THEMATIC ARTICLE

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The influence of Reorientation Programs on Training courses in the Healthcare field

A influência de Programas de Reorientação da Formação em cursos da área da Saúde

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Abstract

The Ministries of Health and Education, since 2005, have proposed several editions of the National Program for Reorientation of Training of Healthcare Professionals (Pro-Health) to promote reformulation of teaching processes in this area. Objective: this study aimed to analyze the proposals and the final reports presented by a higher education public institution in the Central-West region of Brazil, seeking to understand the influence that these programs have had on reformulating health education curricula. Methodology: This is a qualitative document study. Results and Discussion: From the organization of these data, four categories emerged: 1) Implementation and development of reorientation programs in health education; 2) Evaluations of Pro-Health and Pet-Health; 3) Difficulties faced in the process of change in the healthcare field; 4) Suggestions / advances created by the processes of change in the healthcare field. Conclusions: It was found that although these policies have influenced training of healthcare professionals it takes time to consolidate the changes required by the proposals of these healthcare training reorientation programs due to difficulties in changing existing traditional education models.

Keywords: Health Policy. Curriculum. Higher Education.

Resumo

Os Ministérios da Saúde e da Educação, a partir de 2005, propuseram várias edições do Programa Nacional de Reorientação da Formação Profissional em Saúde – Pró-Saúde, com a

intenção de promover a reformulação dos processos de ensino na área. Objetivo: Analisar as propostas e os relatórios finais apresentados por uma instituição pública federal de ensino superior da região Centro-Oeste, Brasil, visando compreender a influência que estes programas tiveram nas reformulações curriculares de cursos da área da saúde. Metodologia: Trata-se de uma pesquisa documental, de cunho qualitativo. Resultados e Discussão: Da organização dos dados, emergiram quatro categorias: 1) Implementação e desenvolvimento dos programas de reorientação da formação em saúde; 2) Avaliação do Pró-Saúde e do Pet-Saúde; 3) Dificuldades enfrentadas nos processos de mudança na área da saúde; 4) Sugestões/avanços gerados pelos programas de reorientação da formação Pode-se afirmar que as políticas indutoras tiveram influência na formação em saúde e oportunizaram a comunicação e interação entre os cursos da área da saúde por meio do trabalho em equipe, aumentaram a articulação ensino-serviço e a qualificação do trabalho dos profissionais. Conclusão: As dificuldades e os avanços do processo de mudança da formação em saúde demonstraram que este é permeado por valores, simbologias e readaptações, entre outros sentimentos que perpassam o perfil dos profissionais, docentes e discentes. Há necessidade de tempo para a consolidação das mudanças requeridas pelas propostas dos programas de reorientação da formação em saúde, devido à dificuldade em mudar o modelo de ensino tradicional existente.

Palavras-chave: Políticas de Saúde. Currículo. Ensino Superior.

Introduction

Healthcare training in Brazil, since the 1940s, has been marked by the Flexnerian concept that arose in 1910 in the United States, characterized by the fragmentation of courses into basic and professional cycles, curricular organization into disciplines and structuring in hospital settings.[1,2]

Fragmented education does not allow for integration and closeness to reality and causes loss of creativity and inventive capacity.[3] Various social movements have pointed out to the need for a change in health education, especially to meet the current healthcare system and the population's actual needs.[4,5]

From the perspective of reorganization of the healthcare system, an important milestone was the Alma-Ata Declaration in 1978, which identified Primary Healthcare (PHC) as the strategy to promote health. Concurrently emerged the sanitary reform movement, which proposed a universal,

integral, decentralized healthcare system, based on co-responsibility between government levels and social participation. The Sanitary Reform was approved in 1988 by the Federal Constitution and in 1990 the *Sistema Único de Saúde (SUS)* (Unified Healthcare System) was created.[1,2]

The creation of SUS prompted a demand for health professionals with capacity to act in a humanized, universal model, and aspects relating to their respective training was considered vital. The challenge to change the profile of health practitioners made that the Ministry of Education (MEC) extinguished the minimum pre-established curriculum and the *Lei de Diretrizes e Bases da Educação (LDB)* (National Education Guidelines and Framework Law) passed in 1996. The latter ensured more autonomy to Higher Education Institutions (HEI) to formulate their curricula with a more effective focus on training and conformity with the local reality and needs.[6] This fact culminated with the approval and publication of the *Diretrizes Curriculares Nacionais* - DCN (National Curricular Guidelines) for courses in the health area,[7] and the medical course presented an update of its guidelines in 2014.[8]

The curricular reformulations began in medical courses, through the *Programa de Incentivo às Mudanças Curriculares nos Cursos de Medicina* (Program of Incentive to Curricular Changes in Medical Courses) (PROMED, 2003), the professional category that faced challenges regarding health education due to the great influence of the Flexner's biomedical model.[3] In order to break this pattern, PROMED aimed to fit the medical education to the SUS precepts based on the DCNs.[4]

In 2005, the Ministries of Health and Education proposed the *Programa Nacional de Reorientação da Formação Profissional em Saúde – Pró-Saúde* – (National Program for Reorientation of Professional Education on Health – Pro-Health), designed to promote the reformulation of educational processes and allow a critical and enlarged view of the health-disease process, especially primary care. Pro-Health is considered a reformulation-driven policy for education in the health area and initially covered Medical, Nursing and Odontology courses (Pro-Health I) and, later, in 2007, the other courses in the health area (Pro-Health II).[9]

To complement Pro-Health, the government launched in 2008 the *Programa de Educação pelo Trabalho para a Saúde (PET-Saúde*) (Program of Education for Work in Health – PET-Health), aimed to the qualification of students for healthcare practice through the improvement and specialization of healthcare practitioners and experiences on professional reality through education-service-community integration.[9-11] Therefore, the aim of this study was to analyze the proposals and final reports submitted by a public higher education institution located in the Central-West region in Brazil, aiming to understand the influence that these programs had on the curricular reformulations of courses in the health area.

Method

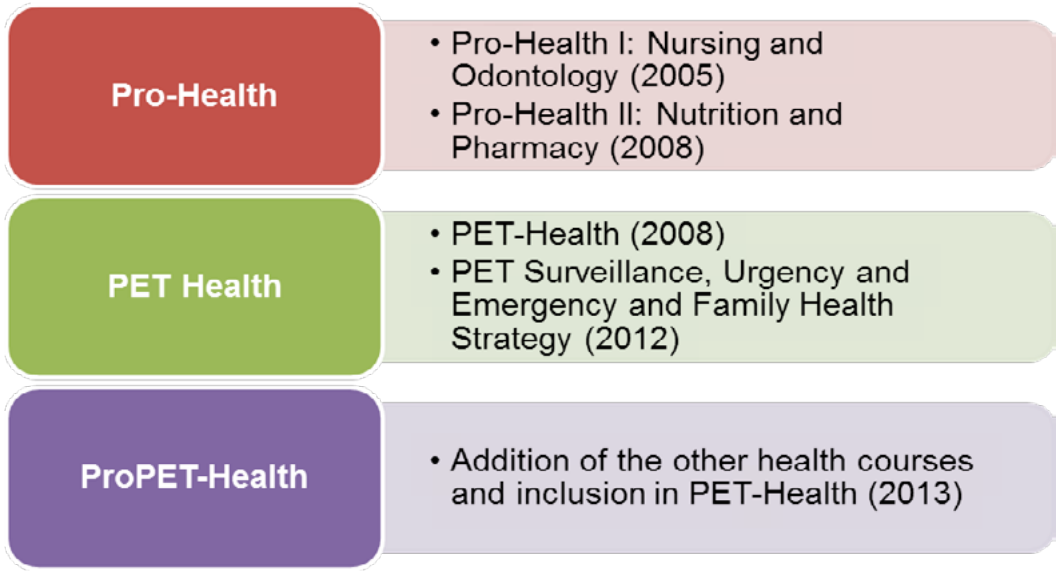
A qualitative document survey was carried out,[12,13] important for understanding key information of the phenomenon under study that had not been subjected to previous analytical treatment.[12]

Document sources allow to know the history of the phenomenon, investigation of processes change and may contribute as additional sources to other data.[12,14]

The documents used as sources in this investigation were Pro-Health and Pet-Health proposals developed by the Nursing, Pharmacy, Medical, Nutrition and Odontology courses of a Higher Education Public Institution in the Central-West region in Brazil, approved by the MS/MEC call notices (Pro-Health I, Pro-Health II, Pet-Health and ProPet-Health in 2005, 2007 and 2014) and their respective final reports.

The studied courses were created between 1945 and 1975; Pharmacy and Odontology in 1945; Medicine in 1960, and Nutrition and Nursing in 1975, all of them with bachelor's degree.[15,16]

These courses had their proposals approved by the Pro-Health and PET-Health call notices by the Ministry of Health (MS) and Ministry of Education (MEC). Fig. 1 illustrates the courses and documents analyzed.



*Analysis of the proposal accepted by MEC/MS call notices and final report.

** Analysis of only the proposal accepted by MEC/MS call notice.

Figure 1. List of the documents used in the document analysis of this work.

This survey is part of the research project "Evaluation of the impact of Pro-Health and PET-Health programs on undergraduate courses in health sciences", with financial support from CNPq in 2012. To conduct the research, all ethical principles and rules set by the Resolution CNS no. 466/2012[16] were observed. The research project was approved by the Ethics Research Committee of the investigated institution with protocol no. 497.548/2013. The analyzed documents were made available by the directors of the courses included in the Pro-Health and PET-Health program after signing the Agreement Term, which also included permission to publish the data generated by this research.

Interpretation of the data was made through thematic analysis, one of content analysis modalities. Firstly, all document sources were float read in order to have an overall understanding of the sources. Then, the codification process was carried out, which started from recurrent readings of the sources to identify the core meanings or the documents' structure axes, around which common characteristics are grouped. Afterwards, the categories that guided the data analysis were outlined.[13,17]

To discuss the categories of analysis, the National Curricular Guidelines (DCN) were used for the courses that were included in the investigation, and as guiding references we used the call notices for the reorientation programs in health.

Results and Discussion

From the data organization, four categories emerged: 1) Implementation and development of reorientation programs in health education; 2) Self-evaluation of Pro-Health/PET Health in HEIs; 3) Difficulties in the reorientation processes of undergraduate health courses; 4) Advances in health training courses based on the studied programs, which are analyzed in the next section:

Implementation and development of reorientation programs in health course

The HEI under study has participated in various movements of change in health education since the creation of DCNs, as show in Fig. 1. Firstly, in 2003, the medical course participated in PROMED and later, in 2005, the Nursing, Medical and Odontology courses participated in the first Pro-Health call notice. In 2007, after the Pro-Health expansion, the courses of Nutrition and Pharmacy also integrated the Pro-Health II. Participation in PET-Health was possible through 2008, 2012 and 2013 call notices, but the latter also included the courses of Biomedicine and Physical Education in addition to the other courses participating in previous call notices.

The reports examined indicated that the period for development of the programs allowed a partnership with the Municipal Health Secretariat and the HEI, which since 2009 has expanded

the fields of practice for PET-Health. Thus, this partnership became a facilitator for the integration process between health education and health services.

Cruz et al.,[18] analyzed the experiences reported by tutors, preceptors and students of PET-Health and found that these programs have provided opportunities for institutional partnerships, adoption of practices and exchange of experiences between students and healthcare professionals. Also, the teachers that joined the healthcare network had the opportunity to improve their understanding on the practice dynamics and the teaching process.

The HEI under study participated in all MS/MEC proposals available after the DCN in order to support and encourage renovation of the institution curricula. Studies indicate that the Pro-Health and PET-Health proposals were key to promoting a shift of the paradigms that existed in the HEIs, because they helped build learning spaces in healthcare, promoted a better communication between students, teachers and practitioners as well as a significant problem-solving learning acquired from the teachers' development.[19,20]

The adequacy of health education to the demands of the healthcare services and, consequently, of the society, is still incipient, but this fact cannot be used to justify failure in transforming the healthcare education. In general, efforts by the HEI's top management are needed to sensitize and support the social actors in a movement toward an ever-increasing effectiveness of curriculum reformulation.

Self-evaluation of Pro-Health/PET-Health in the HEI

One of the Pro-Health objectives is teaching and care integration. To achieve this, professional training should be reformulated in order that the individual's integral care is attained, with a priority on primary care and valuing the community participation in the learning process.[9]

According to the public call notices for the programs herein investigated, the HEIs should evaluate themselves as to the stage where they currently are. In other words, the participating courses should be subjected to a diagnosis of the current status regarding the core aspects, or axes, suggested for the program development: 1) theoretical orientation; 2) practice scenarios; 3) pedagogical orientation.[9] Details of vectors of each axis can be seen in Chart 1.

Chart 1. Arrangement of the axes and vectors of the National Health Education Reorientation Program.

AXIS	VECTOR
Theoretical orientation	Determinants of Health and Disease
	Research adjusted to reflect local reality
	Continuing education
Practice scenarios	Teaching-care integration
	Approach on the diverse care levels
	Integration of the HEIs own services with healthcare services
Pedagogical orientation	Basic-clinical integration
	Critical analysis of the services
	Active learning

Source: Brazil (2007).[9]

The vectors orient the parameters that guide each axis, and each educational institution conducts a self-evaluation to determine the educational stage where they are: stage I, which is basically the traditional, conventional training, following to stage III, which would be the model considered optimal, innovative.[9]

The studied HEI's reports and documents indicated that, when they evaluated themselves, the courses considered most of the vectors of stage II, defined as the stage of transition from the traditional model to the innovative model. Only in the graduate and continuing education vector (vector 3), the courses studied considered themselves as being in the stage III.

Study conducted by Brito[21] also found similar results. In the theoretical orientation axis, the courses were considered as being between stages II and III. With respect to the healthcare determinants, nearly 85% of the actors involved considered their courses as being in stage III, referring to the support of activities that consider biological and social determinants of a disease and associating individual and community aspects.

It can be seen that the courses are familiar with the enlarged concept of health, but still consider health as the opposite of disease, considering the curative approach of medical care as a priority. This biologist approach enhances the need to work on healthcare training that transcends the

scope of cure-over-care, or clinical activities. by fostering new paradigms to support the health-disease process.[22]

When the HEI implemented the educational reorientation programs, it conducted a self-evaluation, and from this category emerged the discussion on the school typology.

When the Practice Scenarios axis was examined in the reports and proposals submitted as a result of the MS/MEC call notices, it could be seen that the reorientation programs on health education provided a better interrelation between the university's academic units and the healthcare services and more diversified practice scenarios.

Concerning the Theoretical Orientation, the documents also revealed the HEI's efforts to orient education toward health promotion and disease prevention, taking into account regional needs and their social determinants, from a collective healthcare perspective. The courses also included extension projects that considered a holistic approach of the individual and the current health system.

With respect to the Pedagogical Orientation, experiences acquired from Pro-Health and PET-Heath contributed to promote interdisciplinary activities, which allows for the sharing of knowledge, insights, experiences and the consolidation of the bond between institution and healthcare services. These aspects, considered in the practice scenarios, theoretical orientation and pedagogical orientation, made that the HEI placed themselves in the transition stage from the traditional model to the innovative model. These experiences further foster research efforts that promote curricular reorientation.[23]

Cyrino et al.[24] understand that the experiences acquired from the PET-Health project, as an intervention of reality, have showed that the diversity of opportunities and pedagogical strategies can be addressed within the HEIs, in addition to strengthening the teaching-service articulation and valuing the work in community.

Difficulties in the reorientation processes of healthcare training

The studied courses prepare final reports to present the difficulties that they had in implementing the process of change and, consequently, the performance of healthcare professionals in relation to individuals, family and/or community. Chart 2 describes the difficulties reported by the courses studied.

Chart 2. Difficulties in implementing changes in healthcare training.

Regarding the university and healthcare services structures

- Inappropriate facilities to receive students for internship
- Difficult communication between the Pro-Health management and the participating courses

Regarding integration

- Poor teacher-healthcare integration, based on the teacher's individual initiatives with healthcare professionals, with reduced quality in the relationships with the Family Healthcare Strategy teams and in interventions planning;
- Poor integration between disciplines and/or the studied courses;
- Poor multi-disciplinary integration;
- Disarticulated relationship between theory and practice and the individual and collective healthcare.

Regarding the actors' resistance

- Teachers' and healthcare professionals' resistance to change;
- Students resistance to active methodologies.

Regarding the teachers' development

- Insufficient preparation of teachers for the application of active teaching methods;
- Difficulty in breaking the Flexnerian teaching model (overuse of technology, professional commodification, knowledge fragmentation, among others).

As can be seen, several difficulties were presented, beginning with the university's lack of structure, change of pedagogical orientation, insufficient teachers' training and the actors' resistance to change, which brings to light the complexity of curricular reformulation processes. Bureaucratic and operational difficulties were also observed, e.g. time incompatibility between activities in common, courses and the service.

The results of this study were also found in previous works. A case study conducted with academic and practitioner nurses working in Primary Healthcare Units (PHU) in a Southern city in Brazil found similar difficulties in teaching-care interaction, such as: lack of communication between the social actors; integration between the activities of different courses with the PHU; overlapping activities and the HEI's difficulty in managing common time schedules of courses.[25]

Lima & Rozendo[20] found a pedagogical deficiency in evaluating, planning, developing researches, working in a team environment, developing actions with healthcare practitioners and other course' students as well as lack of infrastructure in healthcare services and material resources.

The resistance to change by the courses' faculty was pointed out as the greatest difficulty to shift from the technicist education model to a humanized, critical, reflexive and liberating education. The courses have not yet succeeded in arranging common schedules for joint activities, a fact that causes solo actions and of low impact on the curriculum,[26] hinders a critical, expanded view of users and the context in which they are, and contributes to a professional training with technicist, Flexnerian features.[26,27]

It is known that the Pro- and PET-Health programs promoted changes in the teachers' vision and sensitization toward the importance of academic training according to the DCNs.[26,28-30] These initiatives must continue and be improved as in the case of the target courses in this investigation, solidifying new teaching-learning methodological strategies and the partnerships made between the courses aiming to an inter-disciplinary approach and teamwork.

It is natural that the processes of change are permeated by difficulties and facilities when implemented. However, changes must go through a (re)assimilation process in order to occur not only in theory but, especially, in practice.[31]

Advances in healthcare training based on the studied programs

According to the documents examined, it is clear that the programs studied contributed to more active, interactive students, co-responsible for their learning and well informed on processual and educational learning assessments. Therefore, a change can be seen in the standards pre-established by the traditional education, and by changing the scholars' posture it is expected that the students will think over about their practice, training, attitude and actions related to theoretical/practical activities.[26]

A concern with scientific production and continuing education of teachers and healthcare professionals was also clearly stated, which can be considered a challenge, considering that the courses have discussed ways to address the issue, suggesting, to achieve this, an upgrade of the teachers' qualification for teaching-research-extension, encouraging teachers and students to participate in scientific events that address public healthcare and/or teaching-care integration, and the promotion of continuing education with an emphasis on primary and specialized care, workshops for teachers and preceptors in active teaching methodologies and emphasis on medical and multi-professional internships with interface with the public healthcare system.

There were expanded scenarios for internships, which allowed integral actions relating to health care, management and surveillance, and also promoted spaces for dissemination and sharing of production resulting from teaching-service-community partnership with institutional involvement. These moments provided by the studied HEI enabled group discussions and insights on education, qualification, inter-professional practices and continuing education.

As a contribution to research development, the creation of the Professional Master's Program for Healthcare Training and a research line on Healthcare Teaching in the Health Sciences Program, both in the medical course, were also cited.

Concerning the Course's Pedagogical Projects (CPP), in order that advances can be achieved, it was suggested an increase in practical classes in detriment of theoretical classes, the discussion, implementation and monitoring of the CPPs based on a knowledge-building network, teaching integration of the basic cycle with the professional one and integrated activities with all course's terms and disciplines.

As a major advance provided by the Pro- and Pet-Health programs, it can be said that they ensure the possibility for professionals to recognize the relevance and performance of all healthcare team components, respecting each one's features and seeking better experiences and communication in teamwork to discuss the cases and propose solutions, which can ensure more skills for professionals to cope with the challenges that they face in daily practice.[31]

The information available in the documents that were examined allowed a better understanding of the changes, interactions, communications between the courses, discussions, researches and other activities that have been performed based on the influence and/or encouragement provided by the reorientation programs for healthcare education and implemented by the targeted courses.

Conclusion

The analysis of the documents contributed for the understanding of the process of change in healthcare education at the studied HEI, from which four major categories of analysis originated: implementation and development of the reorientation programs in healthcare education, self-evaluation of Pro- and PET-Health by the HEI; difficulties in the reorientation processes in healthcare training; advances in the healthcare training derived from the programs studied.

The categories illustrate the difficulties and advances in the process of change in healthcare training. They also demonstrate that the process of change is permeated by values, symbologies and re-adjustments that may influence on the profile of practitioners-teachers-students.

It is worth mentioning that the HEI's adherence to the movements of changes in health education brought about partnerships between the institution and the municipal health secretariats

of neighboring towns, which contributed to the expansion of the fields of practice for PET-Health and the integration between training and care. Based on the analysis of the reports, it can be seen that adherence to the Pro- and PET-Health provided a larger interface between the university and healthcare services.

The articulation allowed a better orientation of training toward healthcare aspects as a phenomenon that involves social determinants and local diversities from the perspective of the individual's integral care in detriment to the Flexnerian model.

Although the reports indicate advances in the teaching-learning process, some difficulties were considered barriers to important changes in training. The teachers' resistance to abandon the traditional training model and work on a humanized, critical approach, and the schedules incompatibility between the courses interfere on the achievement of an inter-disciplinary structure. These are key elements pointed out in the evaluations and ratings about the school typology and are directly associated with the change in the educational proposal announced by driven policies, such as Pro-Health and PET-Health.

Time is necessary for the consolidation of the changes required by the reorientation programs in healthcare training, due to the difficulty in changing the existing traditional educational model.

This study is pertinent, and there is a need for further researches to complement it because there are few works published in Brazil that made analyses of documents on educational changes encompassing several courses in the area of health and/or the individual courses, and so this is an important research to understand the development of professionals prepared to work in the Brazilian healthcare service.

This study did not intend to exhaust this vast theme, but brings the proposal of (re)viewing the academic/scientific community about the importance of training healthcare professionals who are able to move from the technical and mechanistic approach, a paradigm that is difficult to be overcome.

Contributors

B.A. Moraes contributed to the conception and design of the work, analysis and interpretation of data and in writing the manuscript. M.S.N. Vieira jointly contributed to the development of the work, analysis and interpretation of data and in writing the manuscript. M.S.C. Costa contributed to data interpretation and revision of the final version of the paper.

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References

1. Gonzales AD, Almeida MJ. Movimentos de mudança na formação em saúde: da medicina comunitária às diretrizes curriculares. Physis Revista de Saúde Coletiva 2010; 20(2):551-570.
2. Moraes BA, Costa NMC. A formação em saúde no Brasil: o currículo e as políticas indutoras de reorientação da formação. In: Costa NMSC, Pereira ERS. Ensino na saúde: transformando práticas profissionais. Goiânia: Gráfica UFG; 2015. p.17-34.
3. Silva IF. Dicotomia básico-profissional no ensino superior em saúde: dilemas e perspectivas. In: Batista NA, Batista SH. Docência em saúde: temas e experiências. São Paulo: Senac; 2014. p. 135-152.
4. Dias HS, Lima LD, Teixeira M. A trajetória da política nacional de reorientação da formação profissional em saúde no SUS. Ciênc Saúde Coletiva 2013; 18(6):1613-1624.
5. Paim J, Travessos C, Almeida C, Bahia L, Macinko J. The Brazilian health system: history, progress and challenges. The Lancet 2011; 377(9779):1778-1797.
6. Brasil. Lei de Diretrizes e Bases da Educação Nacional Lei nº 9.394, de 20 de dezembro de 1996. Estabelece as diretrizes e bases da educação nacional. 1996. Diário Oficial da União 23 dez. 1996.
7. Brasil. Ministério da Educação e Cultura. Resolução CNE/CES nº 1.133/2001. Institui Diretrizes Curriculares Nacionais do Curso de Graduação em Enfermagem, Medicina e Nutrição. Diário Oficial da União 3 out. 2001; Seção 1E:131.
8. Brasil. Conselho Nacional de Educação. Câmara de Educação Superior. Resolução nº 3 de 20 de junho de 2014. Dispõe as Diretrizes Curriculares para o curso de graduação de Medicina. Diário Oficial da União 23 jun. 2014; Seção 1:8-11.
9. Brasil. Ministério da Saúde. Ministério da Educação. Programa Nacional de Reorientação da Formação Profissional em Saúde – Pró-Saúde: objetivos, implementação e desenvolvimento potencial. Brasília: MS, MEC; 2007. 86 p.
10. Brasil. Ministério da Saúde. Portaria interministerial nº 1.802, de 26 de agosto de 2008. Institui o Programa de Educação pelo Trabalho para a Saúde – PET-saúde. Diário Oficial da União 14 jan. 2008; Seção 1(9):37.
11. Oliveira NA, Meirelles RMS, Cury GC, Alves LA. Mudanças curriculares no ensino médico: brasileiro: debate crucial no contexto do PROMED. Rev Bras Educ Med. 2008; 32(3):333-346.
12. Gil AC. Métodos e técnicas de pesquisa social. São Paulo: Altas; 2008. 206 p.
13. Minayo MCS. O desafio do conhecimento: pesquisa qualitativa em saúde. São Paulo: Hucitec; 2014. 407 p.
14. Sá-Silva JR, Almeida CD, Guindani JF. Pesquisa documental: pistas teóricas e metodológicas. Revista Brasileira de História e Ciências Sociais 2008; 1(1):01-15.
15. Moraes BA, Costa NMSC. Understanding the curriculum the light of training guiding health in Brazil. Revista Escola de Enfermagem da USP 2016; 50(n. esp):09-16.
16. Brasil. Conselho Nacional de Saúde. Resolução nº 466, de 12 de dezembro de 2012. Aprova as diretrizes e normas regulamentadoras de pesquisas envolvendo seres humanos.

17. Bardin L. Análise de conteúdo. São Paulo: Edições 70; 2011. 279 p.

18. Cruz KT, Merhy EE, Santos MFL, Gomes MPC. PET-Saúde: micropolítica, formação e o trabalho em saúde. Interface: Comunicação, Educação e Saúde 2015; 19(1):721-730.

19. Batista SHSS, Jansen B, Assis EQ, Senna MIB, Cury GC. Formação em saúde: reflexões a partir dos Programas Pró-Saúde e PET-Saúde. Interface: Comunicação, Educação e Saúde 2015; 19(1):743-752.

20. Lima PAB, Rozendo CA. Desafios e possibilidades no exercício da preceptoria do Pró-PET-Saúde. Interface: Comunicação, Educação e Saúde 2015; 19(1):779-791.

21. Brito JP. Análise da reorientação curricular dos cursos de graduação em Nutrição participantes do Programa Nacional de Reorientação da Formação Profissional em Saúde (Pró-Saúde) II [dissertação]. Brasília: Universidade de Brasília; 2013.

22. Câmara AMCS, Melo VLC, Gomes MGP, Pena BC, Silva AP, Oliveira KM, Victorino LR. Percepção do processo saúde-doença: significados e valores da educação em saúde. Rev Bras Educ Med. 2012; 36(1):40-50.

23. Ferraz L. O PET-Saúde e sua interlocução com o Pró-Saúde a partir da pesquisa: o relato dessa experiência. Rev Bras Educ Med. 2012; 36(1):166-171.

24. Cyrino EG, Cyrino APP, Prearo AY, Popim RC, Simonette JP, Villas Boas PJF, et al. Ensino e pesquisa na estratégia de saúde da família: o PET-Saúde da FMB/Unesp. Rev Bras Educ Med. 2012; 36(1):92-101.

25. Andrade SR, Boehs AE, Boehs CGE. Percepções de enfermeiros docentes e assistenciais sobre a parceria ensino-serviço em unidades básicas de saúde. Interface: Comunicação, Educação e Saúde 2015; 19(54):537-547.

26. Sordi MRL, Lopes CVM, Domingues SM, Cyrino EG. O potencial da avaliação formativa nos processos de mudança da formação dos profissionais da saúde. Interface: Comunicação, Educação e Saúde 2015; 19(1):731-742.

27. Costa NMSC. Docência no ensino médico: porque é tão difícil mudar? Rev Bras Educ Med. 2007; 31(1):21-30.

28. Pinto TR, Cyrino EG. Com a palavra, o trabalhador da Atenção Primária à Saúde: potencialidades e desafios nas práticas educacionais. Interface: Comunicação, Educação e Saúde 2015; 19(1):765-777.

29. Bellini MIB, Faler CSA. Intersetorialidade e fragmentação: partículas a respeito. In: Bellini MIB, Faler CSA. Intersetorialidade e políticas sociais: interfaces e diálogos. Porto Alegre: EDIPUCRS; 2014. p. 23-40.

30. Costa MV, Borges FA. O Pró-PET-Saúde frente aos desafios do processo de formação profissional em saúde. Interface: Comunicação, Educação e Saúde 2015; 19(1):753-763.

31. Costa MV, Patrício KP, Câmara AMCS, Azevedo GD, Batista SHSS. Pró-Saúde e PET-Saúde como espaços de educação interprofissional. Interface: Comunicação, Educação e Saúde 2015, 19(1):709-720.

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