **Conclusão:** evidenciou-se a confusão do papel do enfermeiro, a sobrecarga de trabalho, a baixa habilidade de gerenciamento por parte destes profissionais, sentimentos de insatisfação e frustração que refletem na sua saúde e na resolubilidade do serviço. E, a equipe multiprofissional apresenta desafios para a interprofissionalidade, com vistas à prática colaborativa para atingir a integralidade do cuidado. **Contribuições para a prática:** repensar a função gerencial do enfermeiro na Atenção Primária à Saúde, propondo e implementando estratégias que orientem sua atuação no cotidiano.
Descritores: Organização e Administração; Enfermeiros; Cuidados de Enfermagem; Estratégias de Saúde Nacionais.

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Introduction

The work process in the Family Health Strategy (FHS) involves the intersection between the nurse's management role and care demands. Nurses are central in managing family health teams and coordinating services and available resources, which are essential for achieving effectiveness. In addition, through their managerial functions, nurses plan strategies to meet the demand for care efficiently and satisfactorily, ensuring that resources are directed toward the community's priority needs[1].

A study with nurses reveals that, although they recognize that the administrative responsibilities of the FHS are specifically assigned to nurses, they agree that this represents an obstacle, as it restricts the direct provision of care to the user. They recognize that care and management are connected activities and not dichotomously separated. However, there is a challenging dynamic in reconciling these two dimensions of work, mainly due to the overload attributed to nurses[2].

There is a real work overload for nurses due to the daily incorporation of responsibilities that are not their responsibility, such as the high demand for bureaucratic activity and even the performance of activities by other professionals, as provided for in the National Primary Care Policy, but which are not yet part of the national reality, such as the unit manager[3-4].

It should be noted that the overlapping of bureaucratic tasks, excessive paperwork, and additional administrative requirements increase the pressure on the team, making the profession even more stressful. This can affect the job satisfaction of nursing professionals and, ultimately, the quality of care offered to patients[5].

Therefore, this study aims to uncover the management role of nurses in the Family Health Strategy and its impact on nursing care.

Methods

This is a qualitative study using the dialectical hermeneutic approach, which is an excellent tool for analytical methodology. It produces understanding and discernment of the context of the human being, considering the variables that involve social factors, health, and illness. These methods complement each other and serve as a foundation for qualitative research[6]. It should be noted that the Consolidated Criteria for Reporting Qualitative Research (COREQ) was used to guide the execution of this study and to prepare the final report.

The eligibility criteria for inclusion were nurses aged 18 or over with more than 6 months' experience in management or coordination positions in the FHS team. The exclusion criteria were nurses working exclusively as Primary Health Care coordinators. Eleven nurses in management roles in Family Health Strategy teams in municipalities in the southern region of Minas Gerais took part in the study.

The number of participants was justified considering the quality of the data collected, which met the research objective, and the phenomenon studied. No new information, categories, or emerging themes were observed during data collection. This means that the research reached a sufficient and comprehensive understanding of the phenomenon under study. Collecting more data would not add significant information or new perspectives to the study[6].

The participants were selected using the Snowball non-probabilistic sampling technique, in which chains of references were used from the researcher's initial contact. The participants were invited by phone and WhatsApp. The first nurse was known to the researcher, and the other participants were referred, with the second being referred to by the first, the third by the second, and so on.

Not all nurses accepted the invitation, and the

researchers had to contact them again. Once they had confirmed their interest in participating in the research, they were sent the Informed Consent Form by e-mail, asked to sign it in duplicate, return one copy, and keep the other, as well as information about the purpose and objective of the research.

To conduct the online interviews, the participant was instructed to choose a quiet, comfortable place with closed doors, avoiding outside interruptions and the presence of other people, keeping the presence of only the researcher and the interviewee connected via the Google Meet Platform. It should be reiterated that, if interfered with, the interview would be interrupted and rescheduled, or the participant could withdraw their consent and refuse to participate in the study, which did not happen in any of the interviews performed.

Likewise, the researcher conducted interviews from a location that ensured the participants' privacy and confidentiality, preventing interference from people not involved in the study, noise, or other external factors that could hinder their development.

Data were collected in April and May 2024 through open-ended, one-off, individual, and virtual interviews using the Google Meet platform, guided by a script drawn up by the researchers based on their experiences, consisting of two parts. The first was for personal and professional characterization, using the variables age, gender, the marital and professional status of the participants, plus the variables' education, length of professional experience, municipality of work, length of time working in the family health strategy, and time in management. The guiding question led to the second part: Tell us about your experience performing management and care roles in the FHS.

A pilot test of the data collection instrument was carried out with two nurses, which made the subsequent interviews easier. The question approach did not need to be adjusted. The two nurses interviewed in the pilot test were among the 11 participants in the study.

The participant researcher, a master's student, conducted the interview, guided and monitored by her supervisor, the principal researcher. Two digital voice recorders were used: a Knup LCD mp4 recorder and a Samsung voice recording app. The interviews were scheduled according to the availability of the participating nurses and lasted an average of twenty-five minutes.

At the end of the interviews, they were fully transcribed using the Gladia application, a voice typing tool. The transcription of the testimonies was carried out in two stages: the first with automatic transcription utilizing the application, simultaneously with the scrolling of the interview recording, and the second, by reviewing the generated texts, repeating fragments of the recording, and checking by two researchers, from the beginning to the end of the interview. Grammatical corrections were made to clarify the interviewees' understanding of the speech. Afterward, the transcripts were returned to the participants for correction and/or suggestions, with feedback without adjustments.

The interviewees were identified by the letter N, referring to nurse, followed by Arabic numerals from 1 to the last interviewee, according to the sequence in which the interviews were conducted, guaranteeing the anonymity of the participants. The personal and professional variables in the characterization questionnaire were tabulated manually and presented in tables in absolute values and percentages.

Content analysis[6] was used to organize the data collected from the semi-structured interviews, following three stages. In the first stage, pre-analysis was carried out with the aim of organizing the interview material. To this and, a cursory reading was carried out, aiming to constitute the corpus, where relevant excerpts of the statements were highlighted and identifying by colors.

In the second stage, called Analytical Description, the testimonies were treated in greater depth to codify the knowledge built up from the interviews. In the third stage, the data obtained were interpreted based on the theoretical frameworks that address and

guide the concepts related to the research in question.

To analyze the results, we used the axes of the study's theoretical foundation through the theoretical-methodological framework of dialectical hermeneutics. The Federal University of Alfenas Research Ethics Committee approved the research with the Certificate of Presentation of Ethical Appreciation 77093624.0.0000.5142, Opinion 6,701,230/2024.

Results

Nine nurses were female, married, or in a stable relationship; eight were aged between 30 and 40, and nine had a postgraduate degree. The length of professional experience of the eleven nurses ranged from five to twenty years. Six management nurses reported having between 10 and 20 years of experience. All eleven interviewees worked in municipalities located in the south of the state of Minas Gerais.

Two categories were identified: a lack of understanding of the managerial and care role and its impact on the nursing care provided and the nurses' perception of their role as managers of the Family Health Strategy.

Misunderstanding of the managerial and care role and the impact on nursing care

The nurses differed on whether they agreed on the management of care, the management of the nursing service, and the role of the unit manager, which they perform concurrently on a daily basis.

N1 reveals this confusion of roles: *There is confusion regarding being a manager and managing. As nurses, we're going to operate a unit anyway; we're going to provide, we're going to predict, and we're going to organize the team. You don't just manage nursing; you also manage everything from the coffee cup to the sheet of paper you will use. We get confused about the role of managers and nurses simultaneously* (N1).

N4 adds that, besides her managerial duties, she takes on the role of other team members in cases of absenteeism: *I do the organizational and car parts in the unit. In addition, when there's a staff shortage, during campaign periods, I do the vaccine administration part; I'm on reception at times to control demand and organize something that's needed... I also take care of bureaucratic problems. So, there's a lot we do* (N4).

Notably, nurses understand that they carry out care management and service management duties: *ESF nurses are always involved in various administrative and care functions. They assist in terms of screening, listening, meeting the demands of each life cycle, higher risk populations, cancer patients, and hemodialysis patients... as well as administrative issues, meeting the targets set and demanded by the Ministry of Health, the Bolsa Família population, the Health Network Project, which restructured and reorganized the service* (N5). There is a lot of pressure in management, not just in *managing people. We manage all unit issues, team conflicts, health promotion, prevention strategies, adjusting the professionals' schedules, or organizing the room and the unit. We manage material, which demands a lot from us* (N3).

However, the nurse's understanding of himself as the manager of the FHS and the lack of organization of the work process makes it difficult for him to reconcile the activities of care management with those of the service in fulfilling all the bureaucratic/documentary requirements: *We find it difficult because in addition to being the coordinator of the unit, you're also the care nurse. We have all the bureaucratic parts of the health unit, documentation, and care. These two roles are complementary... what is lacking is our presence with the patient* (N6). *In my unit, there's a lot to be desired: the management part, the bureaucratic part because care demands a lot of time, there are the agents, the population that we have to go home to, the demands that arrive daily and the nurse management part, which is us sitting at the computer, planning, setting up meetings, continuing education, health education, we do it in a rush, between one little time and another, I say I have to be a thousand and one utilities* (N7).

The challenges faced by nurses in managing care and managing care led them to experience an overload of activities in their day-to-day practice, which highlights the issue of centralization in solving situations/problems that could be solved by another professional and which end up being left to them to solve: *Nurses today in Primary Care carry a hefty load. The demand is very high, and so is the management. There are times when it feels like it's*

just you. You know what must be done, so it's all down to you. This centralization in the professional nurse gets in the way (N2). *Everything that is an administrative process is the nurse's responsibility, be it bureaucracy, the unit's documentation, the municipality's protocols, or the unit's protocol. I don't think the unit will move forward if the nurse isn't there on the day. There's only one professional in the unit* (N9).

It should be added that, in addition to the duties of care and service management, nurses take responsibility for other demands: *We are also responsible for physical structure because a light bulb burns out in the unit; it's the nurse. So, you must be on the lookout for a solution to that problem* (N3). *This week, we had a problem with a water tank. Last week, they replaced it, but it kept leaking water. That's a complicated situation because all the staff at the unit come to the nurse and tell him that the tank is leaking. And I, as a nurse, can't solve this problem. We call the maintenance team, but it's up to them to come and fix it, too* (N4).

In contrast, N11 and N4, in their statements, unveiled strategies to minimize overload, given their remarkable ability to delegate activities and organize the FHS's management processes: *If you have a quality and efficient team, the work pays off. You can provide much better care. On the care side, I have two nursing technicians. On the management side, I have my receptionist and two health agents who handle all the management. So, whatever I need, they're there to help me. And if I'm tight at any point, they come and help me. So, I manage very well and autonomously* (N11). *Tasks within the unit must be shared among the other employees. Someone else could supply the unit and buy materials. It's not only the nurse's job; other staff members could be responsible for these issues* (N4).

However, N2 points to the existence of two nurses in the FHS team: *The solution would be to have a management nurse and one who is more focused on care because one nurse doing everything is very complicated and challenging* (N2).

Nurses' perception of their role as managers of the Family Health Strategy

The nurses revealed their helplessness in the face of the simultaneity between managing and assisting, expressing frustration/ dissatisfaction at reconciling the activities of management and assistance in their day-to-day work at the FHS: *We feel frustrated because we have noticed that our activities sometimes don't turn out how we would like at the end of the day. An everyday example: we're at an appointment, listening to a spontaneous demand, and someone is knocking on our door; what for? Is this missing, is that missing? Has that order arrived? And our work is interrupted by one function or another!* (N1). *You must be able to organize and provide care; simultaneously, management is all on you. There's only one nurse, so we get a bit frustrated on a day-to-day basis because I want to meet the needs of the community rather than the management* (N2). *What is most detrimental currently is the physical presence of the nurse with the patient. When you're inside the unit, you can talk to the team; you can have this exchange. But you're only with the patient when you must do prenatal care or collect a preventive test. Apart from that, there are very few exceptions when you meet the patient. Sometimes, the patient knows who you are, but you don't know who the patient is. We end up feeling dissatisfied* (N6). *Of these two functions, one is lost... I believe that one is always falling short ... Why? Goals, goals, goals ... we stop being nurses to do paperwork, the bureaucratic part ... which leaves us dissatisfied* (N10).

Concerning the Multi-professional Team: the interdisciplinary challenge in the Family Health Strategy, only two nurses mentioned the E-multi team as a support network for care. However, this falls far short of the interdisciplinary approach recommended for the Family Health Strategy: Primary Care has dozens of employees, nurses, doctors, technicians, and community health agentes: *The multidisciplinary team, E-MULTI, has a psychologist, nutritionist, physiotherapist, and dentist. My unit has all these professionals. As well as being responsible for the nursing team, I'm also responsible for the other E-MULTI staff and the administrative side of the service* (N4). *The nurse is the flagship of everything, so it's a long way from seeing networking. I see this distance from E-MULTI. The nutritionist is just a nutritionist. I often have the professional, but it's a long way from this team working as an E--MULTI with the nurse to plan the goals. I don't see the involvement of the other professionals who form the team daily. Primary care must work this way and try to work together* (N2).

Discussion

There was a similar profile of female nurses in Primary Health Care, which aligns with the predomi-

nance of women in the profession[5,7]. Concerning age, 73% were aged between 30 and 40, with an average of 38[8], but there are findings that the age range extends to 53 to 56[7].

It is worth noting that more than 80% of those interviewed had completed a *Latu Sensu* course in a related area, which characterizes nurses' professional responsibility in continuous training, which is essential for individual development and excellence in health care[8-9].

Concerning length of experience and managerial role, the nurses were between 5 and 20 years old, as the results found in the literature[9]. There was a lack of understanding of the managerial and care role and the impact on nursing care, whose understanding interfered with the organization of management processes and contributed to an overload of activities.

Nurses' management activities include organizing the work of technicians, assistants, community health agents, and other professionals, coordinating programs and team meetings, reporting on the actions carried out, monitoring targets, and implementing strategies. In addition, nurses carry out care work and manage the unit[10-11].

In addition, assistance activities include those related to direct user care, either individually or in priority groups, with a focus on comprehensive care, such as nursing consultations for hypertensive patients and diabetics, preventive care, prenatal care, and childcare, which are privileged moments for care[10].

In addition, clinical and care practice includes actions such as supervising the vaccination room, performing dressings, requesting complementary tests, and prescribing medicines according to clinical and therapeutic protocols and guidelines or other technical regulations in compliance with the legal provisions of the profession[12].

It should be noted that the National Primary Care Policy recommends the inclusion of a primary care manager in the technical management role. It provides for a qualified professional, preferably with higher education and experience in the area, who should not be part of the minimum FHS team[3]. However, given the incipient reality of the services, it was up to the nurse to take on these functions, as there is no unit manager in most FHS.

It is emphasized that the nursing staff takes on administrative demands, which restricts the time for care, mainly due to the lack of support workers to carry out these tasks, which is a challenge for nursing care practices in the FHS[10]. There are also situations in which an insufficient number of nursing professionals leads nurses to cover the basic activities of other team members to the prejudice of their specific activities[13].

It should be emphasized that in PHC, the continuous clinical care provided by FHS nurses to patients, families, and the community is essential, both in terms of disease prevention, health promotion, and control of chronic conditions, which is often hampered by the overload of administrative and managerial activities[10,14]. The study also revealed nurses' perceptions of their role as managers of the Family Health Strategy.

The targets and indicators converge on quantitative production, which compromises the quality of the service. To this end, it should be noted that the problem is not just the bureaucratic activity itself but the lack of flexibility in managing it according to the needs and realities of the assigned area[15].

The nurses reported that it is up to them to solve problems that another professional could often solve. To this end, democratic and participatory management makes it possible to establish better relationships and agree on common goals for all team members[16].

It is apprehended that the immense range of care, management, and administrative demands in daily professional life has led nurses to become overloaded and experience feelings of dissatisfaction, frustration, and impotence, which reflect on the quality of the working environment, both on the team and the care offered.

Literature confirms the continuity of this situation, which almost always contributes to stress and anxiety[10-11] and leads to the psychic, physical, and emotional illness of these professionals, a phenomenon known as Burnout[17]. As a strategy for developing effective and quality care and management practices, it has been revealed that there is a need for more nurses in the FHS team[18].

It should be emphasized that nurses' accumulation of administrative, managerial, and care functions in PHC makes them multi-skilled professionals since they concurrently assume functions related to the team, planning service activities, and providing care to the population[19].

The importance of training nurses in the development of managerial competence is emphasized, strengthening them for teamwork, prioritizing the delegation of functions, and better-distributing activities to minimize the centralization of power in the nurse's figure. Thus, nurses who can plan and carry out their activities, involving and stimulating the team, can achieve better results, as revealed in one statement.

Another issue was the role of the multi-professional team as a challenge for interdisciplinary in the Family Health Strategy since the nurses said that they had not yet achieved the recommended guidelines. Also, E-Multi has become the nurse's responsibility, further overloading their list of tasks.

The Ministry of Health has instituted a federal financial incentive for the creation and operation of multi-professional teams (E-Multi) in Primary Health Care (PHC), which emphasizes the premise of interprofessional as one of its guidelines[20].

Although they maintain some similarities with the work of the old Expanded Family Health Centers, this new arrangement has introduced new points of structure and organization, work process, attributions, and collaboration with PHC teams[21].

Comprehensiveness of care, to be achieved, needs to go beyond the technical approach, focusing on the procedure and the disease. To this end, it is essential that the multi-professional family health team exercises effective communication and collaborative practice in prioritizing care for the person, family, and community-based on their singularities[22-23].

In strengthening collaborative practice in PHC, it is essential that E-multi be effective, with a view to improving the quality and effectiveness of care and transforming the practice of health care[24-25], which is a challenge to be met.

Study limitations

It would be possible to cover a broader range of scenarios and thus have a view of other realities beyond the micro-region of the study, contributing to the robustness of the discussion.

It is understood that, besides the demands made, conducting the survey virtually prevents us from grasping essential qualitative data elements. Another limiting aspect is that the approach was carried out in just one meeting with the participant.

Contribution to practice

Knowing the reality experienced by nurses in the context of Primary Health Care, with a focus on the Family Health Strategy, leads us to rethink strategies for organizing the management processes of the FHS considering the guidelines of the National Primary Health Care Policy, with a view to greater satisfaction in daily professional practice and contributing to the quality of nursing care for the population.

Conclusion

There was confusion about nurses' roles, work overload, poor management skills for these professionals, feelings of dissatisfaction and frustration that reflected on their health, the resolvability of the service, and impacted nursing care for users.

It is also clear that in the nurses' reality, there is no unit manager in the Family Health Strategy units in which they work, whose functions assigned by the National Primary Care Policy are left to nurses to carry out, which increases their workload.

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Authors' contribution

Conception and design or analysis and interpretation of data; Writing of the manuscript or relevant critical review of the intellectual content; final approval of the version to be published; responsibility for all aspects of the text in ensuring the accuracy and integrity of any part of the manuscript: Lourenço LFF, Silva VC, Soares MI, Terra FS, Sanches RS, Brito TRP, Resck ZMR.

References

1. Oliveira IB, Peres AM, Martins MM, Bernardino E, Haddad MCFL, Lowen IMV. Innovative actions developed by nurses in primary health care. Rev Bras Enferm. 2022;75(1):e20200782. doi: https://doi.org/10.1590/0034-7167-2020-0782
2. Souza DPR, Figueirêdo DSTO, Andrade LL, Nogueira MF, Santos NCCB, Andrade LDF. Assistance and management in the context of the family health strategy from the perspective of the nursing assistants. Rev Enferm Atenção Saúde. 2021;10(2):e202117. doi: https://dx.doi.org/10.18554/reas.v10i2.4545
3. Ministério da Saúde (BR). Portaria nº 2.436, de 21 de setembro de 2017. Política Nacional da Atenção Básica [Internet]. 2017 [cited Dec 7, 2024]. Available from: https://bvsms.saude.gov.br/bvs/saudelegis/gm/2017/prt2436_22_09_2017.html
4. Viana VGA, Ribeiro MFM. Challenges of the nursing professional in the family health strategy: adepreciated key piece. Ciênc Cuid Saúde. 2022;21:e59900. doi: https://doi.org/10.4025/ciencuidsaude.v21i0.59900
5. Felix RS, Pinheiro VRM, Neves Junior TT. Percepções dos enfermeiros sobre as condições de trabalho e infraestrutura das unidades de atenção primária em saúde. Tempus. 2022;16(4):65-72. doi: https://doi.org/10.18569/tempus.v16i4.3062
6. Minayo MCS. O desafio do conhecimento: pesquisa qualitativa em saúde. São Paulo: Hucitec-Abrasco; 2014.
7. Peruzzo HE, Marcon SS, Silva IR, Matsuda LM, Haddad MCFL, Peres AM, et al. Essential management competencies of nurses: actions and interactions in the context of the Family Health Strategy. Rev Bras Enferm. 2020;73(6):e20190511. doi: http://doi.org/10.1590/0034-7167-2019-0511
8. Sacramento RC, Vendruscolo C, Silva CB, Metelski FK, Trindade LL, Adamy EK. Care dimensions of nurses' work in primary care. Esc Anna Nery. 2023;27:e20220404. doi: https://dx.doi.org/10.1590/2177-9465-EAN-2022-0404pt
9. Lopes OCA, Henriques SH, Soares MI, Celestino LC, Leal LA. Competences of nurses in the Family Health Strategy. Esc Anna Nery. 2020;24(2):e20190145. doi: https://dx.doi.org/10.1590/2177-9465-EAN-2019-0145
10. Mendes M, Trindade LL, Pires DEP, Martins MMFPS, Ribeiro OMPL, Forte ECN, et al. Nursing practices in the family health strategy in Brazil: interfaces with illness. Rev Gaúcha Enferm. 2021;42(esp):e20200117. doi: http://doi.org/10.1590/1983-1447.2021.20200117
11. Mondragón-Sánchez EJ, Bernal-Ordoñez LK, Corpus-Quiguanás J. Proceso de trabajo de enfermería en la atención primaria de salud: estudio observacional. Rev Ciênc Cuidad. 2021;18(3):22-31. doi: http://dx.doi.org/10.22463/17949831.2850
12. Alvarenga JPO, Sousa MF. Work and practices of nursing in Primary Health Care in the state of Paraíba – Brazil: professional profile and care practices in the care dimension. Saúde Debate. 2022;46(135):1077-92. doi: http://doi.org/10.1590/0103-1104202213509
13. Nunciaroni AT, Cunha CLF, Borges FA, Souza IL, Koster I, Souza IS, et al. Enfermagem na APS: contribuições, desafios e recomendações para o fortalecimento da estratégia saúde da família. APS Rev. 2022;4(1):61-80. doi: https://dx.doi.org/10.14295/aps.v4i1.234
14. Biff D, Pires DEP, Forte ECN, Trindade LL, Machado RR, Amadigi FR, et al. Nurses' workload: lights and shadows in the Family Health Strategy. Ciênc Saúde

Coletiva. 2020;25(1):147-58. doi: http://dx.doi.org/10.1590/1413-81232020251.28622019

15. Bica MC, Cremonese L, Barreto CN, Rodrigues ALM, Alves FQ. Care management in family health strategies in nurses'perception. Rev Enferm UFSM. 2020;10:e74. doi: https://dx.doi.org/10.5902/2179769242518

16. Mateus LC, Condeles PC, Bracarense CF, Parreira BDM, Simões ALA, Goulart BF. Management in the Family Health Strategy: nurses' perceptions. Rev Enferm UERJ. 2021;29:e57262. doi: http://dx.doi.org/10.12957/reuerj.2021.57262

17. Santana LC, Ferreira LA, Santana LPM. Occupational stress in nursing professionals of university hospital. Rev Bras Enferm. 2020;73(2):e20180997. doi: https://doi.org/10.1590/0034-7167-2018-0997

18. Metelski FK, Silva CB, Vendruscolo C, Trindade LL, Geremia DS. Enfermeiro gerente de unidade na atenção primária: o desafio de ser polivalente. Enferm Foco. 2022;13:e-202235. doi: https://doi.org/10.21675/2357-707X.2022.v13.e-202235

19. Metelski FK, Alves TF, Rosa R, Santos JL, Andrade SR. Dimensions of care management in primary care nurses' practice: integrative review. Rev Enferm UERJ. 2020;28:e51457. doi: http://dx.doi.org/10.12957/reuerj.2020.51457

20. Ministério da Saúde (BR). Portaria GM/MS nº 635, de 22 de maio de 2023. Institui, define e cria incentivo financeiro federal de implantação, custeio e desempenho para as modalidades de equipes multiprofissionais na atenção primária à saúde [Internet]. 2023 [cited Oct. 23, 2024]. Available from: https://bvsms.saude.gov.br/bvs/saudelegis/gm/2023/prt0635_22_05_2023.html

21. Bispo Júnior JP, Almeida ER. Multiprofessional teams (eMulti): potentialities and challenges for the expansion of primary health care in Brazil. Cad Saúde Pública. 2023;39(10):e00120123. doi: https://doi.org/10.1590/0102-311XPT120123

22. Rodrigues MR, Sousa MF. Integralidade das práticas em saúde na atenção primária: análise comparada entre Brasil e Portugal por meio da revisão de escopo. Saúde Debate. 2023;47(136):242-52. doi: http://doi.org/10.1590/0103-11042022313616

23. Dias KDC, Dias DS, Dias NS, Turci MA. Contribuições da educação interprofissional ao ensino odontológico no Brasil: uma revisão sistemática. Rev Eletr Acervo Saúde. 2021;13(2):e6490. doi: https://doi.org/10.25248/reas.e6490.2021

24. Xavier DP, Fernandes FNS, Ferreira GRS, Gonçalves IYL, Dias KDC, Barbosa VPB, et al. Educação permanente em interprofissionalidade e prática colaborativa na atenção básica. Rev Eletr Acervo Saúde. 2024;24(2):e15286. doi: https://dx.doi.org/10.25248/reas.e15286.2024

25. Fernandes SF, Trigueiro JG, Barreto MAF, Carvalho REFL, Silva MRF, Moreira TMM, Costa MV, Freitas RJM. Interprofessional work in health in the context of the COVID-19 pandemic: a scoping review. Rev Esc Enferm USP. 2021;55:e20210207. doi: http://doi.org/10.1590/1980-220X-REEUSP-2021-0207