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Articles

Strategies used for collaborative work in family health teams: a cartographic analysis

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Cartografía de las estrategias utilizadas para el trabajo colaborativo en equipos de salud de la familia (resumen: p. 18)

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The study aimed to map the strategies used for collaborative work in Family Health Teams (FHT), inserted in Primary Health Care, in a municipality in the North of Minas. This is a qualitative study, with the methodological proposal of Cartography. Data were produced in four FHT, through participant observation, identification questionnaire, cartographic diary, semi-structured individual interview and focus group. Discourse analysis and mapping screening enabled the construction of two thematic categories and a cartographic map. It was reached that the strategies, considered lines of flight, allow existential transformations in teamwork, since they originate springs in crystallized soils, problematizing thoughts, subjectivity, and disciplinary interactions. It was concluded that hard lines should not be eliminated from teamwork, for they coexist in this reality, and what matters is how they are experienced in relationships.

Keywords: Primary health care. Family health team. Cartography.

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Introduction

Preventive medicine, was established in university curricula by the University Reform Act of 1968, and it constituted one of the foundations of the health movement in Brazil, whose aim was to reconcile the production of knowledge and the way of organizing health practices[1]. This led to the construction of projects aimed at transforming medical practice. As a result, multi-professional teamwork was incorporated into undergraduate curricula for the first time[2].

Over the years, teamwork has become vital, as, owing to the Brazilian Constitution of 1988, the Brazilian National Health System (SUS) emerged, offering comprehensive, free, universal care and proposing a new approach to the health-disease-care process[3]. This change that encompassed multiple factors that interfere in people's health and that ratifies the need to readjust teamwork, no longer as a combination of different disciplines. Providing access to different health professionals is not enough to guarantee comprehensive care[4]. Teamwork is fundamentally based on disciplinary interaction, which enables knowledge to integrate with each other in order to create a holistic, collective vision in line with the principles of the SUS[5].

In order to achieve its principles, the SUS is systematized into Health Care Networks (HCN), including primary, secondary and tertiary care services[6]. The Family Health Strategy (FHS) is the priority entry into the HCN and aims to overcome the fragmented model through longitudinal care, in the territory where people work, live and relate to each other. To achieve this, a team must take responsibility for health, which means that care is based on teamwork[7].

The National Primary Care Policy (NPCP) of 2017 recommends that the Family Health team (FHT) has the competence to establish links, provide continuous and organized care to the assigned population. It is multi-professional: doctor, nurse, nursing technician and/or assistant and community health worker (CHW). It can also add an endemic disease control agent and an oral health team, made up of a dental surgeon, an oral health assistant and/or an oral health technician. In addition, if appropriate, the FHT can count on matrix support from specialist professionals: speech therapists, physiotherapists, art teachers, psychologists, nutritionists, among others[7].

It can be seen that the FHT has a wide range of knowledge, highlighting the need for coordination and collaboration. A study in the field of the FHS pointed out that collaborative teamwork is configured as an active and continuous partnership between members, even if they have different scientific technical knowledge and cultures, they work together to provide health care[8]. Corroborating this finding, other literature points out that collaborative work is intrinsic to recognizing the interdependence and complementarity between instrumental and communicative action. However, instrumental action prevails as a response in the daily life of the FHT[9].

Communicative action has equivalent value to instrumental action, but it is more complex to execute due to the relationship between the team, precisely because this relationship is permeated by continuous, diverse and transitory aspects that include what goes beyond the clinical, such as culture, art, education, politics and others[10]. In this context, the bet for collaborative work is found in the relationships that occur in the dimension of micro-politics, in living work in act, but which also limit the linear lines of macro-politics through capitalism, mechanization and biologization[11].

It is understood that the strength of relationships can only be converted into collaborative work when the team allows itself to be affected by the reality of the living territory. The methodological proposal of cartography favors the territories of local production, based on the resulting flows and the relationships that cross and intertwine in the daily life[11]. For this reason, it provoked us to enter the multiplicity and investigate the mapping of strategies used for collaborative work in FHTs.

Methodological approach

This is a qualitative study based on the cartographic method. Cartography is structured in the theoretical field of schizoanalysis, which allows for intervention research[12]. It is a method that proposes to follow processes of reality, which imply constant production of subjectivities. In this way, cartography does not delimit reality in an immutable and hierarchical way, but thinks of it in a complex way, through the assumption of the rhizome[13]. The process of thinking using the botanical image of the rhizome as basis, the stem, allows to understand that reality is in constant transformation and is crossed by multiple variables, in other words, reality is a mobile network of stems, which produces living maps, without a centralized structure, with various inputs and outputs[14].

The field of the study was Family Health Units (FHU) and the data was collected from four FHTs in a municipality in the north of Minas Gerais, with the participation of forty-two professionals. The municipality had 136 teams, including rural teams, and four teams were chosen and drawn initially, taking into account: the likelihood of the teams being selected joining the study, given that the municipality has a partnership with educational institutions and encourages field research at FHUs on a daily basis; and an analysis of the experience of the researchers and the study's supervisors over the last two years or more, that the FHTs are fertile territories for producing data compatible with the topic. As the stages of the research unfolded, there was no need to draw lots again, as we achieved the study's objectives with the four teams. The inclusion criterion was: all FHTs were interested and willing to take part in the study. The exclusion criterion was: the FHT in which the researcher was working.

The data was produced between August and December 2021. The starting point was a telephone call to the immediate manager of the FHTs selected, a nurse. The teams were then visited at their place of work for participant observation, recorded in the cartographic diary, and the interviewee identification questionnaire was

applied, characterizing: gender, age, schooling, occupation and profession, time since graduation, time working in the occupation and/or profession and time working in the current service. Forty-two individualized semi-structured interviews were then carried out, lasting between ten minutes and one hour, and four focus groups lasting approximately forty minutes.

The interviews and groups had a script with guiding questions. From the interviews: "What is teamwork?"; "How do you perform your duties at work?"; "What are the facilitating and hindering factors in teamwork?"; "What strategies do you use to deal with the hindering factors?"; "What is the relationship between teamwork and the care provided?"; "Do your team's actions go beyond the recommended duties?" If so, describe how this happens."; "Do you feel affected by working as part of a team?"; "Does disciplinary interaction take place?". The focus group questions were: "What do we need in order to work collaboratively as a team?"; "What are team relationships like?".

In order to keep trustworthiness in what was said, the interviews and focus groups were audio-recorded using a digital recorder and then transcribed for analysis and interpretation. The theoretical saturation sampling method was used to establish the final sample[15]. After the transcriptions, discourse analysis was carried out. This, in turn, made it possible to go beyond the literal content of the speeches, making it possible to interrogate meanings[16].

At the first moment of the analysis, detailed readings were carried out to understand the effects of meaning, what was being addressed within the speeches, in addition to the sensitivity of the observation technique, which covered gestures, environment and phrases. The statements in the discussion were identified by professional category and numbered in ascending order of the interviews conducted.

In a second moment, for the purposes of interpretation, the research used the fundamental precepts of the plane of forms, the plane of forces and agencying that can be mapped within the rhizome. The plane of forms, produced by the hard lines, is composed of defined, instituted and binary aspects. The plane of forces is associated with the part formed by flexible lines that reach the form and temporarily circumvent it. The modulations produced by this line give rise to agency, which is dynamic, constantly changing and produces the new. As a consequence of the agency, lines of flight emerge through active processes that end up in transformations[17].

The research was carried out with the consent of the Municipal Family Health Coordinator (FH) and the participants, who signed an informed consent form. This research was carried out as a conclusion to the Multiprofessional Residency in Family Health (MRFH), which was cleared by the Research Ethics Committee under Opinion No. 4.838.707 and followed the tenets of Resolution No. 466/12 of the National Health Council[18].

Results and discussion

Characterization of the territories and participants

Resulting of the field observations, recorded in the cartographic diary, it was possible to recall numerous experiences. On the way to the territories, the researchers experienced unique and opposing directions in the city. In the first few visits, the observation highlighted the symbolic and physical reception, the team's interest in taking part in the research, the ambience and the team's relationship within the work environment. Twenty-three meetings took place and six were not held due to the specific nature of each FHT, especially time commitments, busy schedules and the "unforeseen events" of the FHT. These facts helped the researchers to understand the work routine in each team.

The four teams are located in territories that have different characteristics and impact on the work process. Among the most significant are issues of social vulnerability, an excess number of registered users, favorable socio-economic conditions and a community oriented towards the team's work process. Two teams are shared in the same FHU and the other two are unique in terms of physical space. Of these, two adhere to the "Health on the Spot" Program[19] and two are centers of the Multiprofessional and Medical Residency Programs in Family Health, and Multiprofessional in Mental Health. The number of members in each team is: five, twelve, twelve and thirteen.

Regarding the characterization of the forty-two people, four are nurses, three dental surgeons, three doctors, two psychologists, four nursing technicians, three ASBs, one administrative assistant, three janitors and eighteen CHWs. Of the total, seven are men and thirty-five women, with ages ranging from twenty-three to seventy-two. The length of time they had been working varied from five months to thirteen years, with the majority having been working for three years. Having been at the FHT for three years or more proved to be a favorable factor for collaboration between professionals, since the time they have been together makes it possible to build bonds with colleagues and the community, as well as robust guidance in the work process.

In terms of qualifications, all had completed high school, twenty-six had higher education, five had a specialization in the *Latosensu* modality, five had a specialization in the Family Health Residency modality and four were currently in the process of doing so. It was also noted that two professionals have a master's degree in health.

Derived from monitoring the living reality of the four FHTs, it was possible to construct two thematic categories: the intersection of hard and soft lines in FHTs and lines of flight as strategies for collaborative work. After the categories, Figure 1 shows the cartographic map that provides a holistic understanding of the object under study.

The intersection of hard and soft lines in FHT

Corresponding to each question put to the teams, there was a response-invention, a production that only took place during the meetings, already denoting one of the interventional points of the research. The discussion begins with statements that add up to a possible characterization of collaborative teamwork, statements that escape formatted definitions, since they produce problematizations and implications.

> Teamwork isn't a gift, it's something we learn, right?! (DOCTOR1)

> Everyone has to cooperate [...] It's not because I have that role that I can't guide, inform and collaborate with my team. (CHW6)

> It's that work as if it were a chain. It's a work of unity, of strength, of collaboration [...] No work goes without stumbling [...] I feel like a little piece of this chain. (CHW13)

Against the historically hierarchical teamwork model, there are multiple aspects in the dialogues that dilute the hegemonic consistency[20]. Comprehensive care, carried out by many in a cooperative way and interwoven like a chain, demonstrates the crossing over in the expected form of what collaborative teamwork can become and makes it possible to identify the existence of flexible lines, the demands of the FHT and soft technology, which make up the plan of forces. The existence of flexible lines allows for modifications, impulses and deviations in the plan of form. In the plane of form, the property of what is fixed, expected and without dynamism, there are the hard lines, here the demands of the FHT. The dual effect of the FHT's demands is evident, sometimes as a hard line and sometimes as a flexible line[21].

The primary function of the FHS is to respond to the existing demands of its territory and, in order to do so, it must know it in depth. Territorialization, a basic attribute of all team members, provides a social, cultural, epidemiological, health and socio-economic overview that guides the construction of the actions to be carried out. Therefore, de-territorialization and, consequently, re-territorialization are practices that should be habitual for the FHT, considering that the territory is moving[7]. The implication with the living territory, perceived in the speeches, demonstrates the movement of the team, which,at the same time, affects and is affected by the demands of its territory, when they recognize the stumbling blocks, care in its multiplicity and when they make learning together a possibility of strength. And it is this strength that has an impact on the FHT's hard line of demands, which have presented themselves through norms, the need for care for all life cycles, established flows and natural work, as if it were a gift.

> We're here to join forces in order to do the best for the population. (CHW8)

> Teamwork aims to promote care. And it's not just provided by one professional. [...] No team ever is, it changes every day. (DENTIST1)

> The team is like a gear; one part depends on the other. (CHW13)

As stated, the FHT is constantly changing, because it is also made up of forms. Hard lines shouldn't mean anything bad, since what matters is how they are experienced in relationships, i.e. whether they are maintained, whether they produce life and whether they change[22]. An example of this change, focused on in the meetings, is the pandemic caused by the SARS-COV-2 virus, which brought about the need to readjust, in other words, to learn. This learning had an impact, above all, on the demands of the FHT, as a new way of designing care became necessary. Even with the directives set by the Federal, State and Municipal bodies, each team had to jointly build coping strategies according to the reality of their territory.

Building together can be represented by the symbolism of the authors Merhy and Franco[23] when they emphasize soft technology, a flexible line, as a toolbox for each professional, in which each one is essential to complete the other. The speeches show the importance of the feeling of belonging in the team, just like in a workshop, where everyone depends on the exchange and loan of tools to get the chain moving.

With the idea that each professional has their own box, it was possible to infer the existence of varied professional stance involved in collaborative teamwork:

> It has a differential which is when the professional wants to understand, is available, wants to learn. (NURSE2)

> Teamwork will never end. Because we'll never be the same. We'll always have to create new skills to deal with things and keep changing. (CHW9)

> There's a lot that we have to work on from our side for things to work out. (JANITOR2)

The professional stance has the particularity of being dynamic and was perceived as a flexible line that has a greater impact on objective work, considered here as a hard line, through predictable and countable thinking. At the same time as there is a dependency between the toolboxes, each professional needs to be minimally committed to their own

toolbox. In other words, everyone's part is essential. In this way, the professional stance referred to in the speeches and observed in the groups is one that enables impacts on interactions, movement in teamwork that is not fixed and traces, outside of circularity, a beyond that will help in the "de-construction" of skills[24].

The effect generated by the flexible line, the professional's stance, was seen as twofold: positive, as highlighted, and negative, when there is a lack of involvement in the work, causing slowness in the service, personal and team dissatisfaction. The negative effect of the flexible line, the stance of the professional, has a subjective impact on the subject, the territory and the collaborative progress of the team, therefore conflicts can arise from this impact.

> It's difficult when there's a lack of interest, when there's a blind eye at work and a lack of willingness. (CHW5)

> I've never had a problem with a patient, but the team is difficult because there's conflict, if there's no conflict it's not normal. (CHW4)

> We have to see if we are having this conflict to attack or to correct, to offend or to resolve, we have to know what our intention is. (PSYCHOLOGIST2)

Conflict is analyzed in two ways: as a hard line, imprisoning life; as a flexible line, enhancing life. As an imprisonment, it enhances stress, damages psychological organization, fostersgrudges and competitions. Competition, expressed between the lines during all stages of the research, can be exemplified by productivity comparisons, vertical relationships and the excessive use of technological tools by some professionals. Conflict, on the other hand, as a potentializer, produces reflective movement, drives inventive changes and strengthens the work that is concatenated. Conflicts, in both their forms, are frequent and necessary in the routine work of the FHT, but they must be articulated with an active understanding of the intention[25], as the speeches inferred.

Along the production of the data, it was observed that the excessive use of technological instruments (computers), as well as promoting competition, is associated with achieving productivity targets. These goals were referred to as organizational structures that are often experienced in a circular logic, which can be related to hard technology. The concentrated use of this technology is analyzed as a hard line because it has a materialized and structured characteristic, highlighted by equipment and machines that compromise the quality of living work in act[26], as can be seen below:

> A lot of targets for employees and sometimes you end up working for quantity rather than quality. (CHW16)

> We feel suffocated. (CHW8)

> I'm just like that old saying, sponge [...] I absorb a lot and it wears me out. (ADMINISTRATIVE ASSISTANT1)

In this sense, the concentrated use of hard technology affects the progress of collaboration between the team and the care they provide. For this reason, the exchange of "information-action" between the FHT, analyzed as a flexible line, proved to be a strong resource for boosting work based solely on targets. The information circuit, noted in the participants' speeches based on their day-to-day actions, was emphasized through scales in its variability of functions, including the use of computers; information boards; the use of tables, schedules and digital transmission resources, for example, datashow and WhatsApp groups.

During the meetings, it was noticeable that the professionals articulated their responses-productions, to a greater extent, to the patients, thus hinting at the intrinsic relationship between team and patient.

> Working as a team in PHC, we are able to approach the patient's demand from different angles. (DENTIST2)

> Everyone performs different and connected functions in order to serve the user well, if the team isn't working in a well-oiled way, care is compromised. (DOCTOR2)

> We have to develop certain professional bonds that contribute to the care provided. (NURSE3)

The patient, a flexible line, was associated as an important axis for team interaction, since it drives horizontal communication between professionals in order to provide responsible care. In the FHT routine, each member contributes both in terms of care and subjectively, shaping the interaction processes, which can take different forms, such as interprofessional collaboration[27]. Portraying the care and subjective contribution in the reality of the mapped teams, the following can be mentioned: the bond capable of producing stimulation and empowerment, celebrations of symbolic dates, sharing snacks, proactively helping a colleague to carry out a task, covering care in a micro-area discovered by a member on vacation or on leave, and the presence of a team manager and/or coordination by higher-level professionals.

Team management was analyzed as a flexible line.

> The nurse always encourages us with something [...] knowing how important I am helps me to keep going. (CHW11)

> Higher-level professionals bring harmony to the team, their attitude makes a big difference. (DENTIST2)

> To develop well, you need a good leader who directs the team towards a purpose. (JANITOR3)

The Ministry of Health accredited the presence of FHU managers, the 2017 PNAB addressed their attributions,while Ordinance No. 6/GM/MS, of September 27, 2018, presented their financing[19]. The presence of this professional in the FHU is associated with the municipal assessment of this need and, when there is the Health on the Spot Program, it is a mandatory requirement. The professional in question has the role of ensuring the management and organization of the work process; participating in the planning and programming of the teams' actions and guiding them, including the organization of their agendas; acting in conflict mediation; stimulating the bond between professionals, favoring teamwork, among others[7]. The statements represented the effects after the managers joined two FHUs in 2020. In the other two teams, it was analyzed that the coordination of higher-level professionals has a similar function to that of the manager, as they have team management in common.

Collaborative work in the FHT adds up to a complex range of subjectivities, sometimes imprisoning in established realities, sometimes enhancing life, the new and invention. It can be inferred that there is no closed definition of what this work is, but it is possible to understand from the discourses associated with the literature that the work is permeated by hard, natural and predetermined strata (demands of the FHT, objective work, conflict and hard technology), which are most often affected (demands of the FHT, soft technologies, professional stance, information, management and conflict) and trace modifications. In other words, the crossing of hard and soft lines encourages interaction between members, a fundamental aspect of collaborative work.

Lines of flight as strategies for collaborative work

Following the exposition of the mapped process, the impulse of the flexible lines under the hard lines gives rise to agency. When analyzing agency, the strategies used for collaborative work in FHT emerge as lines of flight, which enable existential transformations of reality. The following narratives show evidence of these transformations:

> By listening, we position ourselves better, we have a different attitude. (CHW9)

> Nobody knows about the other person if they don't talk, so communication is very important. (NURSE1)

> We learn to communicate with the other person, we understand how the other person is, how it's best for me to talk to them, we learn to listen. (DOCTOR1)

The lines of flight, communication and listening, were listed as strategies in the face of limited interpretations. When there is room for team members to speak and communicate, relationships tend to move more actively. Communication in its diversity of possible languages includes, in addition to the voice, behavior, the look and the listening position. It's listening that is sensitive even to silence, that leaves one's place and jumps to the different ways of perceiving the other[11]. These two strategies were analyzed in a complementary way, since one does not occur without the other.

Communication and listening produce processes that highlight subjectivity and are expressed and enhanced, above all, through team meetings.

> Team meetings have to happen with a certain frequency, a time to think together. (NURSING TECHNICIAN2)

> We have meetings every week, it's constant, a time for us to raise the points that need to be improved. (CHW2)

> At these times we have a voice, an opinion, and the team decides on the best strategy to use. (CHW10)

The meeting was analyzed as a line of flight, as it refers to the powerful experience of producing knowledge. From these statements, it can be inferred that the team meeting is a meeting that should take place on a regular basis, as it drives the production of thoughts, not annihilating differences, but as exchanges that favor the bond and stimulate the work carried out. In the production of the data, it was realized that a set script is not feasible, but rather a meeting facilitated by the environment, teaching resources, niche agendas, exchanges between members and post-meeting evaluation of the effects. This is because there will always be points to be made and points that need to be reworked. Concurring with this finding, Dall'Agnol and Grando[28] state that meetings, as well as providing planning related to care, encourage the sharing of ideas, interpersonal relationships, the fluidity of creative thinking and the evaluation of the team's daily routine.

Another strategy that contributes to collaborative work, analyzed as a vanishing point and highlighted in the individualized interviews, is the Multiprofessional and Medical Residency in Family Health. This was identified by professionals who have completed the residency, those who are still in the process and the majority of professionals who do not carry it out directly.

> I learned to be proactive and I attribute this to the residency [...] technical capacity related to team management, interpersonal relationships. During residency, I began to move away from the traditional medical practice of providing care to participate more actively in this part of care. I'm a different professional and person after residency. (DOCTOR1)

> There's a lot of difference when you do residency. (DENTIST3)

> I think that after the residency came in, it improved a lot. (CHW15)

Residency programs come from the link between education and work, in an action between the Ministries of Health and Education, and are a postgraduate course that falls under the *Latosensu* modality. It has the characteristic of providing qualified training for professionals who are able to work based on the principles and guidelines of the SUS. The Family Health Residency (FHR), as shown in the speeches, has the function of developing education in a critical and reflective way, teaching in service associated with the process of discovering paths. These paths are both singular and collective, but always subjective, since they go beyond the territories marked by curative and prescriptive practices, the compartmentalization of the team and the lack of comprehensiveness[29].

The impact of the FHR is multifaceted, given that team members, the physical environment, the community and the soil are driven to fertility by building what is not fixed, such as human and welcoming care, management skills, the organization of care compatible with the attributes of the FH and collaboration between the team. For this reason, it is understood that the FHR, as an educational process, not only trains the resident, but the whole complex set-up of that service, especially the team.

The FHR is biennial and for this reason there is a high turnover of professionals in the FHU, which means that in addition to the development process during the two years, it is essential that continuing education remains, with or without residency, as observed in the speeches:

> In order to enhance action, bringing more resolutivity to the service, we have improved through professional training. (NURSE1)

> The person who has the skills enables the person who doesn't, and there's also the question of interest. (PSYCHOLOGIST1)

As seen through the speeches, training refers to permanent education, analyzed as a line of flight present in numerous contexts: when there is a lack of practical-theoretical knowledge, the incidence of demands, the reworking of flows and health production workshops. Continuing education was presented as an expansion of a single disciplinary field and also through the desiring production of health professionals. The expansion

of a disciplinary field when continuing education is a vehicle for transforming reality, for example, the logic of partnerships with undergraduate institutions, FHR master's degrees and doctorates. In turn, the production of desires of the professional is based on the desire to vivify routine care through a willingness to learn together[30]. These two points are articulated with the team, as the National Policy for Permanent Education proposes that the education processes for health workers should be based on the joint problematization of the work process[31].

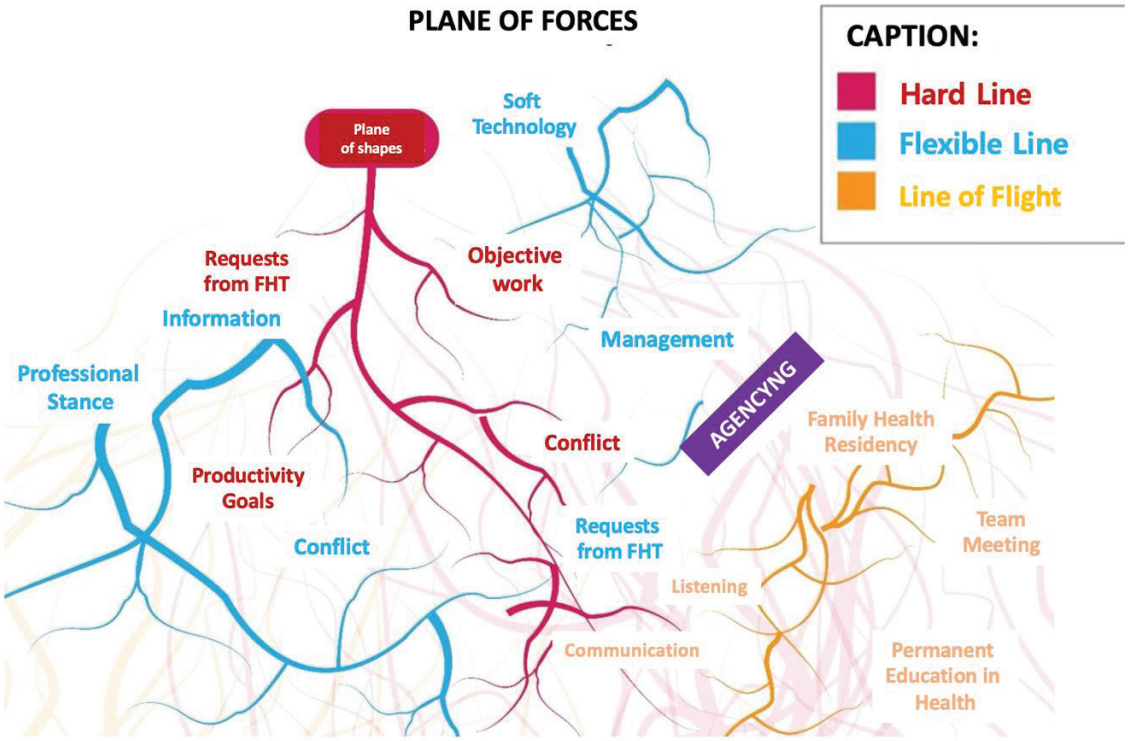

Figure 1. Cartographic map of the strategies used for collaborative work in FHT.
Source: results of the study.

Final considerations

The study proved to be innovative, as it was inferred that collaborative work is a mutable process, permeated by various variables, and this analysis was only possible with the guidance of the clues seen, felt and invented with the participants. Data production could only take place when the researchers immersed themselves in the living reality of the teams, since the slightest paralyzing aspect was the act of producing questions, with the aim of causing small deviations, springs in crystallized soils, problematizing thoughts and subjectivity. In this way, recognizing the importance of hard lines was essential, since they coexist in reality. It is therefore important to know how to deal with them, not eliminate them.

Time, a crucial factor, provided encounters that lasted a long time, but lacked continuity, limiting the accuracy of the unhurried screening, so it is necessary to develop new studies with more time. Finally, it is certain that cartography has made it possible to follow the process of FHT relations and visualize the manifestations of forces as molding, creative and emancipatory arrangements, present in the mapped strategies.

Authors' contribution

All authors actively participated in all stages of preparing the manuscript.

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Conflict of interest

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O estudo objetivou mapear as estratégias utilizadas para o trabalho colaborativo em equipes de Saúde da Família (eSF) inseridas na Atenção Primária à Saúde (APS), em um município do norte de Minas. Trata-se de um estudo qualitativo, com a proposta metodológica da Cartografia. Os dados foram produzidos em quatro eSF por meio de observação participante, questionário de identificação, diário cartográfico, entrevista semiestruturada individual e grupo focal. A análise do discurso e o rastreio cartográfico possibilitaram a construção de duas categorias temáticas e um mapa cartográfico. Alcançou-se que as estratégias, consideradas linhas de fuga, permitem transformações existenciais no trabalho em equipe, pois originam nascentes em solos cristalizados, pensamentos problematizadores, subjetividade e interações disciplinares. Concluiu-se que as linhas duras não devem ser eliminadas do trabalho em equipe, pois coexistem nessa realidade, e o que importa é como são vivenciadas nas relações.

Palavras-chave: Atenção primária à saúde. Equipe de saúde da família. Cartografia.

El objetivo del estudio fue mapear las estrategias utilizadas para el trabajo colaborativo en equipos de Salud de la Familia (eSF), inseridas en la Atención Primaria de la Salud, en un municipio del Norte de Minas Gerais. Se trata de un estudio cualitativo, con la propuesta metodológica de la Cartografía. Los datos se produjeron en cuatro eSF, por medio de observación participativa, cuestionario de identificación, diario cartográfico, entrevista semiestructurada individual y grupo focal. El análisis del discurso y el rastreo cartográfico posibilitaron la construcción de dos categorías temáticas y un mapa cartográfico. Se vio que las estrategias, consideradas líneas de fuga, permiten transformaciones en el trabajo en equipo, puesto que originan manantiales en suelos cristalizados, pensamientos problematizadores, subjetividad e interacciones disciplinarias. Se concluyó que las líneas duras no deben eliminarse del trabajo en equipo, puesto que coexisten en esta realidad y lo que importa es cómo se experimentan en las relaciones.

Palabras clave: Atención primaria de la salud. Equipo de salud de la familia. Cartografía.