

# The health care in scene: a training experience in Nutrition at Universidade Federal de São Paulo, Baixada Santista campus

## O cuidado em saúde em cena: relato de experiência na formação em Nutrição na Universidade Federal de São Paulo *campus* Baixada Santista

Maria Fernanda Petrolí Frutuoso<sup>1</sup>

<sup>1</sup> Universidade Federal de São Paulo, Departamento de Gestão e Cuidados em Saúde, Instituto de Saúde e Sociedade. Santos-SP, Brasil.

Correspondence  
Maria Fernanda Petrolí Frutuoso  
E-mail: fernanda.frutuoso@unifesp.br

### Abstract

From the report of a scene lived in an interdisciplinary activity of the Nutrition Course of the Universidade Federal de São Paulo, campus Baixada Santista (Federal University of São Paulo, Baixada Santista campus), some aspects of health care for the training of nutritionists were discussed. In this training experience, the construction and execution of care projects for a family, composed of the mother and four children, have raised questions about the care in vulnerable situations, including food, for all students, regardless of the training area. The use of food surveys and anthropometric data for nutritional diagnosis lost meaning in the complexity of the family's life and health condition, the possible food insecurity situation and the perspective of care based on interdisciplinary and intersectoral actions. Based on the diagnosis of dyslexia in children, the social construction of health and the possible pathologization of life were topics of discussion among students, teachers and health team. We concluded that this strategy of interdisciplinary training causes the questioning of decontextualized diagnoses and care actions that reinforce the vulnerable life and health conditions, which result in prescriptive professional practices with little resolution. It is not a matter of devaluating the use of protocols, techniques and prescriptions in health care, in the training and professional practice of nutritionists, but in giving meaning to their use.

**Keywords:** Teaching. Nutritionists. Unified Health System. Nutrition. Teamwork. Integrality In Health. Social Vulnerability.

## Resumo

A partir do relato de uma cena vivenciada em uma atividade interdisciplinar do curso de Nutrição da Universidade Federal de São Paulo, *campus* Baixada Santista, discutiu-se alguns aspectos do cuidado em saúde para a formação de nutricionistas. Nessa experiência de formação, a construção e execução de projetos de cuidado para uma família, composta pela mãe e quatro filhos, trouxeram problematizações quanto ao cuidado em situação de vulnerabilidade, incluindo alimentação, para todos os estudantes, independente da área de formação. O uso de inquéritos alimentares e dados antropométricos para diagnóstico nutricional perdeu sentido diante da complexidade da condição de vida e saúde da família, da possível situação de insegurança alimentar e nutricional e da perspectiva de cuidado a partir de ações interdisciplinares e intersetoriais. Com base no diagnóstico de dislexia das crianças, a construção social da saúde e a possível patologização da vida foram temas de discussão entre alunos, docentes e equipe de saúde. Conclui-se que esta estratégia de formação interdisciplinar provoca o questionamento de diagnósticos descontextualizados e de ações de cuidado que reforçam as condições vulneráveis de vida e de saúde, que resultam em práticas profissionais prescritivas com pouca resolutividade. Não se trata de desvalorizar a utilização de protocolos, técnicas e prescrições no cuidado em saúde, na formação e prática profissional de nutricionistas, mas de dar sentido ao uso.

**Palavras-chave:** Ensino. Nutricionistas. Sistema Único De Saúde. Integralidade em Saúde. Vulnerabilidade Social.

## A scene to think about health care

*The team of the Family Health Unit suggested that we follow a case of a single woman, mother of four children, being that three of them had a possible diagnosis of dyslexia. At the first home visit, the students and I entered the house built with wooden slabs in a winding alley of the stilt region. The community health agent was with us. It was a sunny afternoon and the house, lit with electric light, was a small room that served as bedroom, living room and kitchen, with a tiny separation for the bathroom. It was very hot and at the time of the visit only the youngest son was at home with his mother, Ana. The boy said that he was thirsty and opened the refrigerator to get some water. The refrigerator door was empty and we could not see what was inside the appliance. We spent most of the time talking about the fifteen, twelve, five, and two years old children. Everyone attended daycare or school. The family's income came from the Bolsa Família Program and the pension paid by the father of the*

*two older children, who were currently unemployed. After the visit, walking with the students back to the health unit, many questions arose, among them: How do they sleep? What they eat? Are Ana's three children dyslexic? What can we propose in the care project, since there is nothing obvious like the diagnosis of some Ana's disease or malnutrition of the children?*

This is the report of a scene of the experience as a teacher, since 2009, in one of the interdisciplinary activities involving the teaching-service integration of Nutrition Course of the Universidade Federal de São Paulo, Baixada Santista *campus* (UNIFESP-BS). It is understood that experience “is what occurs to us, what happens to us, what touches us. Not what occurs or what happens. Many things happen every day but, at the same time, almost nothing happens to us” (p.21).<sup>1</sup>

In this sense, the choice of the scene considered the dislocations, estrangements and possibilities that emerged during the experience of construction / execution of care projects, from the accompaniment of Ana and her four children, by students, teachers and workers of a basic health care unit. Inspired by the proposal of a “device for thinking about the forces that were crossed at that time” (p.57),<sup>2</sup> it was hoped, from the scene, to problematize some questions related to health care, discussed by all actors of this interdisciplinary teaching-service integration experience.

The commitment of teaching-service integration of UNIFESP-BS requires the active posture of the student in the production of knowledge and care, and facilitator / mediator attitude of the teacher in the teaching / learning process, in a way of acting and caring that is permeated by advances, but also by tensions and disputes.

Studies have shown that integration has produced changes in service practices and in the construction of care networks<sup>3,4</sup> and have been striking in the evaluation of students on the training process.<sup>5</sup> For Nutrition training, the interdisciplinary experience has evidenced the power of teamwork and the construction of caring strategies, from listening and bonding, in which the other person is recognized as legitimate, with his/her knowledge and desires. On the other hand, the students point out difficulties in proposing shared actions of care based on the demands and meanings for the subject and refer fear of losing their professional identity in actions as well as technical aspects consolidated in the area, such as nutritional diagnosis and the prescriptive dietary guidelines.<sup>6</sup>

To insert the students in the scenarios of professional practices, in the perspective adopted by the University, implies, among other objectives, to discuss the conduct of each professional area and the conception of health and care, including aspects related to food.

Many authors have looked at the discussion of health care,<sup>7-11</sup> indicating that one of the perspectives of care, that of standardization of life that prioritizes the logic-complaint-diagnosis-

conduct and fragmented care actions, has not responded the health needs of individuals, families and communities.

Health care involving the nutritional dimension is predominantly based on the relationship between nutrient intake and the risk of illness and death, resulting in behaviors based on normative and guilty dietary prescriptions, far from the symbolic, social, cultural and subjective environment of food and of eating.<sup>12,13</sup>

In this context, without exhausting the discussion that health care instigates, it is important to give visibility to the issues that arise from the insertion of students from different professional areas into a basic health care unit in the perspective of training and health care. That is, the interdisciplinary training strategies of UNIFESP-BS provoke what kind of problematization of the predominant practices and what possibilities of joint construction of other propositions related to health care?

### About the pedagogical context of the scene

The Political Pedagogical Project (PPP) of the UNIFESP-BS Nutrition Course, started in 2006 and updated in 2016, is guided by the inseparability between teaching, research and extension; by professional practice as the guiding principle of the PPP; by interdisciplinarity and integration with the community.<sup>14</sup> This political-pedagogical approach, inserted in the movement of changes in health education, values the dissociation between the locus of formation and work, inserting students in places of professional practice, strengthening the formative role of the Unified Health System - SUS<sup>15-17</sup> and contemplating the social needs of health, with emphasis on SUS, as recommended by the National Curricular Guidelines of the Course.<sup>18</sup>

Having as profile of the egress the “interprofessional training based on ethical and humanistic principles, focused on a vision of integral care and health care of individuals and collectivities, and focused on teamwork, built on the continuous practice of knowledge and experiences acquired in the society-university interface, in all periods of the Course” (p. 29),<sup>14</sup> the curricular matrix is structured in four axes, composed of modules that bring together related disciplines / subject areas, favoring the construction of teamwork, as well as the integration of content and the empowerment of training processes in search of integral care.<sup>14</sup>

One of the axes - “Approach to the specific practice of the Nutritionist” - is called the specific axis, since it is directed only to students of the course and its modules serve the great areas of “Attention in Nutrition” and “Practices with Food”, fundamental for the training of nutritionists.

The other three axes - “The human being and his social insertion”, “Human being and his biological dimension” and “Work in health” - are called *common* axes, since they mix Nutrition

students with students of other courses of the *campus*: Physical Education, Physical Therapy, Psychology, Occupational Therapy and Social Work, breaking with the isolated formation of a single profession and with the traditional disciplinary structure.

Although the presence of all the axes and the interactions between them are recognized as fundamental for the training of nutritionists, it is interesting to highlight some questions that arise from the experience of the interdisciplinary practices provided to Nutrition students. In this sense, the activities of the modules of the Work in Health (Trabalho em Saúde - TS) axis stand out, in which, with differentiation and advancement of the complexity of the tasks, the students are exposed to the directed experience in the territories and scenarios of practices, starting from the work in team, to explore the diverse possibilities of health work and the production of care.<sup>19</sup> The description of the activities in the different axis modules is given in Table 1.

**Table 1.** Description of the modules of the Work in Health Axis of the Nutrition Course of UNIFESP-BS.

| Module  | Year / Semester | Overall objective and strategies   |
|---|-----------------|--|
| Living conditions and the social production of health | First semester  | Analyze and discuss the health-disease process from the perspective of the subject in the territory, and the implications for the professional practice in health. Mixed classes perform practices in different territories and health units.  |
| Social inequalities and health policies in Brazil     | Second semester | To discuss the basic foundations of analysis of living conditions, health and work situation, as well as the contributions of epidemiology to health management in a context of social inequality. To discuss the historical constitution of Social Security and the national health policy, the principles, guidelines and legal bases of the Unified Health System and the management and organization of public health services. Mixed classes perform practices in different territories and health units. |

to be continued

| Module                                       | Year / Semester           | Overall objective and strategies  |
|--|---------------------------|---|
| Encounters and the production of narratives* | Third semester            | To contribute to the construction of a common approach to the different professional areas that considers the reality lived by the people and the various dimensions involved in the health / illness / care process.<br>Mixed students pairs conduct narratives with individuals in different territories of the city.   |
| Teamwork and collective practices*           | Fourth semester           | To enable the exercise of collective practices common to the five undergraduate areas with population groups broadening the spaces of listening, dialogue and reflection in order to enable actions to promote health. Mixed teams of students, based on listening to the different living conditions and the main health demands of the resident population in the different regions of Santos, create intervention actions of health promotion, using the group device. |
| Integrated clinic: care production*          | Fifth and sixth semesters | To continue the formation of an integrated and <i>common</i> clinic to the various professional fields, advancing in the production and management of individual and collective health care.<br>Students in pairs or mixed trios prepare and implement therapeutic care projects for individuals and / or families selected by the health services teams.   |

\*Modules offered in two semesters, for half the class on each occasion.

Note: Students of the Social Work course participate in the modules of the first three semesters.

Source: UNIFESP.<sup>14</sup>

Students experienced living with each other and building interpersonal relationships and professional practices shared with students, teachers, workers and users. The support and supervision of all the activities of the axis are carried out by teachers in the area of Collective Health and also of different professional areas that combine to discuss and interact knowledge and practices of different professions, as well as of diverse backgrounds.

It should be noted that in the course matrix, the content of Collective Health is approached in a transversal way, both in the TS axis modules and in the specific axis. The contents of public policies, health system; organization of the work process and service network; health concept; team work; comprehensive care, among others, are present in the TS axis.

The scene under analysis is the result of the experience in the module 'Integrated Clinic: Care Production', in which students organized into pairs or trios are invited to propose and reflect on care strategies built together, breaking with hegemonic knowledges.

In this module, the training strategy is based on the concept of *common* clinic to the different professional areas. The proposition of the *common* clinic involves a sense related to what is fundamental for any health professional, such as listening, dialogue, bonding, ethics, the ability to establish trust relationships, and accountability. Another sense involves what happens in the production of shared intervention strategies, in the encounter of the differences of the professional areas, in the exploration of what is 'between' the disciplinary areas.<sup>5,6,19</sup>

The care project - the guiding activity of the semester module - is constructed from weekly home visits to an individual / family and includes a description of the demands and needs identified, the health priorities assumed, the study of the situation accompanied by the theoretical basis, the proposed goals and care actions.

From the perspective of the *common* clinic, learning occurs from the experience of encounters with users, workers, students and teachers, where there is distancing from ready-to-care forms and the creation of actions shared by all professional areas.<sup>5,19</sup>

Experience has shown that, given the complexity of life and care situations and the constant movement of dialogue and discussion with health teams, many follow-ups and care projects have continuity and unfolding in the subsequent semesters, such as with Ana and her children.

Another dimension of continuity concerns the articulation of actions between the different fronts of teaching-service integration of the University in the units and in the territory, such as in the Family Health Unit (USF) in question, where there are activities of curricular internships of Nutrition and Physical Education and other modules of the TS axis. These strategies have been potent in the discussion of cases with teams, in the construction of the care network and in the partnership between the University and the Family Health Unit.

## Regarding health care issues that emerged from the scene

The process of accompanying Ana and her children produced a myriad of overlapping health care issues especially related to care under vulnerable situations and care from a diagnosis.

The scene under analysis showed the perspective of care in - or from - home visits that implied the direct and concrete contact with the life context of Ana and her children. In that sense, the questions “how do they sleep?”, “what do they eat?” illustrate problematization based on what was observed during the visit, and was not necessarily said at the meeting(s) with Ana, and also by the sensations and presences - space, smell, temperature, people, animals. These issues, related to family life habits and especially to food, were *common* to all students, teachers and workers, regardless of the area of training.

In this context of vulnerability, the hypothesis of Ana and her children living in situations of food and nutritional insecurity became a central part of the construction of care projects, especially due to housing conditions and the emblematic scene of the empty refrigerator door during the first visit. The discussion on Food and Nutrition Security (SAN)<sup>a</sup> permeated the supervision and expanded the meaning of food, as it relativized food as a biological necessity and specifically considered access, preparation and consumption of food. Thus, the students understood that the health sector often fails to respond to the demands of the population and that the strategies of care for Ana and her children would only make sense from an intersectoral perspective.

The investigation of aspects such as access and quantity of food consumed by the family was one of the challenges for the construction of care actions, since the conditions of vulnerability indicated the delicacy of addressing the issue of food in order to reinforce the lack / vulnerability of the family. The question “Do I need to apply a 24-hour recall to find out what the family eats and think about care actions?” was recurrent among Nutrition students.

Entering households implies approaching social and cultural contexts that focus on the limits of some technical actions inherent to the professions and highlight alternatives that often involve the articulation of people, knowledge and services.<sup>21</sup> Thus, the home visit opened the perspective of perceiving food through information that did not necessarily need to be said or investigated through a food consumption assessment tool. Therefore, it is not a question of neglecting the use of traditionally used indicators for nutritional assessment and food and nutritional security,<sup>22</sup> but of thinking to what extent these evaluations would aid in the proposed care projects.

The discussion of the diagnostic dimension, regarding the meaning and implication for the definition of care strategies, from the case of Ana and her children, also appeared in reference to dyslexia and malnutrition.

---

a The right of all to regular and permanent access to sufficient quality food, without compromising access to other essential needs, based on health-promoting food practices that respect cultural diversity and which are environmentally, culturally, economically and socially sustainable.<sup>20</sup>

Regarding the question “Are Ana’s three children dyslexic?”, rather than the confirmation of the diagnosis of dyslexia, defined as a learning disorder in the area of reading, writing and spelling,<sup>23</sup> the care projects involved problematizing it, especially with the USF team.

If, on the one hand, dyslexia can be understood in an organicist perspective, as a genetic disease, due to neurobiological alterations related to learning, behavior and attention; on the other hand, it can be considered a disorder from the process of pathologization of education, as a socially constructed phenomenon.<sup>23,24</sup> Thus “questions of an affective, socio-educational, pedagogical, linguistic, cultural and political character become organic aspects in the school and in the clinic” (p. 972).<sup>23</sup>

The students pointed out the tension in having to define care projects without confirming the diagnosis of the pathology, as exemplified by the question “What can we propose in the care project, since there is nothing obvious regarding the diagnosis of some Ana’s disease or malnutrition of her children?”

Given the vulnerability of Ana’s family, the perspective of assessing, in addition to food consumption, the nutritional status of children was discussed by teachers, students and workers.

Understanding the possible food insecurity of the family beyond the biological conception was one of the problematizations of the group, which dilutes the question of nutrition to the diagnosis of nutritional deficit, or malnutrition, especially in children. The reduced clinical concept of hunger (or food insecurity) and its physical consequences (such as malnutrition) present in low-income population studies reinforces the importance of considering, beyond the physical sensations, the individual and intersubjective meanings and symbols “generated by concrete insecurity of eating “(p.38).<sup>25</sup>

In other words, although the monitoring of child growth and the prevention, control and treatment of malnutrition are attributed to basic health care, important questions about the diagnosis of malnutrition brought by students have permeated the discussion about care projects. It was not a question of denying the scientific evidence, nor objective and measurable criteria of the conditions of life and health of the family. But it was important not to reduce the precarious family situation to an anthropometric and biological diagnosis, far from a sociocultural and everyday context of vulnerability, and a possible violation of the right to food.

The broad understanding of normality and pathology is not only limited to measurable criteria, based on distributions of values and population averages, as in the case of infant nutritional status, but is permeated by social constructions. Health can be flexible, a harmonious way of living far from the search for healing and an ideal state.<sup>26</sup>

The problematization of what is normality and malnutrition deserves to be interpreted beyond growth curves, especially regarding low-income children, for whom normality and mild forms of nutritional deficit are not considered relevant health problems, nor is the socially produced context in regions of high vulnerability.<sup>25</sup> In this sense, the question “What would the nutritional diagnosis (of malnutrition) change in the care project?” was made with the intention of making sense of the diagnosis from the anthropometry.

Understanding the health-illness-care process, based on the singularities and complexity of the living / eating situations observed in the home visit and in the territory, brought the limits of professional activity to the forefront and the students encountered the “not knowing” situation. Informing Ana about the nutritional status of her children was a proposal that lost strength throughout the care process because it seemed, at that moment, not to change intervention strategies. During the discussions, there was a predominance of defending the idea that it could be another “problem” to be informed to a single woman, mother of four children, living in the stilt area of a peripheral neighborhood. In addition, Ana (who is 1.50 m tall) said in one of the conversations that “the father of the older children had the same height as her.”

In this case, the discomfort of informing the diagnosis of malnutrition has caused the distance from the logic of a diagnosis that results in *a priori* defined treatment which, in turn, determines a prognosis, in which disease matters and not the subject.<sup>27</sup> Thus, the care projects did not include the measurement of children’s weight and height.

Therefore, the *common* clinic perspective, strategy used in this training experience, distances itself from the presentation and defense of a pre-established way of health care known *a priori*. In this perspective, the care projects for Ana and her children did not start from the assumption of the application of a specific technique of each profession, but from thinking about more relevant aspects, significant fragments of health care, from the demands of the family, the interdisciplinary training experience and also professional practice.

### Regarding the proposals for health care actions that emerged from the scene

Conversations with Ana at home, in walks through the territory, visits to the USF and a picnic in an open space located in the territory, were proposed activities that allowed the students to make contact with the family’s food repertoire.

In addition to the food consumed, it was important to have clues as to the place of food for those people. Ana reported that she was responsible for preparing meals at home, predominantly rice, beans, vegetables and meats, and that she used the money from the Bolsa Família Program (PBF)

to buy food and, when it was left, for leisure or recreation activities. She said that her children always commented on the food of the school and that the teachers reported good food consumption of the children in the school institution. In this case, school feeding could guarantee part of the daily feeding of children and contribute to minimize the possible situation of food insecurity.

The discussion of the Human Right to Adequate Food emerged from the follow-up of the case and the challenge of assuring it in the face of extreme vulnerability. There was contact with the theoretical framework of conditional income transfer programs (TCR), as potential strategies to guarantee SAN.<sup>28,29</sup>

The woman as the main interlocutor of the TCR programs placed Ana as a beneficiary of the PBF and responsible for compliance with conditionalities, as a follow-up of the vaccination and attendance of children in school. One of the strategies of care was to assist her in the contact with the Center of Reference in Social Assistance (CRAS), to know the programs at the municipal level. One possibility was the Municipal Income Transfer Program for those with a per capita average income of up to one hundred and twenty Reais and with children and / or dependents under 16 years of age at risk situation, which aims to guarantee a minimum income and foster social inclusion.<sup>30</sup>

In their discussion of gender issues and TCR programs, the students brought up the issue of single-parent families, which reinforce Ana's female role in providing childcare, including food. If, on the one hand, the woman as a beneficiary of the PBF can reinforce the position of the her as caregiver and the socially configured contexts;<sup>31</sup> on the other hand, it can confer the autonomy to arbitrate its use and give to the woman the role of interlocutor between the family and the world, without the need for male figures.<sup>32</sup>

Considering the complexity of the female role in the domestic and reproductive sphere, and particularly Ana's place as head of household, some issues were addressed in the meetings, such as the possibility of formal work and informal care networks such as family, friends and neighbors, who were fragile. In this sense, Ana mentioned making some "informal jobs" in the face of the difficulty of working routinely because of her daughter, who attends school only in the morning, and the dependency of the neighbor to care for the child.

The activities of the care projects sometimes counted on the presence of the children of Ana and the interaction with the children was increasing and, in concrete situations, spoken language was present. Activities with books and comics were also proposed to stimulate the relationship of children with this material and the inclusion of the mother and siblings in the re-signification of the children's learning, in an attempt to give a place to reading in family life.

These strategies illustrate the composition of a way of thinking based on the articulation of knowledge and sectors and also of different care technologies: hard, light-hard and light. The first

refers to diagnostic and therapeutic procedures (laboratory tests, medicines); the second allows us to process the professional's view of the user from a structured thought (epidemiology, for example); and the latter produces relationships based on the encounter with the user, listening, building bonds and trust. In this field of relationships, ways of capturing the complexity and singularity of the life and health context of each person / family, constitutive of living work, are constructed.<sup>33</sup>

In the experience in question, it can be said that the students were able to think about the possible combination of technologies, depending on the identified demands and the wishes of Ana, in meetings of production of acts of health with predominance of light technologies.

In order to strengthen the teaching-service partnership, strategies for permanent education in health and the formative role of the SUS, all actions of care projects were informed and discussed with the USF team during the semester or at module completion meetings. Considering that the dyslexia diagnosis of the children motivated the health team to indicate Ana's family for follow-up on the TS axis, questions about what is considered "normal", the existence of a dominant and homogeneous model of child development, the quality of interactions in the school and family context, and the precariousness of the Brazilian education system and teacher training, were guiding the dialogues among all the actors involved in the discussion of the case.

In a meeting with the USF team, two fronts were suggested for continuity of care actions to Ana's family: 1. Attention to the moment of re-registration of PBF beneficiaries, an activity performed by the USF team in partnership with Nutrition trainees, when the anthropometric evaluation of the children occurs, with the proviso that the anthropometric data of the records were non-existent or inconsistent (the only information available in the medical records was that the third child has been born with low birth weight); 2. Scheduling a network meeting, with representatives of health, education, social assistance and university units, for a more in-depth discussion of the family situation, with a view to strengthening the family's formal care network.

Although the pedagogical strategy of this training proposal - the exercise of the *common* clinic through care projects - has enabled students to think, propose and execute contextualized care actions, there were many challenges of the field work in the sense of transiting through spaces of vulnerability, distant from the reality of the students' lives; to have contact with the unexpected health work, such as the absence of Ana at home on some visits previously scheduled; and to perceive the complexity of the meeting in the private space of the residence.

This bet of teaching-service integration is not the only way to think about and experience the health care contemplated in the curricular matrix of the course. Different modules offer students the opportunity to experience care in different practice scenarios and perspectives of nutritionists' performance. There are many challenges to sustain and strengthen this proposal, such as the

difficulties of fieldwork (rain, flooding); integration with workers (in times of precariousness and a reduced number of professionals) and teaching work (in constant negotiation and agreement with different levels of health management of the municipality and in the instances within the University). Taking health education, thinking about contextualized care actions and problematizing established professional practices are challenges not only to students, but also to teachers and workers, in an experience filled with many questions and doubts, and few certainties. Therefore, it is the daily routine of health care and living labor, always under construction.

## Final considerations

The scene and care projects described in this health training experience, involving the *common* clinic, allow us to state that thinking about living and health conditions, including food, and the diagnosis of pathologies such as dyslexia and malnutrition, are themes that extrapolate the specificities of the professional areas.

Although the report focused on an activity of one of the modules of the third year of the Nutrition course, the discussions and strategies of care indicate that the experience in the other modules of the axis, as well as the knowledge acquired in the other axes, is a tool that makes up the discussions and proposed care actions.

The interdisciplinary training strategy of the Universidade Federal de São Paulo, Baixada Santista *campus*, causes the questioning of the decontextualized diagnoses and care actions that reinforce the mark of vulnerable conditions of life and health, and that result in professional practices with little resolution. For the formation of nutritionists, the experience of the TS axis invites us to reflect on how to establish nutritional care strategies based on the reflection on the use of protocols, techniques and prescriptions, which is not to devalue them, but to give meaning to their use.

## Acknowledgment

To the members of LEPETS - Laboratory of Studies and Research in Training and Work in Health of the Universidade Federal de São Paulo, Baixada Santista *campus*, and to all those involved in the activities of the Work in Health Axis.

## References

1. Bondia JL. Notas sobre a experiência e o saber de experiência. *Revista Brasileira de Educação* 2002; 19: 20-28.
2. Siegmann C, Fonseca TMG. Caso-pensamento como estratégia na produção de conhecimento. *Interface (Botucatu)*. 2007; 11(21): 53-63.
3. Junqueira V, Frutuoso MFP, Castro e Silva CR. Os (des)compassos entre a universidade e os serviços de saúde. In: Capozzolo AA, Casetto SJ, Henz AO. (Org). *Clínica comum: itinerários de uma formação em saúde*. Rio de Janeiro: HUCITEC, 2013, p. 229-247.
4. Vasconcelos ACF, Stedefeldt E, Frutuoso MFP. Uma experiência de integração ensino-serviço e a mudança de práticas profissionais: com a palavra, os profissionais de saúde. *Interface (Botucatu)*. 2016; 20(56):147-158.
5. Capozzolo AA, Imbrizi JM, Liberman F, Mendes R. Experiência, produção de conhecimento e formação em saúde. *Interface (Botucatu)*. 2013; 17(45): 357-370.
6. Frutuoso MFP, Junqueira V, Capozzolo AA. A experiência de formação (em) comum de nutricionistas na Unifesp, campus Baixada Santista. *Saúde em Debate*. 2017; 41(112): 298-310.
7. Ayres JRCM. Sujeito, intersubjetividade e práticas de saúde. *Ciência e Saúde Coletiva*. 2001; 6 (1): 63-72.
8. Pinheiro R. Cuidado em Saúde. In: FIOCRUZ. *Dicionário da educação profissional em saúde*. 2009. Disponível em: <http://www.epsjv.fiocruz.br/dicionario/verbetes/cuisau.html>. Acesso em 30/04/2017.
9. Silveira LC, Vieira AN, Monteiro ARM, Miranda KCL, Silva LF. Cuidado clínico em enfermagem: desenvolvimento de um conceito na perspectiva de reconstrução da prática profissional. *Escola Anna Nery*. 2013; 17(3): 548-554.
10. Camargo Jr KR. Epistemologia numa hora dessas? (os limites do cuidado). In: Pinheiro R, Mattos RA. (org). *Cuidado: as fronteiras da integralidade*. Rio de Janeiro: CEPESC/UERJ, IMS: ABRASCO, 2013, p. 159-172.
11. Bustamante V, McCallum C. Cuidado e construção social da pessoa: contribuições para uma teoria geral. *Physis*. 2014; 24(3): 673-692.
12. Bosi MLM, Prado SD. Alimentação e nutrição em saúde coletiva: constituição, contornos e estatuto científico. *Ciência e Saúde Coletiva*. 2011; 16(1): 7-17.
13. Santos LAS. O fazer educação alimentar e nutricional: algumas contribuições para reflexão. *Ciência e Saúde Coletiva*. 2012; 17(2): 453-462.
14. Universidade Federal de São Paulo. *Projeto Político-Pedagógico do Curso de Nutrição*. São Paulo, 2016. Acesso em 23/04/2017. Disponível em: [https://www3.unifesp.br/prograd/app/cursos/index.php/prograd/arq\\_projeto/782](https://www3.unifesp.br/prograd/app/cursos/index.php/prograd/arq_projeto/782)
15. Gonzalez AD, Almeida MJ. Integralidade da saúde – norteando mudanças na graduação dos novos profissionais. *Ciência e Saúde Coletiva*. 2010; 15(3):757-62.

16. Frenk J, Chen L, Bhutta ZA, Cohen J, Crisp N, Evans T et al. Health professionals for a new century: transforming education to strengthen health systems in an interdependent world. *The Lancet*, 2010; 376:1923-58.
17. Feuerwerker LCM, Capozzolo AA. Mudanças na formação dos profissionais de saúde: alguns referenciais de partida do eixo Trabalho em Saúde. In: Capozzolo AA, Henz AO, Casetto SJ. *Clínica comum: itinerários de uma formação em saúde*. São Paulo: Hucitec; 2013, p. 35-58.
18. Brasil. Ministério da Educação e Cultura. Resolução CNE/CES nº5, de 7 de novembro de 2001. Institui diretrizes curriculares nacionais do curso de graduação em Nutrição. *Diário Oficial da União*. 2001, 9 nov; p.39, Seção 1.
19. Capozzolo AA, Casetto SJ, Henz AO, Kinoshita RT. Movimentos de constituição do eixo trabalho em saúde. In: Capozzolo AA, Henz AO, Casetto SJ. *Clínica comum: itinerários de uma formação em saúde*. São Paulo: Hucitec; 2013, p. 69-123.
20. Brasil. Lei nº 11.346, de 15 de setembro de 2006. Cria o Sistema Nacional de Segurança Alimentar e Nutricional – SISAN com vistas em assegurar o direito humano à alimentação adequada e dá outras providências. Disponível em <[http://www.planalto.gov.br/ccivil\\_03/\\_ato2004-2006/2006/lei/111346.htm](http://www.planalto.gov.br/ccivil_03/_ato2004-2006/2006/lei/111346.htm)>. Acesso em 30/04/2017.
21. Cunha MS, Sá MC. A visita domiciliar na estratégia de saúde da família: os desafios de se mover no território. *Interface (Botucatu)*. 2013; 17(44): 61-73.
22. Burlandy L. Methodological reflections on food insecurity, nutritional status, and poverty. *Cadernos de Saúde Pública*. 2013; 29 (2): 235-236.
23. Signor R. Dislexia: uma análise histórica e social. *Revista Brasileira de Linguística Aplicada*. 2015; 15(4): 971-999.
24. Massi G, Santana APO. A desconstrução do conceito de dislexia: conflito entre verdades. *Paidéia (Ribeirão Preto)*. 2011; 21 (50): 403-411.
25. Freitas MCS. *Agonia da fome*. Rio de Janeiro: Editora FIOCRUZ; Salvador: EDUFBA, 2003. 281 p.
26. Canguilhem G. *O normal e o patológico*. 4ed. Rio de Janeiro: Forense Universitária, 1982.
27. Merhy EE, Feuerwerker LCM, Cerqueira P. Da Repetição à Diferença: construindo sentidos com o outro no mundo do cuidado. In: Franco TB, Ramos VC. (Org.). *Semiótica, Afecção e Cuidado em Saúde*. São Paulo: Hucitec, 2010. p. 60-75.
28. Burlandy L. Transferência condicionada de renda e segurança alimentar e nutricional. *Ciência e Saúde Coletiva*. 2007; 12(6): 1441-51.
29. Siliprandi EM. A alimentação como um tema político das mulheres. In: Rocha C, Burlandy L, Magalhães R. (org). *Segurança alimentar e nutricional: perspectivas, aprendizados e desafios para as políticas públicas*. Rio de Janeiro: Editora Fiocruz, 2013, p.187-198.
30. Prefeitura Municipal de Santos. Benefícios assistenciais e auxílios: Assistência Social. Disponível em: <http://www.santos.sp.gov.br/?q=cidadeaberta/link/889426-beneficios-assistenciais-e-aux-lios>. Acesso em 30/04/2017.

31. Mariano SA, Carloto CM. Gênero e combate à pobreza: Programa Bolsa Família. *Revista Estudos Feministas*. 2009; 17 (3): 901-90.
32. Pires A. Orçamento familiar e gênero: percepções do Programa Bolsa Família. *Cadernos de Pesquisa*. 2012; 42 (145): 130-161.
33. Merhy EE. *Saúde: a cartografia do trabalho vivo*. 2ª ed. São Paulo: Hucitec; 2005.

Received: May 07, 2017

Reviewed: July 11, 2017

Accepted: August 24, 2017