ISSN 2237-4434

CADERNO FNEPAS

NÚMERO ESPECIAL
Abril / 2012

Caderno fnepas

Caderno fnepas

Publicação oficial do fórum nacional de educação das profissões na área de saúde - fnepas.

Missão do caderno fnepas

Veículo de comunicação fórum nacional de educação das profissões na área de saúde – fnepas. Tem como objetivo publicar relatos reflexivos sobre experiências desencadeadas pelo próprio fnepas ou identificadas como relevantes e que contribuam para a mudança na graduação das profissões da área de saúde.

Produção editorial

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Arte gráfica e impressão:

Mangava editora e gráfica.

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Caderno FNEPAS, Fórum Nacional de Educação das Profissões na Área de Saúde. – Nº Especial, (2012)--. – Rio de Janeiro: FNEPAS, 2011 -

Anual
ISSN 2237-4434
ISSN 2237-4175(online)

I. Educação Médica. II. Fórum Nacional de Educação das Profissões na Área de Saúde

Depósito legal na biblioteca nacional, de acordo com a lei nº 10.994, De 14 de dezembro de 2004.

Tiragem 300 exemplares

Texto completo em: <http://www.Fnepas.Org.Br/caderno.Php>

Apoio

Secretaria de Gestão do Trabalho e da Educação na Saúde

Ministério da Saúde

GOVERNO FEDERAL
BRASIL
PAÍS RICO É PAÍS SEM POBREZA

INTRODUCTION

The National Forum on Education of Health Professions (Fnepas) congregates organizations involved with education and professional development in health care and aims to help change the training of health professionals, based on the guiding principles of comprehensive health care and continuous education.

The Fnepas is composed of the Brazilian Association of Medical Education (ABEM), Brazilian Nursing Association (ABEn), Brazilian Association of Nutrition Education (ABENUT), Brazilian Association of Pharmaceutical Education (ABENFAR), Brazilian Association of Dental Education (ABENO), Brazilian Association of Physiotherapy Education (ABENFISIO), Brazilian Association of Psychology Education (ABEP), Brazilian Association of Social Work Education and Research (ABEPSS), National Network of Occupation Therapy Education (RENETO), Brazilian Speech Therapy Association (SBFa), Brazilian Association of Graduate Studies in Collective Health (ABRASCO), Brazilian Association Rede UNIDA and, more recently, the Brazilian Association of Physical Education Teaching for Health (ABENEFS).

The Fnepas has developed a technical cooperation project with the Ministry of Health to conduct regional workshops. Initially workshops were held to raise awareness about the topic. In 2007, 60 awareness-raising workshops were conducted throughout Brazil, attended by roughly 4,000 people. In 2008, the following primary discussion themes were defined: a) Cross-functional teamwork; b) Active teaching-learning methodologies; c) Curricular guidelines and change processes in undergraduate studies: general skills and abilities; and d) Service-learning-community integration: social mobilization, continuity of service-learning integration projects and sustainability of change processes. This last theme culminated in the proposal for the compilation of this publication, named *Caderno Fnepas*, which shall be published in print (ISSN 2237-4434) and digital format (ISSN 2237-4175).

This first edition presents experiences identified in the work carried out throughout Brazil in relation to Service-Learning-Community Integration. These experiences were drawn from different regions of the country and involve various professional classes and a cross-functional perspective. The reports reflect local experiences and the influence of inductive public policies, such as the National Program for Professional Training and Reorientation in Health (Pro-Saúde) and Tutorial Education Program (PET-Saúde) and multiprofissional residency in health.

This is, therefore, the product of a long, collectively-built path, which we are sharing with the whole community.

We have taken the liberty to contextualize aspects related to the theme of Service-Learning-Community Integration, widely discussed at the awareness-raising workshops and the discussion workshop conducted in Porto Alegre (RS) on 26 and 27 March 2010, described as follows:

> Service-Learning Integration: collective work, agreed and integrated between students and teachers of undergraduate health courses and health care service professionals, including managers[1].

Article 200 of the Brazilian Federal Constitution of 1988[2] establishes that the Unified Health System (SUS) is responsible for organizing the training of health care personnel. On the same subject, Law8.080/90[3], that

regulates the SUS explains that "the public services that form the Unified Health System (SUS) constitute a practice field for teaching and research, according to specific rules, developed *in conjunction* (our italics) with the education system" (article 27, sole paragraph).

In the sphere of health training, the National Curriculum Guidelines for health courses indicate that the training of these professional must be compatible with the effective health system of the country, involving practical activities since the start of the courses. Therefore, the curricular structure of health courses should support practical-theoretical integration with approaches of increasing complexity throughout the whole course. Considering that learning is more effective when associated to practical experience, especially in real life situations, the interrelation between training spaces and health services are fundamental for training based on the reality of health services, contemplating the entire dynamic and wealth of day-to-day practice in health care settings. In this context, service-learning integration supports health care training with the aims of transforming the professional practices and the actual work organization, based on the critical questioning of the work process and the capacity to offer reception and care for the various health needs and aspects of individuals, groups and whole populations[4].

In the field of health services, care practices linked to teaching leverage the implementation of the care model proposed in Brazil: a universal, user-centered health system which focuses on primary health care. In order to create this new form of health care practice and organization, a new work and worker profile is required, and one cannot fail to observe that spaces which allow for dialogue between work and education are privileged environments for the transformation and consolidation of health care models based on SUS values, and support the transformation processes of professionals and health systems[5].

It is therefore apparent that the relations between education and work are fruitful both for the health production spaces and the training spaces. However, in the daily routine of health services and educational institutions, we have observed difficulties that limit the performance of the legally-established premises, distancing the public services that serve as practice fields for student health professionals from the educational institutions and thus restricting effective integration between such institutions and the health services. In situations where service-learning does effectively occur, with teachers, students and health professionals sharing a central focus on the user, the gaps between health care work and education are minimized[1].

Spaces that support interaction among professionals, courses, teachers, students, services, managers and users are fundamental to ensure connection between the proposed transformation of the care model and the changes in health professional training. In this regard, service-learning-community integration becomes a privileged space for reflection on learning and care production. This theme is an integral part of the Fnepas agenda, entailing discussion, reflection and analysis of the potentials and limitations of service-learning integration experiences, as well as the formulation of strategies to overcome the challenges identified in health services and educational institutions. Fnepas has become an important social actor in the education and health sphere in Brazil, representing a unique setting where the different health professions join forces to build institutional and political scenarios that lend themselves to changes in training, multiprofessional action and teamwork for the consolidation of the SUS.

As the SUS cannot be consolidated without changes to the training of health professionals and that such changes are impossible without service-learning integration, which constitutes a privileged space for examining the reality of health production and the need for transformation of the care model in force to a user-centered model, Fnepas, through representatives of its various member entities, has identified successful service-learning integration experiences in Brazil. Those responsible for such experiences were invited to share them in this compilation. Therefore, it is hoped that these experiences can be diffused among different training and health care spaces and help engage a large contingent of health care actors to work towards practices involving service-learning integration, closing the gap between teaching and health care settings, connecting teachers, students and health professionals to the central focus of resolving individual and collective health needs.

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SUMMARY

ARTIGO

Nursing Education and Partnerships in the Brazilian Unified Health System

Ensino de Enfermagem e Parcerias no Sistema Único de Saúde

Maria Jose Moraes Antunes[I]

Palavras-chave: Sistema Único de Saúde; Educação em Saúde; Parcerias.

Keywords: Unified Health System; Health Education; Partnership.

INTRODUCTION

In the treatment and mistreatment of Mother Earth, throughout mankind's everyday development, new paths to follow have been constantly built. These have always emerged whenever the paths in use ceased to meet our needs or were hard to access for groups of people who used them at the same time and for different reasons, travelling in the same direction.

In virtue of obligations, regulations or personal preferences, to comply with rules, overcome difficulties encountered and arrive at one's destination with more safety or speed, the will to prevail led the leaders or the bravest of those groups to seek and create new tracks, bridges, viaducts and other adaptations to ensure arrival at the chosen destination for collective movement. Of course, these official inventors or creators of new paths depended on the consent of the landlords whose land would be crossed and on the acceptance of their partners on foot to consolidate their proposal with the ideal route.

As time passed, these new paths might turn into shortcuts, alleys, roads or major avenues; or simply disappear out of disuse, with the first rainfall in spring. Other old paths were abandoned; vanishing in the solitude of disuse and time, only to be later recovered, readapted and reutilised, as life comes full circle.

How long the new paths would last depended on the care and attention they received from their creators or users who, joined by a common vision, multilateral cooperation and continuous maintenance, kept the roads in simultaneous operation so that everyone's needs were met and the activities of all the partners involved could be performed successfully.

This little anecdote can be correlated to the complex construction of the internal tracks of the Brazilian Unified Health System built by the service managers and teachers in the area, that ensure the movement in the same space and time of people caring for those who need care and students learning "live" on patients with multiple and urgent needs who pass through the system.

Each with their own specific needs, but, for different motives, walking the same path…

The regulatory process of formal education in health care has attributed the teaching professionals in the area with the responsibilities of defining the paths for internships, and of establishing interinstitutional agreements and relations that support relevant and opportune learning experiences for students in the health care field.

Within these interinstitutional relations in the field of Basic Health Care, conflicts begin to arise as soon as internship planning begins.

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In almost every case, the service manager, pressed by ever-increasing demand, decides on which space and actions are to be permitted to the student. The duration of the internship, on the other hand, depends on the pedagogical policy in force and the school calendar.

This is a harmful situation for all those following the path, especially due to the ruptured relational processes of experiences among students and the people they care for, generating incomplete and inconclusive learning.

This report of experiences presents a four-year joint effort involving the collective attempt by those following the path to overcome this and other conflicts in the institutional relations between health services, nursing schools and the general public. The aim is to describe some of the new tracks achieved in the complex world of the public health service, which hosts a convergence, fusion and conflict of interests, desires and numerous, sublime stories. The view expressed is of just one follower of the path and is, therefore, subject to bias.

PREDECESSORS OF THE PRÓ-SAÚDE I PUC MINAS NURSING COURSE IN BETIM

Pró-Saúde I is the fruit of partnership between the Ministries of Health and Education and the Pan-American Health Organization (PAHO)/World Health Organization (WHO), that proposes to fund and support through public tender the project development at medical, nursing and dental schools, integrated to the SUS public health service in order to meet the real needs of the Brazilian public in terms of human resource qualification, knowledge production and service provision.

In response to the Public Call SGTES/MS # 1/2005 and after liaising with the health services and SUS social control authorities, the coordination team for the Nursing Course at PUC Minas (Catholic University of Minas Gerais) – Betim Campus, developed their project in November 2005.

The proposal was organised into three parts: the first included the general principles of the Pedagogical Political Project (PPP) of the Nursing Course at Betim, its design, objectives, conceptual framework, graduate profile, reference qualifications and skills of the course, followed by summaries of the previous assessment processes of the course, demonstrating how the PPP adhered to the principles of the Unified Health System (SUS) and the shared references in relation to the axes, vectors and internship program proposed by Pró-Saúde. The second part presented a brief diagnosis of the needs, identified through a sample survey, for continuous education required for the implementation of Basic Health Care in the municipality and region of Betim, extracted from the report produced by the Permanent Health Education Office for the micro-region of Betim in 2004. Finally, in the third and final part, the Pró-Saúde I development proposals, developed in five subprojects, classified by axes and vectors, as per requested in the inter-ministerial proposal, or considered high priority for carrying out the proposals identified by Pró-Saúde. Each part aimed to meet specific demands of the partners that were following the same road. Therefore, when the five subprojects were developed, criteria were established for each one to govern the "expected results and evaluation."

In December 2005, the Official Government Gazette published the list of the projects and schools selected to develop the Pró-Saúde program in Brazil, including the Nursing Course of PUC Minas in Betim.

In 2006, before receiving any financial resources, the selection of old paths and creation of new tracks that could support the learning experiences proposed in the project were already being executed at several different links in the chain.

Relations were established between academics, teachers, course coordination, health care managers at the units, health care secretaries and consortium of the region in order to implement the objectives of each one of the five subprojects. A specific item on the agenda was requested for the presentation of Pró-Saúde I to the members of the Municipal Health Council for their appreciation and approval.

Still in 2006 the school received a visit by the Ministry of Health advisory commission, responsible for monitoring the project, with the partners of the journey defined in several meetings and correspondences. Each subproject was developed by a network of responsible parties, formed by one member of the course teaching staff, one nurse in service and one academic monitor.

Together with the municipal health councillors and representatives of the public health consortium of the region, they all composed the framework of the Local Management and Monitoring Commission, responsible for the project development.

In February 2007, the Letter of Agreement was signed by the PAHO and the Minas Gerais Society of Culture, the managing body of PUC Minas, with the reference number AM/BRA/HRN-403 – PG/0607 999 BRA/06/02935 4 GDS . BR LOA /0600121.001. However, the notice of liberation of financial credit only reached the coordination team in May 2007, whereupon the development of the five subprojects could be optimised and executed in practice.

As they are based in the same institution, the PUC Minas nursing course in Betim, and serve the same clients, the teachers and students of the course, health professionals and the regional SUS, each subproject shares interfaces with the others, but also contains its own specific characteristics, which shall be described next. The activities conducted are described for each Pró-Saúde I subproject of the PUC Minas Nursing Course in Betim, from the creation of the proposal up to 2008, a period in which the author was responsible for the project, in terms of the objectives, activities developed and results achieved.

SUBPROJECT – LESSONS IN SUS NURSING

The focus of this subproject was to develop proposals for intervention in the SUS Basic network – supervised nursing internship in the SUS network, in the municipalities belonging to the Intermunicipal Health Consortium of Médio Paraopeba (CISMEP), with Betim as the base, having voluntarily accepted to receive the project.

The six objectives were: 1) To enable graduating students of the nursing course to relate the theoretical and practical knowledge taught in the detailed fields of the Course Syllabus for the seventh, eighth and ninth semesters to the reality of Basic Health Care in the Unified Health System, SUS, in partnership with the nurses in activity in the field where they develop their internships, in epidemiological, technical, humanistic and social aspects. 2) To integrate service-learning, contributing to knowledge exchange and enabling continuous self-assessment of the PUC Minas Nursing Course in Betim and the SUS/micro-regional Nursing Services in order to adjust them to the changes resulting from scientific progress and the incorporation of new technologies and epidemiological realities. 3) To use scientific methodology, with focus on social research, to detect, understand, resolve problems and propose actions that require nursing intervention. 4) To offer nurses in activity reconciliation with the methodological instruments of understanding, analysis and intervention in the nursing work process. 5) The production of scientific work for publication in the half-yearly periodical "Lessons in SUS Nursing". 6) To create a physical space and support framework for the constitution of a CISMEP Health and Nursing Permanent Research Office.

In practice, the actions of the Lessons in SUS Nursing subproject gave visibility to and expanded the curricular activities already developed by graduating students from the nursing course at the local SUS Basic Health Care Units, in partnership with the nurses in activity from the fields where the internships were held.

With the allocation of the necessary infrastructure and purchase of books, specific study and reflection areas were created near the work place of the SUS professionals. Three decentralised study and research centres were created for collective use: one in a regional public hospital, another at the head office of the Betim municipal secretary and the last at the Casa de Saúde Santa Isabel, the former leper colony, and today a benchmark rehabilitation unit.

Subsequently, a book was published entitled "Lessons in SUS Nursing: the Research Experience in the Nursing Course at PUC Minas in Betim", presenting the best end of course dissertations developed by the students with the nurses from the SUS network in the year 2005/2006.

Also the Introductory Course in Work and Research Methodology in Nursing was tested for review of the theoretical, conceptual and methodological references of health and nursing work, in terms of suitability and equality, following the norms and methodology for research on human beings. The target public consisted of 20 nurses from the municipal health care network of Betim and 10 students from the 4th semester of the PUC Minas Nursing Course in Betim. The activities were developed in face-to-face meetings and extracurricular activities.

As a result, two research projects were developed by the nurses of the Betim municipal health network and three by the student nurses.

Based on the experience of the pilot project, workshops for the Systematization of SUS Health Research and Nursing Care were held in 2007.

These courses involved training workshops with nurses and health professionals from the SUS network, from the micro-region of Betim, students and teachers from the PUC Minas Nursing Course in Betim. All participants received learning material to support their studies, and texts were produced to guide the workshops and related activities.

These activities were developed in the period from August to October 2007, for 14 groups (with 37 participants per group), and a total of 518 participants, over 45 hours. The modules, each lasting 8 hours, had the following contents:

- Module 1: Introduction to the SUS: Nursing Work Process, in Betim. Research in the SUS: Lines of thought and investigation. Virtual resources. Priorities and problems of investigation in the SUS and in Nursing.
- Module 2: SUS: Levels of health care, basic care, family health and nursing care: advances and challenges.
- Module 3: Planning of investigative practices and research in the SUS – Research Project – Methodological Paths. Systematization of Nursing Care: Theories of nursing. Nursing Process. Nursing Diagnostics.
- Module 4: Planning investigation in the SUS – Research Project – Methodological Paths. Semiology and Physical Examination Techniques. Physical Examination.
- Module 5: Systematization of Care and Nursing (SAE): Electronic registration of nursing – CIPESC (International Classification of Nursing Practices in Collective Health). Strategies for the POSSE. Planning investigation in the SUS. Choice of paths, definition of research groups and tutoring.

The workshops were attended by 329 people, including students in the final semesters of the nursing course and professionals in activity, nursing assistants and technicians, physicians, dentists, psychologists and social workers. However, the sixth module, forecast in the workshop project of the Systematization of Nursing Care and Research in Health in the SUS Course, involving distance tutoring for projects in the network on the investigative lines of Management, Care and Education, was not carried out. This was partly caused by the funding entity's delay in conducting the tender requested by the project's technical coordination to hire a company to perform this work, as well as the creation of software to record the nursing practices across the various levels of care in the regional SUS, which was only selected in June 2008, by which time the project was almost over.

In the absence of IT support, orientation for the projects was conducted through face-to-face meetings, but hindered by the lack of available time of the professionals in service to develop their research projects, as well as the difficulties in matching the availability of the supervising teachers and professionals of the network, as well as the lack of space at the institutions for on-site orientation meetings.

To overcome these difficulties, face-to-face meetings and seminars were conducted, like the integrated nursing weeks, during the month of May 2008.

Worthy of mention is the success of the 4th Integrated Nursing Week of Betim, the main theme of which was: "Health and Citizenship: relations of Caring and Power", held at the SESI Betim auditorium from 12 to 16 May 2008.

With network-wide planning, coordination by the Pró-Saúde Management Committee and the support of other educational institutions in the region, including other Nursing courses, the 40-hour schedule of activities was concentrated over a five-day period, with the participation of nurses from throughout the region, averaging 600 per day.

As well as lectures by nationally renowned guest speakers, reports were presented of joint, creative work processes developed in the local SUS based on the implementation of Pró-Saúde I.

However, the decentralized seminars foreseen in the project were not carried out, as had been proposed, outside the university campus. This was due to multiple factors, including: a lack of nurse interlocutors, nursing technical references in the municipalities of the CISMEP region or with governability to submit proposals for the development of nursing. What could be observed is that these municipalities still lack work management and health education policies that can support continued education projects with the university, even with no financial burden for the municipal SUS. This perception was confirmed in the first semester of 2008, the year of

municipal elections, where the possibility of any events outside the municipal agendas was unfeasible. Furthermore, the difficulties remained in transporting the teachers and students with time available to travel to the municipalities, some of which are some two hours away, such as Piedade das Gerais. There are no regular public bus routes from Betim to these municipalities. To reach them one has to travel to Belo Horizonte or else wait at bus stops on the side of the BR 381 "Fernão Dias" highway in the hope of catching one of the passenger vehicles that follow no regular timetable.

In other words, for a 4-hour activity in the municipality, it took another 4 hours to get there and back, reducing the amount of time available for academic work. This problem could have been resolved if the purchase of a minibus had been authorised to serve the Pró-Saúde I integration activities. Despite this difficulty, five integrated teaching-service seminars were held regarding the development of the SUS, organised by health management students, all in the first semester of 2007 on Saturday mornings at the PUC Minas auditorium in Betim to allow for the presence of SUS health professionals from the region, with the topics: Social Rights and Non-Governmental Organisations: paths of citizenship; SUS, Management, Health Councils and Regulatory Boards of the System; SUS and the Organisation of Education in Health Care as a Path to Self-Care, Autonomy and Citizenship; SUS: Management of the Care Model of Public Health Surveillance, Private-Public Sector Relations, Comprehensiveness and Health Promotion: Successful Experiences; SUS and Nursing Work Management: Technologies, Limits and Challenges.

Lectures were given by representatives of NGOs such as a homeless organisation, community health service, public institutions that develop health programs for teenagers, as well as representatives from the Military Police, the Secretaries of Education and Social Welfare and health councillors. The seminars were concluded with reports of successful experiences in the SUS, related to health promotion and public-private sector relations, presented by health care agents and nurses from the SUS network.

In 2007 the research group Heuristic Processes and Health and Nursing Care (PHASE) was registered on the CNPq, based on the foundations of the Pedagogical Project and the Pró-Saúde Project of the PUC Minas Nursing Course in Betim. The conceptual framework for the group was defined as: The comprehension of man in his entirety and in the dimension of the complexity of life; understanding of the new concept of health and the health-disease process; principles of the SUS as guidelines for the new model of health service production, based on epidemiological profile; the comprehension of the role of the nurse in the national and local context of health, of service production and of reformulation of the care model with commitment and autonomy; the practice of health care research.

> In 2008, the PHASE research group developed three seminars:
> 1st Research Seminar of the PHASE Research Group: Challenges and Possibilities for Research in Nursing – A Report of the Experience of Student Nurses from PUC Minas in Betim, held on 1 April 2008, with 273 participants.
> 2nd Research Seminar of the PHASE Research Group: Challenges and Possibilities for Research in Nursing - A Report of the Experience of Nursing Teachers from PUC Minas in Betim, held on 15 April 2008, with 87 participants.
> 3rd Research Seminar of the PHASE Research Group held during the 6th Nursing Week of PUC Minas in Betim. The last one included a roundtable review of the Pró–Saúde I program, composed of five nurses from Basic Health Care units of the Betim SUS network, which were course internship fields, who reported the enhanced organisation of nursing work in their work places. However, they identified a series of difficulties in consolidating research into effective nursing practice in the everyday routine of SUS services, such as: lack of habitual research action, breakdowns in communication with the central level of the local SUS, with the basic network and with student nurses, and the absence of fast recording instruments, such as electronic patient records.

Furthermore, in 2008 this subproject generated the execution of 60 intervention projects coordinated and executed by student nurses, managers of the Basic Health Care Units (UBSs), nurses in service and course teachers. Using criteria based on technical and social ap-

plicability, compliance to deadlines and methodological rigour, twelve of these projects were selected and published in the book entitled "Lessons in SUS Nursing: the extended activity of Pró-Saúde I in the Betim Nursing Course", ISBN 85-87579-19-5, with 1,000 copies printed and distributed free of charge throughout the whole SUS network.

One important proposal, feasible regardless of any lack of financial resources, emerged from the numerous interinstitutional integration meetings between teachers and coordinators of SUS Basic Health Care projects and of the FHEMIG, Casa de Saúde Santa Isabel. This involved the project to create the Professional Masters Course in Family Health. The conceptual framework, objectives and syllabuses were designed in partnership and the project now awaits a political decision for it to materialise.

In conclusion, the development of the "Lessons in SUS Nursing" subproject provided an unparalleled experience to those following the path, enabling them to surpass the academic boundaries and build new learning opportunities and knowledge, woven in the fragile spaces of everyday life, where citizenship in health care is built and rebuilt each passing day...

SUBPROJECT – PLANNING, ORGANIZATION AND SYSTEMATIZATION OF SERVICES (POSSE) AND NURSING CARE IN THE SUS BETIM NETWORK

This subproject, designed by the nurses of the Regional Public Hospital of Betim and drafted with input by teachers of the field, had the following ambitious objectives: 1) To implant the Nursing Care Systematization (SAE) for SUS Services in Betim, for improved nursing care quality and opportunities. 2) To help the IES and health care services develop, contributing to the systematization of health care with focus on basic care, the family health strategy and comprehensive health care. 3) To congregate the regional nursing schools (higher and secondary levels) with the SUS Betim services in the areas of Basic, Secondary and Tertiary Care to discuss networked and continuous SAE. 4) To learn about and promote exchange between the levels of nursing care for the Betim SUS network and to develop, implant, implement and validate clinical procedures for nursing care in the SUS network, ensuring uniform care to SUS Betim patients throughout the network and methodological knowledge ensured by the IES. 5) To ensure efficacy of the treatment plan of the service user, integrating several levels of health care. 6) To understand the specifics of each level of nursing care and provide access to continuous classroom and distance learning processes for the nursing professionals of the Betim SUS.

In 2006, twelve thematic meetings were held with working nurses and the coordinators to fulfil mutually agreed strategies. Initially, the main difficulties encountered were related to the irregular presence of teachers, students and nurses from the basic health care units, given the difficulties of finding mutually available time for meetings due to clashes in the work timetable of each segment.

Improvements were identified in the review of some components, such as a regained interest in studying or updating one's own knowledge, enhanced relations among professionals of the same network who were not previously acquainted, demystification of the university as a place of difficult access as regards knowledge and discussion of eventual problems, democratization of the project providing opportunity for the members of the group to voice their ideas and suggestions and optimization of the meetings held at the times scheduled by the group and with prior scheduling and planning of the next meeting.

In 2007, attendance of the fortnightly project meetings was consolidated, with the permanent attendance of 30 representative nurses of the health services, connected to the central coordination of the health secretary, basic health care units, maternity wards, accident and emergency services and hospital, allowing for a substantial exchange of experiences.

The group work gave rise to new paths. These included raising awareness about what SAE was and at whom it was aimed, promotion on notice boards, posters, as well as an article in the newspaper "Saúde em Movimento". The project was also promoted though cardboard triangle mobiles about the SAE and POSSE, hung from the ceilings in the health care units. The meetings involved updates about specific technical skills required by the group by means of classes and/or study of texts that would lead to a consensus about the project aims.

In 2008, the proposal was agreed to review and reconcile the data collection instruments for Women's,

Children's and Teenagers' Health, constructed by SUS nurses, based on Wanda Horta's Theory, as well as to define the strategies to implement SAE in the SUS services. Workshops were held to prepare the group of facilitators to train public municipal nurses of Betim to implement SAE in the health care units, while the network nurses completed the nursing care procedures for the whole network. This project was a rich experience for all those involved. Its tangibility was interrupted when the municipal managers were changed.

SUBPROJECT – EDUCATION IN HEALTH LABORATORY (LES)

The Education in Health Laboratory: conducting Interdisciplinary Curricular Projects of the PUC Minas undergraduate course in nursing in Betim was a result of an idea by the teaching staff to coordinate, by means of interdisciplinary curricular projects, teaching, extension and research into education for real time health promotion and disease prevention, in other words, to involve the health care services in the revision, updating and execution of the principles of the Pedagogical Political Project of the Course, with emphasis on Education in Health.

Its objectives were: 1) To contribute to the development of curricular projects of the nursing course, which are founded on the Pedagogical Political Project of the Course. 2) To encourage the qualification of students to resolve problems in the reality of the health sphere, in the community of the Metropolitan Region of Belo Horizonte, in particular, in Betim. 3) To create innovative learning opportunities for student nurses to train them in skills and abilities to manage and apply health information, with the presence of working professionals, equipping student nurses with the theoretical instruments in the sense of education for health and to develop educational material aimed at health matters in Betim.

This was aimed at the whole educational community of PUC Minas, including the health care services related to the SUS and attempting to meet the educational demands identified through conversations with professionals who work and compose the health services.

The first meetings with the nurses in activity brought to light recurrent problems in the health services and defined the themes for the LES:

- The multiple realities of the health services: lack of planning in Management of the service.
- Retrieving the Citizenship of the service users.
- Need to address the family health process and not just family diseases as they occur.
- Need for work in the area of Mental Health and Psychiatry: Help groups for unhappy mothers, benzodizepine dependents and alcoholics.
- Need to give form to Betim's Anti-Sedentary Lifestyle Program in relation to the process of educating people to maintain a healthy body.
- Work with teenagers: education for health in the health care centres, schools and child protection shelters, rescue of self-esteem, Drugs – Aids and teenage pregnancy – and other sexually transmitted diseases (incidence of contamination via HPV)
- Development of a community risk map: who are the risk users of the health services.
- Children's Health: aspects of basic care: nutritional matters.
- Health during old age: at all levels and especially community respect in relation to the elderly.
- Nursing and other professionals of the service: interpersonal and group aspects, possible alliances.
- Rethinking of reception in the health care services.
- Implantation of Epidemiological Assessment of users of alcohol and other drugs.

These aspects, updated throughout the discussions held with SUS health care professionals at the Seminars developed under the POSSE and Lessons in SUS Nursing subprojects, allowed the establishment of some lines of thinking to develop the integrated activities of the nursing course, generating the following themes:

1. Health and Society: investigation and intervention in the reality of local health, in relation to the organization of a Basic Health Care Unit.
2. Child and Teenage Health: aspects related to the processes of social and historical development of infancy and adolescence and their complications.
3. Health during old age: aspects related to ageing at social, biological, cultural and psychological levels as regards nursing care.
4. Mental Health: study of the various fields of sickness and mental suffering of SUS users.

Some of the themes suggested by the nurses were systematized through case studies and their solutions sought in the form of interdisciplinary work from the first to the eighth semester, with groups of six students being set the challenge to resolve them at increasing levels of complexity.

At the end of each semester the groups presented the result of the work they had developed in a large assembly attended by managers, nurses and health councillors, who contributed with suggestions and evaluation of the results.

This path, despite its simplicity, proved to be innovative in its capacity to join interdisciplinary and integrated activities with the nursing curriculum, enabling new experiences like learning how to converse with the services that organize SUS work and health work in general.

This contact with the reality of local health led to the experience of constructing the health communication/information that was developed through the creation of panels in Environmental Health and Ecology and the design of the Body in Anthropology.

As a result, the interdisciplinary works of the nursing course pursued the construction of educational games about health promotion, such as, for example, games about drug use and abuse, circle dances in Collective Health I and games aimed at protecting life, in Collective Health II, as well as clinical studies and internships in Mental Health Care and Psychiatry. Meanwhile, to consolidate the nursing care learning, in addition to the Clinical Studies and Nursing Practices I and II, productions related to women's health, adult health and health during old age were obtained.

An interface with the other subprojects was also established in order to set up the interdisciplinary process in the course. This subproject also produced a book, entitled "Educating for Health: experiences of the Education in Health Laboratory of the PUC Minas Nursing Course in Betim – Pró-Saúde", reporting the experiences of health education-work integration.

SUBPROJECT HOPE

The aim of this project was to develop actions to promote health and quality of life for those who suffer physical and emotional sequelae of leprosy and for their families, residents at the Santa Isabel Colony, in Citrolândia, Betim, Minas Gerais.

Its objectives were: 1) To enable undergraduate student nurses to complement their vocational education through interacting their learning with the reality of Basic Health Care in the SUS, expressed in the everyday provision of basic services, considering the epidemiological, technical (including IT), political and social aspects. 2) To allow the students, on a permanent basis and under teacher/assistant supervision, to exercise techniques and processes relevant to their professional qualification and development of skills. 3) To meet/minimize health care needs and problems, contributing toward social mobilization and improved quality of life of the population confined to the Santa Isabel Colony, in the district of Citrolândia.

Several factors hindered the execution of this project, including: the delay in liberation of the physical space promised by the FHEMIG, manager of the Santa Isabel Sanatorium, focal point of the intended activities and the termination of the agreement between PUC Minas and SES MG for developing the Teaching Service Integration Program (PISE) in place at the time of development of the Pró-Saúde proposal. Despite the fact that PUC Minas was classified in the public tender held by the State Government for renewal of the partnership, the public institution refrained from renewing the contract. This meant that the students were unable to maintain the extension activities, lacking funds for the bus fares and meals, as the Santa Isabel Colony is situated outside the city limits of Betim and a one-hour bus journey from the city centre of Belo Horizonte.

Nevertheless, some of the objectives of the project were developed at the Betim Girls' Home (LAMEB), and at the Municipal Child and Juvenile Delinquents' Shelter of Betim.

In these two neighbouring institutions located in the district of Niterói, students from different semesters had the chance to learn about services for children and youths in situations of social risk and with health problems, developing the skills, knowledge and attitudes to work in the organizational process of equal and high quality nursing care in these social services, which, although not yet integrated into the SUS network, are based on the quality of care to improve the self-esteem and lives of the children and youngsters.

In the second semester of 2008, the partnership with LAMEB and the Guardianship Board was tightened, while at the same time physical area was liberated for the establishment of the Pró-Saúde Nursing and Health Research Centre together with the CSSI Study and Research Centre (NEP). Following the refurbishment, the equipment was delivered and the Nursing and Health Research Centre of the Santa Isabel Colony was opened, with resumption of the effort toward the objectives proposed in the Hope project, which became active on two different fronts.

The incorporation of the former Santa Isabel Colony as a development field for the project was restricted, when compared to the initial proposal. That is, of the 42 student nurses that the project had maintained at the Colony in 2006, only one continued to perform non-required curricular activities, contributing to the FAPEMIG research-action project "Validation of a Care Recording Instrument for the Home Care/Home Hospitalization Model at the Casa de Saúde Santa Isabel (CSSI)."

The end result of this research project was the creation and validation of the "Continuous Care Notebook", for recording the prescriptions and evolution of cases by health professionals. This light and concise instrument facilitated communication among the cross-functional team members, the carer and patient and adequate information flow, leading to improved recovery of patients under home care at the CSSI, with focus on complete care. In 2009, political changes following the local elections led to the closure of the LAMEB.

SUBPROJECT – LIVING HEALTH IN THE MÉDIO VALE DO PARAOPEBA

This project, entirely carried out by student nurses, aimed to provide new students of the work experience course with the opportunity to experience the realities of health care in the small municipalities in the region of Médio Vale do Paraopeba, in Minas Gerais, which is the hub of the PUC Minas nursing course in Betim. Its objectives were: 1) To implement required and optional work experience opportunities in the municipalities that form the Intermunicipal Health Consortium of Médio Paraopeba (CESMEP), in Minas Gerais State. 2) To stimulate integration between the private and public sectors of social welfare, health and education in order to strengthen the institutions and students, promote the qualification of professionals in the consolidation of the SUS and at the same time enable the qualification of various social actors who interact with this health system within Social Control, Care and Management.

This groundbreaking project created a new form of learning and teaching on the Betim nursing course. Designed by students and coordinated by the teaching staff, it provided the students with the opportunity to experience situations of autonomy and commitment with the involvement of their academic lives.

It was constructed over the course of two years through the constant movement of concentration and dispersion, whereby new student nurses would go to the rural community, talk with the organized society and the general public and bring back to the school the main problems and challenges to overcome, related to quality of life. In roundtable discussions they decided what to study in order to gain greater understanding and seek experiences that would help them change the reality. They organized return trips to the small municipalities during the vacations where, with the participation of the local population, they executed the proposed activities, which were then reviewed.

This subproject brought in itself the burning excitement that transforms things and people, defining new paths and constructing new truths.

FINAL CONSIDERATIONS

The experiences and results of the Pró-Saúde I program of the Nursing Course in Betim, from 2006 to 2008, were innovative in their learning methods and in their recreation of policies to integrate the social service network, including health care providers.

Their development expanded partnerships and stimulated common acknowledgement of the difficulties to be faced by the various segments involved in order answer to the needs of the local population, through public health services of the SUS and other public services that ensure citizenship. In other words, the program constructed comprehensive and interdisciplinary experiences in human resource training, in the production of knowledge and the provision of services, which is the main purpose of Pró-Saúde.

The subprojects highlighted special people, who worked with joy and high spirits in the exchange of ideas and experiences, building empowering results, new paths and instances of citizenship.

Because citizenship is just that: far from being concrete, it is fleeting and fluid, and therefore rare when it's dependant on human will and vanity.

Each subproject brought its own accomplishments, non-accomplishments and reaccomplishments, mixed with the marks of hope and appropriation of good-meaning power. They all had defined goals and were each institutionalized as a permanent pedagogical activity in a constructive process, subject to new coordinators, managers and students in the future. There was no end and no return. Always a constant restart, in other places and new tracks...

For the author of this work, it was a rare professional moment, and a privilege to have been a part of its planning and construction. In conclusion, an excerpt from a text by Rosenau[3], the American sanitarian, who wrote in the last century, which expresses the idea that the path, also in the SUS, is made by following it and the followers are infinite and negligible; which cannot be said for their soul-felt desires for a healthier and fairer world.

> I foresee a time in which society will produce enough to meet all individual and collective health needs; in which each member of the community will contribute to that to the extent of their capacity and to the best of their ability, as a duty, never a gift. I foresee a time in which there will be no unnecessary suffering, or premature death; in which the population's welfare will be not only a legally ensured right, but also the main concern; in which the feeling of solidarity will replace that of egotism. All these things will be attained by the directing of human intelligence. I think of them, not with the hope of my own individual benefit, but with the happiness of being able to help others, after us, enjoy them fully. I believe that, when youngsters have vision, the dreams of the old people become reality. (p. 447, our translation)

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Education for the SUS and the Challenges of Service-Learning Integration

Formação para o SUS e os Desafios da Integração Ensino Serviço

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Palavras-chave: Sistema Único de Saúde; Educação; Serviços de Saúde; Pessoal de Saúde.

Keywords: Unified Health System; Education; Health Services; Health Personnel.

SUBJECT MATTER BACKGROUND: THE UNIFIED HEALTH SYSTEM AND THE HUMAN RESOURCES TRAINING POLICY

Since the 1990s, with the establishment of the Brazilian Federal Constitution (CF) in 1988[1] and publication of Law 8080/90[2] which regulated the Unified Health System (SUS), the training of health care professionals has become an increasingly central theme of discussion, as since its creation the SUS has brought about profound changes in health care practices, imposing significant alterations on the process of staff training and development. Considering that the SUS represents the largest health labour market in Brazil, it should be noted that it is in routine health care services that knowledge gains relevance as a life producing action.

From a legal standpoint, the SUS management is responsible for the organization of health care personnel training, as well as the increase in scientific and technological development in its respective field (CF, article 200, III and IV). Furthermore, the CF conceives it essential for the implementation of the System to define a worker-related policy. Article 27 of Law 8080/90 recognises that the public services that form the SUS constitute a field of practice for learning and research, combining the interests of Higher Education Institutions (IES) and of the SUS, with a view to improve public service quality.

According to Lima and Feuerwerker[3], "in recent years, there has been, in a distinct manner among the different health professions, progressive mobilization toward the change in training". As an example of this movement, in 2001 and 2002, the United Network and the Brazilian Association of Medical Education (ABEM) developed the Incentive Program for Curricular Changes for Medical Schools (PROMED), the slogan for which was "A new medical school for a new health system". Twenty schools were selected to receive, as from 2003, funds for the development of activities. The Reference Document for the Program, that inspired the policies in the area, presented three axes for development of the changes: theoretical orientation, pedagogical approach and practical scenarios[4].

Considering that the experience gained in relation to constructing processes of change had not been systematized, and the need to implement a policy focused on SUS human resources, the Ministry of Health created the Department of Health Education Management

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(DEGES), under the Secretary of Labour Management and Health Education (SGTES), which proposed the creation of a national training and development policy for all health professionals, which included: permanent educations hubs; certification of educational hospitals; the AprenderSUS, VerSUS, Pró-Saúde and multidisciplinary residency programs. This policy aims to implement processes capable of leveraging education, health care management, care practices and social control in health. Furthermore, the National Curriculum Guidelines for Undergraduate Courses in Health Care, defined for all courses in this area, suggest that "professional training must include the health system in operation in the country, comprehensive health care in a regionalized and hierarchical system of referral and counter-referral and team work "[5].The AprenderSUS[6] program, launched in July 2004, was a milestone in the relationship between the Ministry of Health and Ministry of Education, which presented as part of this policy of SUS commitments to undergraduate education, another step towards building cooperative relations between the health system and the Higher Education Institutions (IES). The proposal was guided by service-learning about the SUS, proposing as a matter for both teachers and students learning about the SUS at university (knowing and making use of the national health system, understanding and achieving cross-functional team work in health care and defending and building comprehensive health care), thus establishing, unlike what is seen today, relations between SUS managers and health teachers and students. At present, these relations can be summed up as service-learning integration, and may focus on teaching, service, sector management, social control and effective contact with, and respect for users.

Two goals have emerged as essential for this policy: (1) to strengthen links between training institutions and health services and systems and (2) to strengthen and expand processes of change of undergraduate studies so as to prepare professionals with a profile suited to the needs of public health and the health care system.

With the administrative reorganization of the Ministry of Health in June 2005, new strategies were defined for the SUS training and development policy. These include the National Program for Professional Training and Reorientation in Health (Pró-Saúde) and the Health Work Education Program (Pet-Saúde), that have been gradually incorporated into the undergraduate courses of: Biology, Biomedicine, Physical Education, Nursing, Pharmacy, Physiotherapy, Speech Therapy, Medicine, Veterinary Medicine, Nutrition, Dentistry, Psychology, Social Work and Occupational Therapy, corresponding to the 14 health care professions recognized by the National Health Council[7] as a health care human resources with university training.

Following on from the reorganization proposal, decree 1996[8] was published in August 2007, establishing new guidelines and strategies for the implementation of the National Policy for Permanent Health Education in Brazil. This directive proposed a Permanent Education Policy more closely tied to the operational guidelines of the SUS management and to the *Pacto pela Saúde* (Pact for Health) regulation. Article 2 states that "regional implementation of the National Policy for Permanent Health Education shall be performed through Regional Management Boards (CGR), with the participation of the Permanent Service-Learning Integration Committees (CIES)"[8]. Therefore, besides introducing the Permanent Education Policy into the life of the institutions, delegating the decision-making to CGRs, this directive formalized the CIES as an important platform for inter-institutional liaisons for service-learning integration. Without considering legal aspects, there is no doubt that in many parts of the country, this was an important measure so that all actions towards training human resources for the SUS progressed as regards service-learning integration as a condition for the implementation and maintenance of such actions.

However, although the definition of these policies aimed at human resource training for the SUS represents a significant step forwards, its implementation faces enormous challenges, related to several factors.

As indicated by Oliveira[9], we are undergoing changes in the academic sphere and in the health services, due to social transformations linked to the demographic and epidemiological structure of the population, which have an impact on health care needs and demands. According to the author, despite the difficulties, the services respond more quickly to this new scenario, because societal pressure is felt directly in the practice space.

As for the difficulties of the academic sphere, she identifies: a difficulty in finding teachers for this new teaching-learning approach; basic health care considered as a marginal situation to teaching-learning; a difficulty in joint learning by the different professions; student resistance; incipient social participation of the community.

In the services, the difficulties may be related to resistance on the part of the workers, as training is not part of the work agenda ("they are not paid to teach"). Furthermore, there are problems in the physical structure of the units; resistance among the public to the presence of students in the service; fears among the health professionals that their weaknesses may be identified, etc.

The two sets of problems suggest that the pedagogical practice in the actual SUS services presumes the encounter between different actors (managers, professionals, public, teachers, and students) for the proposal to be built collectively, in order to meet different needs and demands of the academia and the health services.

Oliveira[9] refers to some proposals to overcome this problem, such as raising awareness among managers; formal partnerships, through agreements between academic organizations and services that define the roles and responsibilities of the parties; permanent negotiation; implementation of rewards for teaching, among others.

There is little participation by students and the public in these instances whereby partnerships are defined and, especially, in the agreement of the actions. Moreover, it would be very "educational" (in the sense of exercising citizenship and democracy) if representatives of the academia (managers, teachers and students) effectively participated in the social control (Local or Municipal Health Council), to learn to listen to the knowledge and desires of the population and reflect on their role / project.

LEARNING SCENARIOS AND SERVICE-LEARNING INTEGRATION

Considering the university as a privileged locus for reflection and knowledge construction, which should guide its political-pedagogical project to address issues of social relevance, this manuscript aims to report and review the experience of training health professionals for the development of the scope of the SUS-Campinas, defined by a Service-Learning Integration Policy (PIES), coordinated by the Centre for Health Worker Education (CETS), of the Municipal Health Department (SMS). The teaching, research and extension activities at the Centre for Life Sciences (CCV), of PUC-Campinas, are developed at the university, in the University Hospital itself and in the public health service network of Campinas.

The proposed Carer-Teacher Integration (IDA) in health care has been developed since the 1960s in Brazil, to diversify educational settings. The IES, as a player in this story, began the IDA in 1981, installing four Basic Health Units (UBSs) to serve as a platform for internships that, as from 1986, were integrated into the municipal health network. In order to strengthen the relationship between the IES and the Health System, the SMS and IES hold a Cooperation Agreement which provides for the development of teaching, research and extension activities in health care. Most of the internships / activities take place in a Health District, preferably in three Basic Health Units considered full partners, which belonged to the University. In these UBSs, the IES provides the fittings, equipment and supplies, transportation for care activities and the hiring of four staff (nursing assistants) in each service. There is also the administrative structure at the university and support provided by three Academic Integration teachers at the UBS (6 hours per week per UBS), an Academic Integrator to coordinate the demands at full partner units and a one Academic Integrator for external relations of the Service-Learning Integration Policy.

The academic integrators have the role of promoting service-learning integration, both multidisciplinary and interdisciplinary, combining the teaching, research and extension needs of the IESs with the current health care model, and preparing the conditions for implementing educational projects of the CCV Schools, which include the courses in Biological Sciences, Pharmacy, Nursing, Physiotherapy, Speech Therapy, Medicine, Nutrition, Dentistry, Psychology and Occupational Therapy. In addition to the activities at these three UBSs, the Cooperation Agreement provides for the

distribution of students to other units, based on deals struck with the Health District and City coordinators, strengthening the service-learning relationship. These spaces host hands-on and theoretical-practical activities of the CCV Schools, striving to fulfil the guideline of multidisciplinary and interdisciplinary education. The new Cooperation Agreement provides for the inclusion of courses in Physical Education and Social Work, which function on another campus, within the health service network. Preferably the planning of the activities is carried out together with the participation of representatives from the schools, coordinators and heads of services, members of the Northwest Health District and of the CETS/SMS. Teachers and students partake in team meetings, meetings with the Local Council and the Management Board of the units, thus enabling the exercise of co-management and reflection on the roles played by actors from the academic and service spheres.

Considering the need to increase the university's participation in developing policies for human resource training for the SUS, the IESs have been provided with resources from Pró-Saúde and, more recently, from Pet-Saúde, which participated in the majority of the health care courses.

Given the scenario indicated above, both internal and external to the IES, and recognizing that the current situation favours and stimulates reflection on the need for integration of the teaching-learning process to the health service network, periodic Service-Learning Workshops have been held, which have gathered the various actors involved in this process: teachers, students, service managers, workers and users, resulting in numerous suggestions for review of the path we are following.

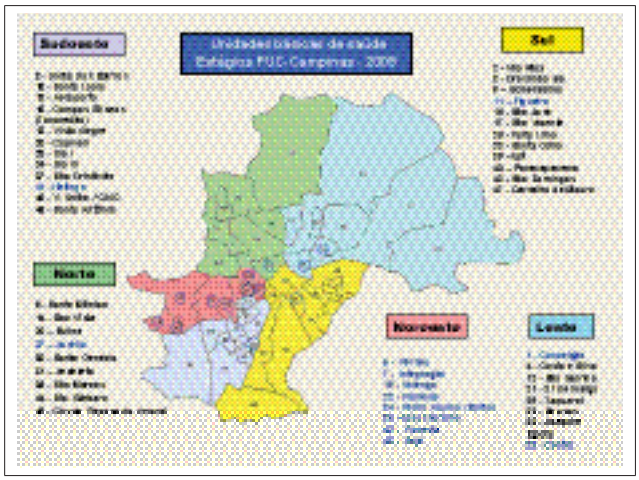
DIAGNOSIS OF INSERTION INTO THE SUS CAMPINAS

The education of health professionals of PUC-Campinas, in the SUS Campinas, was characterized by reviewing the internship agreement chart, with the CETS / SMS, which coordinates the Service-Learning Integration Policy of Campinas, in order to achieve closer relations between the Higher Education Institutions (IES) and the SUS. Each semester, in May and October, the university uses a database stored on a computerized system to request the activities to be developed in the following semester. The information presented below is a result of a Pet-Saúde Project, approved as from public notice No. 12 of 2008 and developed from April 2009 to April 2010, linked to Pró-Saúde (National Program for Professional Training and Reorientation in Health).

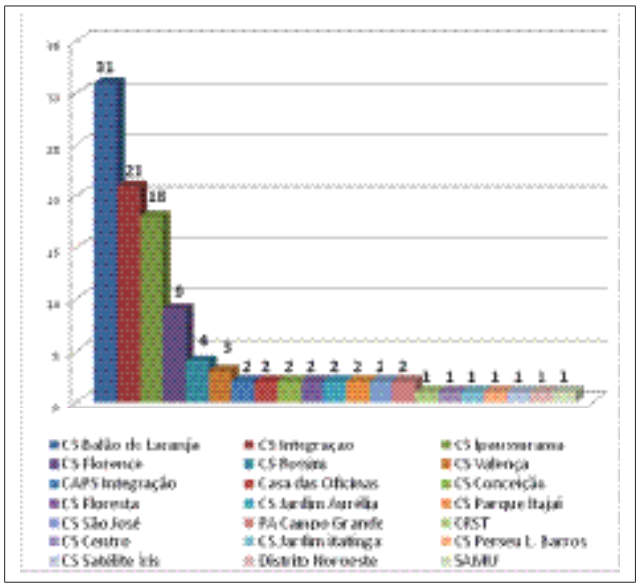
For the development of this project, four mentoring centres were set up, with the participation of 24 mentors and 180 students, monitors and participants. The mentoring centre where this study is situated, formed by students of the courses in Nursing, Speech Therapy and Clinical Nutrition, contributed to the research project "Education in the Unified Health System (SUS) from the perspective of the subjects involved in teaching and care", approved by the Research Ethics Committee of PUC-Campinas. The objective of that study was to characterize the training of health professionals from PUC-Campinas, in the area of basic care, by analysing the agreed internship chart, with the Centre for Health Worker Education (CETS), of the Municipal Health Department of Campinas. The study entailed investigation of the consolidated charts of internship agreements between the PUC-Campinas CCV and the CETS/SMS, for the year 2009, from which the following information was obtained: (1) Regarding the number of units: courses were offered in 21 units of the Municipal Health Network of Campinas, 16 of which in primary health care, two in emergency care, two in mental health and one reference course in occupational health, as well as one discipline that was developed by the management of a Health District, (2) Number of disciplines: 109 disciplines were distributed among those units. The disciplines were concentrated in four units, three of which are full partners; (3) Term of insertion course of the disciplines: in most courses students are admitted to the public network as from the 4th semester of the course, but two Schools were inserted in the first year, and one in the final year, (4) Number of Courses per Health Unit: four to eight courses are concentrated in four health units, three of which are considered full partners; six units have two courses and eleven units have only one.

The distribution of internships in the public health network of Campinas can be viewed on the map below.

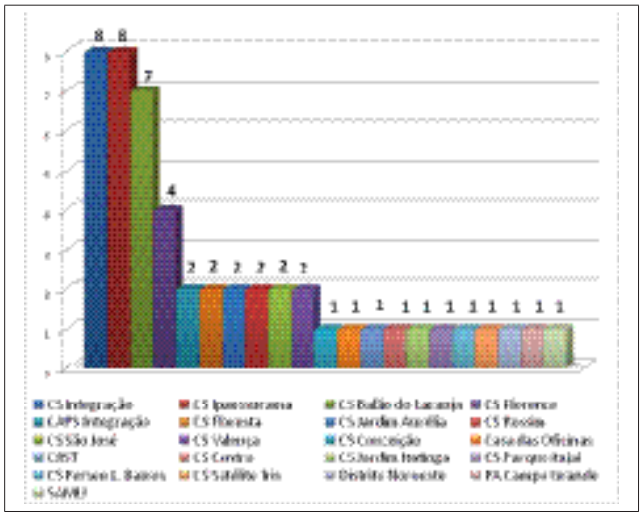
Basic Health Units – PUC-Campinas Internships – 2009



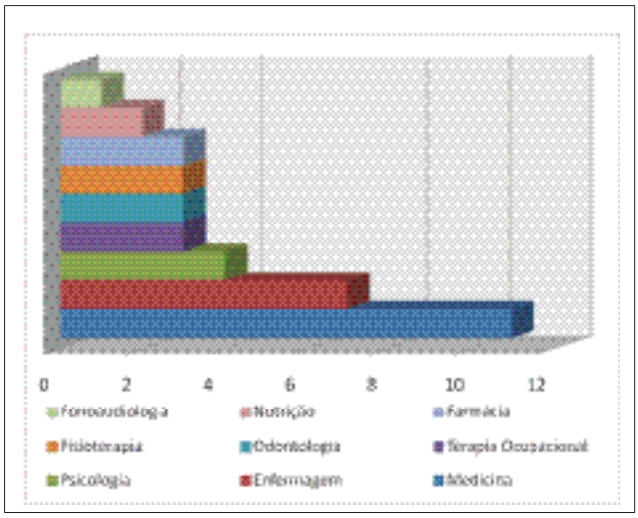
Number of disciplines per Health Unit/SUS



Distribution of courses per Health Unit/SUS



Number of disciplines per course in the Health Units/SUS



POTENTIALS AND CHALLENGES: BUILDING NEW HORIZONS.

The review and planning workshops between the IES and SMS are designed to help strengthen service-learning integration. With the involvement of IES representatives (managers, teachers and students) and the Municipality / SMS (managers, workers and users) the debates support the operational implementation of the required changes, helping to transform the organization of services and training processes, aimed at quality practice and the implementation of the constitutional principles and guidelines of the SUS. These meetings aim to: identify positive factors that facilitate service-learning integration actions from the perspective of the different actors (administrators, teachers and students of the IESs, managers and employees of the Municipal Health Department and service users); identify obstacles that hinder service-learning relations, from the standpoint of these different actors and indicate strategies to overcome the difficulties, improving and strengthening the service-learning partnership. The choice for the workshop is grounded on the assumption that this is a process in which participation and reflection are both key requirements for the collective construction of knowledge. It differs from traditional methodologies, because it assumes democratic and horizontal relationships[10]. It is a workplace where people reflect on their experiences, pose questions, seek solutions and share experiences, supporting the achievement of the proposed objectives. The work-

shops are organized in a dynamic that involves the following phases: (1) Opening: this involves introductory speeches by service and IES managers to welcome the participants, (2) Warm-up lecture, for subsequent activities, (3) Clarification of the methodology, (4) Teamwork: this moment is critical to achieving the objectives, and involves facilitators from the IESs and the services, and the appointment of a rapporteur. At this point, based on the individual experiences brought to the workshop, several themes emerge that engage the participants, touching on the possibilities and conflicts, resulting in the contribution of each participant and the construction of a group summary, (5) Final presentation, at which point the rapporteurs present the conclusions of the groups for discussion among all present, on a panel that indicates proposals / guidelines and actors involved in the process of change and (6) Evaluation of the workshop.

The workshops are usually the platform for discussions about crucial aspects of service-learning integration, in relation to everyday service issues, and to the operation of the IESs and the SMS.

In the workshop held in the first semester of 2010, the option was to instigate a discussion about relevant issues of that time, and the groups discussed the following topics: 1) Actions inductive to training professionals for the SUS; 2) Itinerant Matrix Configuration in the Northwestern District: are they possible? and 3) Teamwork training in health care. As a result, the groups indicated the following potentials and challenges:

1. In relation to actions to induce professional training, the Pet-Saúde and Pró-Saúde projects were identified as potential capabilities, as they provide a multidisciplinary and interdisciplinary vision of health care; a shift in the students' view of Primary Health Care (APS); work through the service-learning partnership, mentor-tutors of the services; the possibility of learning through the exchange of experiences between students from different courses and between teachers/service professionals; on site learning from information and events that occur in everyday services; the possibility of scholarships for students / tutors / mentors; the possibility of physical readjustment of some units; an increased possibility of developing extra-curricular activities; qualification of the partnership between the SMS and the University, based on the education projects; leveraging the creation of the Family Health League and the possibility of internship in APS (5th and 6th years).
   The following challenges were identified: the needs of the IESs to understand that the services produce knowledge and that the partnership with the University qualifies this production; the importance of broadening the debate on the principles, guidelines and legal bases of the SUS, involving course directors, teachers, students, health team professionals, and providing opportunities for discussion and the exchange of experiences in order to qualify the implementation of curricular changes; more systematic participation of the service in the process of implementation, deliberation and monitoring of the projects developed at the health units, such as refurbishments, purchase of materials and activities; scaling the number of students within the services and maintain daily coordination to manage the service and education requirements and seek alternatives for the periods of school recess, when students leave the services, in order to manage the demand created by the academic activities.
2. Regarding the possibilities of the itinerant matrix configuration, the potentials identified were: increased quality in providing solutions at the UBS, with reduced number of referrals to specialist services; reduced number of care workers, of medical consultations, of treatment time and waiting time for specialist care and the possibility of providing a broad vision of the health-disease process. As for the challenges, the following were mentioned: the need to improve communication between UBS and the University; to qualify the referral and counter-referral processes, seeking to overcome issues such as type of employment contract and relationship between the teacher/matrix supporter and the UBS reference team; review of the number of family doctors, often insufficient to meet demand and participate in the matrix configuration process, and problems with the physical space at the UBSs to implement a matrix configuration.
3. Regarding health care teamwork training, the importance of implementing new health care services was identified, such as a Healthy Living Cen-

tres, focused more on health-promoting actions among users rather than their diseases.

The challenges are related to: the differences in the organization of the course curricula involved in practical situations; the contracting form of some of the teachers; the alternation of the groups; the integration of students with the teams; the lack of human resources in the service; the organization of the work by production process; the reception of students by the services and the incipience of public education actions in the health services.

FINAL CONSIDERATIONS

The identification of potential opportunities and challenges in education for the SUS is essential to the implementation of changes both in teaching and in the service. The data presented reveal that there is significant insertion of students in the public health network of the municipality. Strengthened by a formal instrument, the partnership between the university and the SMS has contributed to education focused on the implementation of the constitutional principles and guidelines of the SUS and enabled multidisciplinary and interdisciplinary experiences. On the other hand, in some situations the student only has contact with the system near the end of the course or through one single discipline. The definition of the National Curriculum Guidelines for Undergraduate Courses and the institution of the Secretary of Labour Management and Health Education (SGTES) and the Department of Health Education Management (DEGES), which proposes a policy aimed at the issue of human resources in the SUS, indicate that the University needs to expand and deepen discussions on vocational training, particularly in health care. Traditionally confined to teachers in the area of collective health, the debate about education for the SUS needs to incorporate the other actors involved in this process, with the aim of promoting a broadened view of the Unified Health System, which emphasizes the principle of comprehensive health practices.

The efforts by those on the front line of the service-learning integration work have been devoted to building new possibilities, investing in the establishment of horizontal relationships, where the whole end product and results are shared, with neither an academic structure that simply makes use of the service as an internship site, nor a service that uses the student as merely "manpower". The end product of this workshop reveals that, although arduous, this is the best possible route. We know that it is not ready and that the actors involved will carry on rebuilding it as they tackle each process and each new pact established. As we progress we will learn that the challenge is the work in itself, in the everyday relations and experiments. And, to serve as inspiration, we can end by citing Guimarães Rosa[11]: "Walker there is no path. The path is made by walking it. "

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Integrating Service-Learning-Community Through Pró-Saúde/Unifor: Options for the Implementation of Pharmaceutical Care

Integração Ensino-Serviço-Comunidade Mediada pelo Pró-Saúde-Unifor: possibilidades de Implantação de um Serviço em Atenção Farmacêutica

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Palavras-chave: Atenção Farmacêutica; Atenção Primária à Saúde; Sistema Único de Saúde.

Keywords: Pharmaceutical Care; Primary Health Care; Unified Health System.

INTRODUCTION

Studies indicate that the disease-centred care model has not been capable of responding to public health demands, leading to the need to implement new strategies to retrieve the health promotion-centred paradigm. Several actions designated by the Ministry of Health in partnership with the Ministry of Education, represented by higher education institutions and social control movements in health care have stimulated debate and the construction of a guiding policy for training practices of health professionals and the qualification of human resources inserted and adapted to the mechanisms of the health service that preceded the Unified Health System (SUS)[1]. To enhance the quality of health care it is essential to guide the education of health professionals at undergraduate level for service-learning-social control integration, a process that involves the inclusion of teachers, researchers, managers, students, professionals and various entities[2].

The changes required for the organization of health care practices are clearly outlined in the National Curriculum Guidelines for Undergraduate Courses in Health Care[3-13], the *Aprender SUS* program, the Course in Engaging Changes in Health Work Training (FIOCRUZ, MS), in the Guidelines recommended by the Public-Private Sector Commission of Human Resources of the National Health Council (CIRH/CNS), the National Forum for Education of Health Care Professionals (FNEPAS)[14], professional boards, the Brazilian Association of Medi-

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cal Education (ABEM), the Brazilian Association of Pharmaceutical Education (ABENFAR)[15] as well as specific professional associations. So there is evidently concern regarding the establishment of a connection between higher education and health, with an aim to qualify professionals in accordance with SUS principles and guidelines, and the required development of the service-learning process at health care practice sites.

Parallel to these transformations, the University of Fortaleza (UNIFOR) has been adopting teaching and learning methodologies that distinguish it from traditional curricular organization, following a model whereby the student is able to build knowledge through theoretical and practical interconnection and interdisciplinary study. The learning-service-community arrangement, a strategy to achieve theoretical and practical integration, is therefore implemented by placing students at an early stage in real and diverse learning situations. This activity, guided by the Pedagogical Political Project (PPP), should occur from the start to the end of the course, at all SUS levels, in order to provide understanding of the reality and significant learning. The aim is for students to understand the health system in all its complexity, underlining the role played by basic health care in this process[8].

To construct these changes, the pedagogical political projects of the UNIFOR Health Science Courses were created in partnership with institutions and organizations from beyond the academic realm. Thus, UNIFOR established a partnership with the Fortaleza Municipal Health Secretary (SMS) in order to implement a learning-service practice and strengthen the construction of the Municipal Health-School System (SMSE), representing the priority orientation for service management and organization. The SMSE has the objective of creating permanent education strategies in association with learning institutions, non-governmental organizations and popular movements, transforming the whole health service network in the municipality into contextualized spaces for education and professional development[16,17].

The Ministry of Health established the National Program for Professional Training and Reorientation in Health (Pró-Saúde) through the Secretary of Health Education and Work Management (SGTES), and in partnership with the Secretary of Higher Education (SESU) and the Anísio Teixeira National Institute of Educational Research and Studies (INEP), of the Ministry of Education (MEC), and with the support of the Pan-American Health Organization (PAHO). Pró-Saúde has the main objective of fulfilling the inductive role in shaping health education in Brazil, initially involving the courses in medicine, nursing and dentistry. This represents a new stage in professional training in health care, conveyed through the general aim of encouraging transformations in the process of knowledge generation and service provision to the public, for a comprehensive approach to the health-disease process.

The program highlights the importance of integrating school with health services, with special focus on the practice sites. In response to call notice 13/2007 (SEGETES), National Program for Professional Training and Reorientation in Health – Pró-Saúde II, and in conjunction with the Fortaleza Municipal Health Secretary (SMS), UNIFOR presented a project to the Ministry of Education with the purpose of strengthening UNIFOR-SMS-Fortaleza relations, in order to strengthen the SUS and leverage responses to the population's real needs by means of human resource training, knowledge production and service provision.

In line with the Pró-Saúde precepts, the project has the aim of promoting reorientation of professional training in health care for undergraduate students of the UNIFOR Centre of Health Science, focusing on interdisciplinary care actions and health care in the Local Health-School Systems and coverage areas of the three Family Health Centres (CSF), thus integrating learning and service, raising awareness among health managers and professionals about the interdisciplinary activity and implementing extended health care teams.

The Pró-Saúde/UNIFOR Project centralized resources in the reform and improvement of three health care units of the Regional Executive Secretaries (SER) VI, with permanent material purchases and outlay sufficient to reinstall one unit a year. The Maria de Lourdes Jereissate CSF (CSF-MLJ) was the first to be restructured, involving a retrofit of the physical space with improved sterilization sector, consulting rooms, dental clinic, bathrooms, equipment purchasing, teaching material, as well as other enhancements aiming to offer better conditions for humanized and broader care, to host the UNIFOR undergraduate students and offer them quality educa-

tion. The inadequacy of the physical space, entrance, accessibility for the insertion of all the actors involved in real, practical scenarios were all weak points that were overcome with UNIFOR's participation in policy implementation programs that encourage student work experience (PET and Pró-Saúde).

The Centre of Health Sciences (CCS) offers nine undergraduate courses: Nutritional Sciences, Physical Education, Nursing, Pharmacy, Physiotherapy, Speech Therapy, Medicine, Dentistry and Occupational Therapy. It has a staff of 436 lecturers, of which 377 (77.29%) have either master's or doctorate qualifications.

The UNIFOR Pharmacy Course is formulated on a health care model perspective. It therefore outlines a social reality for the pharmaceutical professional's role, no longer restricted to merely complying with legal requirements related to technical responsibility in all spheres of production, commercialization and dispensing of drugs, but with the effective performance as a health care professional reoriented to understanding the health-disease process through practices such as: health surveillance, pharmaceutical assistance and care, hospital pharmacy, compounding pharmacy, clinical analyses and phytotherapy. To fulfil these new roles, the UNIFOR Pharmacy Course provides a solid understanding based on various areas of knowledge: Pharmaceutical Sciences, Exact Sciences, Human and Social Sciences, Biological and Health Sciences.

PRACTICE REPORT

Placed in this context, UNIFOR, through the Pró-Saúde program and with the participation of the teachers and students of its health science courses have embraced community-centred learning as a learning-service-community integration strategy. This has been implemented through teaching-learning situations with cross-functional teams that work in the health unit itself, the CSF-MLJ, requiring teamwork effort, discussions and collective discovery.

The pharmacy course joined the project with the aim of implementing the pharmaceutical care service, involving outpatient and homecare activities, directed at SUS users cared for at the CSF-MLJ, of the Regional Executive Secretary (SER) IV. This CSF is located in the district of Jardim das Oliveiras, in Fortaleza, and has six family health teams formed by physicians, dentists, nurses, nursing assistants and health care agents who provide services to a population of roughly 35,000 inhabitants.

Following the organization and physical restructuring, purchase of equipment, furnishings, books, development of instruments and human resource training for the service and promotion, the activities at the CSF-MLJ began.

Dispensing

Structural changes in the pharmacy, involving the organization, storage and arrangement of drugs were planned and partially executed. The purchase of air conditioning units, organization of the chiller for exclusive storage of drugs, and the instalment of a Pharmaceutical Distribution Centre (CAF) were all measures that were immediately implemented. Without doubt, there is still a lot to do in this establishment to ensure it has the conditions to provide services that fulfil the premises of humanization, rational use of medications, optimization of resources, education in health and ongoing education of health professionals.

The supervised work experience group in pharmaceutical care has ten students from the pharmacy course and is engaged at the CSF-MLJ Tuesday and Friday mornings. The students were split into dispensing and pharmaceutical consulting activities. It is understood that it is upon dispensing that the pharmacist will select the patients who require pharmacotherapeutic care.

One weak point found by the interns was the absence of the pharmacist in one CSF which has a pharmacy that receives a high demand for drugs. There were cases observed where, during the dispensing, users questioned the pharmacy employee about the purpose and use of the medication, even reporting that they could not understand the writing on the prescription or could not read.

The dispensing should guarantee that the medication is delivered to the correct patient, at the prescribed dose and in adequate quantity, and that sufficient information is provided to ensure correct use. It should be underlined that the act of dispensing is often the user's only contact with the pharmacist, and likewise, the last chance to speak with a health professional before beginning treatment of his or her disease or injury.

Another significant aspect of the dispensing process is the existence of pharmaceutical forms that require the user's specific knowledge for their handling or administration, for instance, eye drops, inhalers, self-injection devices and others. When presented with a prescription for any of these forms, the pharmacist should provide detailed information and, above all, ensure that the user has understood how to use the medication correctly. The frequent absence of pharmacists in public health services allows room for the assignment or delegation of pharmaceutical duties to other health professionals or other workers, so as to meet demands for essential drugs. However, to ensure user safety and the distribution of the correct medications, these duties should always be performed or supervised by a pharmacist. It should be highlighted that the efficacy and safety of medications does not depend solely on high manufacture quality.

pharmaceutical care

In order to implement the pharmaceutical care service in a multiprofessional care environment, it was proposed that patients at the CSF-MLJ be offered guidance regarding the rational use of drugs. Initially, informative leaflets regarding conceptual aspects of pharmaceutical care and the role of the pharmacist were planned and distributed to health service workers, UNIFOR teachers, community health agents and users of the CSF-MLJ services. The aim of this activity was to raise awareness about the pharmacist's work in the health promotion process, thus encouraging people to make use of such professionals.

Users were invited to partake in pharmaceutical care by interns of the subject. This process was carried out whenever there was any interaction with users, whether in the dispensing of drugs, during home visits or other occasions. Users were approached either while queuing for dispensing, when doctors' leaving consulting rooms or in the waiting room.

Although the health service professionals had been instructed about the pharmaceutical service, some simply ignored the service, depriving the patient of safe advice about the use of medications. Despite the efforts to channel information to those who worked in the health service, and the ease of access to the facilities, seeing as the doctors' consultancies and pharmacists were next to each other, the health service professionals were reluctant to facilitate the practice of pharmaceutical care. Contrary to this attitude, adhesion to, acceptance and recommendation of the service were willingly displayed by the teachers of other UNIFOR health science courses, such as medics, dental surgeon, nutritionist, occupational therapist, speech therapist, physical education instructor and nursing teacher, and also by some of the health community agents. This group of professionals, therefore, worked as a team, sharing responsibilities and enabling students to practice skills such as management, coordination, decision-making and leadership.

During the medical consulting, the intern together with the teacher performed an initial interview using an instrument which was then validated by the pharmaceutical care practice. This service involved the pharmacist learning about the user's disease, lifestyle, treatment and beliefs, so as to then provide suitable pharmacotherapeutic instructions in order to gain maximum benefit from the drugs and better therapeutic results. However, the acquisition procedure and information provision process are distinct from the dispensing, since the consultation takes place in an adequate space, in a calm and unhurried atmosphere.

In the interview, the supervised student asked a series of semi-structured questions that enabled an assessment of the pharmaceutical treatment that the user was or would be undergoing, including matters of a holistic and non-centralized approach upon the act of administrating drugs. Still in this context, if deemed necessary, during the pharmaceutical consultation they would discuss relevant matters related to the use of medications, such as: best times to take the medication, with or without food, organization of pictograms, correct use and storage of drugs, self-medication, interactions with other products and herbal medicines, foot care, in the case of diabetics, how to apply insulin, use of inhalers and other aspects. In order to carry out the Pharmacotherapeutic Follow-Up (SFT), later interviews were scheduled; at this point the arduous task began of convincing the patient of the importance of returning for the next consultation.

Subsequently, there is the case study phase, with situational analysis and identification of any potential or real medication-related problems. Finally, a proposed intervention plan is outlined to resolve any problems found, which should be agreed as to its execution with the patient, the prescribing doctor, or carer, if necessary. This approach is based on the principle of promoting user autonomy, partaking in and agreeing to his own treatment.

health education actions in pharmaceutical care

Education in health care consists of a set of areas of expertise and practices directed at disease prevention and health promotion[3]. It is, therefore, a means of support through which scientifically produced knowledge in the field of health, conveyed through health professionals, affects people's everyday lives, since the understanding of conditioning factors in the health-disease process enables the adoption of innovative health care conduct and habits. In the area of pharmaceutical services, education in health is related to promoting the rational use of drugs for effective health care resolvability. Therefore, by adopting the traditional model of learning practices, the students produced folders, videos, gave lectures and performed individual orientation sessions. The target groups of such activities were pregnant women, elderly people, diabetics and hypertension patients, with focus on preventive and curative actions to encourage changes in the lifestyle of the people cared for at the CSF-MLJ. Therefore, the students made interventions in schools, the community hall, and in other projects, adopting a dialogical approach that reached beyond the physical space of the health care unit. In all these activities, the participation of students from other courses was liberated, thus encouraging interdisciplinary work.

technical support for the health team

Students and teacher offer guidance and provide technical and scientific information not only to the patients at the health unit, but also to other professionals, thus promoting a support service to the clinic through updates about medications.

FINAL CONSIDERATIONS

One could initially argue that the results are not very measurable due to need for greater awareness of the CSF-MLJ health care team, and also that there were obstacles as regards the continuity of the service, as the pharmaceutical care is a gradual process that requires several encounters with the users. One could also point to the conditions imposed upon by the lack of a pharmacist at the CSF-MLJ, thus leading to frustration among students and teachers alike, knowing that only during the times of the supervised work experience in pharmaceutical care was there any guidance and follow-up provided to users.

However, at the same time, when I observe the students providing pharmaceutical care, whether in the queue for receiving drugs, in the corridors of the CSF-MLJ, or in the pharmaceutical consulting room, the limitations surrounding us are cast from my mind, as I can see the massive evolution of the student, the user's satisfaction and the expansion of health care. In the words of one of the work experience students in pharmaceutical care:

> *"We believe that those (users) who have the chance to have contact with us, certainly receive a better prognosis of their diseases, as they have enjoyed a unique moment with the medication professional, offering them manoeuvres for taking care with the medication and of their health." (our translation)*

> *"In relation to working together with other professionals, this is of great and essential importance, as we are inserted in a broader functional context, allowing our work to be exalted for the distinct impact it can have, if performed in the best possible manner, on the success of the treatment of many diseases, and also on disease prevention and health maintenance among the population." (our translation)*

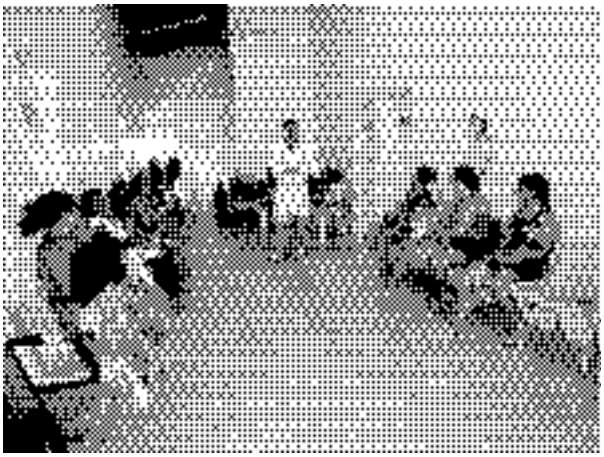

Figure 1 – Pharmaceutical care work experience student explaining the importance of pharmaceutical care to users waiting for medical attention and at the same time inviting them to participate in the pharmaceutical support.

Figure 2 - Pharmaceutical care work experience student explaining the importance of pharmaceutical care to users queuing for medications and at the same time inviting them to participate in the pharmaceutical support.

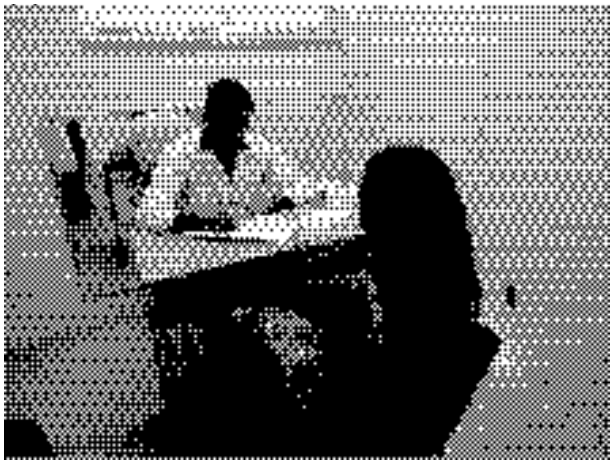

Figure 3 – Pharmaceutical care work experience student in a pharmaceutical consultation.

Figure 4 – Pharmaceutical care work experience students in a school giving advice about the use of contraceptives and explaining aspects related to pharmaceutical care.

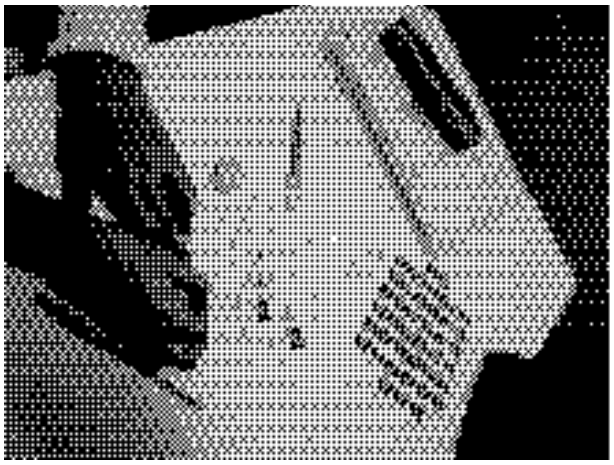

Figure 5 – Pharmaceutical care work experience students in a pharmaceutical consultation.

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Educational Program Through Health Work: the Experience of University of São Paulo and the Municipal Health Department of São Paulo.

Programa de Educação pelo Trabalho para a Saúde: a Experiência da Universidade de São Paulo e da Secretaria Municipal de Saúde de São Paulo.

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Palavras-chave: Educação Superior; Processo Saúde-Doença; Necessidades de Saúde; Necessidades e Demandas de Serviços de Saúde.

Keywords: Higher Education; Health-Disease Process; Health Needs; Health Service Needs and Demands.

INTRODUCTION

The flexnerian biomedical model, proposed in 1910 by Abraham Flexner and reaffirmed in 1926 by Gies, of transforming medical and dental education into a scientific model[1, 2] has proven to be limited for the professional to engage in solving health problems of the public, as such health problems have changed and become more complex since the late 20th century[2]. Whereas in the early 20th century acute infectious diseases decimated the population, by the end of the century, it was chronic degenerative diseases that had become more prevalent and, requiring expensive treatment, took on the form of one of the biggest challenges for health systems.

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Furthermore, in recent years understanding of the health-disease process has broadened due to the recognition of the role played by social determinants of diseases, representing a new challenge for public health policy makers, in view of the need to include other societal sectors (education, work, housing, sanitation) in order to promote health among the population[3].

In the initial training of health care professionals, classroom discussions about the conditioning factors of the health-disease process could be better understood once the students have experience in domains related to public health services. After having this contact, it is the actual practice of the service that enables the student to perceive that the socioeconomic context is not external or disengaged from health, but indeed intrinsic to it and a mediating factor in all practices[4].

With the paradigm shift in higher education, early experience in professional practice scenarios have been established, allowing for the association between theory and practice in the training of future health care professionals. It is therefore necessary to implement mid to long-term maturity actions aimed at improving the professional training. To this end, the Higher Education Institutions (IES) of the whole country, responsible for this training, should take on a proactive role and be the subjects of this actions, and not just one of many participants.

The process of change in professional health care training has been reinforced since the 1980s, with different incentives (Kellogg Foundation, Rede Unida) for its implementation. In Brazil, the Ministry of Health in partnership with the Ministry of Education recently implemented the National Program for Professional Training and Reorientation in Health (Pró-Saúde).[5]

Since 2006, the USP Teaching Units - Capital campus (School of Nursing, Faculties of Medicine and Dentistry) have conducted curricular reorientation processes, supported by Pró-Saúde. At these units, Pró-Saúde has helped consolidate certain principles in the training environment, such as the work place being an important defining factor for the training process, which requires from the University greater involvement in the continuous health education processes. The practice scenarios constitute privileged stages for the generation of questions that guide the learning, and the health care training is based on the SUS principles and guidelines, especially when referring to a public university.

However, the desired closer connections with health services required greater coordination, so that this would not be a one-way process. The insertion of health professionals from the public system into the education process should permeate professional training so that the undergraduate student acquires a better understanding of the actual work process in health care. Moreover, an opportunity is created to bring the professional closer to the academic world, encouraging the development of research studies and engaging continuous education processes.

One way of stimulating the insertion of educational institutions in health care units has been the Health Work Education Program (Pet-Saúde), created by the Ministry of Health, through the Departments of Work Management, of Health Education and Health Care, in conjunction with the Ministry of Education, through the Department of Higher Education. The program is aimed at supporting in-service learning and specialization, as well as work initiation, internships and work experience directed at health care students and professionals, in line with the SUS needs[6].

Therefore, the same universities participating in Pró-Saúde, through their courses in nursing, medicine, dentistry, physiotherapy, speech therapy and occupation therapy, took part in the selection process for PET-Saúde 2009-2010, with their respective disciplines related to basic health care, in order to enable education linked to the Family Health Strategy (ESF) for six categories of health care professions.

This process witnessed an expressive adhesion by students, preceptors and tutors. The project involved the participation of 8 professor tutors, 48 preceptors and 4 basic health services, with 96 scholarship students and 144 non-scholarship students.

When it was proposed, the following objectives for the project were listed: 1) to improve undergraduate student participation in field learning of the disciplines of primary health care and collective health care from the different courses involved, bringing them closer to the health service professionals through a common project; 2) to strengthen the process of recognizing the population's health needs within the project health units, aiming at adapting and applying health care technologies in the Family Health Strategy; 3) to provide students with the experience of complementary academic activities to improve understanding of team work, general engagement of health promotion activities as central pillars of the Family Health Strategy; 4) to retrieve the contribution of an inquiry into health needs in

the process of work improvement and with the potential to transform the epidemiological situation under the scope of the health units in the project; 5) to contribute to the Pró-Saúde coordination and expansion process in USP, as well as expansion of the Family Health Strategy and implementation of Family Health Support Offices in the region of Butantã, western zone of São Paulo.[7]

The purpose of this article is to describe the experiences in the first year of the PET-Saúde, so as to register and publish the joint, and therefore challenging, work in which different areas of health training in USP worked together to consolidate a common project, in line with the Unified Health System and as recommended by the new curricular guidelines for health care education courses.

OBJECTIVE

To assess the expansion of activities developed in the PET-Saúde USP-Capital as a form of verifying compliance with the objectives, identifying potentials and limitations and proposing new strategies that support effective service-learning integration.

METHODOLOGY

Considering the insertion of the PET-Saúde USP-Capital in the central-west region of the city of São Paulo, where the University's main campus is located, this region was used as the practice scenario. Therefore, a case study was proposed to describe the territory, the people involved and their actions during the first year of the project.

RESULTS AND DISCUSSION

description of the territory

Since 2008 the São Paulo Municipal Department of Health (SMS) has administered its services through public-private sector partnerships. In October 2008, a partnership agreement was signed for health service management between the SMS and the School of Medicine, entitled Project West Region (PRO). Specifically in the case of this agreement, an education and research platform was created grounding the establishment of the management activities and targets, in line with the principles of the University of São Paulo. This platform was developed by the education units that form the PRO Management Board and this coordination has been fundamental for the execution of PET-Saúde USP-Capital.

The region of Butantã was chosen for the development of the PET-Saúde Project of USP-Capital, as that is where there is a partnership in place between the university and some health units that work with the Family Health Strategy. Of the 14 units in the region, four are part of the 2009-2010 project: Centro de Saúde Escola Butantã, UBS Boa Vista, UBS Vila Dalva and UBS São Jorge.

Table 1 presents all those involved in the first year of the project, split into professional categories of undergraduate students, tutors (teachers) and preceptors (municipal public service workers).

Table 1 – Distribution of scholarship participants in the PET-Saúde USP-Capital Project, according to categories and Health Units, 2009-2010.

Health Unit	Role	Professional Category						
		Medicine	Nursing	Dentist	SPL/AUD	PSY	OT	Others
CSEscola	Tutors	-	-	-	-	1	-	-
	Preceptors	2	1	-	1	1	1	-
	Students	-	3	3	2	2	2	-
Subtotal		2	4	3	3	4	3	-
Jardim Boa Vista	Tutors	-	1	1	-	-	1	-
	Preceptors	6	6	2	-	-	-	1
	Students	15	5	13	-	-	2	-
Subtotal		21	12	16	-	-	4	1
São Jorge	Tutors	1	1	-	-	-	-	-
	Preceptors	4	6	3	-	-	-	-
	Students	6	8	8	-	-	-	-
Subtotal		11	15	11	-	-	-	-
Vila Dalva	Tutors	1	-	1	-	-	-	-
	Preceptors	5	5	1	1	1	-	-
	Students	10	7	6	2	2	-	-
Subtotal		16	12	8	3	3	-	-
Grand total		**50**	**43**	**38**	**6**	**8**	**6**	**1**

Nota: SPL/AUD - Speed language pastology/audiology
PSY - physiothera py
OT - occupational terapy

The participating students were at different stages of their undergraduate courses, depending on the course linked to the project. Therefore, whereas dental students (1st and 2nd semesters) and student nurses (3rd and 4th semesters) were at early stages of the course, medicine students were at an intermediate stage (5th and 6th semesters) and Physiotherapy, Speech Therapy and Occupational Therapy students were already in their final year (7th and 8th semesters).

Although the disciplines indicated had substantial contact with the proposal of the PET-Saúde projects, it was observed that the students' knowledge differed greatly, not least because some of the courses had placed first year students and others final year students. The experiences of the preceptors also varied greatly, particularly as regards the new challenges of primary health care in the SUS. Therefore, it was necessary to devote more time to conceptual alignment regarding the central topics of the Project, in order to achieve more significant involvement by all participants.

activities developed

The project entailed a survey of the population's health needs and, therefore, the conceptual alignment between the students and preceptors involved themes including the SUS, Family Health Strategy and territorialisation.

At the health units of Jardim Boa Vista, Vila Dalva and São Jorge, where the Family Health Strategy was engaged, the teams, in general, and the preceptors in particular, already understood the catchment area of the units and, at these units, the students were also invited to learn about how the services worked both through accounts given by the preceptors and observation of some activities before developing characterization of the families.

At the Centro de Saúde Escola Butantã, which has only two ESF cases, there was also the need to develop specific activities for greater contact between preceptors and students with the families that the teams accompanied. This is because the ESF at this unit is organized in a peculiar manner, whereby some of the preceptors (physiotherapist, speech therapist and occupational therapist) were not part of the ESF. Therefore, all the preceptors participated, together with the students, in instances of recognizing the unit's territorial scope, performed by the unit's community health agents, who presented their interpretation of the organization and the problems faced by the local population.

improvement of family registration

Each scholarship student, in partnership with the respective preceptor, was able to gather more information about the health needs of local families living in the unit's catchment area by performing structured interviews as part of a home investigation. Each student performed 16 interviews on average, at locations predefined by the health units, in accordance with their organizational interests:

At the Centro de Saúde Escola do Butantã, the region selected for the interviews was the area of the São Remo community, where the ESF was already in place. At UBS Jardim São Jorge, the red zone was chosen; the area of highest social risk and a region earmarked for team expansion and in need of new territorialisation. At UBS Jardim Boa Vista, the interviews were concentrated in the blue zone, of the Morumbizinho community, of greatest social vulnerability and the site of a favela. At UBS Vila Dalva, meanwhile, the teams opted to conduct the interviews throughout all the micro-areas of the unit.

Alternative times were made available to account for any prior engagements of the preceptors, students and USB employees and interviews were also conducted at the homes. The experience of conducting the investigation over a few Saturdays was well assessed by the team members and the interviewees were also very receptive toward the process.

The investigation, divided into characterization of the family, work, perceptions about health and risks, identification of the social support network and health conditions, allowed the students not only to be immersed in an entirely distinct domain to any other provided by educational institutions, but also the understand the conditioning factors behind the health-disease process. The preceptors also regarded it as an opportunity to learn about certain areas that had not been previously mapped by the local team, or to increase the interpretation of the health indicators on Form A of the Basic Health Care Information System (SIAB), which could guide planning and development of other learning and care activities from the perspective of adaptation to the needs of groups and to the pedagogical interests of the courses.

Systematization and discussion of the data

Following the investigation, the students filled in a spreadsheet on Microsoft Office Access, developed by the IT technical team of the Department of Nursing in Collective Health at the Nursing School, after being trained in groups of 12.

In all, 1.445 families were interviewed, and 5.545 individuals (average of 3,8 people per family), with the majority being female. The dominant birthplace of the interviewees was the Metropolitan Region of São Paulo (46,4%), with a large contingent from the northeast of Brazil (30,1%), who were primarily concentrated in the age groups of over 40 years.

As regards race/colour, it should be noted that these data were obtained from the spontaneous response given by the interviewee. The results show a dominant proportion of mixed race (40,1%), followed by white (36,3%) and black (12,9%).

Despite public efforts to increase coverage of access to education, there was a large contingent of illiterate adults (41,6%) or adults who had not competed elementary education.

The majority were nuclear families (couple, couple with children or children with one of the parents) with 62,5%, followed by extended family (with more relatives), with 16,1%; 5,5% of cases were people living alone and 3,2% expanded family (including non-family living together).

For the second set of information members of the investigation characterized the needs of families, and this was related to the forms of working with the population, an important category for understanding the health-disease process of the individuals, especially for Primary Health Care, which is has as one of its attributes the longitudinal monitoring of the population, acting on prevalent problems[8]. Despite its relevance, this information is not part of the medical records. Its inclusion in this survey was considered timely to draw the attention of students and professionals to this dimension of adult health, and also to broaden the dialogue with the population.

The majority of the population (60,8%) were in paid employment with a formal employment contract, indicating a more stable situation. However, there was the high number of people working without any formal employment relationship (33,7%), which can make it difficult to follow therapeutic recommendations, such as resting or taking time off work.

Regarding living conditions, the first aspect asked about was home ownership, due to the stability that this can offer one's living conditions. There largest proportion owned their homes on their own land (50,6%), which is the most stable situation. There was, however, a high percentage of families living in homes on land that was not their own or in rented accommodation (41,2%), also considered a normal situation in terms of stability, besides the families who were living in illegally occupied or lent (7,7%), a more unstable situation.

The data relating to the suitability of the residence in terms of ventilation, lighting and the presence of mould and mildew were obtained through the interviewees' perceptions. It was observed, therefore, that most considered their homes to be well ventilated (62,2%), well lit (62,0%) and without any mildew or mould (51.0%). However, there was an alarmingly high number of inadequate homes, especially as regards the presence of mould and mildew, which can be directly associated to respiratory diseases both in children and in elderly people. Many answers were left blank, which could indicate a greater number of unfavourable conditions for the health-disease process.

The population studied lived in homes that, in most cases, allow access to public water supply (99,1%), electricity (98,3%), garbage collection (90,0%), sewage system (89,8%) and telephone lines (67,3%).

Other information included in the study was the accessibility of housing, characterized by the presence of architectural barriers that could pose a risk of people falling or hindering the movement of disabled or elderly people. The main obstacles identified were stairs at the entrance of the house in 73,7% of all households surveyed, which exposes a large number of vulnerable people to domestic accidents. Inside the homes, stairs posed less of a problem, present in only 36,4% of the houses.

The potential for strengthening and wear and tear should also be analysed in relation to the territory of the home, as well as to individual households. The survey also sought opinions in relation to exposure to risks in the neighbourhood. 88,1% of the respondents reported some form of perceived risk in the neighbourhood. Violence (55,7%) and contact with insect vectors (53,4%)

were the main concerns expressed by the respondents. Also significant were pollution (47,7%) and road accidents (43,9%). All the issues raised could be changed through intersectorial actions.

The main instances of social participation reported by the people interviewed were referred the church (18,7%), neighbourhood associations (3,4%) and schools (2,6%). These spaces should therefore be considered by health professionals when outlining intersectorial actions aimed at transforming the unhealthy conditions of the population.

Another important element to understand the health needs of the population is forms of leisure, which also indicate lifestyles. When asked what they usually did in their spare time, the most common answer was watching TV/video (45,3% of respondents), followed by going out to places in the city (32,0%) and sports and games (23,6% families). The responses indicated preferences that could be used in social communication processes and for strengthening social networks in the territory.

The respondents were also asked about where they went when they were ill and the responses indicated that UBSs appeared in first place as the reference site for the population interviewed, indicated by 88,0% of the interviewees, followed by the University Hospital, which was mentioned by 68,1%. It was noteworthy that nobody mentioned the Outpatient Medical Care (AMA) linked to one of UBSs, which probably indicates that the population considered the service as a whole.

The data indicated the importance of developing service procedures, which integrate the time of disease with subsequent follow-up, combining curative and preventive dimensions, without their dissociation in distinct moments. This can be extremely important in the construction of new therapeutic projects aimed at the population's health needs.

Specifically in relation to UBSs, the most common motives for visiting the units were informed, regardless of the disease. The alternatives were presented to the respondents by the interviewer. Medical consultation (87,3%) and medication (70,3%) were the main activities mentioned. Vaccination (68,7%), cervical smear (59,5%) and taking blood pressure or capillary blood glucose testing (43,7%) were also listed by many. Interestingly, specific programs such as the prenatal and baby care, were only mentioned by about 20,0%.

Among the care provided by other professionals, besides physicians, consultations with nurses was the most prominent, reported by 36,5%. The group modality, despite its importance to health promotion and disease prevention actions, was mentioned by only 6,5%, displaying a low level of adherence to that activity.

Aspects related to the health-disease process were identified from the diseases reported by the interviewees, in view of their own conditions, as well as the diseases/conditions of their family. It is emphasized that the data are approximate as they were obtained based on the interviewee's own perceptions. It is also worth noting that the data may reveal an underestimated vision of the reality. Nevertheless, there is significant information to recognise the health needs, particularly through the identification process that related diseases, illnesses, adherence to programs after the dimensions of socio-demographic, work and life characterization. This information, reviewed by each UBS, could support the discussions for revising priorities and increasing equity.

strengthening cross-functional training/ coordination

Two seminars for conceptual alignment were held with all participants, on the following topics: Territorialisation and Health; Challenges of Basic Health Care in the SUS and Health Needs.

In each UBS, in view of the interdisciplinary mentoring of the students, each common moment was shared by students, preceptors and tutors from various professional groups. As well as adding content to the discussions, these opportunities have resulted, in practice, in these students and future professionals having the opportunity to be more easily and effectively inserted into family health teams.

The activities resulting from the PET-Saúde have enabled students to engage in the services earlier and in a better connected way to the health teams, promoting a better understanding of professional practice at different levels of complexity of the health system.

Prior contact and multiple opportunities to get closer to the world of health care favour observation of the service routine. A similar example was shown by researchers[9] who reported that when medicine students had contact with the UBS since the beginning of the undergraduate course and for a prolonged period, it was possible to show the complexity involved in health care, thus contributing to a perception the public system as a worthy work site and place of life production. Teachers observed students overcoming preconceptions and incorporating new perceptions. Such activities contributed to increasing the identification of population's needs, as well as improving the quality of care provided.

Another contribution in this regard was the opportunity for the University to act in a more continuous manner in the permanent education of health service professionals. The recognition of health as a right and the citizen as a subject of care processes and professional training was highlighted.

On the other hand the educational institutions and health services could be blamed for the cold and distant attitude of the workers[10]. According to the author, this attitude is not simply a matter of personality or character, nor does it express a lack of theoretical foundation, but speaks to the workplace where these professionals work and interact and the quality of relationships in these places, which contribute greatly to the development of work skills and standards of conduct for workers.

These experiences have favoured interdisciplinary education in health, by enabling students to participate in real life studies concerning the work and health of service users and in shared care proposals, creating favourable conditions for better qualification of the health care provided both in the services that are practice fields for students and in those where they may be inserted as professionals.

Coming closer to the everyday reality can reframe the educational process. The experience of new situations "conjugates the inductive knowledge process, sparing in preconceived generalizations, to the deductive process, mediated by concepts systematized into global explanatory systems, organized in a socially constructed framework and recognized as legitimate"[2].

When the university and health services are coordinated in an objective and constructive manner, the experiences of continuous education are strengthened, as occurred in the region where this project was developed. Deeper integration with the services facilitated the absorption of demands of qualification for primary care and increased communication between health workers and the university, as well as bringing the education more in touch with the reality of SUS health care at a regional level.

FINAL CONSIDERATIONS

The challenge of integrating students from different undergraduate courses into the health services, forming cross-functional PET teams was no mean affair. The difficulties encountered were related, above all, to a lack of financial resources for the department, printing the material for the survey and transporting the students to the UBSs (for some this meant a journey of more than 20 km), as well as reconciling the timetables between the students of day and night courses with the teams and opening hours of the UBS.

The disciplines involved have contributed to the professional training based on the principles of citizenship, by recognising user autonomy, interacting with the population and health teams, seeking solutions to the problems identified and being involved with the results of the care. It has also allowed recognition of the social history of disease and the Family Health Strategy (ESF) as a form of health care and structural axis of the SUS network, with the direct involvement of different fields of professional activity.

The complexity related to recognising the health-disease process and its interfaces with the forms of working and living was better captured with participation in the PET-Saúde program; widening the opportunities for interaction among students, teaching professionals and the population, which added meaning to the activities traditionally restricted to the disciplines. The involvement of the participants was intense and enabled fortification of the process of identifying needs.

The complexity of the problems and primary care alternatives, as opposed to the technological complexity found in large hospitals, favours experiences that strengthen the construction of the Unified Health System

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FNEPAS and Pet-Saúde of UFMG/SMSA/PBH: Multiprofessional Education for Teamwork Skill Development

O FNEPAS e o Pet-Saúde da UFMG/SMSA/PBH: A Educação Multiprofissional Desenvolvendo Competências para o Trabalho em Equipe.

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Palavras-chave: Equipe Interdisciplinar de Saúde; Política de Saúde; Educação Baseada em Competências.

Keywords: Interdisciplinary Health Team; Health Policy; Competency-Based Education.

INTRODUCTION

The PET-Saúde[1] project, proposed by the Federal University of Minas Gerais (UFMG) in partnership with the Municipal Health Department of Belo Horizonte (SMSA/PBH) was developed by a committee formed by UFMG lecturers, members of the Board of the National Forum on Education of Health Professions (FNEPAS) and service professionals who attended the regional FNEPAS workshops held in Minas Gerais in 2007 and 2008. The UFMG/SMSA/PBH PET-Saúde project aims to provide professional training in health, focusing on teamwork skills and with emphasis on comprehensive care and scientific training as the driving force behind the teaching and learning. The project adopts an approach of development of common general skills for healthcare professionals as indicated by the National Curriculum Guidelines (DCN)[2].

Created in 2004, the FNEPAS is a stage for forging multiprofessional partnerships, based on the goal of shifting the guiding principle of professional health care training toward comprehensiveness. The FNEPAS is composed of the Brazilian Association of Medical Education (ABEM), Brazilian Nursing Association (ABEn), Brazilian Association of Nutrition Education (ABENUT), Brazilian Association of Pharmaceutical Education (ABENFAR), Brazilian Association of Dental Education (ABENO), Brazilian Association of Physiotherapy Education (ABENFISIO), Brazilian Association of Psychology Education (ABEP), Brazilian Association of Social Work Education and Research (ABEPSS), Brazilian Association Rede UNIDA, Brazilian Association of University and Teaching Hospitals (ABRAHUE), Brazilian Association of Graduate Studies in Collective Health (ABRASCO), Brazilian Speech Therapy Association (SBFa) and the National Network of Occupation Therapy Education (RENETO).

The FNEPAS, as well as supporting and defending integration between health professions as a fundamental step toward comprehensive care, also encourages

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partnerships between health services and education, by coordinating actions between all sides of the health care complex, namely: health workers, students, teachers, managers and the public. It also proposes to tackle the technical and scientific dimension by incorporating elements of interest or social relevance that lead to improved health care quality.

Therefore, the objective of this work is to report the activities conducted during the UFMG/SMSA/PBH PET-Saúde project, considering the contribution of FNEPAS, not only in the planning phase, but also in its consolidation. The history of FNEPAS played an important role in reflecting on the need for multiprofessional training at UFMG, primarily in relation to the support required to form the project tutorial groups composed of students from different courses, and teachers (tutors) and professionals (preceptors) from different healthcare professions.

FNEPAS IN MINAS GERAIS

In December 2006, the FNEPAS Experimental National Workshop held in Rio de Janeiro instigated a process of regional networking with the objective of implementing workshops throughout Brazil with the presence of strategic players in the field of health care and health training.

FNEPAS began organizing the Regional Workshops in Minas Gerais in February 2007. Initially those invited to participate were representatives of undergraduate courses in the field of health based in Belo Horizonte and graduating students from the Specialization Course in Engaging Processes of Change in Higher Education of Health Professionals*[1]*. Other actors were invited in subsequent meetings.

The working group that organized the workshops was composed of regional teacher-representatives of the educational associations (ABEM, ABEn, ABENO, ABENFISIO, ABENUT, RENETO, SBFa), who also represented undergraduate courses in nursing, physiotherapy, speech therapy, medicine, nutrition, dentistry and occupational therapy. The group also included professionals from the State Health Department and representative of the Municipal and State Health Council. A survey of all health courses in the state was carried out to identify the regions of greatest concentration. Five operational regions were defined, where the working group conducted six workshops on *Comprehensiveness and quality in health care training and practices: integrating training, services, managers and users*. A state workshop was also organized for the representatives elected in the regional workshops.

In all six workshops, the presence of a large number of teachers, health workers, students, managers and community representatives created a space for closer relations and reflection on the topic of comprehensiveness, considered as essential to the development of innovative health practices and training. Many projects of an innovative nature were kick started by the workshops, as well as movements for closer ties between educational institutions and the municipal health management.

It is important to point out other platforms provided for actors linked to the FNEPAS. In 2006 and early 2007 a forum for following the National Program for Professional Training and Reorientation in Health (Pró-Saúde) projects was established in Belo Horizonte, involving the courses of nursing, medicine and dentistry at UFMG, dentistry at PUC/MG and in partnership with the municipal health department (SMSA/PBH). In 2008, the Local Pró-Saúde Management Council was established, and in 2009 it included representation from the PET-Saúde projects.

PARTNERSHIP BETWEEN THE FEDERAL UNIVERSITY OF MINAS GERAIS AND THE MUNICIPAL HEALTH DEPARTMENT OF BELO HORIZONTE

The UFMG is a pioneer institution in terms of integration between the university and society. The discussion regarding a pedagogical model that qualifies professionals to work efficiently in their own community and the critical review of such model has allowed, in secondary education, the structuring of a curricular reform that was implemented in the medicine course in 1975.

Subsequently, in 1978, through the implementation of the *Rural Internship* and internships in the primary

[1] Este é um curso cujo objetivo é "formar especialistas em ativação de processos de mudança na formação superior de profissionais da saúde capazes de desencadear e ampliar o pensamento crítico e a ação estratégica, no sentido de difundir e dinamizar os processos de mudança na formação superior de profissionais de saúde no país". À época o curso foi oferecido por meio de uma parceria entre a SEGTES do Ministério da Saúde, a Escola Nacional de Saúde Pública da Fundação Oswaldo Cruz e a Rede UNIDA.

care network in Belo Horizonte, the teaching-care integration model was installed in the municipality. Similar movements occurred in other UFMG courses, enabling new forms of integration between education, health services and the community. With the changes in the primary health care model in Belo Horizonte, which since 2002 has been organized in line with the Family Health Strategy, new possibilities have arisen for the introduction of various UFMG health courses in health care practice settings [3,4].

There are currently six UFMG undergraduate courses in the health area that offer disciplines and internships in the SMSA/PBH primary health care network, present in the nine public health districts of the municipality and involving over five hundred students per semester. Another four courses, in the process of curriculum review, propose primary health care as a practice setting.

While on the one hand a growing number of UFMG courses have implemented work experience activities in the primary care network, on the other, opportunities for multiprofessional training through coordinated activities between undergraduate courses were few and far between.

The SMSA/PBH has the institutional mission of structuring health care in the municipality, ensuring the principles of the Unified Health System (SUS). These principles are aimed at universal care, comprehensive actions, guaranteed access and equality in public health care in Belo Horizonte. Within the municipality, the organization of health care into public health districts allows the definition of the geographical, population and administrative scopes of coverage. Each district is apportioned primary health care units, accident and emergency services, mental health centres (CERSAMS), as well as the public and contracted hospital network[5].

Service-learning integration, the diversification of practice settings and the organization of the academic institutions' services have ensued from the permanent cooperation between the two institutions. All the UFMG courses in the field of health have shared efforts with the SMSA/PBH in relation to human resource training, aimed at the needs of the SUS and at all levels of care, but, traditionally and especially in primary health care.

In the sphere of interinstitutional or intrainstitutional relations in UFMG, the FNEPAS has been of utmost importance since it has the clearly defined objective of contributing toward changing the training process in accordance with the principle of comprehensiveness, with integration between health care professionals, beginning during their undergraduate studies, and in a coordinated fashion with health services.

EDUCATION THROUGH HEALTH WORK PROGRAM

The Education through Health Work Program (PET-Saúde) was established by the Ministries of Health (MS) and Education (MEC) by Interministerial Directive 1802, of 26 August 20081, to promote tutorial learning groups within the Family Health Strategy. It was inspired by the Tutorial Education Program (PET) of the Ministry of Education, legally grounded on laws 11.129/2005[6] and 11.180/2005[7]. According to the interministerial directive, the program:

> "constitutes an instrument to support specialization and educational programs in professional health services, as well as work initiation, internships and work experience, aimed at students from the area, according to the needs of the Unified Health System – SUS."(our translation)

As an intersectorial action directed at strengthening primary health care and in line with the principles and needs of the SUS, PET-Saúde is a strategy of the Pró-Saúde program, which was implemented in 2005[8,9]. PET-Saúde is based on the principle of education through work and provides grants for academic tutors (professors), preceptors (service professionals) and undergraduate students in the health area.

The PET-Saúde program is open to all fourteen health care courses offered at public or private non-profit higher education institutions (IES), in partnership with the municipal health departments of all the regions of Brazil. The projects are presented, reviewed and selected through notices published every year by the Ministry of Health[1]. Until now the notices[10,11,12] have considered projects developed in the academic years of 2009/2010 and 2011.

The PET-Saúde tutorial groups are instruments for in-service qualification of health professionals, as well as work initiation and experience aimed at students, based

on the needs of the services as the source of knowledge production and research[1]. Moreover, they aim to facilitate the service-learning-community integration process, establish and foster the pedagogical action of professionals through preceptor training and may be an incentive for these professionals to follow a teaching career. In the field of training future professionals in accordance with the DCN, PET-Saúde offers skill development for training professionals in line with a profile suitable to health care needs and policies, through new care practices and pedagogical experiences. More specifically tied to the axis of Pró-Saúde practice scenarios, PET-Saúde aims to encourage interaction among students and teachers with service professionals and the public. It therefore promotes interaction between the school and practice scenarios, fostering teamwork and alignment between training and professional practice.

The PET-Saúde[13] management is performed by the Department of Health Education Management (DEGES), the Department of Work Management and Education in Health (SGTES), the Ministry of Health, with support from the Management Information System (SIG-PET-Saúde).

PET-Saúde is supported through partnerships between SGTES, the Department of Health Care (SAS), the Ministry of Health and the Department of Higher Education (SESu), under the Ministry of Education. These partnerships, established in the formulation, implementation, monitoring and evaluation of the PET-Saúde program, also involve the Department of Health Education Management (DEGES/SGTES/MS), the Department of Basic Health Care (SAS/DAB/MS), the National Health Fund (FNS/SE/MS), the DATASUS/SE/MS, the National Council of Health Departments (CONASS), the National Council of Municipal Health Departments (CONASEMS) and the Departments of Development of the Network of Federal Higher Education Institutions and of Federal University Hospitals and Health Residencies/SESu/MEC.

In January 2010[14] 111 PET-Saúde projects were selected from 84 higher education institutions and 96 Health Departments, involving 461 PET-Saúde/Family Health groups. A look at the experiences underway and new projects reveals a wide variety tutorial group models, educational practices and service-learning-community integration vis-à-vis the huge inter-and intra-regional and institutional differences.

Advancing the implementation of PET-Saúde as a strategy of professional training for the SUS[15] requires thorough knowledge and analysis of the process and demands of education through work, the reconfiguration of the service model, dynamic engagement of the concepts and of professional/multiprofessional education practices, proposed actions of service-learning integration and opportunities for the development and expansion of initiatives for professional skills development.

In the policy for better professional qualification for the needs of the SUS, FNEPAS plays a key role, since it brings together the education associations in the health field and other bodies, forming a privileged forum for coordinating and proposing cross-functional actions and ensuring comprehensive care. Therefore, for the UFMG and SMSA/PBH the actions developed by FNEPAS have entailed the preparation of a critical mass and fertile environment for proposing, through PET-Saúde, initiatives with great potential for changing the training of health professionals.

PET-SAÚDE UFMG/SMSA/PBH

In addition to the core objectives of the PET-Saúde Program, the PET-Saúde UFMG/SMSA/PBH project also had the following specific objectives:

- stimulate initiation to professional practice as from the first semesters of undergraduate courses,
- induce the insertion into primary care of UFMG departments/courses that still do not use this setting for undergraduate studies,
- strengthen service-learning integration practices of health courses that are already inserted into primary care,
- induce multiprofessional and interdisciplinary work in primary care,
- encourage the development of health promotion and disease prevention activities in primary care,
- contribute to the processes of curricular change of UFMG courses in health,
- stimulate academic production focused on the needs of the SUS, with emphasis on primary care,
- stimulate in-service professional training, aimed at strengthening primary care in the municipality,

- tighten relations between undergraduate courses in health and the Family And Community Medical Residency program (RMFC),
- develop and maintain the Centre of Excellence for Applied Research in Primary Care (NEPAB) of UFMG.

The PET-Saúde UFMG/SMSA/PBH project is open to eleven undergraduate courses (Physical Education, Nursing, Pharmacy, Physiotherapy, Speech Therapy, Medicine, Veterinary Medicine, Nutrition, Dentistry, Psychology, and Occupational Therapy). In 2009, 13 tutorial groups were implemented and in 2010/2011, fourteen. In 2011 the project is being conducted by 16 tutors, 84 preceptors, 168 scholarship students and a variable number of volunteer students, reaching up to 18 students per tutorial group. In order to enable participation by a larger number of teachers, the professors chose to split the tutors' grant. Some of the 14 tutorial groups have two professor tutors.

The tutors were selected considering the conditions and criteria set forth in the PET-Saúde Notice[1], their tendency toward the proposal and insertion as tutors into primary care. The number of scholarship students per course was defined taking into account the total number of students enrolled on the course and on the disciplines related to primary health care. The preceptors were selected from those who work in the Family Health Strategy and who met the conditions and criteria defined in the PET-Saúde public notice. In selecting the health units and the preceptors, priority was given to the presence of activities with undergraduate students and with the family and community medical residency. Professionals from the Family Health Support Centre (NASF) also partook in the process. One positive result from the participation of NASF professionals included the strengthening of these centres and the closer ties to the Family Health Teams (ESF). For the selection of the students, a public notice was published with online access on the UFMG Dean's Office for Undergraduate Studies website, where the conditions and criteria for insertion, selection and approval of candidates were explained.

The PET-Saúde UFMG/SMSA/PBH fosters multidisciplinary action among students, teachers and professionals in interactive activities in the workspace, health promotion projects with the community, research in line with SUS needs, training activities in research methodology and topics linked to service organization. Training opportunities are also arranged for health teams, various qualifications in specific areas according to the work plan requirements of each tutorial group and assessment of the project development. The assessment instrument also includes matters that allow self-evaluation.

The lines of research of the PET-Saúde UFMG/SMSA/PBH have qualified the care and learning and encouraged in-service training. The results from the partnership between SMSA/PBH and the UFMG in the sphere of the PET-Saúde were presented at the *1st Pró-Saúde and Pet-Saúde Show of Belo Horizonte*: *Reflecting on Paths to Service-Learning Integration*, held in 2010, which demonstrated the potential of the PET-Saúde to generate knowledge and improve primary health care. Considering the 1st show held in Belo Horizonte and other events throughout Brazil, from April 2010 to March 2011 there were 108 reported presentations made about PET-Saúde UFMG/SMSA/PBH. Of those, 79 were also published in periodicals and annals. A further three articles were accepted for publication in periodicals in the same period.

The work coordinated among students, teachers, workers and managers promotes the improvement of health practices by providing an opportunity to tackle real life situations related to health, to social conditions, values and the response to actions planned in everyday health services. This process allows the conjugation of different knowledge fields, which are applied in the review and proposal of solutions to management, care and education problems in health care. In this regard, PET-Saúde has provided alignment between the teaching-learning process and the population's needs.

It should be highlighted that all the tutorial groups are multi-professional and use significant pedagogical practices aimed at developing the skills established in the DCN. In the context of training health professionals, the two-way skills approach enables reflection on the professional practices and a dialogued construction between the academic and work world with the society. This dialogue occurs in the identification of different interests, values and knowledge fields, constituted socially and historically[16]. In this regard, PET-Saúde has also proven to be a powerful ally by providing real working conditions in the service space and community, allowing the manifestation of conflicts between actors.

Despite some factors that hinder the development of the PET-Saúde project, for instance, the precarious conditions of the physical space in health care units, lack of equipment to access information and overworking of the preceptors in care and health demands, the preceptors, managers and professionals involved are very enthusiastic about the project.

CONCLUSION

The experience has shown that the PET-Saúde project promotes critical training of future professionals through research opportunities. Teamwork training is achieved by the tutor group model which includes representation of the various different health professions. The health services, meanwhile, benefit from the knowledge generated through the work, the opportunity to participate in research and the skills developed related to health care training. In the specific case of the PET-Saúde UFMG/SMSA/PBH project one can perceive progress in the service-learning integration with promising signs of answers to the old deadlocks that obstructed the improvement of health care. PET-Saúde has shown that multiprofessional training strengthens ties and joint responsibility in health work.

For the FNEPAS, the PET-Saúde experience outlines some challenges to be tackled. The first of these is to have educational institutions increase the debate and formulation of strategies to support multiprofessional training as an integral part of course syllabi. The second is to ensure that knowledge regarding health education generated in the tutorial groups is not restricted to the most directly involved subjects, but that it carries some internal weight in the educational institutions. The third is to provide more exposure and space so that the DCN can clearly indicate the need to develop throughout professional training all six skills common to all health care professionals.

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Discussing The Daily Work of Family Health Teams: the Experience Of The 3rd UFPB Primary Care Workshop

Discutindo o Cotidiano das Equipes de Saúde da Família: a Experiência da III Oficina De Atenção Básica da UFPB

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Keywords: Tea ching; Primary Health Care; Human Resources Training; Health Personnel.

Palavras-chave: Ensino; Atenção Primária à Saúde; Formação de Recursos Humanos; Profissionais de Saúde.

CONCEPT AND BACKGROUND

The health care courses at the Federal University of Paraíba - UFPB are in process of implementing the new educational projects - PPP, based on the National Curriculum Guidelines - DCN. Thus, the current formative process of these courses has been influenced by the need for changes to the understanding of the health-disease process and care production, which was previously biological and fragmented. These projects point to a new form of experiencing teaching practices and provide an institutional moment that favours the inclusion of courses in the health service network, particularly in Primary Health Care. The educational projects include internships throughout the course, starting in the first year, encouraging the educational problem-solving practices and the generalist profile of professional training. These are clear examples of the favourable conditions for reorientation of professional health training at UFPB.

Faced with this new training reality, which focuses on health service spaces, in 2005 Municipal Health Department created the João Pessoa School Network, consisting of the services that serve as the learning scenarios for partner educational institutions. This involves teachers, students, administrators and the community, with the aim of facilitating closer ties and coordination between the services and education institutions in the municipality. Currently, all teaching activities, including research and extension, developed in the municipal health network are put into effect through pacts between teachers and service workers, and later authorized by the School Network in an effort to ensure these activities are contextualized and responsive to the real needs and demands of workers and the community.

In the case of the UFPB Physiotherapy course, its current PPP was reformulated and approved in June

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2005, according to resolution 12/2005 of the Higher Council of Education, Research and Extension - CONSEPE. Although there has been an advance in the design of a professional profile for the physiotherapist compatible with current needs, some features of the curriculum, as well as the organizational structure of the University, restrict faster progress. Despite the curricular innovations with the implementation of this PPP, one can see remnants of fragmented training, such as the names themselves of the disciplines, based on dysfunctions of the systems to be studied and the lack of coordination between physiotherapeutic care activities and other health courses.

The learning experiences in care, developed in the course, take place predominantly in hospital and outpatient clinic environments. However, Primary Care work experiences, beginning in the fifth semester for all professional disciplines, are being developed in order to adapt the acquired knowledge to the needs of the work place. These experiences have enabled students to interact with the family health teams and enjoy better contact with the users, through house calls and training groups, with a preventive and health promotion approach, without losing sight of the huge specific care demand, which characterizes the core physiotherapy activities.

Some difficulties related to these Primary Care experiences have been identified in the course of this process, in terms of the profile of the teachers to work in these spaces, the integration between the students of the UFPB various courses and between the students and the team, and disruptions in the actions jeopardizing the resolution of some treatments. It is evident, however, that the experience of this new approach of academic training, although still under the process of construction, is beneficial to both students and community service workers. While the academic is trained for an area on the rise in physiotherapy and plunges into the complexity of primary care, the family health teams and the community learn about the role of physiotherapy and enjoy its contributions toward care production. One can attribute such fragilities faced to the teething problems in the coordination between UFPB undergraduate and the João Pessoa service network.

Service-learning integration can be defined as

> "the collective, agreed and integrated work between students, health education teachers and workers who compose health service teams, including managers, aimed at quality individual and collective health care, quality professional training and development/ satisfaction of the service workers "[1](p.357).

In this regard, the event entitled "Extended Primary Care Workshop" is a tool used by the discipline Internship II – Collective Health, supported by the Physiotherapy course coordination. It aims to provide students of all UFPB undergraduate health courses the chance to discuss and review together with family health workers and local managers the knowledge developed during their work experience in Primary Care. It therefore presents an opportunity for professional training and the construction of interdisciplinary practices, for students, teachers, workers and managers of the health care network, in line with the National Policy for Continuous Education - PNEP[2]. It addresses undergraduate training issues associated to the everyday routines of the teams, adopting practical experience and challenging situations that transform health work, stimulating those involved to play a major role in building team knowledge and expanding learning spaces outside the university.

HISTORY OF THE WORKSHOPS

One challenge for the physiotherapy course to overcome is its insertion into primary health care. The students of have experienced this challenge first-hand, from the fifth semester of professional health care courses up to the collective health internship during the eighth semester. In this reality, the students have encountered many difficulties in providing assistance to users and working with the family health teams, due to training that still focuses primarily on preparing the professional to work in outpatient clinics and hospitals. The student has therefore been faced with a work scenario that exposes other complexities inherent to the life and lifestyle of people in the areas.

Public health care management in Joao Pessoa has, since 2004, been implementing a life-protection health project. Some proposals are inserted in this management model, among them the implementation of matrix support and reception, the organization of attention based on lines of care and the construction of therapeutic projects. As from 2008, 13 Family Health Support Centres (NASF) were

also installed. Physiotherapy students inserted into the municipal health services therefore work in line with this model of management, care production and its devices.

In the second semester of 2008, students involved in this internship were faced with several queries regarding topics such as referrals and counter-referrals, reception, support networks in the work process in Physiotherapy, interdisciplinary care, the model of physical therapy assessment in primary care and about performing group therapeutic work. Faced with the challenge of building this knowledge and exchanging information with teachers, other students and with the service workers and management, the students and teachers of Internship II proposed the holding of the 1st Primary Health Care Workshop in March 2009, with the theme: "The challenge of physiotherapy practice in Primary Health Care (PHS)."

The meeting was attended by about 90 participants and aimed to describe the weaknesses and challenges encountered in physiotherapy practice in Primary Care. The result of this experience was referred to the Physiotherapy Department, the PHS internship committee, the pedagogical board of the course, the course coordination, the academic centre, as well as the education management of the João Pessoa-PB municipal health department, and was published in the second edition of the book *Fisioterapia na Comunidade*, published by UFPB.

The second Primary Health Care Workshop was motivated by the discussion that permeated UFPB health care courses, involving academic training reorientation programs for the area of health, aiming to better prepare professionals for the SUS. This debate gained momentum among collective health student interns in the first semester of 2009, which led to the proposition that the Primary Care Workshop needed to reach other UFPB health courses, as they face difficulties in their insertion and work in primary care.

Some authors, studying the changes in DCN implementation in the undergraduate courses in Nursing, Medicine and Dentistry at UFRN, have suggested that the focus on family health occurs in a one-off, defragmented and decontextualized manner in the new PPP courses involved in the research. They have also observed differences in the theoretical understanding of fundamental concepts for the training of health professionals. They conclude that the interviewed students of the courses find it difficult to carry out health promotion activities at the health units and in their catchment areas, when faced with situations that require complex resolutions. They also tend to feel powerless, frustrated and useless for ignorance or lack of practice in applying the principles of comprehensive and intersectorial care[3].

As mentioned earlier, institutional and government initiatives aim at and encourage changes in health care training, and UFPB is involved in this process with the National Program for Professional Training and Reorientation in Health (Pró-Saúde) and the Health Work Education Program (PET-Saúde). In 2008, the integrated proposal of for the courses in Physical Education, Pharmacy, Physiotherapy and Nutrition was funded by Pró-Saúde II. The objective of the project is to join forces with Pró-Saúde I (Nursing, Medicine and Dentistry courses) and develop an integrated referral model between the health service network in João Pessoa and teaching practices of UFPB, aiming to transform the realities of service and learning, based on the change in the training process, from a problem-solving, interdisciplinary and cross-functional perspective.

Therefore, the decision was made to hold the Extended Primary Care Workshop, organized by academics of the Internship II - "Collective Health" discipline of the Physiotherapy course at the University, supported and included in the activities proposed by Pró-Saúde II, since it was connected to all the courses in the area of health and was focused on the reorientation of training. This meeting was held in November 2009 and was attended by about 100 health care students, as well as service workers and health management of the Municipal Health Department of João Pessoa. The workshop was held at the Federal University of Paraíba and deepened the discussion of the central topic of Primary Health Care, adopting the theme "(Re)building practices and integrating knowledge."

The number of vacancies for all courses in the area of health was one of the novelties of the Second Extended Primary Care Workshop. This initiative aimed to integrate these future professionals, who are key players in primary care, promoting dialogue across the board in their academic training, and incorporating the principles of Primary Health Care in Brazil and the broader concept of health. This workshop also aimed to provide scholars with the chance to expand their knowledge about working in primary health care, from the preparation, execution of the work process and organization of strategies to solve problems encountered by family health teams; to promote

learning among interns about the preparation of an event that allows dialogue and integration among university students and about the Unified Health System (SUS), in a more extensive and democratic manner; to strengthen relations between the University and the health service and enable the construction of collective thinking/action on health, in such a way that actions can be agreed and valued.

The third workshop was motivated by interests that permeate practical experience in the area on ways of organizing health service practices, developed as part of primary care. Thus, investment in this new event takes on organizational characteristics similar to the previous one, because it intends to join together education, service and management in the debate arena, but has specific aspects in that it aims to discuss current issues in the National Primary Health Care Policy and other policies related to it.

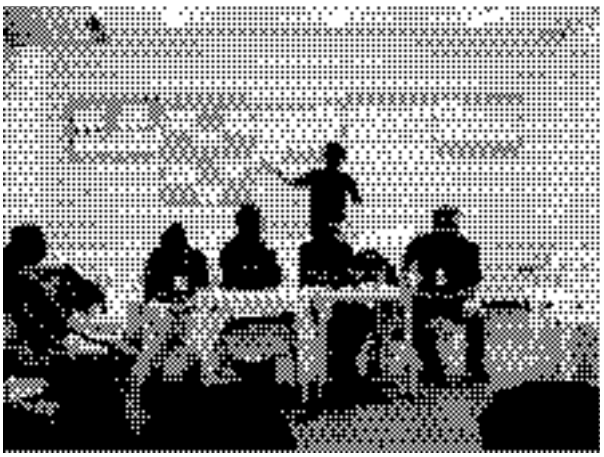
In recent decades there have been a series of reflections, circumstances and expectations for the entire Brazilian population, especially when considering the government's commitment to ensure means of promoting health in society. One of the strategies to increase access to health services in Brazil is the Primary Health Care scheme, which, according to the National Primary Health Care Policy[4], is characterized by a set of health actions, at an individual and collective level, which cover the promotion and protection of health, disease prevention, diagnosis, treatment, rehabilitation and health maintenance. Although the concept of Primary Health Care being established, there are still many controversies and disputes regarding this issue, especially with regard to the practices of workers who are not yet included in the basic team and currently work toward Primary Health Care through the Family Health Support Centres - NASF.

Linking this issue to the main questions that emerged through the students' experience of inclusion in family health teams in the first semester of 2010, there was a perceived need for further discussion on this topic, hence the Third Primary Health Care Extended Workshop was held in June 2010, with the theme: "The living work of Primary Health Care: from the reception to the significance". The event was attended by 132 participants, composed of: 93 students from UFPB health courses, 21 municipal team workers and managers and 8 UFPB teachers.

The workshop addressed four themes of utmost importance to Primary Health Care, in the context of the local conditions: matrix support, the role of professionals in the NASF; reception and access to health services and teamwork at the UBS. Below are some moments from the event.

Opening of the 3rd Workshop

Working Group at 3rd Workshop



Final presentation at 3rd Workshop

Student organizers of the 3rd Workshop

Each working group (WG) used as a starting point one objective and one challenging issue and was instructed to highlight the strengths and weaknesses found in the practices related to the theme, identifying strategies for overcoming them. Based on these instructions, each facilitator developed the work methodology of his/her WG. The contributions of this last workshop are broken down in the following paragraphs and are currently serving as a parameter for reorienting Pró-Saúde II actions.

WORKING GROUP I – MATRIX SUPPORT

concept and context

The expression matrix support is composed of two operative concepts. The first term suggests a way to operate the horizontal relationship between subjects through the construction of several transversal lines, applied to the health system; it also suggests a methodology for ordering the relationship between referral and specialist based on two-way procedures and no longer on authority[5]. The second term indicates a radical change in stance of the specialist in relation to the professional that demands his/her support. In the theory of health systems, which establishes a difference of authority between those who refer a case and those who receive it, the primary level addresses the secondary and so forth, including a transfer of responsibility upon the referral[6].

Thus, the matrix support is configured as a specialist technical support, which is offered to an interdisciplinary health care team in order to expand their field of work and qualify their actions, and may be executed by professionals from diverse areas[7]. This work methodology complements that set forth in hierarchical systems, following those that treat knowledge as mechanisms of referral and counter-referral, protocols and regulation centres[8].

The matrix support strategy emerges so as to rethink the logic of the health/disease process. Contributing with the extended clinic, which involves regarding disease not as occupying the main space in the subject's life, but rather as part the subject's life, thus centring health care on the subject rather than on the disease. The subject cannot be reduced to an object, given that the subject is a biological, social, subjective and historical being[9].

The matrix supporter is a specialist who has a nucleus of knowledge and a distinct profile from that of other referral professionals, but who can add knowledge resources and even contribute with interventions that increase the capacity to resolve health problems of the team primarily responsible for the case. Matrix support intends to build and initiate spaces for active communication and knowledge sharing between referral professionals and supporters[8].

The Municipal Health Department of Joao Pessoa - SMSJP adopts matrix support in its health management practices and the Family Health Support teams were also implanted from a matrix support perspective, which is identified by the SMSJP as an important advance in the daily monitoring of teams and support participation in continuous education activities.

Thus, the SMSJP continues to invest in matrix support as a foundation of its health management and coordination of Specialist Services and Primary Health Care. However, issues such as identifying the difficulties and possibilities of work organization within a matrix support framework, remain at large in the local setting and guide the WG's objective, which is to review the management-technical practice of matrix support through detailed analysis of the experience of João Pessoa - PB.

the workshop

The facilitator, physiotherapist and Director of Health District II / SMSJP began the WG's activities with a presentation, and then triggered a debate by asking questions on the topic for participants to develop their ideas on the matter, namely: What do you understand by Ma-

trix Support? How is Matrix Support work performed? What are the difficulties and potentials of organizing work in a matrix framework? The methodology used worked well, seeing as the debate flowed freely, arousing the interests of the group over as the questions were tackled.

the product

At the end of the debate, the participants were able to identify the strengths and weaknesses of matrix support, which were used to construct these next steps:

Table 1: Final product of the matrix support WG

Strengths	Weaknesses	Next Steps
Health service network connected to Primary Health Care Multi/interdisciplinary work to ensure comprehensive health care. Specificity in the work, guaranteed through actions of each worker's knowledge. Reflection and changes in care practices, focusing on the user, comprehensive care, equity of care and easier access.	Working conditions in the FHS are still poor and inadequate, both in terms of UBS facilities and worker training and value. Training of professionals is fragmented and still guided by the biological hospital-centred model. Resistance against and difficulties in teamwork, reflected by hierarchical (physician-centred) and fragmented care Difficulty in implementing the organizational model to support matrix framework. Weakness in dealing with conflict and interpersonal relationships between family health workers in PHC.	Intersectorial coordination and action for effective health care network, aimed at joint actions with other important public policies such as education, employment and income, urban infrastructure, etc. Invest in professional training that values the SUS and its principles of service-learning integration. Further discussions on matrix support from different theoretical frameworks. Propose flexible, responsive and dynamic matrix support, according to the needs of the context where it is inserted. Learn about the specific characteristics of the health catchment area, to help sustain matrix support. Improvement in working conditions (structure, resources, job training) to enable more effective performance of the worker.

Source: Final Report of the Third Extended Primary Care Workshop/UFPB

WORKING GROUP 2 - FAMILY HEALTH SUPPORT CENTRE

concept and context

The Family Health Strategy Support Centres - NASF, created by Ministerial Decree nº 154 of 28 January 2008, propose to support a matrix-arranged team linked to the family health teams in order to broaden the scope of Primary Care actions, helping to organize the demand and interacting with the public to achieve a new understanding of the health-disease process. The NASF guidelines include the concept of belonging to operate in the territories assigned to the teams[10].

A NASF should consist of a team, in which the professionals from different areas of expertise work together with professionals from Family Health (FH) teams, sharing and supporting health practices in the territories under the responsibility of those teams. The composition should be defined by the municipal managers and FH teams, by criteria of priorities identified based on local needs and availability of professionals from each of the different occupations. The NASF is not a gateway to the system for users, it is not a centre or strategy for individual care, referrals or counter referrals by family health teams, but rather for team support[11]. According to Ministerial Directive 154, the definition of the professionals to form each type of NASF is the responsibility of the municipal manager, following, however, priority criteria identified based on local needs and the availability of professionals from each of the different occupations[11].

Experience with the NASF has proven relevant both in terms of expanding health care for people, and learning for the academic training of future professionals in academic, since it enables students first-hand experience with the range of demands that run through the SUS network services.

The experience of the NASF in João Pessoa is based on the concept of matrix support. Different professional categories form the NASF teams, yet the work of these teams has focused more on managerial support than on the clinical dimension.

The WG about the NASF therefore aimed to analyse the activities carried out by the professionals who effectively make up the NASF, looking to perform clinical and managerial activities. To this end, the following question was proposed: "How should we configure the NASF, based on the reference of the activities developed with a view to a work process that aligns management and extended clinical activities?"

the workshop

The facilitator of this workshop was a matrix support worker from the Health District II / SMSJP and tutor of the multiprofessional residency program in family and community health - UFPB / SMSJP. The first round of the workshop began with an introduction activity for the participants entitled: baptized miner, in which each participant introduced him/herself and made a gesture representing an activity he/she enjoyed doing, and then the rest repeated the name and the gesture.

Later, the facilitator, in order to capture the main demands brought by the participants proposed that each of them write on a piece of paper their understanding of the topic NASF and/or what they wanted to know. The papers were placed in a bag and mixed so that each one of them could pick one out randomly and read it out. As the participants read out the messages, the facilitator noted down the main points, which would serve as input for the discussion.

Once all the reading was done, the actual topic of the NASF was addressed. A brief historical overview of the implementation of the theoretical foundations of SUS was presented, up to the work model proposed by the NASF. It was an informal presentation, open to all participants to contribute or to ask questions. In the afternoon the discussion was resumed; together with the facilitator and the group rapporteurs the participants prepared the work, highlighting the steps to be exposed at the final presentation. A final review of the activities was carried out to wrap up the work of this group.

the product

The table below shows the product of the discussions about the strengths, weaknesses, and next steps, prepared by the NASF WG.

Table 2: Final product of the NASF WG

Strengths	Weaknesses	Next Steps
Capacity to shift professionals from the curative framework and insert them into other forms of care production. The NASF encompasses the concept of matrix support in its work, thus demonstrating care and management actions, which supports its profile as an innovative program. Possibility to combine practical alternatives to the conventional work process executed by the family health teams. Discussions between family health teams - supporters - District, using management focus in order to think up strategies for family accompaniment.	Lack of disciplines in some undergraduate courses aimed at addressing issues concerning the field of primary care, which is often only possible through student participation in extension projects. Shortage of investment in research aimed to evaluating the effectiveness of actions developed by the NASF so that it can be validated as a strategy. Heterogeneity for NASF practice in different cities. Lack of continuity of public policies with changes of government.	Broadening the discussion about the NASF, and the SUS, at the university. Implementing content and practices in undergraduate training about primary health care (NASF, matrix support, notions of SUS financing). Importance of conducting research that shows the effectiveness of the NASF program. Ensure that at the units within the school network the services are presented (health district) and closer ties between matrix supporters and students.

Source: Final Report of the Third Extended Primary Care Workshop/UFPB.

WORKING GROUP 3 - RECEPTION

concept and context

Reception is an action implemented in some municipalities, aiming to reach the goal of providing health services based on technical, ethical and humanistic criteria. Reception, in the context of health services, is to welcome, listen to the demand, look for ways to understand the person and sympathize with her. This should be done by the whole health care team, in every relationship that involves the health professional and the person being cared for[12].

Reception was included as a base element of the work process in health care centred on light technology, which refer to care in its broadest sense, not requiring specific professional knowledge. This differs from the current organization of health services, focused on hard technologies, intrinsically dependent on equipment and light-hard technologies, characterized by the control of a specific core of knowledge, such as medical or nursing consultation[13].

The term "access" involves a variety of facilitators and barriers for access to the resources people seek. Socioeconomic and demographic factors were considered major de-

terminants in the pursuit and use of health services, mediated by secondary categories, including family, social support, health needs and characteristics of the available services[14].

The analyses and alternative solutions to the problem of access, in strictly quantitative terms, such as number of consultations and professional performance, are shifting toward qualifying the problem upon reception of the user. The issue is not restricted to how many ways in are available, but above all, the quality[15]. Reception has been implemented as an activity, with a specific time and objective to be achieved - ensuring access to users - to be performed by certain professionals, depending on the service, and in a specific place for this purpose, which expresses the reduced notion of reception as a way to organize the supply of the services[16]. In this conception, reception becomes more an instrument of criteria change making appointments for consultations.

These findings lead to the reflection that reception must be considered as an instrument that incorporates human relations, suitable for all health professionals in all sectors, in each sequence of actions and modes that make up the work process, and not limited to the act of receiving[17]. The Family Health Strategy's incorporation of new forms of organizing work in health is one way to accomplish a set of propositions that define it, as well as a need to consolidate it as a strategy that intends to reorganize the SUS based on Primary Care.

Thus, reception can be understood as a form of work organization in health and also as a desirable attitude in the activities of all health professionals, especially in Primary Care. Reception has been implemented by health care management in Joao Pessoa at the Family Health Units in a gradual manner. The implementation process began with workshops and meetings to give a theoretical support to the proposal and raise awareness among the teams of its validity as a device capable of qualify the assistance. Some teams are at an advanced stage of implementation, while others are still in discussion about beginning implementation.

The WG on reception was to evaluate the experiences of implementation of reception in Joao Pessoa, highlighting the advances and setbacks. The question proposed to challenge the theme was "How can the practice of reception be integrated into the provision of services, aiming at interdisciplinary action?"

the workshop

The working group was facilitated by a teacher from the UFPB Social Work Course and developed in two stages. First was a slide presentation was made, setting the foundations of the theme. In the second stage, a discussion circle was formed and the participants attempted to list the potential strengths, challenges and next steps.

the product

The result of this WG's discussions is presented in the table below. Regarding the weaknesses of reception, these were scored on two criteria: employee training to implement this mechanism and the service infrastructure.

Table 3: Final product of the Reception WG

Strengths	Weaknesses	Next Steps
Guaranteed equality in service provision.	Poor understanding by workers, user and managers of the	Workshops of this kind in the context of the service.
Encourages curricular changes to undergraduate courses.	Humanization Policy.	Conduct a process of evaluation, mapping and monitoring of reception experiences.
Political willingness of workers to implement policies at family health units.	Poor adaptation of methodology for adoption of policy by workers.	Create spaces for exchange of aforementioned experiences.
Broadening of the service-learning relation.	Lack of training opportunities about humanization and work process.	Socialization of research involving humanization and reception process.
Better service, care and access for users.	Working conditions incompatible with implementation of the reception strategy.	Improved operation of health units (Primary Care, medium and high complexity).
More valued relationship constructed with the user.	Difficulties in mediating with the private-public sector network	Strengthen and improve the referral and counter-referral system
Accountability of workers with users.	Materials incompatible with reception strategy (lack of ambience).	Strengthen intersectorial network relations.
Team and user empowerment.	Lack of dialogue between referral and counter-referral.	Encourage public participation to identify the standard of reception the population wants.
Coordinated fields of expertise in user care.	Weakness in the discussion on the work process (discussions are one-sided).	

Source: Final Report of the Third Primary Care Extended Workshop /UFPB.

WORKING GROUP 4 - TEAMWORK IN FAMILY HEALTH CARE

concept and context

The Brazilian public health system emphasizes the importance of teamwork, in that it establishes the creation of cross-functional, integrated groups as critical to the development of the family health program work[18]. In the Family Health Program, the health service production unit is not one single professional, but rather a team, and the central focus of attention is not only the individual but on the family and its context. Any required health interventions should consider the biopsychosocial determinations of the health-disease and care in the professionals' autonomy and accountability toward users, families and the community. Thus, the health care gains the central characteristic of a complex, collective effort that seeks interdisciplinary action[19].

Teamwork consists of a form of collective work that is configured in the mutual relationship between technical interventions and agent interaction. There are two types of team: integration team and grouping team, and the criteria for recognising the type of team relate to the communication between the agents, technical differences and unequal social valuation of specialist activities, formulation of a common care project, the specificity of each professional area, and flexibility of the division of labour and technical autonomy[20].

Teamwork should involve cross-functional engagement, in which each agent has a defined role and operational base, whether that be in PHC, in the community, or even together with the other team members. The connection between the actions and the interaction between professionals is essential to the configuration of teamwork. This way of producing health - integrating professionals - is regarded as a basic strategy in health care in the SUS, as it emerges as a means of transforming the production and distribution of public health care services in order to reorganise health care practices[21].

Therefore, the service offered by a family health unit should be cross-functional and interdisciplinary, in other words, in team work each professional is encouraged to participate collectively in order to produce results through the contribution of each profession. In the reality of João Pessoa, this is a characteristic and noticeable trait in the everyday work of the family health teams and the education activities developed in the network, since the matrix support, NASF and reception all depend on the correlated knowledge from the various health care professionals.

In this context, the WG that addressed teamwork in family health care aimed to identify elements that weaken and enhance living work in family health teams, based on the following challenge: How is the living work of health care professionals configured in family health strategies?

the product

The end product of the collective thoughts activity about teamwork can be seen in the table below.

Table 4: End product of the WG on teamwork in family health care units

Strengths	Weaknesses	Next Steps
Contribution of each speciality in the construction of comprehensive care. Biopsychosocial approach that considers a broadened view of the health-disease process. Complementary care actions through diverse professions. Different opportunities for health care interfaces. Learning from the knowledge of other professionals. Understanding of multidisciplinary and interdisciplinary collective actions. Possibilities of planning multidisciplinary and interdisciplinary collective actions.	Isolated, fragmented and inefficient work. Not knowing how to deal with personal and collective differences that interfere with teamwork. Resistance to admission of new team members. Isolated professional work in the care actions. Lack of communication among team members. Different interests within the work teams in the care action. Dealing with own personal limitations and those of others. Poor working conditions, and excess and diversity of roles and responsibilities. Improper use of the geophysical and functional space for planning team actions. Excessive health care demands and of high complexity. Lack of basic professional training for teamwork.	Encourage teamwork during academic training with a view to redirect the professional profile toward this work. Create moments of interpersonal experiences in teams to leverage integrated work. Encourage integrated and group care actions. Exchange of knowledge in multidisciplinary and interdisciplinary team actions. Build experiences on integrated curricula in the training arena.

Source: Final Report of the Third Primary Care Extended Workshop /UFPB.

the workshop

The methodology used by the WG facilitator (a lecturer at the Department of Health Promotion/CCM/UFPB) was a brainstorming activity, by organizing the ideas on cards to facilitate visualization. The ideas were developed through questions that prompted critical reflection by the group. Before coming to the discussion of group work, some concepts were discussed such as working, living work and the importance of teamwork.

FINAL CONSIDERATIONS

The Primary Health Care workshops have revealed the need to reflect and review health care practices, and seek to overcome the difficulties. The expansion of the workshop to other health courses proves the potential of the debate involving all the players involved the service network, ensuring the presence of workers, managers, teachers and students, enabling the identification of the possibilities and critical knots in service-learning integration.

The product of the working groups exposes issues regarding the service, management and teaching. In relation to the service, the outstanding issues refer to work process of the teams, such as, the importance of worker accountability by users, the potential of reception to tighten relations, the interpersonal relationship difficulties inherent to teamwork. As regards management, there are issues identified both in terms of national policy, such as the lack of continuity in health care actions resulting from changes in management, and in terms of the health care structure and wage policy.

Many of the issues indicated as difficulties, but also identified as next steps for overcoming the problems, are related to education. There was a strong idea present in the groups' work that changes in training can reflect in significant and profound changes in professional practice. In this respect, the main issues are the inadequacy of academic experience in Primary Care, the need for interdisciplinary experience in training, the need for research that may help to review health policies, such as the NASF proposal, and work in Primary Health Care.

We must also thank all the students who have committed to the changes in training and taken on, in magnificent fashion, the responsibility to organize the workshops and prepare the final reports. We would also like to acknowledge the contribution made by all the João Pessoa family health team workers and management staff toward the UFPB education activities. Finally, as stated in Creole by a student from Cape Verde at the close of the third workshop: "Ki Deus ta djuda nhôs!" (May God help you!), in the struggle to build a universal, equal and comprehensive health care system, with workers and managers committed to the Brazilian population.

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Social Work Residency at UFJF: Innovative Experiences of Service-Learning Integration in Primary Health Care of the Unified Health System

Residência em Serviço Social na UFJF: Experiências Inovadoras de Integração Ensino e Serviço na Rede de Atenção à Saúde do Sistema Único de Saúde

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Palavras-chave: Ensino; Residência; Serviço Social; Saúde da Família.

Keywords: Education; Residency; Social Work; Family Health.

INTRODUCTION

One of the greatest challenges facing the SUS is overcoming the profound inequalities in health. This entails resizing the State's role in order to actually bring health policy into effect, starting with the structuring, at a municipal level, of physical-conceptual spaces and the financial-economic and managerial basis for health care services. As regards professional training, the policies and actions that ensure personal choice for comprehensive dedication to the public service need adapting so as to help strengthen the commitment, accountability and relationship of the professionals in relation to the users of the health system.

The principles and guidelines implemented by the Public Health Reform were restricted by the State Management Reform (or counter-reform) with reduced public spending and privatizations, expressed in various formats, such as social organizations and intermunicipal health consortiums. Largely conflicting with the Public Health Reform, these alternatives contradict the principle of regionalization and actually support serious deviations in the SUS model, duly identified in the current health policies of the regional centre municipalities, along with significant advances in the process of decentralization and increased physical access.

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In light of these complex, contradictory and challenging circumstances, this article demonstrates Social Work training experiences in the Health Care Residency Programs of the Federal University of Juiz de Fora (UFJF). The pioneering creation of such programs, previously restricted to only the classic forms of medical and pharmacist-biochemist training, is officially credited to the Social Service Faculty of UFJF. This is because between the professors and researchers of the health area at this particular academic institution, there was a strong commitment to qualify professionals capable of dealing with the intricate relationship between politics, economics, care quality and management of public health services.

The historical course of this creative movement will be described here, presenting its objectives, forms of intervention and distinctive nature of the experience that dates back 12 years.

The Hospital Residency in Social Work was implemented in 1998 at the University Hospital – Health Care Centre (HU/CAS) with the intention of offering assistance work in hospital, outpatient and primary care services, guiding the residents to help them understand the various levels of complexity in the health system and strengthening the care quality provided to users. The underlying objective was to make use of the theoretical and practical experience of the hospital residency program to provide a space for training improvement, both in relation to health policy management and the work process followed by social workers in the health care team. The aim, therefore, involved increasing access and referrals to undergo specialist consultations and tests and qualified care for users through health education technology, in order to ensure the provision of information about the health and disease process and attainment of social rights.

The UFJF Residency Program in Family Health (RESF) began in 2002 on the back of a partnership between the UFJF Centre of Consultancy, Training and Education in Health (NATES) and the then Juiz de Fora municipal Secretary of Health, Sanitation and Environmental Development (SSSDA/PJF). As a proposal for service-learning integration, the RESF upholds the purpose of training human resources through work experience for the Unified Health System (SUS) and, above all, for Primary Care, based on the local reality. It has also represented a rich space for reflection, production of knowledge and qualification of health care.

In 2010, the Multiprofessional Residency Program in Adult Health was implemented, closely following the Residency Program in Family Health model, and was added to the set of Residencies in Clinical Analyses, Physiotherapy, Pharmacy, Nutrition, Physical Education, Psychology and Social Work. This *young* initiative adds to the others in the sense of promoting collective and interdisciplinary work qualification, as by numerically increasing the range of the Health Residency program, this considers the historical interest in relating the thirteen professions that form the health care field, as foreseen in the guidelines issued by the National Health Council in 1997.

The two UFJF Residency programs are funded by scholarship grants. The first, the Hospital Residency in Social Work, is maintained by UFJF funds; and the other two modalities, Multiprofessional Residency in Family Health and Multiprofessional Residency in Adult Health, are funded by the Ministry of Education (MEC). Both programs have complete work and remuneration equality, just as is practiced by the traditional medical residency model. These programs develop their teaching and care experiences at complex levels of the health system, serving each one specifically, as per the SUS guidelines and in accordance with the Social Work parameters for the health care area. The residency is a full-time (60 hours per week) program that lasts 2 (two) years, corresponding to 5,760 hours of work.

The Hospital Residency in Social Work develops service-learning integration in the HU/CAS – Santa Catarina and Dom Bosco Units - through individual and group works on the wards and special outpatient facilities, combining these efforts with primary health care.

The training of multiprofessional residents in Family Health takes place through their direct participation in Family Health team at two Municipal Health Units of Juiz de Fora (Parque Guarani and Progresso). The Multiprofessional Residency in Adult Health is also developed in the municipality, at the Santa Cecília Health Unit, through programmed contact at the secondary and tertiary care levels and also through the Specialization Course in Collective Health Research and Policies, that considers the two modalities of Hospital and Multiprofessional Residency in Family and Adult Health. The latter, Multiprofessional Residency in Adult Health, that involves activities similar to those developed by the

Family Health Residency, will not be considered in this article, due to the short time since its implementation (8 months).

Following the description of the existing programs, the conceptual bases of the ethical-political and pedagogical project that support the residencies work shall be presented. Three founding and guiding principles for the Residency Programs in Social Health shall be focused on, which have already been introduced in this work: service-learning integration, related technology aimed at care production and the integration of other UFJF courses.

CONCEPTUAL-THEORETICAL BASES OF UFJF SOCIAL WORK RESIDENCIES

service-learning integration

The following statements are supported by the theoretical discussions of Ceccim and Feuerwerker[1] and Albuquerque et al[2], that address the importance of permanent education in health and of service-learning integration, and whose orientations have guided the Residency Programs in Social Work, built over the years between 1998 and 2010. These discussions have become to conceptual and operational basis both in the HU/CAS space and in the basic health units, providing the main contributions to relations between learning and assistance by recognising that a space for intersection between service and learning is essential for the formation and consolidation of the SUS.

These discussions are based on the SUS values and the Code of Ethics for Social Workers. Internal to the debate and also evident in indicators are conflicts, difficulties, strategies and tactics that have unfolded for occupation in the care network, that upon implementation require accurate stewardship in order to ensure that the proposed principles are followed for this special kind of training developed in a simultaneous work and learning process.

Therefore, according to Albuquerque *et al*[2], constant interaction between theory and practice is sought, leading to critical review that becomes a requirement for the practice, without which the theory could be construed as a fallacy, and the practice as mere activism. The service-learning integration effectively occurs upon the uniting of teachers, residents and professionals from the various health care fields, focused mainly on the user in order to minimize the dichotomy between teaching and health care production.

The current intention is to reverse the direction of implemented user care, alternating, as per necessary, the costly flexnerian health care procedures of medical specialities, burdened by excessive medicalization, with related technologies centred on receptive attitudes and on the relationship with the user. Therefore, the idea is to practice care through prevention rather than cure, with the ultimate purpose of health work based on protecting lives and citizens' rights. In this sense the construction of disease control and health promotion actions and strategies, of continuous training and qualification, of education and communication in health, of comprehensive care, private-public sector interaction and equality becomes a part of the agendas and approaches for intervention of health care teachers, residents and professionals.

In this context, it is worth highlighting the role of the resident in health care. Whereas on the one hand social, economic and political factors determine to a great extent the structure and organization of the services, as regards macropolitical aspects; on the other, the care profile and functioning are given by micropolitical processes and the technological configurations of the work, through which health care production effectively takes place. It is therefore impossible to disassociate the proposed change to the technoassistential model suggested by the SUS from the changes in the training of health professionals. In this regard, service-learning integration becomes a privileged space for reflection on learning and care production.

The aforementioned authors observe important aspects in the dialectics of learning, directed at a user-centred model that is gradually transformed into the presence of new technological arrangements, sustained by the relationships among individual workers and between them and the users. It is often the autonomy of the health professional that determines the profile of the technical care model. Their freedom of action proposes changes capable of cooling the traditional health service organization processes. That is why any change in the care model requires, to a large extent, the construction of a new consciousness regarding sanitation and education and the adhesion of these professionals to a new

project that constantly adapts to reviews made of the procedures.

It is always important to achieve a consensus regarding the forms of work in line with the new care proposal, which is not possible through vertically established standards. Hence the emphasis on the permanent education process, grounded on the service-learning process, that invests in knowledge development aimed at user protection and the user's right to health care. This rests on the technological relations established through service-learning and aimed at health care production.

Service-learning integration, based on teamwork developed in residency programs, should be conceived bearing in mind both the development of collective and interdisciplinary competences and the strengthening the specific skills of each profession. Every residency educational process is built around the conception that the resident is capable of developing work together with professionals from other health care fields, focusing on interdisciplinary work to compose health care shifted from the corporate axis, cropped and reduced, to the plural, complex and user-centred axis[2].

For Ceccim and Feurweker[1], the intertwining movement within the cross-functional health team would, through the therapeutic resources and instruments of each body of knowledge and actions of each professional, offer the opportunity to form and construct collective intervention, consisting of each individual performance amplified or modified within a team-protected performance, with the goal of treatment projects responsible for providing solutions through health services and actions.

The proposal for permanent education arises from a central challenge, consistent with the intentions of service-learning integration, close to the heart of health care residencies. Learning should take place in a decentralized, ascending and interdisciplinary manner, in other words, at all sites, involving the whole set of knowledge available and developed through everyday interaction in health services. This is expected to result in more democratic work spaces, the development of learning and teaching skills of all actors involved, the search for creative solutions for problems encountered, the development of group and matrix teamwork, permanent improvement of the quality of health car and humanization of the service.

The concept of permanent education in health, adopted by the UFJF health care residency programs, notably for social work, offers the central proposal of establishing a close relationship between education, management, care and participation in this specific field of knowledge and practices, through the intercessions promoted by the health care education methodology (education *intercedes* in health care, renewing its learning technologies) and by interdisciplinary and cross-sectorial training (the alliance between fields of knowledge and the combined modes of intervention of public policies).

relational technologies and care production

The UFJF social work residencies, ever since the creation of their specific projects, have involved the implementation of relational technologies in the production of health care. Authors such as Merhy[3], Franco[4] and Ayres[5] have added contributions to the construction and implementation of these continuous training processes, offered in specialization courses, study groups for disciplinary integration and analysis of everyday experiences.

It should be stressed that relational technologies have always played an active part social work practices, regardless of the different names assigned to the profession over the course of its development. They have always belonged to the compositional design of the social service (theoretical foundations, principles, ethical guidelines, policies and methodologies and interventional understandings). They therefore represent an immediate support arm for intervention, according to the requirements of the specific field of work, as exemplified by health care in this text.

The relational technologies based on respect for human dignity, for different values and cultures, for denying any form of discrimination and prejudice and on people's right to receive all the information about their social status, over the course of time incorporate other indispensable principles, such as: the defence of democracy in general, of social participation and guaranteed citizenship in terms of civil, political and social rights, and of a commitment to maintaining a high standard of public services. These foundations, underlying the relational technology operated by the Social Service, are transposed to the health care field and establish the work

performed by social workers/residents and are continuously reviewed by supervision and monitored by tutors and preceptors of the practice in all three complexity levels of the health system.

Social workers, as professionals committed to providing care, are trained to build relationships with the user, making use of technological options, such as: teamwork, care production/assistance management, home visits and group work, which create a bond and a sense of responsibility in the user. Inherent to this is the knowledge that the act of caring is central to health work. By means of care production it is possible to attain health, which is indeed the desired objective, whether through individual or collective care, executed with user groups.

The singular therapeutic project, which involves relational and therapeutic technologies, is aimed at analysing health services as a space for understanding user flows, demands and needs by means of shared work. The aim is to compose a horizontal care model capable of absorbing the integrated health networks, relativizing the concept of hierarchical services, and forming teams receptive to user demands and needs.

The conception of health work that underlies social work residencies is expressed beyond traditional technological skills. Residency programs use the concept of light or relational technologies of the type that produce bonds, autonomy, reception, management, special and alternative forms of reinforcing the work processes, centred on the user's right to access to quality services.

The relational technologies usually developed by the Social Service in the various levels of complexity of the health system are: Education in Health or Emancipatory Education, Planning and Management, Teamwork, Collective Work, Information and Communication, Reception and Bonding Practices, Home Visits. All these are directly implied in the execution of research projects and updated in the acquisition of new learning from continuous social work studies.

Information technology and communication, teamwork, home visits, production of progressive care lines in the integrated health networks and horizontal, democratic management are all cultivated, to the highest standard, by the specific formation of the UFJF social work residencies, that involve the main instruments of intervention in their language and line of development.

social work residencies integrated into other ufjf courses

In 1988, through the FSS/UFJF, the University Hospital Collective Health Program was implemented. The intention was to combine social work hospital residency with a 360-hour specialization course. The aim was, and still is, to offer residents the opportunity to add investigative and theoretical reflection in the field of health care, the social service and collective work to their professional experience.

This project represented an unparalleled example of contribution toward human resource training that UFJF was able to bring to the sphere of Brazilian Federal Universities by defending a training project centred on interdisciplinary and complementary health work processes. The Specialization Course is currently the basis for hospital residency programs in: social work, psychology, nursing and clinical analyses and multiprofessional residencies in Family Health and Adult Health, and also involves the courses in Management, Economics, Physical Education, Physiotherapy and Nutrition.

Moreover, the residencies reinforce the training that takes places in the space devoted to undergraduate internships, when students from different professional disciplines share with residents the social work and health practices in the wards and outpatient clinics, participating in thematic discussions regarding the social service and health policy and adding depth to the embryonic elements of the collective work process.

Twelve years since the implementation of the social work residency program and specialization course, gaps can still be found in terms of interdisciplinary training. Some professions tend to remain somewhat guarded behind closed doors, preserving their specific expertise and work methods. In these cases, it is fairly common to observe attempts to reinforce corporate stances or shield themselves behind their respective codes of ethics when they are unwilling to share information, want to maintain the power relations in place or even ensure that management of the health care institutions remains exclusively in the hands of the medical profession, which is historically considered the natural leadership in the health care environment.

Sharing everyday routines in the same work space combined with attending the same specialization course

gradually started to minimize the differences embedded during undergraduate study. Now, such singularities are beginning to be reviewed through the MEC policy, aimed at achieving comprehensive training, as can be seen in the multiprofessional residency programs. The first of these was created in 2002 and has been assessed in positive light by several published studies and dissertations that portray the everyday work routine of the Family Health Strategy. The second, recently created, Multiprofessional Adult Health Residency, which is currently under its first review, has already proven its worth despite the lack of facilities and human resources typical of the current municipal health management of Juiz de For a.

In order to resolve the myriad health problems, integrated and collective discussions and reviews are needed, allowing the problems inherent to the development of the different disciplines to be tackled, and creating an adequate space for building therapeutic projects. The groups, working in hospital wards and outpatient clinics, are now strong components of the hospital residency and are partly coordinated by the Social Service or by social workers belonging to the work teams. In order to transform the relations with users and other health professionals, there is nothing better than joint review from a multi-focused and consolidated perspective through the implementation of thematic studies and research projects.

It becomes evident that only recognition of the thirteen health care professions by the National Health Council in 1997, although fundamental, is insufficient if no support is provided for an education policy and methodology that aim for integration of the specific knowledge sets of each of them.

The creation of the Specialization Course added to the HU/UFJF and the family and adult health multiprofessional residency programs is, without a doubt, an important space for enabling such integration, but requires reinforcement by service-learning integration methodologies that follow the proposed innovations resulting from the everyday practice of health services.

The specialization course aims to qualify health professionals with the ability to reflect on: the context of the practice, the adoption of a critical posture in relation to the work and knowledge acquired, the integration of different knowledge sets in health care action planning and focus on teamwork, and the exercise of working in an ethical manner, extending their dedication beyond cure and towards disease prevention and health promotion.

That is precisely why the overriding objective of this aggregating experience is to shape the teaching so that it is always aimed at ensuring understanding by the professionals of the needs presented by the health service user public.

TRAINING SOCIAL WORKERS IN THE UFJF MULTIPROFESSIONAL RESIDENCY PROGRAM IN FAMILY HEALTH CARE

The learning process is supported by strategies structured on interdependent and complementary "axes" that interact and translate the various residency training possibilities. These different "axes" include:

theoretical-methodological reflections and discussions

It is our understanding that in their everyday work, social workers require a theoretical-critical grounding for precise comprehension of the reality, revealing the contradictions that have emerged within society and in health policy.

Any qualified health care professional should have a reasonable understanding about health policy and its implications for the social service in order to make concrete mediations between professional demands and responses.

> The distance between professional practice and theoretical content of the professional reality, resulting from a lack of critical interpretation of how the reality moves, reveals opportunities wasted by social workers and other health professionals in relation to the different practice possibilities that could be captured in the reality in which they perform their actions, in redirecting public policies toward user interests[6]. (p. 254)

Drawing on this understanding, discussion spaces are set up so as to ensure constant communication and exchange of experiences and theoretical-methodological reflections between academic and service experts and

residents. The following activities are organised under such an approach: a) Monthly meetings for residents and preceptors – these meetings address issues relative to the functioning of the residency program, defining social work actions, exchanging work experiences developed at health units, review of the inclusion of social work in the residency program and the activities developed by social work residents; b) Study Group (General) - the study group is also a monthly activity. This group brings together all the residents and preceptors, constituting an important space for theoretical thoughts and exchange of knowledge. The discussion topics are defined together with the residents, in accordance with the needs they feel for deeper theoretical understanding; c) Study Groups (Per Health Unit) - study groups are held at the units at two different times. There is a group of teams that discusses cases seen in the units and another that brings together all the social workers for a discussion regarding the topics defined according to the needs of the service; d) Participation in Congresses and Seminars – residents and preceptors are encouraged to participate in such events, as an excellent way of staying up-to-date. In these events, we also seek to present works relative to the activities produced in the family health residency program (RESF).

The activities proposed on this axis are aimed at professional qualification and updating, since a social worker's activity is directly linked to the social reality and movement of society. This concern is manifest in the sense of "ensuring" a fundamental principle of the Code of Professional Ethics which is to guarantee service quality for the public.

assistance to users and families

In the assistance for users and their families, we draw on the understanding that these people hold rights and should be cared for based on the principles of the SUS.

The objective of the work performed in APS is to socialize information and ensure the fulfilment of rights, seeking to contribute to the collective distribution of demands, service access, public participation, granting users autonomy to cope with their lives, in short, the practical application of the principles of the SUS and the PSF.

Residents participate in different actions in the health units. These include: individual and collective care for users and families; referrals of users and families to social assistance resources; advice on rights and social and welfare benefits; home visits; planning and participation in arranged groups - pregnant women, SAD (Home Care Service), Reproductive Rights, among others.

During the assistance services, the social worker attempts to identify the user's family background, welfare and employment situation, housing conditions, basic sanitation and knowledge of the health-disease process, any barriers to accessing treatment and care options.

Based on this review, individual and group advice is given, including clarifications and referrals for insertion in social programs and benefits such as the basic food basket, family allowance, social security benefits, social care and other user rights, and referrals to the health and social care network; advice regarding mental health and relationships with family members and the wider community.

Iamamoto[7](p.176) points out that in their professional exercise, social workers intervene in everyday relationships, expressed by the manifestations of social issues and "experienced by social individuals at work, in the family, in the struggle for housing and land, in health, public social welfare, etc".

Buss[8] shows that the main health problem in Brazil is unequal health and social conditions, and difficulties in overcoming these obstacles. Therefore, the health service clearly requires the insertion of a professional whose training has been focused on the living conditions of the public and the formulation of social policies.

participation and social control

From the perspective of social control and participation, the residents participate in the University Extension Project "Health Promotion: Shared Construction", the main objective of which has as main objective is to develop actions that strengthen community participation and their capacity to make effective interventions.

The project arose from the need to expand Social Service intervention and create new alternatives and possibilities of resident training. It emerged, therefore, through the Social Service's commitment to increasing community participation in defence of their health and quality of life and to the training process of the residents.

We understand that this experience of university extension has represented a rich training ground for

residents and an effort by UFJF to expand beyond its boundaries. According to Iamamoto[9] "the extension consolidates and broadens the political dimension of the university - at the service of the community - democratizing it and reverting its activities in an effort in the public sphere."

In addition to participating in the Extension Project, the residents partake in the Local Health Councils (CLS) advising the Councillors in their struggle to ensure their communities the right to health care.

We can also highlight their role in Health Councillor Training Projects. We note that such projects entail a level of concern regarding the safeguarding of democratically available information, working towards contributing to the "users appropriating categories of intellectual property analysis, so that they can, as far as possible, place themselves critically before their everyday experience and participate in the political struggle to defend their interests'[10].

The intervention process through the Councils is of utmost importance, as the Health Council represents a stage for struggles between conflicting interests, which express different societal projects and different directions for health policy. And "the segment that represents the subordinate classes could intervene so as to avoid the commercialization of public funds"[11](p. 127), helping to ensure that the resources are spent on caring for the public's real needs and "are not placed at the mercy of elitist, private interests and/or "electoral herds"[11] (p.135). Mioto and Nogueira[12] add that platforms for community participation are essential to the process of public sphere construction.

surveys and research into socioeconomic and sanitary conditions

We understand that access to data about the economic, political, social and cultural conditions of users is essential when working with the concept of health as a result of living conditions. We believe these data are important for the identification and analysis of the factors involved in the health/disease process of users, at both an individual and collective level.

In this light, we have encouraged residents to incorporate this activity into their daily work. Among the various surveys conducted, we highlight three, either on account of being experiences of team work between Health Units, or for being associated to the University Extension Project: a) Participatory Social Diagnosis; b) Survey of Community Social Resources; c) Children and Teenager Profiling.

We have also encouraged the residents to participate in Research Groups of the School of Social Work. Residents are currently beginning to participate in the research study entitled "(Re)building Primary Health Care in Juiz de Fora/MG: accounts by managers and users of public health services".

production of technical material

The residents have invested in the production of workshops for training Health Councillors for the University Extension Project, as well as for the existing operative groups in the units. The development process of these workshops has represented a special moment, for it is a chance to test the residents' capacity in terms of theoretical reflection and creative capacity to propose work methodologies that transform the meetings with users into platforms for discussion and debate.

planning and work organization

Vasconcelos[13] notes that the definition of professional projects and the possibilities of attending to demands should be attributed to the social work professional. That professional should be responsible for creating the services to be offered, based on the institutional movement and demand by its users. The work should not be centred on attending spontaneous demands, but, to the greatest degree possible, on collective strategies.

> It is the social workers, due to their professional training and the position they occupy, who are able to critically evaluate the wealth of data and information that accumulates and/or can accumulate about institutions, segments of the public and the everyday routine of their practice. They are permitted access to files, to all kinds of documentation, data resources, research projects [...], and can create time, space, routines,

> different activities, aiming at a quality practice. They are responsible for conducting surveys, research, producing knowledge about the institutional movement, about the service itself, about the data relative to assistance given to users [...], explaining the trends in the social reality addressed, they can take a critical stance and define priorities, strategies, alliances, limits and possibilities, evaluating the consequences of the actions taken[13]. (p. 144, our translation)

Residents actively participate in the whole planning process of the working teams. To this end, general meetings and team meetings are held weekly with all professionals, in addition to the meetings split by category. The general meeting addresses administrative matters, whereas the team meetings discuss specific cases, ACS demands and planning. In addition to the general and team planning, the residents also participate in the specific social work planning.

education in health care

We understand that Education in Health Care occupies a privileged space in social worker intervention and as such, permeates all the professional's actions. It is from this standpoint of demarcating this "place" of Education in Health Care that we attempt to train residents. We reinforce that, in the APS, education in health care is a special feature of Social Work, as the professional understands the health/disease process based on a reflective outlook of the relations between psychological, cultural and socioeconomic factors. Referring to participatory techniques, he understands education in health and access to information as a right.

According to Assis[14], education in health care goes beyond a process of transferring information, as it entails the training of individuals and groups to transform the reality into which they are inserted. This perspective draws on the critical capacity to question the vertical transmission of knowledge and information, valuing popular knowledge through a relationship of exchange and dialogue that produces redevelopments, closer relations and learning between professionals and users.

HOSPITAL RESIDENCY IN SOCIAL WORK: TWELVE YEARS OF EXPERIENCE IN HEALTH EDUCATION

background

The Residency Program in Social Work, approved in 1997, aims to: train social workers at *latu-sensu* graduate level, with a view to continuous education and knowledge relative to health; contribute to the integration of professionals within an interdisciplinary, complementary perspective between social and biological knowledge; deepen their knowledge of teaching practices; stimulate research; plan, implement, intervene in and evaluate care programs in the areas of the university hospital; expand knowledge in health, train professionals to generate knowledge and provide benchmark assistance in the teaching hospital.

The residency is the learning space in which social work, while grounded on knowledge predominantly in health care, also presents to professionals of the field concepts from social and political understanding in relation to health. Therefore, it mediates two branches of knowledge that, as well as producing a mutual benefit, directly contribute to qualifying the assistance in the services, with direct answers to the population's needs[15](p.61).

This program intends to establish a paradigm that overcomes the poles of public health/individual medical care, or prevention and cure, to achieve a new quality of care, so that the population is able to understand the meaning of the right to health care and the proportions of the social inequalities. To this end, public representations about health, disease, health services, quality and the availability of professionals should be valued[15].

> Social work, as a discipline belonging to health work, has in its residency programs the greatest opportunity to broaden its own training - assimilating knowledge and practices relative to health care - and contributing with actions that require strengthening of the education and assistance process in the most diverse expressions of health and disease[15]. (p.58)

In the 1990s, the HU/UFJF social work made a jump in quality resulting from the consequences of discussions

held in the 1980s, with the establishment of the LOS, LOAS and the start-up of SUS operations, and the transformations of the profession that reviewed its objectives and defended the issue of a new Professional Code of Ethics, which, among its main guiding principles, prioritizes freedom, the defence of human rights, strengthening of citizenship, defence of democracy, equality, social justice and a commitment to quality services for the public.

conception of hospital residency in health

The residency should encompass two moments (teaching and care) where one sustains the other, removing the exclusiveness of the work performed especially in the care, which sees the residents charged primarily with maintaining the care routine at the university hospital, as still occurs in the medical residency.

The education part remains the responsibility of the teacher/tutor, who guides theoretical discussions based on the work process, supported by the essential work of the professionals/preceptors, responsible for the knowledge provided through hands-on experience in everyday practice of health services. The teacher/tutor and the professional/preceptor are available to provide guidance on intervention projects, research and extension studies, helping include the residents in the theoretical and practical production process.

Residency in social work emerged bound to the concept of Public Health Reform, with emphasis on the following principles: social control, comprehensiveness, universality, equality, decentralization and regionalization. Furthermore, it assumes as a condition for its performance, work supported by guidelines that aim to change the organization of health services based on *reception*, *humanization* and *relations*, core elements that support the work process steps performed in the university hospital.

structure and organization of the work process

The purpose of social worker's activities with users of the HU/UFJF is to enable these people access to public policies and/or community resources, working based on the expanded concept of health, that comprehends health as conditioned to social factors: eating habits, housing, basic sanitation, income, education, and others.

The services performed by the social work team should be based on the logic of social rights, reinforcing notions of citizenship, right to health and other social policies in relation to the users. The education in health process is seen as essential to grasping this logic, as well as to disease prevention and health promotion.

Social work in HU/UFJF is organized into work in the hospital units, outpatient work and duty shifts. In the units, this work is performed through insertion of the social worker/resident in surgical units, paediatric wards, female care and gynaecology units, male care units and intensive care units (ICUs).

To perform the services, the professionals first review the patient's records to gather information about the patient's medical, social and family background and then make bedside social engagement. This approach is made using information gathered from the patient's records and addresses issues related to their welfare situation, employment, family, access to health services, understanding of the health/disease process, to then provide guidance and necessary referrals based on the demand presented.

The most common demands on the wards are: advice and arrangements related to hospital admission; essential documents; contact with family members to reinforce the treatment; arrangements in relation to patient companions (contact with relatives); welfare/assistance advice: welfare sickness allowance, retirement through permanent disability; continuous support benefit for disabled and/or elderly/BPS-LOAS; guidance about sick notices; guidance about public transport concession schemes; request for transport for patient support; contact with institutions about availability of orthoses and prostheses; domestic violence; negligence in relation to elderly and children; contact with institutions about inclusion in a program or service; advice about governmental programs; accompanying hospitalized patients for bone marrow transplant, at the male care unit (exclusive beds) and decisions about medical examination reports by the National Social Security Institute (INSS), and other matters that arise.

The social worker assigned to the wards is also responsible for coordinating a group of users according to the specific characteristics of each hospital unit. These

projects are developed based on education in health, encouraging a continued exchange of experiences between group members and the team. In the Male/Female Surgical Unit, the University Project "Surgical Moment: a perspective of interdisciplinary work" is conducted with the participation of social workers, nurses and psychologists. In the paediatric unit, there is the professional training project "Comprehensive Accompaniment of the Families of Children Hospitalized in the University Hospital Paediatric Unit", with a team composed of social workers, nurses, psychologists, dentists, physicians and artists. Also implemented is the Extension Project: "Interdisciplinary Ostomy Care Aimed at Rehabilitation – HU/UFJF". In the Women's Medical Unit, the Extension Project is entitled "Speak Woman" and has a team of social workers, psychologists and nurses, and the Extension Project in the Men's Medical Unit is "STDs/AIDS: aiming at prevention".

In the outpatient activities, the social workers/residents are inserted in specific outpatient services, in extension projects or professional training schemes, and in on demand services. The specific outpatient services are for Paediatric Nephrology, Cystic Fibrosis, Parasitic Infectious Diseases (PID) and Pneumology. The Extension Projects are: "Chest Out Project: Breast Cancer Prevention and Integrated Accompaniment Program"; "Live Better: Comprehensive Care for Women in the Menopause"; "Interdisciplinary Care for Leprosy Patients: A Health Education Proposal"; and "Monitoring, Education and Prevention in Diabetes Mellitus". The projects "Prevention and Treatment of Smoking – Tobacco Free UH Program" and "Flourish – High-Risk Newborns" are professional training schemes. Some of these projects also include waiting room service, as well as individual and group service.

The duty social worker's job is to receive the health service user at the hospital, inform him/her about how the hospital works, its rules and routines, introduce the social service to the user, guide family members when visiting users and offer instruments to the user in order to ensure their rights.

All these activities are accompanied by the execution of supervision of interns and/or scholarship students and discussed with the HU/CAS preceptors, at the weekly intern supervision at FSS/UFJF, and the most complex situations and theoretical-practical studies are reviewed and discussed in the weekly guidance meetings with the tutor and coordinator of the Social Work Residency Program.

hospital residency in social work and technologies related to assistance/health care production

Today there is great emphasis on the use of health care technologies. These technologies have always been part of the arsenal used in social work, which, through the process of building relations, aims at the defence of human dignity and social rights and respect for differences, which values underlie the profession. All these contributions correspond to sustaining relational technologies used in the everyday business of a teaching hospital, experiences under construction, with the concrete aim of achieving quality management (organization of work process and resources) and quality assistance (care production) that simultaneously present difficulties and solutions experienced by the social workers/residents. The most significant of these technologies are:

assistance/health care production management

Assistance/health care production management is a dynamic process developed by social workers/residents at the teaching hospital, following agreements made between the macro and micropolitical spheres, guided by the SUS foundations and based on organizational practices and knowledge to strictly defend the interests and needs of users. The intention is to retrieve, through the social workers' activities, the precepts of the Public Health Reform so as to ensure comprehensive access to assistance/production of health care services.

democratic service management

The social workers/residents observe and reflect on the management by the General Directorate and the Social Service Management of the HU/CAS, in order to understand the political and administrative agreements and their referrals within the teaching hospitals and reinforce learning about the principal conceptual and operational

elements of public management. The residents reflect on the activities of the health professionals in the work process based on priorities defined in the contracting process, with clear reflections on the administration of assistance between the HU/CAS and SMS/JF managers. This approach of bringing together the educational, care and organizational aspects of the teaching hospital helps one identify the importance of the cooperation and the construction of management based on democratic principles, and simultaneously prepares professionals to understand the relation between micro and macro politics within the hospital.

teamwork and collective work

Team work is a horizontal process of sharing theoretical and practical knowledge. This features mutual relations and complementary concepts and disciplinary practices, in the sense of establishing the efforts required for health service educational practices. This concept of teamwork is based on *interdisciplinary* exchange, communicating ideas, integrating concepts and constructing objects of new investigation and interventions in partnerships, so as to dilute, in practice, the vertical and still hegemonic corporate conceptions[15]

information and communication

Information and communication planning sustained by the social workers/residents inside the teaching hospital is supported on this statement: The user has the right to receive all the information about his state of health. Grounded on the construction of communication bases between all the hospital sectors, using the methods and alternatives that enable the creation of extended communication flows and the negotiation of new and old commitments in order to ensure the users' rights. The information, according to Merhy[3] is a tool that enables continuous review of this game of the apparently functional and non-functional, of the public and private, outlining from which ethical-political point one can judge the meanings acquired by the service and at which interests it is explicitly directed. As a tool of analysis, information can reveal the noises that the instituting forces cause in the everyday work, enabling one to question the functional meanings of the service, the distant forms of interest games and the alternatives in place in the everyday workings of the health services.

FINAL CONSIDERATIONS

In this article we presented the main actions that outline the educational stage for residents. Through direct monitoring of the academic tutors and preceptors of the residents' actions we are slowly but surely building the residencies. A residency committed to professional training and a universal, equal and high quality SUS.

In these final considerations, the first element to be highlighted is the relationship between learning and the service. The educational institutions are responsible for training human resources from a general education perspective, that understands the user as a subject, and not as a reproducer of instructions and prescriptions, with the overall objective of quality in the SUS. The closer relations with the University increase the professionals' access to events, courses, seminars promoted by the institution or externally, as well as providing spaces for meeting and reflecting.

As regards assistance actions, we can highlight the need to overcome the immediate aspect and strengthen continuous actions that aim at putting the expanded concept into effect, for instance, through implementing health education actions. Beyond immediate actions, the long-term actions enable the strengthening of educational processes and training of the population for citizen insertion into public services, contributing to social control and the preservation and expansion of rights.

We can also highlight that the social worker should strive to develop actions qualified and supported by the understanding that her work should be guided by the approach to engage manifestations of a social nature that interfere in the health-disease process through acts aimed at producing a care based on the user's needs.

We consider that social work in the residency programs has represented an unparalleled opportunity for professional development. The platforms provided - meetings, study groups, workshops, seminars, etc. - all represent to the residents, tutors and preceptors a wealth of learning opportunities, socialization of information, exchange of experiences, maturing and the construction of new practices and knowledge.

The Social Work Residency Programs at UFJF constitute innovative experiences, as they establish links between the services and the three levels of health service complexity, incorporate an interdisciplinary matrix from the outset, have the theoretical grounding of a 360-hour specialization course common to all residencies and combine SUS principles with the principles of the social work code of ethics.

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The doctor and the myth of the lone hero: FNEPAS or Dulcinea?

O médico e o mito do herói solitário: FNEPAS ou Dulcineia?

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Palavras-Chave: Profissional de Saúde; Fórum Nacional de Educação das Profissões na Área de Saúde

Keywords: Health Personnel; National Forum on Education of Health Professions

You're alone. No one knows it. Hush and feign.
But feign without feigning.
Hope for nothing that's not already in you.
Each man in himself is everything.
You have sun if there's sun, trees if you seek them.
Fortune if fortune is yours.

Ricardo Reis (Fernando Pessoa)[1]

MEDICINE AND SOLITUDE: AGREEMENTS AND DISAGREEMENTS

It is said that when asked to recommend "the best medicine book," the man nicknamed the "English Hippocrates", Thomas Sydenham (1624-1689), immediately suggested *Don Quixote* by Cervantes[2]. However ironic it may be, this provocation might shed light on the social behaviour of physicians over the course of their long history. Regardless of the likely disdain Sydenham sought to demonstrate in relation to the academic production of the era, we cannot help but reflect on the astute observation behind this recommendation. And not only in the indigence of a direct correlation with doctors' "quixotic" struggle against death, but also to reflect on the stereotype of the physician throughout the history of medicine. Harold Bloom sides with another Miguel, de Unamuno, in interpreting the "*Knight of the Sorrowful Countenance*" as "a quester for survival, whose only madness is a crusade against death": "Great was Don Quixote's madness, and it was great because the root from which it grew was great: the inextinguishable longing to survive, a source of the most extravagant follies as well as the most heroic acts."[3].

Restricting this discussion to the tradition of Western medicine, we can begin with the myth of Asclepius, orphaned by the revenge of a resentful father-God, handed over to be raised by a mythological figure, the centaur Chiron, possessor of the "gift of healing." Chiron taught his art to the enlightened disciple Asclepius[4]. In a short space of time, the boy, a veritable sorcerer's apprentice, surpasses the master and after incurring the wrath of the gods, is struck with a thunderbolt. From the Pythagorean school emerges Alcmaeon of Croton, a loner along his school colleagues, interested more in man than the cosmos[5]. In Kos, in the second half of the fifth century BC, the versatile pilgrim Hippocrates would become the "Father of Medicine", systematizing and organize it into "diagnosis, treatment and prognosis." In the second century of the Christian era, the vain and predestined Galeno[6] was born, to reign over western medicine for almost 1,500 years, sustained to a great extent by Christian authoritarianism[7]. Before Sydenham, there was also the alchemist and iconoclastic Paracelsus[8]. Finally, we come to the wise Osler[9] and our "crusader" Osvaldo Cruz[10], among many

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others. A legion of physicians "married" to medicine! And nowadays, in the eternal return, a televisual myth arises in the unusual and lonely figure of *House*[11].

More than heterogeneous medical knowledge and a vulnerable social image, what transpires as the common denominator among the "great physicians" is the solitude of their lives. Wives almost never appear and the children often remain anonymous in the rigour of history. Of kings, politicians, generals, artists, writers, poets, and others, we all know of wives and mistresses, legitimate and illegitimate children, in short, their life choices, whether true or false. The argument that a physician is a character whose private life is very private and protected is easily demolished by the high prevalence of such characters in novels, films, plays and television: as characters, actors or authors!

In this centuries-old culture - which idealises a physician who idealises himself - could " Medicine" be the "Dulcinea" of this physician? Or perhaps the "Death"? Like Don Quixote, for centuries the physician fought against the "miasma carried by the wind," replaced at the beginning of last century, by "microbes carried by the wind" and now, who knows, by a "medicine based on evidence … carried by the wind". The need for solitude seems to be such that it caused the change from the "ill" to the "illness"! The latter would accompany you, just like a loyal Sancho Panza, in the last two centuries... The adventures, dialogues, threats, in brief, the mythical agreements and disagreements between them -physician and illness - mask the presence of the others who stand by the "white knight", like ghosts or "windmills", celebrating their heroic individuality!

THE PHYSICIAN: A VULNERABLE CHARACTER

The night closes her lips
- Earth and heaven - kept name.
And her long wise dreams
generate the life of men.

(Cecilia Meireles)[12]

By uncovering archaeological niches of medicine in its long trajectory, one can infer the numerous crossroads that it has faced. Its current crisis would represent just one more. And through them all, it has come out stronger, despite the momentary confusion and apparent disconnection. Perhaps the major characteristic of these victories coincides with humble insights, being subjected to the living forces of Nature. This is how it must have been when the medicine man, dressed in chimeric animals,[13] was replaced by the priest, bringing consistent explanations for the designs of the gods; and then they gave way to coherent Hippocratic observation, conjuring the forces of nature that overcame the magic, and then to "open up some bodies"[14] to rewrite a "living history of illnesses." But it was during the transition from the nineteenth to the twentieth century that the connections began to broaden and microscopic living beings replaced the fictional miasma, revealing that the colossal monsters that haunted men with "plagues" were so tiny and almost impossible to believe in! The speed of its propagation triggered a veritable "arms race against the almost invisible enemy" throughout the "brief twentieth century," in which a lack of humility recrudesced and hit new heights in the colonial, capitalist, warmongering, Nazi superman of all colours and hues. The millions killed in the violence of wars seemed not to disturb mankind, who launched himself into space and deciphered the genetic code. "We've controlled it all!"[1] - the politicians, generals and duty scientists seem to say. Even the almost "democratic epidemics" such as HIV/AIDS, dengue fever and bird flu failed to constitute a sufficient warning sign.

It has become commonplace in discussions about building skills for the creation of health teams to refer to the difficulties and resistance from physicians to participate in activities that seek to develop or enhance teamwork. On the one hand, there are countless indicators that support this perception: the low attendance by physicians at multidisciplinary events, their rare participation in mandatory boards at hospitals or other health care units, except when involving more direct personal interests and, finally, their notorious tendency to consider participation in collegiate or collective activities as a waste of time. On the other hand, in today's world of interdependent, interconnected relations, where the borders between

[1] Phrase attributed to the criminal Fernandinho Beira-Mar, after murdering rival drug barons, in September 2002, in the "maximum security facility" of the Bangú Penitentiary Complex.

countries, professions, businesses and areas of knowledge have become tenuous and volatile, it is startling that physicians make such an effort to demarcate and defend themselves "almost quixotically" inside the steamroller of globalization. Their isolation and age-old solitude seem to be conspiring to their resistance in the trenches of "defensive medicine", to the great joy and satisfaction of pharmaceutical and medical equipment industries, private health plans, and of course, the lawyers[15].

DIALOGUE BETWEEN TIME AND THE WIND: THE PHYSICIAN IN THE HEALTH TEAM

First the boy saw a star sitting on the petals of the night
And he told the class.
His classmates said the boy was taking the mickey.
Soon the boy said he had seen the day standing on top of a tin
Just like a bird perched on a rock.
He said: It looked like the tin was supporting the day.
The class scoffed.
But the boy started to tighten the screws on the wind.
The class said: But how can you tighten screws on the wind
If the wind has no body
But the boy said the wind had a body
And carried on tightening the screws on the wind.

(Manoel de Barros)[16]

Two recent factors may contribute to the construction of a dialogic platform for physicians and other health professionals: the crusade for the humanization of health care and the feminization of the medical profession. The former strives to confront the dragon of medical technoscience driving the "humanities." A new version of David and Goliath! The latter constitutes an open pathway to the historically and biologically more welcoming gender.

Moreover, ten years since the initial implementation of the Unified Health System/SUS, legal and change-inductive steps have started to pave the winding road that may lead to breaking through the historical and cultural barriers between the training of the different health care professions. The most important measures include, no doubt, the National Curriculum Guidelines, as from 2001, enforcing the provisions of the National Educational Bases and Guidelines Act of 1996, which signalled the need for closer ties between the courses by establishing the same general skills for the vast majority of undergraduate courses in health[17].

In July 2004, leaders of organizations involved in professional health care training and development committed to the changes in health training and to the consolidation process of the SUS, based on the guiding axes of continuous education and comprehensive health care, creating the National Forum on Education of Health Professions-FNEPAS[18].

"For the first time, the different health professions join forces to build political and institutional settings more conducive to changes in training and multidisciplinary action and teamwork"[19].

In November 2005, the National Program for Professional Training and Reorientation in Health (Pró-Saúde) was launched, contemplating the undergraduate courses of the professions that make up the Family Health Strategy: Nursing, Medicine and Dentistry[20].

In July 2006, two years after its creation, FNEPAS began implementing the technical cooperation project with the Ministry of Health, approved in 2005, and funded by the Brazilian Association of Medical Education/ABEM, with the aim of conducting regional workshops, forums, knowledge production and other efforts that entail improvement in the training of health professionals, especially for continuous education and multiprofessional teamwork.

In November 2007, the extended version of the National Program for Professional Training and Reorientation in Health, Pró-Saúde II, was launched, this time covering the training of all areas of health care and involving the commitment of Higher Education institutions, responsible for the courses included in the projects agreed with the local SUS management.[21]

Several other initiatives strengthened and contributed to joint activities, both in undergraduate and graduate courses. For purely illustrative purposes, we can cite: PROMED (although restricted to the medicine course, this was a true pilot-embryo for Pró-Saúde); Continuous Education Poles; VER-SUS; AprenderSUS; National Humanization Policy/PNH; Teaching Hospitals Restructuring Program; Multiprofessional Residency in Health; PET-Saúde (in the "Family Health", "Health Surveillance" and "Mental Health" versions), among others, always involving at least the Ministry of Health and Min-

istry of Education.

Although it is undeniable that all these initiatives resulted in advances and improvements in the indicators of health professional training, especially for in-service training in primary health care, at numerous sites in Brazil there is still a long way to go in terms of integrated training truly focused on teaching teamwork skills. One of the biggest points of resistance to the advances required for enhancing this kind of work, both at an undergraduate and graduate level, is the "medical school - medical corporation dichotomy". Despite numerous academic and health service leaders understanding the importance of participation by student medics and physicians in this process, there are obvious obstacles in the way. Two examples clearly illustrate this barrier:

1. When the debates were held to formulate and design the "Multiprofessional Residency Program in Health ", the corporate medical world engaged several entities to block the involvement of medicine in these programs, alleging that there were already "medical residency programs" regulated by a National Medical Residency Board/CNRM. At that time, the places available in the medical residency programs covered just over 50% of the graduating student doctors. This would be a great opportunity to increase the number of places, just to achieve a narrower utilitarian dimension. On the other hand, it would be an ideal and generous opportunity to bring over 30 years of experience in regulating residency programs to other professions;
2. "Project FNEPAS" managed to attract roughly 11,000 participants to its regional workshops, forums and meetings, some of whom attended more than one event. The professional category with the lowest rate of attendance to these events was the physician. More than half of the few physicians who did attend were probably there was speakers. It should be kept in mind that there are many other smaller categories, both in terms of numbers of professionals and of teachers and students. Another important aspect to bear in mind is the participation and engagement of the Brazilian Association of Medical Education/ABEM since the beginning of this project, under the remarkable leadership of Prof. Regina Lugarinho, of the Federal University of Rio de Janeiro State/UNIRIO.

It is no easy task to engage and involve physicians, medical professors and students, to have them leave their "comfort zones" and reflect on the enormous achievements available to them if they opened themselves up to learning with other professions, by understanding the scope and boundaries of the other professions, "learning to live together" the most fragile of the four pillars of the "Education for the 21st Century" project of the UNESCO Delors Commission, which form the concept of "learning to learn"[22]. Perhaps this was the shortest path to overcome the "feeling of omnipotence" - so painfully displayed by many doctors - which often leads to other feelings of unhappiness, such as guilt and loneliness. More than that, the best way to build and strengthen professional identity is to become involved with other professions, to understand their foundations, their work scopes, their boundaries, to learn to manage interprofessional borders, together building common spaces for living, that is to say, teaching, that is to say, learning.

"O trabalho do educador, do professor tornado educador,
é esse trabalho de interpretação do mundo, para
que um dia este mundo não nos trate mais
como objetos e para que sejamos povoadores
do mundo como homens."

(Milton Santos)[23]

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Reflections on The Trajectory Recent Brazilian Association of Pharmaceutical Education: ABENFAR

Reflexões Sobre a Trajetória Recente da Associação Brasileira do Ensino Farmacêutico: ABENFAR

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Palavras-chave: Associação Brasileira do Ensino Farmacêutico – História; Educação em Farmácia.

Keywords: Brazilian Association of Pharmaceutical Education- History; Education, pharmacy.

The Brazilian Association of Pharmaceutical Education – ABENFAR was implemented at a time of important initiatives on the national scene, in the early 2000s.

Discussions for regulation of the National Curriculum Guidelines (DCN), approved in 2002, the broad institutional changes that led to the creation of the Department of Science and Technology and Strategic Materials/MS, the publication of Resolution CNS nº 338 of 6 May 2004, establishing the National Policy of Pharmaceutical Care, and the realization of the First National Conference on Drugs and Pharmaceutical Care, held in 2003, are just some examples of the engagement of the progressive pharmaceutical sectors that had historically sought the inclusion of pharmaceutical care into the health policies being developed in Brazil.

This scenario contributed to the pharmaceutical class acting to enable an educational entity to fulfil the role of intermediating the debates and aspirations between the academic community (universities) and professionals and the Ministry of Education/Ministry of Health on issues related to education, research, extension projects, training in the pharmaceutical area.

Thus, ABENFAR was created in 2007; an entity designed to defend pharmaceutical learning and the quality of pharmaceutical education. It aims to bring together the performance of public and private institutions and teachers whose primary mission is undergraduate training of professionals to be qualified to act in the entire professional field in a critical and reflective manner, gathering teachers, academics and pharmacists, and working on initiatives to improve the quality of education.

Following its creation, seeking legitimacy as a national entity and the consolidation of pharmaceutical education, a set of actions and meetings took place

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throughout Brazil in order to support its structuring and acknowledgement by those who constitute its purpose.

The Minas Gerais Pharmacists Meeting, promoted by the Regional Pharmacy Council-MG, held from 20 to 22 September 2007 in Belo Horizonte was a significant moment in this process of legitimation and structuring, attracting, even back then, more than 120 members. Participation in important forums such as the 2nd Congress on Rational Drug Use in Florianópolis-SC, in October 2007, and RIOPHARMA in September 2007, ensured a continued strengthening and coordination of the entity. ABENFAR took part in the 13th National Health Conference in Brasilia, attended by over 3,500 delegates. It was also present at the 30th National Meeting of Pharmacy Students (Enef), held in July 2007 in São Luis (MA), as well as maintaining several meetings with the Ministry of Health, for discussing guidelines of the Pró-Saúde project.

BUILDING THE FNEPAS/ABENFAR RELATIONSHIP

An important point in this process of consolidation and legitimation was the insertion of the Brazilian Association of Pharmaceutical Education in the National Forum on Education of Health Professions (FNEPAS).

The FNEPAS congregates organizations involved with the education and development of health professions and aims to contribute to changing the professional education of this field, based on the guiding principles of comprehensive health care and continuous education.

Created in July 2004, this forum has gradually developed and today enjoys the participation of the Brazilian Association of Medical Education, Brazilian Nursing Association, Brazilian Association of Dental Education, Brazilian Association of Physiotherapy Education, Brazilian Association of Psychology Education, Brazilian Association of Social Work Education and Research, Rede UNIDA, Brazilian Speech Therapy Association, National Network of Occupation Therapy Education, and the Brazilian Association of University and Teaching Hospitals.

The FNEPAS has in different regions encouraged liaisons between local leaders who actively participated in the activities developed by the Forum, notably the regional workshops. On this platform, it has been possible to improve the coordination of pharmacy education in Brazil through the various events that ABENFAR has organized, coordinated or participated in.

Therefore, since the first actions of FNEPAS, even before its participation as a constituent member, regional groups, ABENFAR members, actively participated in the FNEPAS workshops held in the regions: North, Northeast 1 (MA, PI, CE), Northeast 2 (PB, PE, RN), Northeast 3 (BA, AL, SE) Midwest, South, São Paulo, Minas Gerais and Rio de Janeiro/Espírito Santo.

As a constituent member of FNEPAS, we can highlight the activities that formed the FNEPAS agenda and enabled activities that increased the exposure of ABENFAR. Of these we can list:

- *"2007 Review and 2008 Planning Workshop"*
- I FNEPAS Mobilization of Maranhão - São Luis - MA - 22 to 24/05/08,
- Regional Workshop of the Itajaí Valley and Northern Santa Catarina, Blumenau - SC - 05/09/08;
- 1st FNEPAS Workshop of the State of Maranhão and 1st Maranhão Show of Multidisciplinary and Integration Experiences in Community-Service-Learning in Undergraduate Health Courses - São Luis - MA - 11 and 12/09/08;
- Greater Florianópolis and South Santa Catarina Workshop - Florianópolis - SC - 2 and 3 October 2008;
- 3rd National Seminar on Multiprofessional Residency in Health Professions - Brasília - 13 to 15/10/2008;
- 2nd FNEPAS Workshop / Santa Catarina West Region - Chapecó - 04/11/08;
- 1st ABENFAR Forum of Paraná, 9th UFPR Pharmaceutical Conference, 3rd UFPR Integrated Academic Show Displays and 1st Workshop on Medication Advertising.

It is also important to emphasize ABENFAR's participation, in connection with the other health care professions, coordinated by FNEPAS and working alongside the Department of Health Education Management (DEGES/SGTES/MS), in the discussions that led to the establishment of a minimum number of class hours for on-

site undergraduate courses, through the complementary document to the National Curriculum Guidelines for undergraduate courses, approved by the Ministry of Health.

Also in the construction process of the new format of Pró-Saúde, ABENFAR played an active role, working with the Department of Health Education Management (DEGES/SGTES/MS) and the Department of Pharmaceutical Care (DAF/SCTIE/MS), providing directions specific to the area of pharmacy.

ABENFAR INTEGRATED ACTIONS

Seeking to advance in its role as representative of the aspirations and debates arising from pharmacy courses and the pharmaceutical class in the context of National Health Policy, ABENFAR has assumed a prominent role in achieving and improving the quality of pharmaceutical education in Brazil.

To this end, it has promoted and participated in significant events, including:

1st national forum on pharmaceutical education: the pharmacist that brazil needs

1st National Forum on Pharmaceutical Education (held 13 and 14 December 2007 in Brasília) was an initiative by the DAF/SCTIE/MS in partnership with the Brazilian Association of Pharmaceutical Education (ABENFAR). Its goal was to discuss with representative bodies of pharmacists, students, teachers of pharmacy and representatives of health services, the priorities of pharmaceutical training to meet the needs of the country and the SUS.

The central theme of the Forum, "**The pharmacist that Brazil needs**," aimed at instigating the class to create educational proposals directly related to the Brazilian social reality and the demands of society, especially of the SUS, for the pharmacist. The schedule of the 1st Forum gave priority to the active participation of those present, through "dialogue spaces" formed by four discussion groups.

The categorization of the debates and proposals built during the event are briefly presented in the following general proposals:

1. **General proposals**: revisit the proposition of the generalist curriculum (governed by Resolution 02/2002), seeking a core identity for pharmaceutical training, based on pharmaceutical care (from production to dispensing), fully in line with the principles of the SUS; encourage political discussion in the courses and expand the participation of the Ministry of Education in the process of change in pharmaceutical training.
2. **On the offer of postgraduate courses:** stimulate the creation and orientation of postgraduate studies in line with the needs of the SUS in PC, creating conditions for the inclusion of health service professionals in the programs; determine the responsibility of pharmacists, health services and postgraduate programs in the generation and application of research, knowledge and practices aimed at contributing toward the improvement of PC services and the population's quality of life; foster and strengthen the multiprofessional residency programs.
3. **On research promotion:** promote coordination between research support bodies, regulators and the Ministry of Health to encourage research into applied PC and health care; formalize the field of knowledge in pharmacy with the CNPq, to include PC and related topics; align research assessment to the editorial guidelines for the area of PC.
4. **Health service-education integration:** promote pharmacist training activities at undergraduate and graduate levels in health services, at all levels of care and covering the whole scope of pharmacist action, including management of services and primary care; establish a dialogue with managers and regulated forms of offering internships in the SUS.
5. **Qualification of service professionals:** create and implement the continuous education of pharmaceutical professionals practicing in public and private health care; develop professional training at a technical level for pharmaceutical assistance work in health facilities.
6. **Assessment of undergraduate courses:** define a minimum number of class hours; define

the need to submit proposals for opening new pharmacy courses to social control and/or other forms of regulation; insert forms of assessing pharmacist training in meeting the needs of the health process in the INEP assessment system for undergraduate courses.

All the proposals developed by the discussion groups were presented and discussed by representatives of entities directly related to pharmaceutical education: INEP, CAPES, SESU/MEC, DEGES/MS, FENAFAR, ENEFAR, as well as DAF/MS and ABENFAR.

The expressive, motivated and enthusiastic participation of the teachers, academics and pharmaceutical professionals who attended the 1st National Forum on Pharmaceutical Education demonstrated the great commitment of the class to build a model of pharmaceutical training and work that responds actively and decisively to the social demands and development of the country. It also signals the maturing visions of the pharmacist that Brazil needs, defined in his proposed role as a public health agent, technically skilled and politically aware and active.

2nd national forum on pharmaceutical education

Held between 15 and 17 May 2009, the second forum aimed to promote debate about the training of pharmacists and its impact on meeting social needs within the Unified Health System It continued discussions on pharmaceutical education, with a view to changing pharmaceutical training so as to allow the construction of a pharmaceutical care policy in Brazil and provide access to and rational use of drugs, as well as scientific and technological development in the field of pharmacy. The main definitions of this forum were aligned to the FNEPAS agenda for 2009-2010.

In this second forum, the partnership between the pharmaceutical professional bodies and student pharmacists in Brazil was expanded. At the XXXI National Meeting of Pharmacy Students (ENEF), held in July 2008, the students had decided to recognise ABENFAR as a legitimate body and representative of pharmaceutical education, in conjunction with the National Federation of Pharmacists (FENAFAR), which has historically contributed decisively to discussions on pharmaceutical education in Brazil.

These entities have their own diagnoses and evaluations regarding pharmaceutical education in the country and this second forum represented a step forward in the process of strengthening and qualifying pharmaceutical training.

The second forum allowed teachers, academics and professionals a broad platform for engagement and opportunities to reflect on pharmaceutical education; it promoted the exchange of experiences and extended discussions on the teaching-learning process and the implementation of the Curriculum Guidelines; it stimulated the interest of teachers, professionals and academics in learning about ethics-guided health and education policies, stressing the importance of the humanization of health care; it also discussed the Pharmaceutical Care Policy in Brazil as regards guaranteed access and rational use of medicines and scientific and technological development in the area.

3rd national forum on pharmaceutical education

This was held in Florianopolis between 12 and 14 November 2010.

During the third forum, various activities were carried out to discuss the training and role of the pharmacist in his different fields. The discussion took place through panels and roundtables, characterized by cross-functional composition. The issues highlighted included:

1. training/education initiatives for the SUS, currently in progress in Brazil: Pró-Saúde, PET Saúde, specialization courses in Pharmaceutical Care management (on site and distance learning), Hórus Clínico, specialization course for pharmacists in primary care.
2. outlook for undergraduate and graduate studies in Pharmacy
3. curriculum guidelines for pharmacist training that meets the needs of Brazil.

The discussions and proposals formulated throughout the event were consolidated and adopted at the

final presentation of the Third Forum of Pharmaceutical Education, and incorporated into the basis for preparation of the corresponding publication that is being finalized.

VII pan-american conference of pharmaceutical education (CPAEF)

Held between 24 and 26 May 2010, the main theme of this event was "How can training be organized by skills."

The Pan American Health Organization/World Health Organization (PAHO/WHO) has followed this conference since its first edition, being a permanent member of the Steering Committee.

The event was held by the National Organizing Committee, comprised of PAHO, WHO, ANVISA, ABCF, CRF/SP, CRF/SC, CRF/RS, DAF/MS, DEGES/MS, MEC, CAPES/MEC, ABENFAR and FENAFAR, and was open for participation by any new national pharmaceutical entities.

In this seventh edition, pharmaceutical education in the Americas was discussed, focusing on the construction of a proposal for accreditation for careers in pharmacy. Pharmaceutical education is responsible for preparing students to practice pharmacy as vital members of the health care team, equipped with all the required attitudes and knowledge. The Pharmaceutical Education Conferences have been held since 1990, aiming to promote cooperation between pharmacy schools, associations, universities and departments in the Americas. For the first time, an entity related to pharmaceutical education in Brazil participated in the conference.

Brazilian network of drug information centres and services (REBRACIM)

In 2010 the project entitled "Interinstitutional Cooperation for the Constitution of the Network of Drug Information Centres and Services" was developed.

The aim of this project was to structure the Brazilian Network of Drug Information Centres and Services (REBRACIM).

For the project development, a planning meeting was held on 28 and 29 July 2010, in Brasilia. Based on that meeting, the CIM/SIM was engaged to support the formalization of the Steering Committee of the National Network of Drug Information Centres and Services.

The 1st REBRACIM Forum occurred on 27 and 28 October and was attended by 20 CIM/SIM units, as well as representatives of the Department of Pharmaceutical Care, FENAFAR, CONASS and CONASEMS.

The connection of the drug information centre network with projects from the Pharmacy course has also been discussed in various educational forums (VII Pan American Conference of Pharmaceutical Education, 3rd Pharmaceutical Education Forum, ABENFAR regional meetings).

HIGHLIGHTS

Pharmaceutical practice has required a new professional profile, more attuned to skills that go beyond technical excellence (which is no doubt important) and include socioeconomic and cultural dimensions to meet the population's health problems, at an individual and collective level.

Therefore, in line with the transformative strategies defined by the FNEPAS, ABENFAR proposes continuous guidelines for introducing and causing changes in the current educational practices, which are linked to the teacher's role in the processes of change as an essential and fundamental factor.

One agenda currently being addressed is a discussion of the term of reference proposed by FNEPAS through a task force and the preparation of an overview, based on the premise of Resolution CNE/CES 2, of 19 February 2002, which establishes the National Curriculum Guidelines for Undergraduate Courses in Pharmacy.

Another important agenda to be highlighted is the qualitative research of Pró-Saúde and its contribution to the academic training of the pharmacist, as well as supporting knowledge about the profile of universities that offer Pharmacy courses included in the program; knowledge of the pedagogical projects of the courses involved; and knowledge of the possibilities of multidisciplinary interprofessional integration in the actions performed.

This project will contribute toward identifying and measuring the impact of the Pró-Saúde program on the

noticeable change in the training of IES pharmacists involved in the program, as well as on the services provided at primary health care units, especially in terms of access to and rational use of drugs.

CONCLUSION

The contribution resulting from the debates coordinated by FNEPAS, since the second half of the 2000s, has consisted of reinforcing the starting point for the development of the ABENFAR project, which has been gradually taking shape, defined and redefined in the meetings and several discussions between the leaders of health care professionals in Brazil.

Therefore, it is clear that the FNEPAS has helped construct the identity of the health care professions, respecting the diversity and working in a definitive manner toward changes and societal demands and so that the professionals take on the commitment to comprehensive care and health promotion among the Brazilian population, in conjunction with the professional knowledge inherent to each professional class.

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O Movimento Associativo e Educativo da Fisioterapia – ABENFISIO e o Fórum Nacional de Educação das Profissões da Área da Saúde - FNEPAS

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Palavras-Chave: Educação em Saúde; Fisioterapia; Equipe Interdisciplinar de Saúde.

Keywords: Health Education; Physiotherapy; Interdisciplinary Health Team.

THE BRAZILIAN ASSOCIATION OF PHYSICAL THERAPY EDUCATION – ABENFISIO

The Brazilian Association of Physical Therapy Education - ABENFISIO, a civil association of educational/scientific character, is the result of forums and meetings between teachers in October 1999 in Salvador, Bahia, during the XIV Brazilian Congress of Physical Therapy, where they held the First National Forum of Physiotherapy Teachers. ABENFISIO was officially founded on 5 April 2001, in Santos, São Paulo state, during the Fourth Forum of Physiotherapy Teachers, which marked the approval of the first charter and election of the first coordination staff of the entity.

The ABENFISIO, established under the jurisdiction in the city of Porto Alegre, brings together teachers, students, service professionals and associated institutions in order to develop and improve teaching/training in physical therapy nationwide. It commitments include providing subsidies for the development of learning, research and extension studies in physical therapy in Brazil and stimulating the training, improvement and continuous education of physiotherapists, whether teachers or not. It is committed to improving relations with society, facilitating and promoting advances in physical therapy education at all levels, respecting national and regional culture, as well as international indicators.

The entity was created and its objectives proposed at a time when the National Guidelines for Health Care Courses were being discussed on a national level, and with higher education thriving, especially in the area of private administrative schools. These two facts, coupled

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with the need for learning the state of the art in teaching physical therapy, has favoured a nationwide framework of the association, organized into state offices. Currently ABENFISIO has representation throughout Brazil, with State Divisions and Stations, and is the legitimate and legal entity to represent interests relative to undergraduate study in physiotherapy, and to propose and support policies that ensure quality and excellence at all levels of physical therapy education, always in accordance with the national reality. Its priority actions are providing assistance for the creation, review and adaptation of political-pedagogical projects of undergraduate and graduate programs and making conventions, agreements, contracts or arrangements with public or private entities, whether national or not, in order to achieve its goals.

Naturally, the development of ABENFISIO has been leveraged by the agreements and partnerships made, aided by the phase of high public investment, particularly by the Ministry of Health and partnerships with the Ministry of Education for training health professionals in accordance with current legislation which provides for the qualification of professionals to work in the context of the Unified Health System.

It has been with this scope and ethical, political and technical commitment that ABENFISIO has, over the past ten years, assumed the stance of proposing the construction of public policies and programs aimed at training professionals in such a way as to shape care services to the needs of the Brazilian population and in a socially responsible manner. This construction has involved more than 20 National Forums and over 30 regional workshops, involving teachers, students, service professionals and users.

The consolidation of ABENFISIO as a legitimate platform for discussing themes relevant to professional education in physical therapy occurred in a procedural manner. It should be highlighted that ABENFISIO played a fundamental role in promoting discussions regarding the national curriculum guidelines (DCN) for physiotherapy courses throughout Brazil, making a telling contribution to the changes in professional health care training. Through the Technical Cooperation Agreement Letter with the Pan-American Health Organization (PAHO) and the Ministry of Health (MS)/DEGES, ABENFISIO held 23 regional workshops and 3 national workshops in 2005 and 2006. These workshops engaged 1,840 people, including teachers, students, course coordinators, service professionals and representatives of partner organizations, such as the Federal Council of Physiotherapy and Occupational Therapy, the Social Movement *Rede Unida* and the FNEPAS.

The change in professional training in physical therapy and the strategies to achieve it are permanent topics on the ABENFISIO agenda. The National Forum on Physical Therapy Education, the 21st edition of which shall be held in 2011, represents a chance to leverage discussions and the construction of new knowledge and achievements in relation to the formative process. The incentive to build and shape pedagogical projects aligned to public education and health policies in Brazil has drawn the constant attention of ABENFISIO, which, in turn, has attempted to expand the scope of its actions in a committed, responsible and ethical manner, reaffirming its commitment to developing strategies and overcoming challenges so that the desired professional profile becomes a reality in all regions of Brazil. Therefore, ABENFISIO is characterized as an open, democratic space for dialogue, where the various participants are committed to physical therapy and to the health of society. It should be underlined that collective health and cross-functional practices are themes that permeate all ABENFISIO actions, continuously addressing Service-Learning-Community Integration and, above all, teamwork in an attempt to ensure comprehensive health care. In this regard, its participation in the National Forum on Education of Health Professions – FNEPAS, has been fundamental to the expansion and qualification of this debate.

ABENFISIO AND FNEPAS

Since 2001 ABENFISIO has systematically sought to create a standard of quality education for physical therapy by means of forums and collective constructions. Understanding that public health needs go beyond discussions exclusively concerning the physiotherapist and based on comprehensiveness as the guide for professional training and practices in health care, ABENFISIO's participation in the FNEPAS has enabled a broadened scope of reflections and, consequently, of the strategies and guidelines produced by ABENFISIO.

The National Forum on Education of Health Professions – FNEPAS was created in 2004, in the context of the National Seminar on the SUS and Undergraduate Courses in Health", promoted by the Ministry of Health. The organizations that participated in the FNEPAS de-

voted their attention to the debate on strategies of implementation and evaluation of the curriculum guidelines of each profession, holding regional workshops, which generated significant end products, such as diagnoses of the current status of the courses and strategies, which have been implemented to overcome the difficulties. Another topic addressed in the forum meetings was the engagement of teachers and students to deepen the debate on higher education and continuous education in health at the educational institutions and in the various practical health care settings.

As such, FNEPAS has represented a unique space for connections between the different professions, forming a powerful network that, in addition to raising the awareness of the players involved in health care training, increasingly builds up a production of knowledge over the course of the actions. This forum also enabled mutual learning and acknowledgement among educational institutions, leveraging the debate on interprofessional training and producing a matured outlook for the challenge of teamwork, as well as pushing forwards the specificities of each profession and of the interfaces and conflict of cooperative order among them.

In December 2006, following approval of a cooperation agreement between the Ministry of Health/SGTES/DEGES and the FNEPAS, an Experimental Workshop was held in Rio de Janeiro, establishing the target of holding productive and training/awareness workshops involving regional representatives and other local and regional members of health education associations. Beginning in March 2007, the workshops were developed based on a design which indicated a procedure to follow, in which it was established that they would be organized by a local group, with multiprofessional representation; the target participants of the workshops should include teachers, students, managers, professionals and user of health services, and managers of educational institutions. The theme of the regional workshops should be related to comprehensiveness and quality in the training of health practices: integrating training, services and users.

Despite these general guidelines, the regional workshops were heterogeneous due to the characteristics of the regions. Some worked more on the awareness and engagement of the social actors involved; while others advanced in the process of systematization of experiences of comprehensiveness and the identification of strategies to create channels of interaction, debate spaces, promotion and diffusion of concepts of professional training for the SUS. The number of participants in almost all the Brazilian states was remarkable, especially physiotherapy teachers, clearly demonstrating the pertinence of the FNEPAS as means of joining forces directed at change. In 2007, 23 regional workshops were held with roughly 4,000 participants. The proposed theme for all the FNEPAS regional workshops was comprehensives and quality in the training of health practices: integrating training, services, managers and users.

During the meetings held throughout Brazil, members of the various health care professions, from distinct segments, gathered to discuss, learn, construct, exchange experiences, experiment, change and progress together. The active presence of ABENFISIO representatives, participating in these events, brought several physiotherapy teachers from the association closer together, helping promote the growth of ABENFISIO in the inner-state regions where the workshops were held. The numerous physiotherapists, teachers, students, managers and professionals were made aware of and engaged in the process of systematization of experiences of comprehensiveness in a procedural manner, resulting in consequences that are reflected in the strengthening of ABENFISIO.

Strategies were identified for the creation of channels of interaction, spaces for debate, and the promotion and diffusion of concepts of professional training for the SUS. Physiotherapists could also be observed partaking in actions to change professional training and organization of the work process in several municipalities and institutions.

In March 2008, ABENFISIO participated in the FNEPAS 2007 Review and 2008 Planning Workshop. The proposal of this meeting was to systematize and assess the experiences and results achieved, review the strong points and weak points identified in the process, in order to refine the strategies for continuation of the project in 2008. The strong points identified were the coordination between teachers, service professionals and managers, with the objective of sharing visions between professions from different perspectives and formulations in relation to the challenge of implementing curriculum guidelines in these two fields; the creation of

opportunities for joint reflection on the theme of comprehensiveness, considered as central to the innovation of health practices and training, and the construction of a minimum shared repertoire that supports the execution of workshops and other movements toward closer relations between different health professions at a regional level.

The year 2009 marked the 40th anniversary of regulated physiotherapy in Brazil, an apt moment for broad reflection on the historic construction of our profession and on the process of professional training. A diversified program was carefully prepared, with activities that proposed the exchange of experiences, debates, reflection, (re)convening and, especially, the broadening of the work by ABENFISIO nationwide.

The city of Salvador was the setting for the 19th National Forum on Physiotherapy Education, which was not a random choice. Ten years ago, the city hosted the 1st Meeting of Physiotherapy Teachers and the conception of ABENFISIO.

In 2009 there were six State Division of ABENFISIO: Rio de Janeiro, Santa Catarina, São Paulo, Rio Grande do Sul, Mato Grosso do Sul and Mato Grosso. However, this involved little representation of the North and Northeastern regions. In an attempt to achieve presence in all Brazilian states and municipalities where there were courses in physiotherapy, the first FNEPAS/ABENFISIO workshop was held with the participants of the 19th National ABENFISIO Forum, focusing on participation by physiotherapy teachers from the North and North-eastern regions and from states that were yet to organize their own state divisions, such as Minas Gerais, Paraná, Espírito Santo, Goiás and Tocantins.

1ST FNEPAS/ABENFISIO WORKSHOP

theme: "teacher training: the teaching of light technologies in undergraduate studies in health"

held during the 19th national abenfisio forum, salvador, 2009.

With the belief that a country is built with ethics, autonomy and quality both in education and in social conditions, we proposed a FNEPAS workshop with the theme: "Teacher training: the teaching of light technologies in undergraduate studies in health", conducted remarkably by Professor Alcindo Ferla, of UFRGS, and Professor Liliana Santos, of UFBa.

Our objective was to provide an opportunity for joint reflection on work with light technologies in health care, which theme is considered central to the innovation of health practices and training, and to propose strategies to improve service-learning integration and the use of light technologies in curricular activities in practice settings. Teachers from almost all Brazilian states attended the event, as well as students, managers and professionals from other areas. This extremely broad representation of the country fortified the discussion and participation of the whole group.

After a theoretical introduction to the theme, the participants worked in discussion groups addressing the "why, what for and how" of the implementation of these light technologies. In each group the members were introduced and reported their local reality in relation to the use of light technologies by their respective courses. It could be noted that the Brazilian states are at different levels of curricular adaptation as far as implementation of the DCN is concerned. In some states, there is just a process of raising awareness with one-off actions in curricular reorganization; while in others the process of transformation, implementation and consolidation of the matrixes is underway, showing that all the higher education institutions are affected by public policies for curricular reform.

Following this contextualization, the groups concluded that, before discussing "how", they should discuss the "why and what for" behind the implementation of these light technologies. It was prompted that their use dispenses with new teaching-learning methodologies, and that those methodologies, on their own, fail to guarantee learning for humanized care, if detached from the real life context. On the other hand, teachers have not been prepared for this kind of training, which generates a high level of resistance against the implementation of light technologies. It is worth highlighting that often teachers are not open to new experiences that require a change of scenery to carry out new teaching-learning proposals. The group proposed a strategy of promoting actions that raised the awareness of and affected teachers and students so, once these actors were identified, they could be used as multipliers of these "innovative"

proposals for learning and care. Among the proposed actions is a retrieval of the historical process of the construction of the SUS and demonstration of how that process relates to the need for new technologies aligned to the guidelines of the system in the sphere of humanized, comprehensive and effective care.

Also discussed was the need for tighter relations between teaching and service as a means of ensuring the connection between the practical and theoretical, thus providing a field for exchange of knowledge that brings professionals, teachers and students closer together in favour of the teaching-learning process and continuous education. It was concluded that the awareness-raising strategies should be discussed at all action level and by all actors involved. At this point, the need is outlined for a process that steers professional physiotherapy training in line with the care proposed by the SUS, ensuring the employability of the professional and, therefore, preventing any compromise in relation to the job market. Still in relation to the macro universe of education, there is the need to ensure that the MEC/INEP assessments policies contemplate the proposed DCNs, thus avoiding any conflict of interests between the higher education institutions, the SUS and the job market during the IES assessment process.

Finally, as light technologies resume a role in training it is important to understand them as concurrent to hard and light-hard technologies, stressing that their use does not imply in the loss of scientific rigour.

In the following year, 2010, ABENFISIO held the 20th National Form on Physiotherapy Education – ABENFISIO and the 2nd National Congress of Physiotherapy in Collective Health, in Belo Horizonte, Minas Gerais.

It also held, as parallel events: 14th Meeting of Physiotherapy Course Coordinators, 4th ABENFISIO Meeting of Physiotherapy Students, 2nd Meeting of Teachers in the Fields of Physiotherapeutic Knowledge, 1st National Meeting of Physiotherapy Undergraduate Course Assessors. The physiotherapy events had the main theme of "National Policy of Functional Health: a Path to be Built in Health and Education Institutions" and were aimed at teachers, students, professional physiotherapists, course coordinators and managers of health service facilities, as well as other health care professionals.

Two important FNEPAS instances took place in this event, namely: the FNEPAS Workshop on Interprofessional Education and the Working Group for the construction of references for Health Professional Training in Diverse Learning Settings - hospital and non-hospital.

2ND FNEPAS/ABENFISIO WORKSHOP

theme: "interprofessional education for teamwork: assessing skills and attitudes"

held during the 20th national abenfisio forum, belo horizonte, 2010

The primary objective of this workshop was to discuss interprofessional education and the assessment instruments of attitudes and readiness for teamwork, and it was conducted by Professor Nildo Alves Batista (UNIFESP) and Professor Sylvia Helena Batista (ABEP/UNIFESP) .

The workshop was a space for joint reflection on the theme of interprofessional education, considering innovation in health practices and training, and strategies and proposals for learning and working in health based on interprofessional education.

Some challenges were identified for integration between undergraduate courses, such as teacher resistance against leaving their "comfort zone"; resistance by students to the teaching innovations; an academic structure unfavourable to integration between courses; fragmented knowledge, discipline-based curriculum; overcoming the prevalence of the biomedical model with specialist, procedure-centred training.

Furthermore, the need was identified to encourage the student toward the profession, diversifying contexts and establishing a situational commitment that will result in distinct student profiles. Another challenge is to overcome corporatism and stimulate the commitment of everyone to social demands, as well as training professionals for the SUS from an interdisciplinary approach and at different levels of health care.

Service-learning-community integration is fundamental, stimulating the qualification of preceptors to participate in the training of students and integrating universities and services, establishing a process of mutual learning – authorship / exchange of knowledge. In this way, the construction of continued partnership and joint planning becomes an essential factor to the said integration.

3RD FNEPAS/ABENFISIO WORKSHOP

theme: "training health professionals in diverse learning settings"

held during the 20th national abenfisio forum, belo horizonte, 2010

This workshop was the response to a request by the FNEPAS Board, which proposed the organization of discussion groups split by entity. Bearing in mind that the political-pedagogical models for undergraduate courses should be bound to the SUS principles and guided by the curricular guidelines, the FNEPAS Board requested each educational association to hold a workshop with the objective of creating a reference document to guide the organization of the teaching-learning contents and practices in a hospital setting and a basic health care setting for the training of health professionals from diverse areas and the necessary development of management contacts, involving educational institutions and services for the corresponding learning domains.

Abenfisio enjoyed the participation of teachers from various brazilian states and public and private educational institutions. it advanced the discussion and review of experiences and proposals related to teaching/learning practices a hospital and non-hospital setting (BHC/PHC). the final report of this workshop was presented at the brazilian congress of medical education - COBEM 2010, during the fnepas workshop of health professional training in diverse learning settings.

FNEPAS-COBEM Workshop

Theme: "Training Health Professionals in Diverse Learning Settings – hospital and non-hospital"
Held during the 48th Brazilian Congress on Medical Education, Goiânia, 2010

Considering the political-pedagogical models for undergraduate courses should be bound to the SUS principles and guided by the curricular guidelines, the objective of the workshop was: to construct a reference document that guides the organization of the teaching-learning contents and practices in a hospital setting and a basic health care setting for the training of health professionals from diverse areas and the necessary development of management contacts, involving educational institutions and services for the corresponding learning domains.

The participants worked in discussion groups, with the following guiding challenge: How should the training of different health professionals be organized in the field of practice, while respecting the unique characteristics of each one?

Factors that hinder the integration of cross-professional training were identified, including: the power in appropriation of the spaces; competition for the practice settings; maintenance of individuality/singularity in the structure of health services and resistance to change.

The proposed facilitating actions include: raising the awareness of the actors (managers, teachers, students, workers and users); the inclusion of interdisciplinary integration modules on the curriculum; integrated planning of service-learning-community actions; interdisiplinarity as an institutional policy of education; the election/expansion of practice settings; rethinking the service, considering integrated planning of the professional and supervisory classes; the establishment of control mechanisms, so that educational institutions that ignore the DCNs and the educational proposal for the SUS cannot use the SUS as a training field; review of the curricular content so as to contribute to the construction of transformative agents of society; bringing health policies and health education policies closer to the competent management authorities: Ministry of Health (MS), Ministry of Education (MEC), Department of Work and Education Management in Health, National Council of Health Departments (CONASS); National Council of Municipal Health Departments (CONASEMS) and the proposition to the MS and MEC to create support strategies to promote integrated training of health professionals from the start of training.

FINAL CONSIDERATIONS

Physiotherapy and the training of physiotherapists are split by the dividing line in its production of knowledge represented by the implementation of the National Cur-

riculum Guidelines for undergraduate studies in physiotherapy. In its first 30 years, the profession notably established itself as a tool in the functional rehabilitation from physical traumas, regardless of the public health policies of that period. From 1969 (when it was recognised as a higher level profession in Brazil) until the early 21st century, it advanced in terms of technologies, scientific evidence and in fields of activity, making effective use of the field and the process of physical rehabilitation. The construction process of the DCNs and their validation have engaged the movement of changes in training and, consequently, demanded the development of new technologies to respond to the priorities of the SUS and the health policies of the Brazilian State.

The birth of ABENFISIO occurred at a time when this need of the profession was in evidence. Therefore, in its relations with other health professions, some with more baggage in this setting and others in a similar situation, physiotherapy began gathering knowledge and experiences toward this movement, legitimising and reorienting the training of physical therapy professionals and indicating new designs for the construction of pedagogical projects, teaching methodologies, research subjects, in other words, the whole practice of training with repercussions in the field of practice, that expand the prospects of the physiotherapist "being". This insertion into collective movements entails an immediate identification with collective health challenges and the consequent commitment to the reaffirmation of a health care model that acts as a mechanism of social transformation, placing health not only as a right, but also as a determining factor of social development.

Many of our members report processes of change in their work settings, provoked by the FNEPAS discussions. Despite not occurring as quickly as desired, the reports present advances in some strategies, such as the reaffirmation of the active methodologies, the early insertion of the student in practical situations, and above all in the SUS service network, the incorporation of new (light) technologies in the supervised community internship. The collective actions have gained new focuses, and new topics have been addressed in discussions held in courses and services.

The processes of change in several courses have already resulted in interdisciplinary actions and stances.

For physiotherapy, the participation of ABENFISIO in this movement triggered by the FNEPAS has been highly productive, constituting a valuable space for dialogue, reflection and exchange of experiences not only with other associations, but also with the Rede Unida and ABRASCO, which also participated in the forum.

These results confirm that the FNEPAS has established itself as a legitimate platform for multiprofessional discussions on education, committed to promoting and contributing to the process of curricular changes in undergraduate courses in health, aiming to train health care professionals in line with the principle of the SUS and to tackle at a theoretical and practical level the challenge of comprehensiveness in health care.

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Interprofessional Education in Health: Concepts and Practices

Educação Interprofissional em Saúde: Concepções e Práticas

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Palavras–chave: Educação Médica ; Educação Interprofissional

Keywords: Medical Educational; Interprofessional Education

CONCEPTS

IPE (Interprofessional Education) currently represents the primary strategy for training professionals in teamwork, a practice that is essential to comprehensive health care. As a premise to develop our understanding of IPE, a review of the meaning of two essential concepts is required: education and health.

Education understood from a dialogic and critical perspective, committed to building knowledge as an instrument of social transformation, where the teacher and student interact in the teaching and learning. This concept goes a little way beyond the constructivist perspective, because knowledge is conceived as a construction process and the student takes on the role of subject of the learning process, but, above all, it breaks the traditional approach of content transmission, from the teacher as holder of the knowledge to the student as the passive recipient of information.

In this regard, we can cite Paulo Freire, when he says that: "*o educador já não é aquele que apenas educa, mas o que, enquanto educa, é educado, em diálogo com o educando, que ao ser educado, também educa* [...]"[1] (p.64).

Health, meanwhile, is understood from a socio-historical-cultural outlook, emphasizing the comprehensiveness of care, with the health team working from an interdisciplinary approach. This perspective advances the biopsychosocial notion that considers the health-disease process and recognizes the importance of multiprofessionalism in health care, but, above all, breaks the purely biomedical, disease-centred idea of health, with the physician as the protagonist.

It is also important to highlight the current moment in relation to the curricula of higher education courses in health. The implementation of the DCNs (National Curriculum Guidelines), officially announced 10 years ago, still remains a challenge, especially as regards effective mechanisms of curricular integration, diversification of learning settings, coordination with the Unified Health System (SUS), retrieval of the ethical, humanist, critical-reflective and caring aspect of professional practice, taking on a broadened concept of health care.

Associated to these challenges, there is an ongoing discussion regarding the need to expand university education beyond specific professionalization, tackling the challenge within the educational proposal, with consequent changes in teacher and student attitudes, and integration and interdisciplinarity as guidelines of the training proposal.

Among these and other challenges, the need for integration takes centre stage. Integration understood from the perspective of new interactions through interprofessional teamwork, the exchange of experiences and knowledge and respect for diversity, thus enabling cooperation for the exercise of transformative practices, partnerships to construct projects and ongoing dialogue.

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At this point, one could ask:

- Have undergraduate health courses in Brazil been committed to preparing professionals for teamwork?
- How can students be trained for work from the perspective of comprehensive care?
- How can the students be afforded better knowledge about the specific characteristics of different health professions?

Although obvious, these concerns have not featured in new proposals for professional training in Brazil. Their importance is acknowledges, however an emphasis is maintained on the courses in themselves, with development strategies aimed at a vision of practice isolated from the other professions.

The implementation of IPE in health training emerges as a response to these questions. It consists of joint training opportunities for the development of shared learning. In short, opportunities for two or more professions to learn together with and about each other.

As a proposal for training, interprofessional education has been discussed over the last thirty years, especially in the United States and Europe, in order to stimulate the improvement of health care through teamwork. The principles of interprofessional education apply both to the undergraduate training of different health professions and the continuous education of professionals belonging to health teams[2].

For Barr[3], IPE is the inversion of the traditional rationale behind health training - with each practice considered and discussed in itself - opening spaces for the discussion of interprofessionalism. The same author also states that IPE is a proposal where professions learn together about teamwork and about the specifics of each job, improving the quality of patient care.

IPE is committed to training toward interprofessionalism, in which teamwork, the discussion of professional roles, the commitment to problem solving and negotiation in decision-making are hallmarks. Therefore, essential components of this approach include appreciating the history of different professional areas, considering others as legitimate partners toward knowledge building, and respect for differences in an expansive movement that involves dialogue, challenge, commitment and accountability.

This strategy is based on the educational assumptions of adult learning (one learns when one sees the meaning, considering prior knowledge of learner and the perceived applicability of what is learned), interaction-based learning and practice-based learning (movements of observation, simulation and action).

IPE is committed to the development of three types of skills - skills that are common to all professions, specific skills of each professional area and collaborative skills, i.e., respect for the specifics of each profession, participatory planning, the exercise of tolerance and negotiation, through collaborative networks.

In evaluating the experiences of IPE in professional health training, two instruments are described in the literature - a questionnaire with a Scale of Perception of Interprofessional Experience (IEPS), established in 1990 and modified in 2007[4,5], and a questionnaire to assess attitudes and readiness (RIPLS) that uses a Likert scale to assess competence for teamwork and collaboration, professional identity and the discussion of professional roles.

Systematic reviews of the literature have shown the positive effects of IPE in health training. This does not mean there are no difficulties in its implementation, such as lack of precise definition, institutional resistance and the resistance of teachers and students, curriculum barriers, simplified initiatives such as cost-cutting strategies and any problems with professional corporations.

In Brazil, experiences with IPE are few and far between. Joint learning experiences exist, but not with the aim of developing skills for interprofessional practice. We still suffer an almost complete lack of publications on the subject, although there are one-off experiments. Currently, experiments and reports of experiences of joint training and shared learning in policies that induce changes in undergraduate training such as the Pró-Saúde and PET-Saúde projects have emerged as potential platforms for IPE.

AN EXPERIENCE

In the context of interprofessional education we find the curricular design of the new courses at the Baixada Santista Campus of the Federal University of São Paulo, where undergraduate courses in Physical Education, Physiotherapy, Nutrition, Psychology, Occupational Therapy and Social Work have been implemented.

These courses have the objectives of training health care professionals for interprofessional teamwork, with an emphasis on comprehensive patient care, training of technical-scientific and human excellence in a specific professional field, as well scientific training, understanding research as the driving force behind teaching and learning.

To achieve these objectives, the following principles steer the pedagogical project: indissociability between teaching, research and extension, professional practice as guiding axis of the pedagogical project, tackling the problem of education based on practice and research, interdisciplinarity, active student role in constructing knowledge, facilitator/mediator role of teachers in the teaching/learning, integration with the community, integration between different levels of education and research, dynamic pedagogical plan with permanent construction and reconstruction, formative assessment such as feedback from the process, teacher development.

Adopting interprofessional education as the guideline for this project entailed the development of an interdisciplinary and interprofessional training proposal, breaking with the traditional discipline-centred structure, and specific training for a specific professional profile. Therefore, all the courses have a curriculum based on four axes of training that run through the all the undergraduate years. On each axis, understood as paths travelled by students during their training, related thematic modules make up the curricular proposal.

A link between the four proposed axes is established, directed at the training of health professionals committed to consistent, critical and potentially socially transformative work: emphasis on interprofessional education, interdisciplinarity, problematizing approach and knowledge production.

The axis *The human being and his biological dimension* consists of a core of knowledge common to and required for all the proposed courses (biological knowledge required for a professional to work in health care) and a specific set of more detailed knowledge based on the needs of each course.

The axis *The human being and his social insertion*, covers the areas of anthropology, sociology, psychology, education, philosophy, ethics/bioethics, economics and management and grounds its training and learning actions on the permanent effort to link practice to theory, seeking to overcome the conception that separates knowledge into basic and professional. The general aims are to train the student to understand the emergence of humanities as an area of knowledge, and to be committed to health training that incorporates, in theory and methodology, contributions from the different fields of human sciences.

The axis *Working in health* is present throughout all the courses and covers common topics to all health professionals: health as a field of knowledge, health policies, health professions, working in health, health services, comprehensive care, public/collective health, epidemiology, multiprofessional and interdisciplinary teamwork, the production of knowledge in health.

The axis *Development toward a specific health care practice*, developed progressively since the start of the course and respecting the student's autonomy, addresses specific issues to each of the sic professions of the proposed courses (physiotherapy, occupation therapy, psychology, physical education, nutrition and social work).

The commitments to health training are grounded on the understanding of sciences from a perspective that breaks with the instrumental and/or accessory character of the contents and methodologies of scientific fields, engaging in the construction of critical reflection on health practices, in view of factors of a biological and cultural nature, labour, social relations, productive and living conditions in societies.

A central feature of this experience is the intentional creation of classes that mix students from the six different courses: in these "mixed" classes the key question is "what should a health professional know, regardless of his specific profession?" As part of this proposal, the students have shared learning time in each year of the course (80% in the first year, 40% in the second year, 20% in the third year and weekly meetings in the fourth year).

These shared learning opportunities allow the experience of interprofessional groups, where mixing implies a willingness to live and work with each other, get to know each other better, respecting the uniqueness of each one and seeking to build more inclusive interpersonal relationships.

As the traditional logic behind health training changes, dialogue with the teaching practices is introduced: teachers, with their training background based on disciplinary

specialization, are confronted with their desires and possibilities of learning and teaching in a more participatory, interactive and creative manner. And these possibilities can be expanded by teachers helping build an innovative pedagogical project, assuming joint responsibility for the direction and routes of the proposed health training.

Therefore, it is also a new situation for the teachers to leave the disciplinary framework and engage in dialogue with colleagues from other areas, relativizing their beliefs and deeming it possible and necessary to (re)learn the dynamics of knowledge, working and being in health. To form an axis that is intrinsically interdisciplinary and engage in the modules requires approaching subjects from angles yet to be unveiled and/or appreciated, revisiting the known and being open to new paths.

As explained by Larossa and Kohan[6]:

> *Também a experiência, e não a verdade, é o que dá sentido à educação. Educamos para transformar o que sabemos, não para transmitir o já sabido. Se alguma coisa nos anima a educar é a possibilidade de que esse ato de educação, essa experiência em gestos nos permite liberar-nos de certas verdades, de modo a deixarmos de ser o que somos, para ser outra coisa para além do que vimos sendo.(p.1)*

In the crossovers between the practices of the subjects, contents, didactic and pedagogical options, the perceived value of this formative experience is that it could potentially transform health training committed to the construction of the Unified Health System.

This project has been evaluated by different mechanisms: focus groups involving teachers and students, progress tests, qualitative and quantitative tools for student assessment of the process. Moreover, it has been the subject of research presented and approved by funding agencies such as the projects *"A interdisciplinaridade como princípio formativo na graduação em saúde: dos planos às concepções docentes"*[7] and "*A educação interprofissional na graduação em saúde: preparando profissionais para o trabalho em equipe e para a integralidade no cuidado*"[8].

Finally, it is important to note the culture created at the Baixada Santista Campus in relation to Interprofessional Education. This culture, already consolidated in undergraduate studies, has directed the creation of all the graduate programs. With these principles, the Multiprofessional Residency Program has been created, involving the areas of Physical Therapy, Occupational Therapy, Nutrition, Psychology, Social Work, Pharmacy and Nursing as well as the Interdisciplinary Master's Program in Health Sciences.

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Brasilian Association of Nutrition Education and Their Integration into the Nacional Forum of Professional Education o Health

A Associação Brasileira de Educação em Nutrição e sua Inserção no FNEPAS

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Palavras-chave: Nutrição; Educação em Nutrição; Associação de Ensino.

Keywords: Nutricion; University Degree in Nutrition; Association of Nutrition.

INTRODUCTION

The Brazilian Association of Education in Nutrition (ABENUT) was established in May 2008, with the main objective of discussing the training of Nutritionists. In keeping with the national trend of similar entities, the proposal emerged to form an organized representation of nutrition schools in Brazil and their respective academic community, including teachers and students in conjunction with the Ministries of Education and Health and other entities of civil society. The creation of ABENUT occurred at a time when higher education in Brazil reflected the education public policies of the 1990s, which resulted in a disorderly expansion, dominated by the growth in the non-university private sector, regional imbalance and an increasing number of unoccupied places in the private sector. This expansion process generated a complex and diversified system of institutions with distinctive academic practices, vocations and configurations.

In the health area, which includes undergraduate courses in nutrition, concern regarding the high concentration of private-sector trained health professionals and the rise in non-university education sparked a debate about subjecting the opening of undergraduate courses in the area to some form of social control, as discussed at the 11th National Health Conference in 2000[1], and the 12th Conference in 2003[2].

As a result of this movement, in 2003 the National Health Council (CNS) recommended to the National Education Council (CNE) a 180-day suspension of permits for setting up courses in the area of health, through Resolution nº 324/03[3]. In another resolution, nº 325/03[4], the National Health Council recommended a public hearing with the Special Evaluation Committee to review the criteria adopted in health-related courses.

Another measure, which can be associated to the movement for quality training of health professionals, was the involvement of the Ministry of Health in regulating the opening of courses in medicine, the contributions of which were approved by the Ministry of Education in the instru-

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ment that establishes the criteria for opening such courses in accordance with the National Curriculum Guidelines[5, 6].

In 2001, the National Curriculum Guidelines (DCN) were ratified, bridging the two original policies from the Ministry of Health and Ministry of Education, driving the changes in health education. It is noteworthy that the debate on the DCN set the stage for a broad mobilization of all courses in the area, concerning the needs of establishing the professional profile that would meet the demands of health policy. The proposals are developed in the context of the needs of the population, as they emphasize the formation of attitudes focused on health, citizenship and teamwork, while also indicating service-learning integration, binding academic training to the society's health needs. The aim is suitable training for quality health care, with a holistic, interdisciplinary, multiprofessional and balanced approach[7].

With the implementation of the DCN, including those governing undergraduate courses in nutrition, new learning scenarios are required and the roles of teachers and students need to be redefined and redirected[8]. This is where education associations, either individually or in conjunction with other professional organizations and movements, play an important role in engaging change processes, which move from being concerns /objectives of a handful of schools or teachers to become significant projects for the professional segment[9].

Amidst this thriving drive for changes in the training of health professionals, the National Forum on Education of Health Professions (FNEPAS) emerged in 2004 with the aim of contributing to these changes based on the principles of comprehensive health care and continuous education. In 2011 the Forum gathers thirteen entities[I] involved in training and development of health care professionals.

Based on the assumptions described above, this text investigates the impact of national higher education policies since 1996 on courses in nutrition, drawing on the data from the Higher Education Census from the period 1996 to 2009, student performance reports, as well as the National Student Performance Examination (ENADE) in 2007, documents published by the Anísio Teixeira National Institute for Educational Research (INEP), an organization controlled by the Ministry of Education. The Census data allows understanding of the situation of these courses in Brazil, with reference to the indicators of number of courses and student enrolments, in both the public and private sector, and academic organization. The ENADE data form one of the quality indicators for the undergraduate courses.

The investigations suggest that the development of nutrition courses, presented by the above data, and the implementation of the National Curriculum Guidelines for undergraduate courses in nutrition have been driving forces behind the creation of the ABENUT, which, supported in the FNEPAS discussions, plays an essential role in guiding the training of nutritionists, while committed to social issues and capable of tackling new challenges that emerge in the area of health professional training.

HIGHER EDUCATION POLICIES - IMPACT ON HEALTH COURSES

Brazilian Higher Education in the 1990s was marked by a boom in the number of places, resulting from the public policies on education that produced a complex and diversified system of institutions, each with their own distinctive formats, vocations and academic practices, and a growth in the private sector and non-university education.

It is revealed that the main factors that determined the profile of Brazilian education, still present in 2009, are associated to the educational policy guidelines defined by the government of Fernando Henrique Cardoso, especially by the former Education Minister Paulo Renato de Souza, during his eight year term (1995-2002), which favoured the private sector. The data presented in Table 1 show the reflection of the policies implemented:

* FNEPAS é composto pelas seguintes entidades: Associação Brasileira de Educação Médica - ABEM, Associação Brasileira de Enfermagem - ABEn, Associação Brasileira de Ensino Odontológico - ABENO, Associação Brasileira de Ensino de Fisioterapia - ABENFISIO, Associação Brasileira de Ensino de Psicologia - ABEP, Associação Brasileira de Ensino e Pesquisa em Serviço Social - ABEPSS, Rede UNIDA, Sociedade Brasileira de Fonoaudiologia - SBFa, Rede Nacional de Ensino de Terapia Ocupacional - RENETO, Associação Brasileira de Hospitais Universitários e de Ensino - ABRAHUE, Associação Brasileira de Pós-Graduação em Saúde Coletiva - ABRASCOe Associação Brasileira de Ensino Farmacêutico – ABENFAR; Associação Brasileira de Ensino de Nutrição – ABENUT.

Table 1 - Number of Higher Education Institutions (HIE), Places, On-Site Undergraduate Courses by administrative category - 1996, 2002, 2009 - Brazil

	HIE			Places			Undergraduate courses		
	Total	public	private	Total	public	private	Total	public	private
1996	922	211	711	634.236	183.513	450.723	6.644	2.978	3.666
2002	1.637	195	1.442	1.773.087	295.354	1.477.733	14.399	5.252	9.147
Δ% 1996-2002	**77,55**	**-7,58**	**102,81**	**179,56**	**60,94**	**227,86**	**116,72**	**76,36**	**149,51**
2009	2.314	245	2.069	3.164.679	393.882	2.770.797	27.827	8.228	19.599
Δ% 2002-2009	**41,36**	**25,64**	**43,48**	**78,48**	**33,36**	**87,50**	**93,26**	**56,66**	**114,27**

Source: MEC/INEP

Data from the Higher Education Census[10, 11], shown in Table 1, one can see that, between 1996 and 2002, the policies adopted enabled greater expansion of the private sector, to the detriment of the public sector, by all the indicators shown.

In 1996, the year the Law of Educational Guidelines and Bases was approved[12], Brazil had 922 Higher Education Institutions (HIE), of which 211 (22,9%) were public and 711 (77,1%) private; 136 (14,7%) were universities, and 786 (85,3%) not universities. Of the total course places 28,9% were at public institutions and 71,1% private, distributed among 6.644 on-site undergraduate courses, with 62,7% of the courses (4.165) offered by the universities, of which 60% (2.495) by the public sector. The courses offered by non-university higher education institutions accounted for 37.3% (2.479).

In 2002, the end of Fernando Henrique Cardoso's presidential mandate, there were 1.637 HEIs, 195 (11,9%) of which were public and 1.442 (88,1) private, 162 were universities (9,9%) and 1.475 (90,1%) non-university. In terms of places offered, 16,6% were public and 83,4% private, distributed among 14.399 undergraduate courses, which reported a 116% growth; the universities offered 8.496 (58,9%) of the courses, however although the public university sector still retained 54,1% (4.599) of that offer, private sector growth in this indicator was 132,7%, while in the public sector it was 84%; 5.913 (41,1%) courses were offered by non-university HEIs.

According to scholars, the higher education reform during the Fernando Henrique Cardoso government, joined three fundamental principles: flexibility, competitiveness and evaluation, aiming at an accelerated expansion of the system[12].

In 2003, Luis Inácio Lula da Silva took office and proposed to boost the public sector. In 2007, the Lula government launched the Support Program for the Restructuring and Expansion of Federal Universities - REUNI13, recommending the creation of evening classes. Fifty-three federal universities have adhered to this program. Even considering the intended public sector investment in 2009, as per Table 1, the majority of undergraduate places and courses were offered by the private sector, with 87,6% and 70,4%, respectively. However, it is noted that this sector grew at a slower rate between 2002 and 2009 than in 1996-2002, while, the opposite was true for the public sector.

The supremacy of the private sector was also maintained in relation to the number of HEIs: in 2009, 89,4% of Brazilian higher education institutions were private and 10,6% public. The higher education system was largely non-university, seeing as only 8% (186) of the 2.314 HEIs were universities and 92% were non-university HEIs, which, by law[14], offer undergraduate teaching without any integration with research and extension studies[15].

Applying this analysis to healthcare courses[I] it can be affirmed that, despite some specific features, the area has not been immune to the private sector growth.

[I] De acordo com o Censo da Educação Superior, os cursos agrupados em nove áreas; Educação; Agricultura e Veterinária; Básicos / Programas Gerais; Ciências sociais, Negócios e Direito; Ciências, Matemática e Computação; Engenharia, Produção e Construção; Humanidades e Artes; Saúde e Bem Estar Social; Serviços[10,11,15] .

Table 2 - Number of undergraduate courses and enrolments in the area of Health and Welfare - 1996, 2002, 2009, Brazil

Health and Welfare Courses	Courses			Enrolments		
	Public	Private	Grand total	Public	Private	Grand total
1996	366	392	758	114.248	134.121	248.369
2002	403	1.172	1.575	115.474	308.909	424.383
Δ%1996-2002	**10,11**	**198,98**	**107,78**	**1,07**	**130,32**	**70,87**
2009	745	2.636	3.381	167.038	641.823	808.861
Δ%2002-2009	**84,86**	**124,91**	**114,67**	**44,65**	**107,77**	**90,60**

Source: MEC/INEP.

Table 2 shows that the profile of education in the health and welfare area has followed the national trend, with high private sector concentration, yet with greater public sector growth in the period between 2002-2009 than the national average presented in Table 1. We can assume that this fact is associated to the movement arising from the concern within the area in relation to a high concentration of private sector-trained health professionals and the increased non-university education. The discussions indicated the need for greater state regulation for opening new courses and better quality training of health professionals, which needs formed the agenda for the 11th and 12th National Health Conferences[1,2].

Also regarding the characteristics of the undergraduate health studies offered, in 2009[15] 50,7% (1.715) of the courses were offered by universities, and of those, 39,4% (675) were public and 60,6% (1.040) private.

In their evaluation of the growth rates of courses in health[I], Veloso, Silva and Souza16 found that there are internal inequalities. Between 1996 and 2008, courses in medicine presented the lowest growth rate, 105%, representing 91 new courses, while the whole field reported a 306% growth in the same period. We assume that this fact was due to the movement launched by Medical Class for regulation of the opening of new courses[3,4]. The courses with the highest growth rates included: Technologies for diagnosis and medical treatment (2,150%), nursing and primary care (512%), therapy and rehabilitation (453%), Pharmacy (443%), Social work and guidance (284%), health (general courses), (130%) and Dentistry (111%).

undergraduate courses in nutrition - expansion profile

Undergraduate courses in nutrition, according to the classification of the Higher Education Census, fall into the area of \health and welfare in the subarea of Therapies and Rehabilitation[II].

Studies into the profile of the expansion of undergraduate programs in nutrition, associated to data on their quality, both obtained from MEC reports, are important tools that reveal the reality of nutrition education in Brazil, its trends and contradictions.

Table 3 - Number of undergraduate courses in nutrition by academic organization and administrative category - 1996, 2002, 2009 - Brazil

Year	University			University Centre			Schools/Colleges/Institutes			Grand total
	Total	Public	Private	Total	Public	Private	Total	Public	Private	
1996	38	23	15				5		5	43
2002	87	27	56	33	2	31	25	2	23	145
Δ%1996-2002	128,95	17,39	273,33				400,00		360,00	237,21
2009	163	56	106	58		58	104	4	100	325
Δ%2002-2009	87,36	107,41	89,29	75,76	-100,00	87,10	316,00	100,00	334,78	124,14

Source: MEC/INEP.

[I] Na classificação do INEP, inserem-se na área de Saúde e Bem Estar, oito áreas detalhadas ou programas, denominadas: Enfermagem e atenção primária; Farmácia, Medicina, Odontologia; Saúde (cursos gerais); Serviço Social e orientação; Tecnologias de diagnóstico e tratamento médico; Terapia e reabilitação.

[II] A subárea de Terapia e Reabilitação agrega os seguintes cursos de graduação: Fisioterapia , Fonoaudiologia , Musicoterapia , Nutrição, Nutrição e dietética, Optometria, Quiroprática, Serviços de saúde mental, Terapia ocupacional.

Review of the data in Table 3 reveals that the public/private relationship is maintained with the same characteristics of the area of Health and Welfare, i.e., in 2009, 81.2% (264) of the nutrition courses in Brazil were offered by the private sector. Bearing in mind the growth rate in the two periods, there has been a disturbing growth in the non-university private sector, particularly of colleges (*Faculdades*), which, by law are only responsible for the teaching. Although in 2009, 50% of courses were at Universities, it is worth noting that in 2002, this proportion was 60%. With the continuation of the expansion profile, in a short space of time nutritionist training will be concentrated in colleges.

When we add to this analysis the results of National Student Examination (ENADE) of 2007, which results are presented in Chart 1, the need for greater regulation and review of the expansion of the area expansion is reinforced.

In assessing the participation of ENADE 2007[17], it can be seen that of the 19,989 participants 84.7% were from the private sector, and the according to the document, the greatest share was from the southeast region. In relation to the academic organization, the largest share was from universities (130), followed by Colleges (88) and University Centres (53).

Chart 1 - Number of students participating and their performance in the ENADE 2007, according to administrative category and academic organization - Brazil

Group	Administrative Category				
	Total	Federal	State	Municipal	Private
Entrants	13.358	1.253	199	399	11.507
Graduates:	6.631	866	197	144	5.424
	Performance by administrative category				
	Overall Average	Federal	State	Municipal	Private
Entrants	37,9	44,4	32,3	39,4	37,3
Graduates:	48,9	55,2	45,7	51,2	48
	Performance by Academic Organization				
	Overall Average	Universities	University Centres	Integrated Colleges	Colleges, Schools and Institutes
Entrants	37,9	39,2	36,7	36	37,1
Graduates	48,9	49,9	48,8	45,3	46,2

Source: MEC/INEP/ENADE.

In the performance analysis by academic organization, as per the information in Chart 1, one can observe that the highest average mark for entrants and graduates is from the Federal Institutions and Universities. The state sector reported the lowest performance for both groups, as did the Integrated Colleges, Independent Colleges and Institutes.

Therefore, the association of studies on the relationship between the nature of the expansion and its connection with the evaluation of nutrition courses requires further development and investigation into how this reflects in the professional class.

nutrition undergraduate courses - national curriculum guidelines

In the health sector, the debate on this expansion has been seasoned by the discussion regarding consolidation of the SUS, with a consensus that professional training and organization of the health system were closely linked. Therefore, there has been an increasingly evident need for organic collaboration between the sectors of health and education, aimed at the effective implementation of the constitutional guidelines of the SUS and the national curriculum guidelines[18].

In 2001, with the approval of the new Curriculum Guidelines for Courses in Health, a bridge between two policies, originating from the Ministry of Health (MOH) and Ministry of Education (MEC) was established. Veloso[19] and Feurwerker[9] conclude in their studies that, in terms of education and health policies, there are greater discussions about the movements for change with the Ministry of Health than with the Ministry of Education. For these authors, the former is engaging to support and lead changes, whereas the Ministry of Education does not seem to prioritize this discussion on its agenda, despite the approval of the Curriculum Guidelines.

The Ministry of Health, responsible for health policies, upon entering discussions about the need for total change in the health professional training, is supported by Article 200 of the Federal Constitution[20], that determines that such training is designed for the Unified Health System (SUS). Hence, it has become the main sponsor of this transformation, through steering programs, but also through education and work programs, which seek greater formative integration with the health service network. It therefore responds to a State demand, but also a demand of social control, considering a "reality" and all the means therein to impose its decision[19].

The DCN for the training of health professionals present some common assumptions, including the need for a new design for the specific context of each profession. They also establish that the training of health professionals should consider the effective health system of the country, seeking to train professionals capable of developing comprehensive health care, focusing on teamwork. They move towards overcoming the hegemony of the teacher-centred biomedical learning model.

Specifically regarding the DCN for nutrition courses, these were discussed as from June 2001, with reference to the draft presented by the MEC, based in Opinion nº 1133/2001-CNE[21], submitted by the Federal Council of Nutritionists (CFN) to all undergraduate courses in nutrition, with participation by the Brazilian Association of Nutrition (ASBRAN) and the Ministry of Education specialist committee. This opinion was later transformed into Resolution nº 5/2001 (Official Gazette of 9/11/2001), establishing the National Curriculum Guidelines (DCN) for undergraduate courses in nutrition[22].

In general the DCN represent progress in relation to the extinct minimum curriculum. The main content resides in the construction of the professional profile, the principles that should govern nutritionist practice, as well as the breakdown of competencies and skills sets. They highlight elements that indicate a more qualitative direction of the course, aiming to make students more able to understand and act in relation to the health needs of the population.

The proposed innovations include: a) stimulating the implementation of complementary activities (training courses, monitors, extension projects), planned throughout the course; b) more flexible system of subjects offered (semester options, year options, credits, modules); c) incorporation of course management requirements, such as participatory development of the pedagogical project and d) guidance towards equal distribution of internship hours (20% of total) in the three main areas of the nutritionist (clinical nutrition, social nutrition, administration of collective meals)[23].

The document makes no mention of minimum total course hours, causing protests by the CFN, which has favoured a 4,000-hour requirement, as defined for most undergraduate courses in health[24].

Ceccim[25] leads us to perceive comprehensiveness as an underlying axis for changes in health care training and the need for a broader understanding of health through the connection of multiprofessional and interdisciplinary fields of knowledge and practices and health care practice innovations.

Costa[7] draws attention to the importance of the teacher's role in the implementation of the DCN for nutrition courses insomuch that among the proposals presented, the learning methodologies need reviewing, including those used in the classroom, as per necessary, and in the new practical settings for the learning process. According to the author, little attention has been given to teacher development for working in new settings, thus suggesting the creation of spaces for teachers to reflect university teaching matters and on the "development of a critical reflective perspective, which can ground the pedagogical changes required for the training of the Nutritionist "(p.97).

Considering the implementation of the Curriculum Guidelines and their advances and obstacles, several spaces for dialogue and collective construction were generated following the creation, in July 2004 of the National Forum on Education of Health Professions (FNEPAS), a platform for networking and partnerships to strengthen actions aimed at transforming health professions. This Forum has come to represent a social actor committed to the transformation of health education in Brazil, and has the main objective of contributing to the process of change in undergraduate study, fostering the concept of comprehensive care and health training.

BRAZILIAN ASSOCIATION OF NUTRITION EDUCATION (ABENUT)- OPPORTUNITIES AND PROSPECTS

ABENUT emerged from the need for deeper discussions regarding specific problems related to nutritionist

training, considering that issues concerning the inadequacy of such training are similar to those for other health professions. The experiences of Education Associations were very encouraging, such as the Brazilian Association of Medical Education, where studies to assess medical education in Brazil supported the Ministry of Health's reorientation programs, initially intended only for courses in medicine, but later extended to other courses in the area of health.

Likewise, concern about the disorderly expansion of undergraduate programs and the quality of professional training, as described above, indicated a need for an organization to centralize the education discussion. The difficulties of DCN implementation were important aspects for the creation of ABENUT, since most of the teaching staff from Nutrition courses have not had teacher training and such training has not been included in the MEC evaluation policies for undergraduate courses. However, we cannot fail to highlight the leading role that FNEPAS has played. As Lima and Pereira26 have noted, in the FNEPAS, through the joint efforts and connection of the member organizations, the discussions helped overcome the fragmentation arising from the positivist scientific approach and enabled an education where evaluation-based regulation of educational institutions elevated the social commitment to public health policies, as well as multidisciplinary relationships and creative learning experiences, in order to build a continuous, cross-sectorial and multiprofessional education.

In light of these challenges, ABENUT was founded on 18 May 2008; a not-for-profit civil association with educational/scientific purpose and a corporate entity under private law. It proposes to be the representative body for nutrition education institutions in Brazil; instructors of professional nutritionist training and nutrition students, in relation to the Ministries of Education and Health and other civil society organizations. Its objective is the development and improvement of nutritionist training.

Since its inception, its representatives have participated in the FNEPAS Board, the Technical Committee of Multiprofessional Residency and the Technical Committees of the Federal Council of Nutritionists.

In 2010 it had roughly 60 members, setting the goal of expanding the participation of undergraduate courses, teachers and students, making use of conferences and seminars for the profession in order to raise awareness, as happened in the Brazilian Congress of Nutrition in May 2010, in Joinville, which gathered nutrition course coordinators in a workshop on management of undergraduate course teaching in nutrition.

As we conclude this text, the purpose of which is to present the key indicators that led to the creation of the Brazilian Association of Nutrition Education, we can indicate the prospects for this Association, which do not overlap the activities already undertaken, but present a major challenge: to raise the awareness of training institutions through inclusion in the discussion of the interprofessional training of the Nutritionist, trying to break the culture of fragmentation and discrimination of health-care professionals; so that they understand their social responsibility in the training of their professionals, defend the public character of health and education policies, and embrace the idea that, besides being a constitutional right of every citizen, it is the duty of all those who have chosen to be health care workers to defend their principles. Such principles that must be present in their relationship with the "other", with a humanistic and comprehensive approach, whether the "other" be a user of the health system or a member of the health team.

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Preliminary notes on the Brazilian Association of Physical Education Teaching for health – ABENEFS

Notas preliminares sobre a Associação Brasileira de Ensino da Educação Física para a Saúde – ABENEFS

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Palavras-chave: Educação Física; Treinamento; Ensino; História.

Keywords: physical education; training; education; history.

INTRODUCTION

In a recent and pleasant reception enjoyed by the Brazilian Association of Physical Education Teaching for Health (ABENEFS) at the National Forum on Education of Health Professions (FNEPAS), we were also handed the challenge of making a presentation to colleagues from other areas of health outlining the background, advances made and dilemmas of our profession. We believe this forum will support a more harmonious and fruitful relationship between physical education and other categories of health, in the different learning and practice settings, where we have met in recent years to share our knowledge and frustrations, in short, where we seek the alternative point of view for training and multiprofessional intervention in order to achieve comprehensive training and health care.

Thus, we aimed to introduce physical education in terms of who we are, what we do and what ABENEFS intends to undertake to strengthen the ties with teachers, students, professionals and subjects* in order to learn and contribute to the transformation processes in multidisciplinary health training. There is no *a priori* concern in centering the narrative of the text on an exclusively pragmatic or scientific historical basis. These factors naturally delimit one another, in virtue of our own restrictions in terms of space, knowledge and the matter at hand.

With this understanding, we hope you enjoy reading and reviewing the essay, and we would like to make it clear that our opinions do not necessarily represent the same ideals of the whole physical education profession, although the proposal has been well received by leading researchers into training in our field and in health. The text is nothing more than an effort by academics of a young profession, aware that doctrines of the Sanitary Reform Movement and the care that the population long for, must be related to high quality multiprofessional training in health.

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HISTORY OF PHYSICAL EDUCATION: BRIEF OVERVIEW

Training in Physical Education in Brazil began under the auspices of the Royal Military Academy. Back in the imperial period, Opinion Report # 224 (1882) by Rui Barbosa highlights a proposal for the creation of a Regular Gymnastics School, that does not seem to have been carried out in full. However, our military roots are clearly seen in the training of 20 civilian teachers, 60 monitors, 8 first lieutenants and two medic lieutenants in the Provisional Course of Physical Education (class of 1929) of the Military Centre of Physical Education (1922), which became the Army School of Physical Education[1].

From 1930 onwards, several training fronts emerged, whether through the creation of higher education schools for training physical education instructors for schools or through emergency courses and training for gymnastics instructors, medics specializing in Physical Education, massage techniques and sports coaching[2]. In a more current context, the report on the history of undergraduate health courses revealed a 301% rise in the number of Physical Education courses (117 versus 469) between 1991 and 2004[3], and in a recent comparison, this exponential increase (1991=117, 2006=617, 2008=783) follows the trend in other health courses, but in greater proportion (P.E=569%; overall=458%)[4,5].

It is important to clarify that as well as Physical Education being considered a profession belonging to the health sector, it is also considered a profession and curricular element of the education sector. This fact is represented by the distinct training programs for the qualification of bachelors[6] to work outside the school environment and of school teachers[7]. However, it is clear that health-related content can and should be addressed by trained teachers in the school environment, as noted by Loch[8] and Nahas[9]. Yet, the scope of the ABENEFS covers bachelor degree programs in Physical Education, according to the grounds described in Fonseca et al[5].

Continuous training in physical education in Brazil through graduate studies has also increased quantitatively since the first Masters' courses in the country (USP, 1977; UFSM, 1979, UFRJ, 1980) until today, currently with 25 graduate programs, 13 of which offer masters' and doctorate qualifications and 12 only masters'. The start of this teaching qualification process also expanded with its entry into programs in related fields and, especially, masters'/doctorate studies abroad, directly influencing the choice of an academic-practical orientation, which began within the field of Physical Education. After three decades since the first graduate courses in physical education and 80 years of initial training efforts, it can be asserted that Brazilian physical education has Eurocentric and American roots.

In terms of scientific research, physical education has more than 400 research groups featured in the CNPq search directory. We have scientific journals catalogued in leading indexation databases and publish in national and international journals, covering the fields of social sciences, humanities and, in particular, health sciences. There are several scientific and professional associations within the area of Physical Education, including the Brazilian Society of Physical Activity and Health, which seeks to bring together researchers from different fields of knowledge.

Despite the prominent and intense growth of Brazilian Physical Education and the recognition it enjoys in the international arena, we must consider that our profession is new in relation to the more traditional health professions, and also that our growth has been intense and apparently involving conflicts in some historical periods, so it is not uncommon to find reports in the literature about the subjugation of Physical Education to the interests of the nation state, including military and medical-health interests. These are all marks of the history of our profession, and especially of the generation of academics and professionals who have made and make great contributions, despite the inevitable frustrations inherent to the progress and setbacks experienced.

We can highlight, however, that in recent years, particularly in the late twentieth century and first decade of this century, the possibilities for intervention in physical education have expanded in size and shape; our profession is now regulated[10], we have been recognized as a health profession[11], academics expressed our importance to the SUS3 and, above all, at the 13th National Health Conference the motion for social control was declared in relation to the importance of physical education to comprehensive care[5, 12]. Alongside these achievements, we have also benefitted from public investments in training reorientation policies and

programs[13, 14] in the expansion of public interventions to promote physical exercise[15, 16] and in research programs[17]. However, despite these opportunities and responsibilities, we are aware that now is not the time for gloating, but rather for more hard work. In virtue of the above context we requested inclusion in the FNEPAS, as we understand that this moment in time also represents a milestone that requires a new profile for the physical education graduate, focused on comprehensive training and health care.

ABENEFS: HISTORY, GROUNDS AND PRELIMINARY PROPOSITIONS

foundation and purposes

The creation of ABENEFS emerged through debates in physical education graduate studies at UFSC, in scientific events, and disturbing observations, here and elsewhere by authors[5], as well as dialogues with peers of physical education and experiences in service-learning initiatives with colleagues from other health professions. These observations and readings start to become clear and take shape as physical education is considered by policies/programs for initial and continuous multiprofessional training in health care. Finally, our certainties about the potential of physical exercise, in different practices, for physical and mental health care, both at an individual and collective level, as well as our suspicions about the limited time devoted to learning about health matters during physical education training, were confirmed.

Meanwhile, two important initiatives to respond to new demands for physical education training for health were implemented, marked by Physical Activities Sciences at USP/East in 2005, and the Physical Education Course - Health Modality at UNIFESP, in 2006. We therefore began to observe an epistemological incompatibility, with graduate training in physical education involving socio-political knowledge and technical and scientific expertise in health, but also having to consider many other demands in sport and its different aspects (education, leisure, participation, competition). More importantly, we wondered where the space and time could be made to take responsibility for theoretical guidelines, pedagogical guidelines, sets of practices compatible with inductive programs (PET-Saúde, Pro-Saúde, etc.), SUS guidelines and principles and other demands in different areas of intervention in physical education and health, throughout the entire training process.

ABENEFS was created, essentially, to attempt to respond to and provide solutions for these and other issues addressed in the previous essay[5]. We are aware of our limits, but we also know that this struggle is minor in relation to the other challenges tackled by our masters of Physical Education and by many other scholars who have helped and help build our Unified Health System.

The purposes of ABENEFS, therefore, may be declared as follows:

i. To propose and support policies and actions to ensure coordinated actions between initial and continuous training in physical education with emphasis on health, in line with the organization of the Unified Health System (SUS) and other demands of individual and collective health;
ii. To propose and support policies and actions aimed at initial and continuous training and the training of teachers and professionals in Physical Education, who work in service training (intern supervisors and preceptors), in the SUS and other spaces of health intervention;
iii. Advise, when requested, on the creation, review and adaptation of political-pedagogical projects of undergraduate and graduate programs that address the teaching of physical education and health, while respecting, as a premise, any regional demands and vocations of health care;
iv. To represent members and graduate courses in Physical Education with an emphasis on health at the FNEPAS, the Ministry of Health, Ministry of Education and other governmental, scientific or occupational agencies and associations, that in some way involve matters concerning the initial and continuous training of the physical education graduate.
v. To integrate physical education courses with emphasis on health and governmental initiatives to strengthen the development of the field of Physical Education.
vi. To enter into agreements, cooperative arrangements or contracts with public or private entities in order to achieve its objectives.

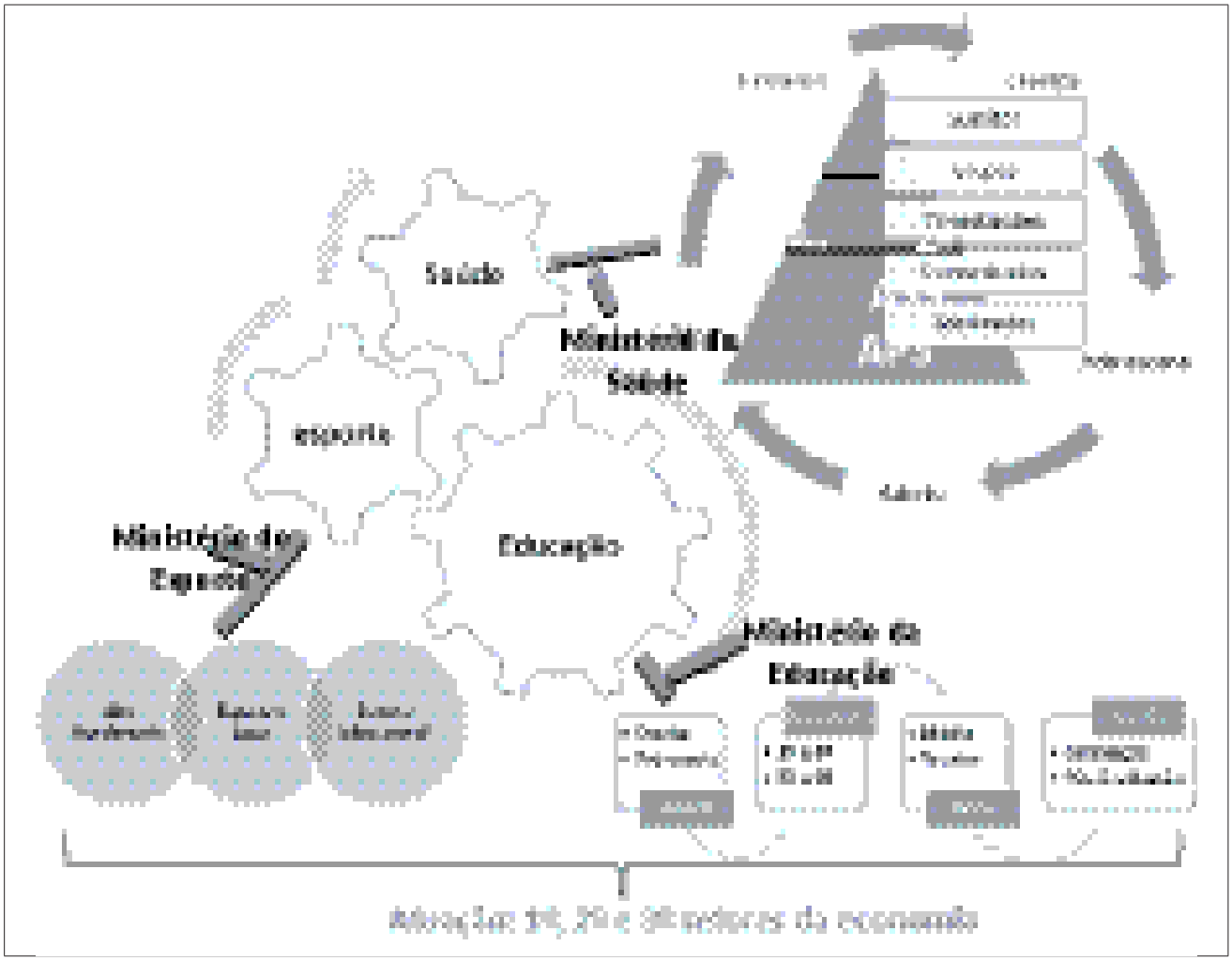
SCOPE AND PRACTICES

In light of this presentation to peers, we cannot shirk our obligation to present some definitions about the scope and objectives of the study, as well as the grounds to justify the inclusion of physical education activities in the health sector. Again, we would point out that these are merely indications by the groups and do not necessarily represent the opinion of other colleagues in the field of physical education.

For the purposes of definition, physical education is a field aimed at training, investigation and academic-professional intervention to promote individual and collective physical activity. It is also considered a profession and a curricular element/discipline.

The field of physical education is basically composed of three areas of intervention, namely: Health, Education and Sports. In light of the set of accumulated evidence and knowledge produced in each of these areas, it would seem coherent and feasible that training, intervention and research in physical education be aligned to the ministerial organization of the Brazilian state and the arrangement of the economic sectors. Figure 1 illustrates this proposal.

Figure 1. Possible structural organization of physical education



In this model, we find that the respective areas of training, intervention and investigation of physical education can also be composed of sub-areas compatible with the organizations of the ministries involved (sport, education or health).

Specifically in the case of the health sector, we made an adjustment in accordance with our scope of intervention, designated as Physical Activity. Others may have a different opinion, but considering that definitions can be double-edged, and this text is not the stage for epistemic

discussions, suffice to say we have adopted the term Physical Activity because it is easily recognized nationally or internationally by both laymen and experts. That is, it facilitates communication between peers, researchers, and especially relationships between professionals and students, professionals and patients or professionals and subjectsa.

Physical activity is considered a human behaviour and, as per defined by Nahas (2010) "*Human physical activity has equally significant characteristics and determinant factors of a biological and sociocultural order in the choices and benefits derived from such behaviour*." In other words, Nahas' concept emphasizes that both the choices and perceived benefits in relation to physical activity depend on biological and sociocultural issues, without, however, establishing any value scale, in line with contemporary thought that seek to understand human complexity.

Meanwhile, Casperson et al[18] (1985) descriptive and operational definition is accepted worldwide: *"physical activity is defined as any bodily movement produced by the skeletal muscles that results in energy expenditure."* The caloric output is derived primarily from four contexts or domains: transport/locomotion, household activities, occupational activities/work, leisure activities. Leisure comprises most of the interventions of Physical Education, through the use of the content inherent in our professional practice, namely: gymnastics, exercise, dance, wrestling/martial arts, sports.

It is noteworthy that, although society in general recognizes that physical education is the primary motivator of intervention in physical activity, and even though scientific communities recognize that physical activity is the scope of Physical Education, one must acknowledge the transdisciplinary and multi-professional potential of that scope, in order to better establish academic and intersectorial boundaries and relations in terms of research and in terms of physical activity intervention.

Regarding research, it should be highlighted that physical activity can be performed in the light of the mother discipline and derivative disciplines of the natural sciences, social sciences, humanities and applied sciences, as well as areas of knowledge without any disciplinary "stability". Therefore, knowledge of sub-areas of public health (epidemiology, social sciences and humanities in health, health planning and management) and clinical health (physiology, kinesiology, functional assessment, etc.), leisure, sport, education, urban planning, the environment and economics, among others, can help to a lesser or greater extent in the promotion of physical activity and the search for explanations of causes and consequences of the practice (or lack) of physical activity.

The same logic can be applied to intervention in physical activity behaviour, which is also not exclusive to any one profession, as although we consider physical education as being primarily responsible for promoting physical activity for different segments of society and life cycles, physiotherapy and occupational therapy also intervene in human physical activity in the rehabilitation and recovery of voluntary movement for work, leisure, mobility (ADL and IADLs) and other daily chores. Moreover, nutrition, psychology, medicine, nursing, as well as other health professions, also can and should understand the benefits and general recommendations for promoting physical activity.

We stress that these observations may not match the consensus among other professions, but no matter, this is a space precisely for sharing knowledge and practices, recognizing the tenuous lines of intervention, but aimed at comprehensive health for the reason of our existence: people!

Moving on, we recall that the benefits derived from physical activity through content of physical education and other professions are useful both for sedentary people and athletes, from sports training to competitive sports and from pregnant women (conception/baby)design/Baby) to the elderly. Finally, physical activity can be promoted individually, among groups, organizations, communities or whole societies. There is a body of forceful and moderate scientific evidence[19] regarding disease prevention, treatment and health promotion through the practice of physical activity for people in different life cycles and conditions.

By virtue of this evidence, of the profile of morbidity and mortality caused by non-communicable diseases and injuries, and of the recognition of physical education for the Unified Health Health[12], among other academic and professional endeavours, physical activity has been included in the Pact for Health, specifically within the strategic actions of the National Health Promotion Policy (Pact for

Life). Such fact has enabled the physical education profession to be included in actions related to the National Plan for Physical Activity, National Network of Physical Activity, Family Health Support Centres (NASF) and also in the newly created Health Academies Program. The different lines of care listed by the Department of Strategic Programmatic Actions of the Ministry of Health also include potential intervention in physical activity that we expect to be implemented in the near future.

In addition to these possibilities, Physical Education has historically participated in other interventions in public, private and voluntary sector spaces (NGOs, foundations, institutes etc.), through individual, clinical and collective interventions.

ORIENTATION FOR INITIAL TRAINING: PRELIMINARY NOTES

Considering the range of possible spaces for intervention for physical education, a curriculum in physical education, in the health modality, must have clear objectives that are consistent with the possibility of intervention. In other words, training should be geared primarily to the entire life cycle for all levels of intervention and to all levels of health care. One therefore perceives the exciting and necessary challenge of our actions to help achieve comprehensive health care. Thus, physical education graduate courses, with emphasis on health, may have the following objectives:

General Objective: to train graduate professionals in Physical Education at a level of excellence, to intervene academically and professionally toward the promotion of physical activity, related to comprehensive health, throughout the entire life cycle, also with intervention levels and levels of health care in order to increase the chances of adoption and maintenance of a physically active and healthy lifestyle among individuals and groups, recognizing the different conditioning and determining factors underlying the complexity of human health.

The **specific goals** are:

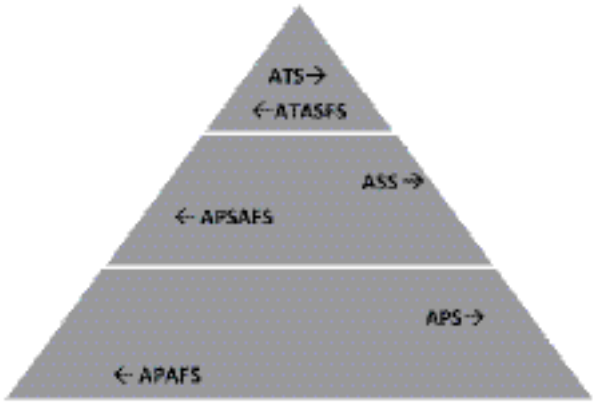
a) to train professionals to plan, supervise, coordinate, implement and evaluate physical activity programs for promoting health and culture, prevention or treatment of non-communicable diseases and health problems in pregnant women, children, teenagers, young adults, middle-aged adults and elderly people in various conditions.
b) to train professionals to plan, supervise, coordinate, implement and evaluate physical activity programs for promoting health and culture, prevention or treatment of non-communicable diseases and injuries at the level of societies, communities, organizations, groups and individuals, and
c) to train professionals to plan, supervise, coordinate, implement and evaluate physical activity programs for promoting health and culture, prevention or treatment of non-communicable diseases and injuries at the three level of health care.

Of course, in light of other health categories, and even within the field of Physical Education, the specific objective of intervention at the second and third levels of health care may sound pretentious and hard to achieve. However, we are aware of our legal and technical limits of performance, a fact to be considered when moving into an intervention scenario in which we assume the roles of "protagonists" or "supporting parts", depending on the level of care required.

The key issue in these preliminary propositions is that the academic community and young people interested in choosing a bachelor's degree in Physical Education, with emphasis on health, understand that this type of training is directed primarily toward a profile of action that allows the graduate to move safely between the three strands (manager, trainer and entrepreneur) of the three economic sectors (public, private and social/voluntary sector) and in the life cycle, which can benefit from physical activity. In short, it is attempts to provide coherent and objective training for an activity profile that is clear, legitimate and decisive in dynamic contexts of the health sector.

Based on these assumptions, we developed a preliminary model to clarify our limits and possibilities in relation to the levels of care. To this end, we combined the simplified pyramid model of health service hierarchy with an adapted model of levels of intervention in physical activity[9]. This idea is represented in Table 1.

Table 1: Levels of Intervention of the Physical Education and Health Professional

Service Locations	Levels of Care	Service Locations
Organizations		Hospitals and Rehabilitation Centre
Groups		Specialist Clinics
Communities and Societies		Homes and Health Units

APC = Primary Health Care; ASS = Secondary Care Health; ATS = Tertiary Health Care; APAFS = Primary Care in Physical Activity and Health; ASAFS = Secondary Care in Physical Activity and Health; ATAFS = Tertiary Care in Physical Activity and Health

This model shows that training in Physical Education with an emphasis on health should enable horizontal and vertical movement, along tenuous lines focused on physical activity, but without losing sight of matters of comprehensive health care of individuals and groups. In Table 2, there is a brief description of the intervention segments split by levels of care in physical activity and health.

Table 2: Care Levels in Physical Activity and Health and their segments.

Level of Care in Physical Activity and Health à	**APAFS** = Primary Care in Physical Activity and Health	**ASAFS** = Secondary Care in Physical Activity and Health	**ATAFS** = Tertiary Care in Physical Activity and Health
Level of Intervention in Physical Activityà	a) Societies and b) Communities	Groups and Individuals	Organizations
Segmentsà	a) Countries/Nations, State, Regions, Cities. b) Small Cities, Districts, Neighbourhoods, Coverage Areas of Family Health Strategy and other service networks.	Fitness Centres, Sports Clubs, voluntary sector, parks, squares, clinics, studios, personal training.	Companies, Hospitals, Clinics, *CAPS, Military Institutions, Churches, Hotels, Cruise Ships, Supplementary Health Services, Voluntary Sector (NGOs, Charities, etc.)

* **Although** CAPS is in the secondary level of health care, in this model of physical activity it fits better into the tertiary level.

The small sample is extended with the inclusion of niches for each segment. For example, at the primary level (APAFS), interventions in societies include the sub-segment of cities, which, in turn, has niches such as government incentives offered through all three federation bodies to implement programs, such as the National Network of Physical Activity. Regarding the APAFS combination - Communities-Areas of coverage, there is the niche of the family health support centres (NASF) in their different modalities. In the case of the ASAFS combination, Groups-Fitness Centres, Academies, there are different niches of service organization, such as: care split by injury, by life cycle, by services/modalities or mixed. Finally, in an ATAFS combination, Organizations-Companies, there is the niche of industries which, incidentally, seems to be one of those that has more physical education professionals in health promotion programs, with enormous potential to approach the adult public and their families.

Finally, a compendium of the classification would be useful for illustrational purposes, but would not be suitable for this paper. It is, however, suitable to present some comments on the characteristics of each level of care in physical activity (Table 3).

Table 3: General Characteristics of Intervention at Each Level of Care in Physical Activity.

Characteristics	**APAFS** = Primary Care in Physical Activity and Health	**ASAFS** = Secondary Care in Physical Activity and Health	**ATAFS** = Tertiary Care in Physical Activity and Health
Physical Activity as end purpose	++	+++	+
Socio-political knowledge	+++	+	++
Technical/clinical expertise	++	+++	++
Approaches	Political and Environmental Informative	Social and Behavioural Informative	Social and Behavioural Political and Environmental Informative
Activity Profile	Management and coordination	Instruction	Management and instruction
Autonomy	++	+++	+
Multiprofessional relation	+++	++	++

This classification is intended to facilitate future career choices of students and, moreover, facilitate curricular organization. Obviously it is not without mistakes, grounds for criticism and improvement. Likewise, it is noteworthy that these are not watertight border lines, as there are also intersections between the levels of care.

Regarding APAFS, Physical Education professionals are assigned primarily to manage policies and programs for physical activity for large population groups, in partnership with other intersectorial actions, which fact calls for a latitudinal emphasis on multidisciplinary relationships. As a rule, physical education professionals will take charge of sports and leisure departments, coordinate physical activity promotion programs in municipal and state health departments or national, state or local projects that have primary aim of physical activity. As in primary health care (PHC), it is at the level of APAFS that the highest number of people can be reached and through which all physical activity promotion actions could be coordinated.

Regarding ASAFS, Physical Education professionals are assigned to carry out coordination, supervision and, in particular, instruction. It is at this level that the majority of services by professional Physical Education graduates have been concentrated, usually in sports clubs, gyms and other areas where physical activity is the end activity. In these places, there seems to be less direct establishment of multidisciplinary relationships, allowing a greater degree of autonomy of the Physical Education Professional. This also occurs at the level of secondary care health (SHC), the ASAFS services are more specialized, covering interventions for individuals or small groups with common needs, conditions or interests.

Regarding ASAFS, Physical Education professionals are assigned to carry out coordination or instruction activities. The physical activity programs/projects developed at this level are performed in organizations where physical activity is not the core activity; these are activities/services that represent a part of larger staff programs at companies, treatment at large hospitals, educational and sociocultural activities in rehabilitation centres etc.. There is a certain degree of autonomy in relation to technical procedures, but a wide range of conceptual and declarative expertise is required to establish multiprofessional relationships with areas of health and administration, among others. As occurs at the level of tertiary health care, the ASAFS services should be adapted to the systems of organization and administration.

Regardless of the level of health care and the level of care in physical activity and health, it is known that the knowledge and practices of health professionals require practical technologies (hard, light-hard and light) and also knowledge foreign, not exclusively, to training and professional practice in physical education. The use of

this knowledge requires, necessarily, that the training be based on a curricular structure or model that accommodates legal requirements in terms of specific aspects of the profession, the consolidation of knowledge in physical education, collective health and health-related physical activity. From this perspective, table four perhaps supports, in the broadest sense, the construction of curricula for the training addressed by the ABENEFS.

Table 4: Model for Curricular Organization in Physical Education and Health

LIFE CYCLE	Health Care		LIFE CYCLE
	Level of Care in Physical Activity and Health	**APAFS** = Primary Care in Physical Activity and Health **ASAFS** = Secondary Care in Physical Activity and Health **ATAFS** = Tertiary Care in Physical Activity and Health	
	Physical Education Content:	Physical exercises, gymnastics, dance, wrestling/martial arts, games and sports.	
	Unit of knowledge of Broadened Training	Human-society relationship; Biology of the human body; Production of Scientific Knowledge and Technology;	
	Unit of knowledge of Specific Training	Cultures of human movement, instrumental technique, educative-pedagogical	
	Axes in Physical Education and Health	Field and area identifiers; Policy and Management and Physical Activity and Health; Care in Physical Activity and Health; Knowledge Production and Divulgation	
	Natural sciences, social sciences and humanities		

Health care encompasses everything involved in looking after human health, including actions and services of health promotion and the prevention, rehabilitation and treatment of diseases**.** Therefore, as a starting point, one can presume that all the health professions apply their training, intervention and research efforts with the goal of improving health care. Given this assumption, it seems reasonable that a curriculum for Physical Education and Health should also be organized in such direction, which is why the term Health Care is included in the first line of the curricular model/structure.

In the second line, the level of care in Physical Activity and Health is indicated, precisely to establish consistency with the goals of an initial training course in Physical Education and Health, as described above. In the third line, the contents of physical education emerge as essential means to achieve the objectives. The fourth and fifth lines contemplate legal requirements as per set forth in Resolution 07/2004[6]. Then the axes in Physical Education and Health are possibilities to bring the traditional courses or modules of the field closer to other new knowledge and practices necessary for health intervention.

Finally, it can be seen in this model that studies regarding the life cycle in various health, socioeconomic and cultural conditions, must be included in all the methodological strategies adopted from the beginning to the end of the course. In other words, this is a crosscutting theme inherent to our practices, which, in turn, must be analysed and justified from the perspective of the natural sciences, social sciences and humanities. Among other obvious reasons for the need to contemplate popular wisdom, knowledge from other sciences form the basis of the model, a fact which further supports the presence of physical education among the health professions and within the academia.

In reviewing these suggestions, we must also consider the necessary establishment for revising our conceptions of curriculum, still structured around disciplinary units with learning apparently centred on the "banking view" of education5. Perhaps this is not a situation exclusive to physical education, but the ABENEFS enjoys the support of other educational associations and the FNEPAS to learn more about active teaching-learning methodologies in professional health training.

In addition to what was described in this text, the ABENEFS is specifically involved in physical education training with an emphasis on health, because we know that there are teachers and students interested in abandoning the myopic pragmatism-centred training and adopting training based on an extended concept of health, focusing on pedagogical approaches that consider the actors involved as subjects of the teaching-learning-work process. In other words, abandoning training directed at the market reserve to adopt training aimed at

the professional profile equipped with a systemic outlook and habits of self-learning for collective action, in favour of population empowerment[5].

This process involves bringing together the knowledge and practices of collective health with the scope (physical activity), content (physical exercise, gymnastics, games, sports, wrestling/martial arts and dance) of Physical Education and knowledge produced by physical activity related to health5. It should be noted, however, that this process is slow and must be based on respect for the constraints of university structures, the history of each course and specific regional and cultural aspects. With respect for the boundaries and with focus on the process, for in health the product will never be finished.

FINAL CONSIDERATIONS

Even considering the limitations of the indications and ideas generated through the initial discussions of the authors, which so not necessarily represent the debate in the field of Physical Education, we hope to have achieved our goals in order to tighten our multidisciplinary relations health. We know that the challenges are multiple, but the effort and initial results seem to demonstrate a positive and significant correlation, as we have seen in the warm welcome afforded by the FNEPAS. We have the support of all education associations of health professions that now, more than ever, are also part of the history of physical education.

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