ISSN-e [2675-5602]

Global Academic Nursing Journal

EXPERIENCE REPORT

The role of the multiprofessional team in health education in primary health care

El rol del equipo multiprofesional en la educación para la salud en la atención primaria

Atuação da equipe multiprofissional no contexto da educação em saúde na atenção primária à saúde

Ícaro Soares de Carvalho Pinheiro[1]
ORCID: 0000-0002-3051-223X
Luan Pereira dos Santos[2]
ORCID: 0009-0005-7033-3980
Anna Vitoria Costa Barradas[3]
ORCID: 0009-0007-9742-7439
Vyrna Rebeca de Carvalho Alves[4]
ORCID: 0000-0002-1641-908X
Pedro Henrique Sutério da Silva[1]
ORCID: 0009-0002-4070-9973
Raquel Pereira da Cruz Silva[5]
ORCID: 0000-0003-1034-1143
Maria de Lourdes Machado de Resende Neta[1]
ORCID: 0000-0002-3001-0547
Mykaelle Soares Lima[4]
ORCID: 0000-0003-2248-8097
Tânia Maria da Silva Ribeiro[6]
ORCID: 0009-0006-1142-7108
Vitória Fernanda Fernandes Nascimento[4*]
ORCID: 0000-0001-9700-7599

[1]Universidade Estadual do Piauí. Piauí, Brazil.
[2]Centro Universitário Uninovafapi. Piauí, Brazil.
[3]Centro Universitário UniFacid Wyden. Piauí, Brazil.
[4]Universidade Federal do Piauí. Piauí, Brazil.
[5]Centro Universitário Adventista de Ensino do Nordeste. Bahia, Brazil.
[6]Universidade Estácio de Sá. Piauí, Brazil.

How to cite this article:
Pinheiro ISC, Santos LP, Barradas AVC, Alves VRC, Silva PHS, Silva RPC, Resende Neta MLM, Lima MS, Ribeiro TMS, Nascimento VFF. The role of the multiprofessional team in health education in primary health care. Glob Acad Nurs. 2026;7(3):e546. https://dx.doi.org/10.5935/2675-5602.20200546

***Corresponding author:**
vitoria1999nascimento123@gmail.com

Submission: 02-02-2026
Approval: 04-05-2026

Abstract

This study aims to report on multiprofessional health education actions within academic training in the context of Primary Health Care. This is an experience report with a descriptive and qualitative approach, carried out in the context of health education in Primary Health Care during the years 2024 and 2025, built from multiple professional experiences in health. Based on the experiences reported by the authors in the Nursing, Dentistry, and Medicine departments, the integration between knowledge and the expansion of care beyond the uniprofessional approaches of each department was compiled. The analyzed experience shows that the role of the multiprofessional team in Primary Health Care consolidates health education as a structuring practice of care, overcoming fragmented approaches centered on isolated professional departments. The actions developed in groups for pregnant women, in the Hypertension and Diabetes Program (Hiperdia), in home visits, in the School Health Program, and in various other health education practices demonstrate that the articulation between Nursing, Dentistry, and Medicine broadens the understanding of the health-disease process.

Descriptors: Primary Health Care; Health Education; Nursing; Family Practice; Dentistry.

Resumén

El objetivo de este estudio es informar sobre las acciones de educación para la salud multiprofesional en la formación académica en el contexto de la atención primaria. Se trata de un informe de experiencias con un enfoque descriptivo y cualitativo, realizado en el contexto de la educación para la salud en la atención primaria durante los años 2024 y 2025, a partir de diversas experiencias profesionales en el ámbito de la salud. Con base en las experiencias reportadas por los autores en los departamentos de Enfermería, Odontología y Medicina, se recopiló la integración entre el conocimiento y la ampliación de la atención más allá de los enfoques uniprofesionales de cada departamento. La experiencia analizada muestra que el rol del equipo multiprofesional en la atención primaria consolida la educación para la salud como una práctica estructuradora de la atención, superando los enfoques fragmentados centrados en departamentos profesionales aislados. Las acciones desarrolladas en grupos para mujeres embarazadas, en el Programa de Hipertensión y Diabetes (Hiperdia), en visitas domiciliarias, en el Programa de Salud Escolar y en diversas otras prácticas de educación para la salud demuestran que la articulación entre Enfermería, Odontología y Medicina amplía la comprensión del proceso salud-enfermedad.

Descriptores: Atención Primaria de Salud; Educación en Salud; Enfermería; Medicina Familiar y Comunitaria; Odontología.

Resumo

O objetivo deste tudo é relatar ações multiprofissionais de educação em saúde dentro da formação acadêmica no contexto da Atenção Primária à Saúde. Trata-se de um relato de experiência com abordagem descritiva e qualitativa, realizado no contexto da educação em saúde na Atenção Primária à Saúde, durante os anos de 2024 e 2025, construído a partir de múltiplas experiências profissionais em saúde. A partir das vivências relatadas pelos autores, nos núcleos de Enfermagem, Odontologia e Medicina, compilou-se a integração entre o conhecimento e a ampliação do cuidado para além das abordagens uniprofissionais de cada núcleo. A experiência analisada evidencia que a atuação da equipe multiprofissional na Atenção Primária à Saúde consolida a educação em saúde como prática estruturante do cuidado, superando abordagens fragmentadas e centradas em núcleos profissionais isolados. As ações desenvolvidas nos grupos de gestantes, no Hiperdia, nas visitas domiciliares, no Programa Saúde na Escola e nas diversas outras práticas de educação em saúde demonstram que a articulação entre Enfermagem, Odontologia e Medicina amplia a compreensão do processo saúde-doença.

Descritores: Atenção Primária à Saúde; Educação em Saúde; Enfermagem; Medicina da Família e Comunidade; Odontologia.

Introduction

Primary Health Care (PHC) is the organizing level of health systems, responsible for actions related to health promotion, prevention, diagnosis, treatment, and continuous monitoring of the population. In Brazil, PHC is mainly structured by the Family Health Strategy (FHS), which is based on multidisciplinary teamwork, territorial assignment, and community orientation, seeking to comprehensively address the health needs of the population[1]. This model promotes the implementation of educational practices in health as an integral part of care, broadening the understanding of the health-disease process and strengthening the autonomy of individuals.

Health education, within the scope of primary health care, is understood as a continuous, dialogical, and participatory process that goes beyond the mere transmission of information and is oriented towards the shared construction of knowledge between health professionals and users[2]. Recent evidence indicates that well-structured educational initiatives contribute to the adoption of healthy behaviors, the proper management of chronic conditions, and the strengthening of the bond between healthcare teams and the community[3]. In this sense, health education assumes a strategic role in consolidating the principles of health promotion and disease prevention in the territory.

The role of the multidisciplinary team in primary health care is central to the effectiveness of educational actions, since different professional groups contribute specific and complementary knowledge to care. Studies indicate that nurses, physicians, and dentists are among the main professionals responsible for planning and executing health education actions in primary health care, with nursing standing out, historically recognized for its proximity to the community and its systematic involvement in individual and collective educational activities[4]. However, recent literature emphasizes the need to overcome fragmented practices, advocating for interprofessional approaches that value collaborative work and shared responsibility among the different professionals on the team[2].

In the contemporary context of the Unified Health System (SUS), health education is also linked to the perspective of continuing health education, understood as a strategy for improving work processes based on problematizing daily practices and the real needs of the territories[5].

This approach contributes to strengthening the competencies of multidisciplinary teams, favoring more contextualized, effective educational interventions aligned with the social determinants of health. The integration between continuing education and health education enhances the teams' capacity to respond to the complex health challenges present in primary health care. In recent years, the expansion of multidisciplinary practice in primary health care has been reinforced by regulations that establish and encourage the organization of multidisciplinary teams, such as the creation of eMulti teams, which broaden the inclusion of different professional categories in health care[6]. This reorganization of healthcare work expands the possibilities for interdisciplinary educational actions, favoring interventions that encompass the biological, psychological, and social dimensions of care, especially in addressing chronic non-communicable diseases and promoting oral, mental, and collective health. International evidence corroborates the relevance of multiprofessional work in primary health care, indicating that the integrated performance of teams is associated with improved health knowledge, greater adherence to preventive practices, and increased user satisfaction with services[7,8].

However, the authors emphasize that the positive impacts depend on effective coordination among professionals, joint planning of educational actions, and institutional recognition of health education as a structuring component of care.

Therefore, the role of the multidisciplinary team in the context of health education in Primary Health Care is fundamental for consolidating comprehensive, humanized care practices oriented towards the needs of the territory. Thus, the objective of this study is to report on multidisciplinary health education actions within academic training in the context of Primary Health Care.

Methodology

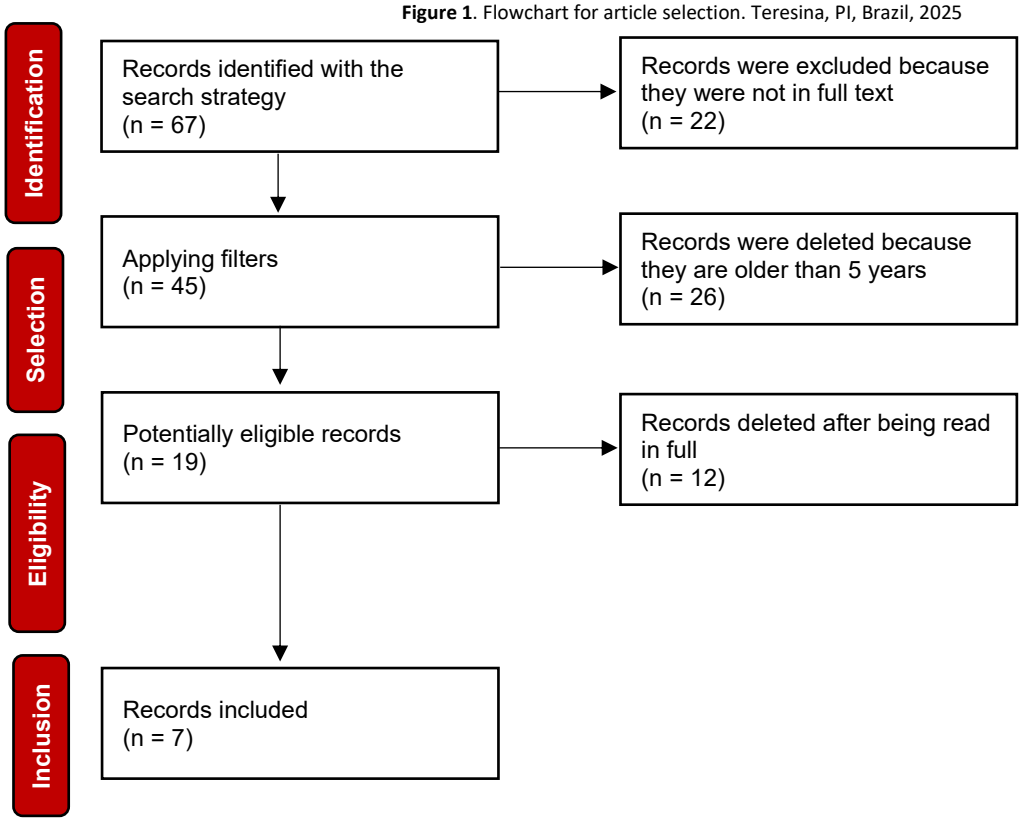
This is an experience report with a descriptive and qualitative approach, carried out in the context of health education in Primary Health Care, during the years 2024 and 2025.

The experience was developed in the work environment of a multidisciplinary team, based on multidisciplinary academic experiences in the areas of Medicine, Nursing, and Dentistry, whose actions were planned, executed, and evaluated jointly. The activities included individual and group consultations, health education actions, and discussions of cases considered relevant to the topic addressed.

The report was adopted as a methodological strategy to describe and analyze practices experienced in the context of teaching, extension, research, or assistance, enabling critical reflection on the multidisciplinary work process.

To support the discussions about the experiences, a search was conducted, as shown in Figure 1, resulting in 67 studies using the Health Sciences Descriptors (DeCS) "Health Education," "Primary Health Care," and "Interdisciplinary Practices," combined with the Boolean operator "AND." In the identification stage, 22 studies were excluded for not having full text. Next, the time frame of the last five years was applied, leading to the exclusion of 26 publications as they were before the established period. Thus, 45 studies remained for analysis, distributed across the LILACS (n = 36), MEDLINE (n = 2), BDENF (n = 4), and BBO (n = 3) databases. After reading the titles and abstracts, 19 publications were considered potentially eligible. Subsequently, in the eligibility stage, 12 studies were excluded after reading the full text, resulting in the final inclusion of seven articles in the study sample.

Figure 1. Flowchart for article selection. Teresina, PI, Brazil, 2025



The selection of materials used the following inclusion criteria: title related to the proposed theme focusing on health education, interdisciplinary, in the context of primary health care. The study respected the ethical principles established in current legislation, ensuring the anonymity of users and the institution involved, without disclosing information that would allow their identification, and therefore did not require review by the Research Ethics Committee.

Experience Report

Based on the experiences reported by the authors, in the Nursing, Dentistry, and Medicine departments, interdisciplinary practices focused on health education were developed, highlighting the integration of knowledge and the expansion of care beyond the single-professional approaches of each department.

Initially, it was observed that actions conducted by Nursing, such as groups for pregnant women, activities in waiting rooms within the context of the Hypertension and Diabetes Program (Hiperdia), and home visits to elderly and bedridden patients, fostered the strengthening of the bond between professionals, users, and family members, in addition to promoting the demystification of popular beliefs, the valuing of self-care, and the understanding of social conditions that directly interfere in the health-disease process. Consequently, in the field of Dentistry, experiences in the School Health Program, smoking cessation groups, and the reception of spontaneous demand highlighted the expanded role of the dentist in prevention, promotion, and health surveillance, reinforcing the relationship between oral health and systemic conditions, such as diabetes and hypertension, as well as the importance of educational and behavioral approaches in comprehensive care.

In parallel, academic practice focused on the medical field involved clinical patient care in primary health care, which includes direct contact with clinical cases that promote reflection, knowledge exchange, and the possibility of adapting and improving practices. Furthermore, health education initiatives providing instructions and clarifications to the community were effectively implemented. To systematize the analysis, all reports were organized in the table below, categorizing the actions by professional core, strategies/practice setting, description of the experience, results, and academic reflections.

Chart 1. Academic experiences in interdisciplinary health education in primary health care: Nursing, Dentistry, and Medicine. Teresina, PI, Brazil, 2025

Professional Core	Strategy/ Practice Scenario	Description of the Experience	Academic Results and Reflections
Nursing	**Group for Pregnant Women (Prenatal Care)**	Roundtable discussion on physiological changes during pregnancy, integrating the topic with oral health (myths about tooth loss during pregnancy) in partnership with the Dentistry team.	Strengthening the mother-child bond; demystifying popular beliefs that keep pregnant women away from dental care.

Nursing	**Waiting Room (Hypertension and Diabetes Program)**	Quick educational action on "Diabetic Foot" and self-care, with direct referral for stomatological evaluation of infectious foci that causes glycemic decompensation.	Development of public speaking and synthesis skills; understanding of the bidirectional relationship between diabetes and periodontal disease.
Nursing	**Home Visit (Elderly/ Bedridden)**	Guidance for caregivers on pressure injury prevention and personal hygiene, including oral hygiene for dependent patients (dentures and mucous membranes).	Perception of social and housing realities; empowering caregivers as agents promoting health in the home.
Dentistry	**School Health Program (PSE)**	Playful activity (puppet show or brushing) about oral hygiene and healthy eating, reinforcing the nutritional screening done by Nursing (weight/height).	Engaging with the school community, understanding the school as a strategic space for the primary prevention of cavities and obesity.
Dentistry	**Smoking Cessation Group**	Lecture on mouth lesions and self-examination for the prevention of oral cancer, integrated with the psychological and pharmacological support actions of the multidisciplinary team.	Experience with the behavioral approach; recognition of the dentist's role in smoking cessation beyond the clinical setting.
Dentistry	**Acceptance of Spontaneous Demand**	Screening patients with acute toothache, checking vital signs (blood pressure) in conjunction with nursing staff to identify undiagnosed hypertension.	Integration of clinical care with expanded clinical practice; opportunistic screening for systemic diseases (hypertension) through dental complaints.
Medicine	**Acceptance of Spontaneous Demand**	Screening diverse and recurring clinical cases in the community to prioritize health education and medication prescriptions for the public of all age groups.	Academic benefit for clinical reasoning and for the development of humanized care, based on active and qualified listening.

Discussion

The experience analyzed shows that the performance of the multidisciplinary team in Primary Health Care consolidates health education as a structuring practice of care, overcoming fragmented approaches centered on isolated professional groups. The actions developed in pregnant women's groups, in the Hypertension and Diabetes Program (Hiperdia), in home visits, and in the Health in School Program demonstrate that the articulation between Nursing, Dentistry, and Medicine broadens the understanding of the health-disease process and strengthens the comprehensiveness of care, an aspect already discussed in the literature on interprofessional work in Primary Health Care[9].

In this sense, health education constitutes one of the main soft technologies of care in primary health care, as it promotes user autonomy, therapeutic co-responsibility, and reorganization of the teams' work process. In this context, multidisciplinary action broadens the traditional clinical approach, allowing biological, social, and cultural needs to be addressed in an integrated way, an essential characteristic for comprehensive care[10].

It was observed that the integration between professional groups occurred not only through the coexistence of categories within the unit, but also through the construction of shared intervention strategies. The collaborative practice identified in the joint planning of actions and in the articulation between clinical and educational demands is like the strategies mapped in cartographic studies on work in Family Health teams, which point to interprofessionalism as a relational and organizational process, dependent on agreement and constant communication[11,10].

Therefore, interprofessional education strengthens person-centered care, promoting communication and shared decision-making. In this way, joint learning among different professionals fosters collaboration and improves the quality of care, as it breaks down the fragmentation historically present in the biomedical model[12].

In the context of training, the experiences reported demonstrate that interprofessional education is constituted in the daily work routine, especially when professionals are exposed to real-world contexts and the complexity of social needs. The experience gained from home visits and community outreach revealed a broadening of the clinical perspective beyond the biological dimension, incorporating social determinants and conditions of vulnerability - a movement similar to that described in phenomenological analyses of interprofessional training in multiprofessional residency programs[13].

Furthermore, multidisciplinarity also enables a more effective territorial and community-based approach. The literature shows that educational actions carried out by integrated teams favor health promotion, disease prevention, and greater social participation, thus increasing the effectiveness of primary health care. Therefore, health education ceases to be a one-off activity and becomes a key strategy for organizing care[14].

In the observed situations, health education presents a dialogical and participatory character, moving away from top-down practices. Discussion groups and

interventions in waiting rooms proved to be spaces for the shared construction of knowledge, in which users assumed an active role in their care. This perspective reinforces the understanding that the improvement of educational practices depends on the articulation between continuing education and the problematization of daily life, strengthening the effectiveness of primary health care[15].

However, the consolidation of these practices does not occur without tensions. The overload of care, the prioritization of curative demands, and the fragility of formal institutional planning spaces can limit the continuity of educational and interprofessional actions, challenges also pointed out in analyses on the implementation of training programs in SUS[16]. Thus, although the experiences described demonstrate transformative potential, sustainability requires institutional investment and recognition of health education as an essential component of care.

It is observed, therefore, that health education in primary health care should not be attributed to a single professional, but should constitute a collective, interdisciplinary, and continuous practice. The interaction between Medicine, Nursing, and Dentistry promotes complementarity of knowledge, considering the role of the medical professional, who contributes to clinical reasoning and longitudinal follow-up; the nurse, who strengthens the bond and coordinates care; and the dentist, who broadens the preventive approach, since oral health is directly related to systemic conditions. Therefore, this articulation favors user-centered care and strengthens the comprehensiveness of care[16].

Furthermore, the integration of actions within the territory, especially in the school environment and at home, reinforces the centrality of the community as a space for health production. The integration between school, health unit, and family has demonstrated that health education gains greater effectiveness when contextualized within local realities and articulated with social demands, expanding the reach of preventive and promotional interventions[17].

Thus, multiprofessional action in health education within primary health care is configured as an ethical and political practice that strengthens comprehensiveness, co-responsibility, and the bond with the community. More than a complementary strategy, health education emerges as a structuring axis of care, whose effectiveness depends on the consolidation of collaborative practices and permanent processes of improving teamwork.

Conclusion

The findings of this study demonstrate that multiprofessional action in health education, within the scope of Primary Health Care, constitutes a structuring element for the consolidation of comprehensive care and for the strengthening of collaborative practices in daily work. Returning to the proposed objective - to critically analyze the construction and articulation of educational actions developed by Nursing, Dentistry, and Medicine - it was found that interprofessionalism, when supported by joint planning, effective communication, and therapeutic co-responsibility, favors overcoming fragmented approaches and increases the effectiveness of interventions in the territory.

The experiences reported demonstrate that health education, conceived as a dialogical and contextualized practice, enhances user autonomy, strengthens community ties, and incorporates social determinants into the care process. However, the consolidation of these practices depends on addressing institutional and organizational challenges, such as healthcare overload, the centrality of curative demands, and the insufficiency of formal spaces for interprofessional planning. These tensions indicate that the sustainability of health education as a structuring axis of primary health care requires continuous investment in continuing education and institutional recognition of its centrality in the work process.

Thus, the evidence produced contributes to the advancement of the scientific debate on interprofessionalism in primary health care and reinforces the strategic relevance of health education for strengthening the Brazilian Unified Health System (SUS). By highlighting the transformative potential of multiprofessional action in promoting person- and community-centered care, the study supports the formulation of political-pedagogical and organizational strategies aimed at improving collaborative practices, with a view to increasing the effectiveness, equity, and quality of care offered to the population.

References

1. Brasil. Ministério da Saúde. Política Nacional de Atenção Básica. Brasília: Ministério da Saúde; 2017.
2. Fittipaldi ALM. Educação em saúde na atenção primária: abordagens e estratégias nas políticas públicas de saúde. Interface (Botucatu). 2021;25:e200806. https://doi.org/10.1590/interface.200806
3. Costa Pereira HL, Silva MA, Andrade RS. Atenção primária e educação em saúde: fortalecendo a prevenção de doenças e o autocuidado. Rev Cient Saude. 2025;12(1):45-58.
4. Barreto ACO, Rebouças CBA, Aguiar MIF, Barbosa RB, Rocha SR, Cordeiro LM. Percepção da equipe multiprofissional da atenção primária sobre educação em saúde. Rev Bras Enferm. 2019;72(1):266-73. https://doi.org/10.1590/0034-7167-2017-0702
5. Brasil. Ministério da Saúde. Política Nacional de Educação Permanente em Saúde. Brasília: Ministério da Saúde; 2018.
6. Brasil. Ministério da Saúde. Portaria GM/MS nº 635, de 22 de maio de 2023. Institui incentivo financeiro federal para as equipes multiprofissionais na Atenção Primária à Saúde. Diário Oficial da União. 23 maio 2023.
7. Reeves S, Pelone F, Harrison R, Goldman J, Zwarenstein M. Interprofessional collaboration to improve professional practice and healthcare outcomes. Cochrane Database Syst Rev. 2020;(6):CD000072. https://doi.org/10.1002/14651858.CD000072.pub4
8. Smith T, Fowler-Davis S, Nancarrow S, Ariss S, Enderby P. Interprofessional working in primary care: a systematic review. BMC Prim Care. 2023;24(1):112. https://doi.org/10.1186/s12875-023-02012-9

9. Bergamasquini AC, Silva CM, Castro MMC. Residência multiprofissional, atenção primária à saúde e serviço social: potencialidades do trabalho interprofissional. Serv Soc Saude. 2021;20:e021001. https://doi.org/10.20396/sss.v20i00.8665372
10. Vieira ATG, Silva LB. Educação interprofissional na atenção básica: um estudo cartográfico da formação de residentes em saúde. Interface (Botucatu). 2022;26:e210090. https://doi.org/10.1590/interface.210090
11. Martins JD, et al. Cartografia das estratégias utilizadas para o trabalho colaborativo em equipes de saúde da família. Interface (Botucatu). 2024;28:e230342. https://doi.org/10.1590/Interface.230342
12. Souza RR, Rossit RAS. Interprofessional health education and person-centered care: graduates' perception. Medicina (Ribeirão Preto). 2024;57(3):e223849. https://doi.org/10.11606/issn.2176-7262.rmrp.2024.223849
13. Medeiros AV, Forte FDS, Toassi RFC. Educação interprofissional na residência multiprofissional em atenção primária à saúde: análise fenomenológica. Saude Debate. 2024;48(143):e9140. https://doi.org/10.1590/2358-289820241439167P
14. Silva LVC, et al. Promoção à saúde e multiprofissionalidade na atenção primária à saúde: revisão de literatura. Braz J Implantol Health Sci. 2023;5(5):5608-18. https://doi.org/10.36557/2674-8169.2023v5n5p5608-5618
15. Marangon CMLV, Souza JM. O pediatra e a educação permanente em saúde no Núcleo Ampliado de Saúde da Família e Atenção Básica (Nasf-AB). Interface (Botucatu). 2021;25:e200626. https://doi.org/10.1590/interface.200626
16. Souza RB, et al. Barreiras à implementação da educação interprofissional: uma análise do Programa de Educação pelo Trabalho para a Saúde (PET-Saúde). Saude Soc. 2023;32(2):e230215. https://doi.org/10.1590/S0104-12902023230216pt
17. Queiroz MG, et al. Estágio comunitário interprofissional na formação do estudante de odontologia: relato de experiência da Universidade Federal de Goiás. Rev ABENO. 2022;22(2):e1689. https://doi.org/10.30979/revabeno.v22i2.1689