THE CONTRIBUTION OF THE TEACHING-SERVICE INTEGRATION TO THE IMPLEMENTATION OF THE HEALTH SURVEILLANCE MODEL: EDUCATORS' PERSPECTIVE

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This descriptive-qualitative research aimed to describe how educators perceive the integration between teaching and health services in São Paulo, SP, Brazil and the contribution of this partnership to the implementation of the Health Surveillance (HS) model. Data were collected through semi-structured interviews and analyzed according to the Collective Subject Discourse technique. Results revealed that there is integration between teaching and service, mainly at the initiative of the academy. The university hires health professionals practicing in health services, who have a teaching profile, and includes them in the internship program. The contribution of the academic community to the implementation of HS in the region is incipient and restricted to isolated actions, mainly because educators do not consider it an academic task. We conclude that a political-pedagogical project is needed, so that professionals involved in teaching and service get aligned with a view to transforming health practices and models.

DESCRIPTORS: population surveillance; teaching care integration services; health care (public health)

LA CONTRIBUCIÓN DE LA ARTICULACIÓN ENSEÑANZA Y SERVICIO PARA LA CONSTRUCCIÓN DE LA VIGILANCIA DE LA SALUD: LA PERSPECTIVA DE LOS DOCENTES

Esta investigación tuvo como objetivo describir la percepción de docentes sobre la articulación entre enseñanza y servicio, en una región del municipio de San Pablo y sus contribuciones para la implantación del modelo de Vigilancia de la Salud (VS). Se trata de una investigación cualitativa, cuyos datos fueron recolectados mediante entrevistas con docentes participantes en esa articulación. Los discursos fueron analizados según la técnica del Discurso del Sujeto Colectivo. Los resultados mostraron que la integración enseñanza-servicio ocurre principalmente por iniciativa de la academia, a través de la contratación de profesionales de los servicios de salud con perfil docente y su incorporación en la enseñanza práctica de las disciplinas. La contribución de la enseñanza para la implantación de la VS en la región es pequeña, restringiéndose a la realización de acciones aisladas, principalmente debido a que los docentes no consideran ser esa una tarea de la academia. Se concluye que existe la necesidad de establecer un proyecto político pedagógico que aproxime los profesionales participantes en la articulación enseñanza-servicio, para la transformación de prácticas y modelos de salud.

DESCRIPTORES: vigilancia de la población; servicios de integración docente asistencial; atención a la salud

A CONTRIBUIÇÃO DA ARTICULAÇÃO ENSINO-SERVIÇO PARA A CONSTRUÇÃO DA VIGILÂNCIA DA SAÚDE: A PERSPECTIVA DOS DOCENTES

Esta pesquisa objetivou descrever a percepção de docentes sobre a articulação ensino-serviço numa região do município de São Paulo e suas contribuições para a implantação do modelo de Vigilância da Saúde (VS). Trata-se de pesquisa qualitativa, cujos dados foram coletados mediante entrevistas com docentes envolvidos nessa articulação. Os discursos foram analisados segundo a técnica do Discurso do Sujeito Coletivo. Os resultados mostraram que a integração ensino-serviço ocorre principalmente por iniciativa da academia, através da contratação de profissionais dos serviços de saúde com perfil docente e sua incorporação no ensino prático das disciplinas. A contribuição do ensino para a implantação da VS na região é pequena, restringindo-se à realização de ações isoladas, principalmente porque os docentes não consideram ser essa uma tarefa da academia. Conclui-se pela necessidade de se estabelecer projeto político-pedagógico que aproxime os profissionais envolvidos na articulação ensino-serviço, para a transformação de práticas e modelos de saúde.

DESCRITORES: vigilância da população; serviços de integração docente-assistencial; atenção à saúde

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INTRODUCTION

With the implementation of the Brazilian Single Health System (SUS) in the 1980s, critical thinking in health gained strength. It includes discussions about how social aspects determine the health-disease process. Associated to this idea is the need to change care models and models of professional education in health, so as to promote a connection between clinical practice and epidemiology[1].

Seeking to overcome the hegemonic multi-causal health care model, the Health Surveillance model (HS) was proposed at the beginning of the 1990s as an alternative to overcome fragmented practices in the SUS construction and implementation process in the different regions of Brazil[2]. The concept of health, included in the HS proposal, puts in question aspects related to the way of life and work as important determinants of health problems. This way of conceiving the health-disease process points to the need for health intervention strategies that take into account the totality of life, that is, strategies not only focused on the clinical condition of health system users. HS points to the need to construct a health care model based on quality of life and not only on the search for signs or symptoms of diseases. It proposes the connection between epidemiology, planning and organization of health services and the understanding of social inequalities as determinants of unequal distribution of health problems in the population. It puts into operation health actions of three groups of activities: health promotion, prevention of diseases and accidents, and collective care[2].

Professionals trained on a clinical, epidemiological and humanistic base are needed so that a healthcare model based on HS is implemented. These are expected elements in the education of professionals, so that they are qualified for this expanded practice in health[2].

Many authors[3-6] have discussed the lack of professionals with an adequate profile to work in the HS perspective, who argue that training human resources in health is one of the most severe problems in the Brazilian Single Health System. They argue that teaching institutions have reproduced conservative teaching models focused on pathophysiology or anatomo-clinical physiology, on diagnostic and therapeutic support procedures and equipment, which are limited to the teaching in hospitals[3-4,7]. Thus, newly graduated professionals are unprepared to adequately face the complexity inherent in the HS proposal.

The fragmentation of knowledge in professional health education has its origin in the North-American model of medical teaching, the so-called Flexnerian model. It is mainly characterized by its sound training in basic sciences in the first years of the program, with emphasis on individual clinical care to the detriment of preventive aspects of health promotion, valorization of learning in the hospital environment and medical specialties[8].

The Flexnerian model has been predominantly used in the education of health professionals, both in undergraduate and continued education programs. However, in recent years, this model has been widely discussed, especially because it is considered incapable of promoting an educational model that enables professionals to face the challenges imposed to the health area in the SUS perspective[9].

Records related to the need to prepare health professionals to practice in the SUS perspective can be found in the VIII Brazilian Health Conference held in 1986. The report of this conference suggests that, in addition to the education of health professionals, continued education programs should be integrated to services that compose the hierarchical and regionalized health system[10]. In 1988, article 200 of the Brazilian Federal Constitution established the competence of SUS management offices to guide the education of human resources in health and promote scientific and technological development[11]. The Health Conferences that followed (1992, 1996, 2000, 2004) reinforced this attribution to SUS managers.

Brazilian Curricular Guidelines were elaborated in 2001 for Medical, Nursing and Nutrition undergraduate courses. These guidelines orient the elaboration of curricula by higher education institutions, so that education offered to students is more flexible and adaptable to the health system existing in the country[12].

Based on this sociopolitical context, the Ministry of Health (MH) and the Ministry of Education and Culture (MEC) are encouraging partnerships between professional health education and health service institutions to develop teaching projects in the area. This initiative seeks to promote the development of professional education in health, aligned with the SUS principles and more involved with the health needs of the Brazilian population. There are some examples of such partnerships: PROMED (Program for the

Encouragement of Curricular Changes in Medical Courses – Ministry of Health 2002); VERSUS (Experience and Training Program in the Reality of the Single Health System – Ministry of Health 2004); Integrality and Learning – SUS (Ministry of Health, 2004); and the Pro-Saúde (Pro-Health - National Program for reorientation of professional education in health - Ministry of Health 2005).

Confidence in this kind of initiatives is based on the idea that the construction of a critical and reflective teaching-learning process provides students (future health professionals) a critical understanding of the social order their practice is inserted in. This teaching process is also an important instrument to promote citizenship and social transformation. Investing in the organization of teaching-learning processes that provide health students/professionals more than technical knowledge means enabling them to become active agents of change, as the Brazilian society needs to become more equitable and fair. Another possibility of this teaching process, connected to the reality of health, is to make health students/professionals construct (not only consume) knowledge based on the link, *in loco*, between theory and practice and on interdisciplinary experience[7].

In this perspective, connection between teaching-service is an important strategy for the effective integration between theory and practice and should be at the service of reality, allowing students to elaborate critiques and search for adequate solutions for the health problems presented, stay committed and maintain responsibility with users through care with a view to their emancipation[6].

An idea that has been increasingly disseminated is that, when teaching is disconnected from reality and focuses on the content *per se*, it generates a distorted perspective of reality and alienates students from their true professional reality. This kind of teaching creates dissociation between thought and action and limits questioning because what matters is how much knowledge is produced at the least time possible[13].

The guiding hypothesis of this study is based on the assumption that the use of the city system to develop practical teaching linked to the education of physicians and nurses can promote powerful partnerships to redefine the health model.

In this perspective, this study aimed to describe the connection between teaching-service – developed in São Paulo, SP, Brazil – and identify the contributions of this partnership to implement the Health Surveillance model, from the perception of educators involved in this process.

REFERENCE FRAMEWORK

The political opening at the end of the military regimen towards the end of the 1970s and beginning of the 1980s coincides with an intense mobilization of educators in favor of more critical approaches to social, political and economic changes. In this context, Marxist thinkers and progressive groups in pedagogy emerged and contributed to the educational area. The university started to "re-think" its social role and to construct educational proposals supported by the Teaching-Welfare Integration (TWI) and by experiences in the teaching-service connection as a way to play its role in society's transformation.

TWI can be defined as "human work inserted in a concrete, historically determined society, which aspires to approximation between teaching institutions, care and population. It aims to overcome the contradictions of theory and practice, taking into account the health aspirations and possibilities of different social classes that compose the population and also the aspirations and possibilities of action of teaching institutions in a process where responsibility is shared. It aims for the effective transformation of care practice and teaching, joint work to achieve goals/horizons, linking agents from the educational institution (professor and student) and the health institution (physician, nurse and others). This work is mediated by the acquisition and deepening of specific content and content in the common domain and by the exercise of reflection about facts, seeking to understand them according to a defined ethics based on scientific investigation"[14].

For some authors, the main results of the TWI proposals are: "encouragement for quality teaching and research; education of professionals with social commitment; transformation of teaching (changing courses); improvement of quality of care by possible orchestration of health team in the social determination approach; employees' continued education; health care based on the needs of the population; social participation in the planning of actions and transformation of population's quality of life"[15].

Although the transformation of social reality was sought through TWI, these same authors appoint

factors that negatively affect its viability, including: its character, which is often more reformist instead of promoting transformation, especially because it does not refer to real determinants of the social and health scenario and only proposes inter-sectorial planning; vertical, unilateral and not committed to the continuity of programs; dichotomy teaching/service/research; potential control of professors over assistants; TWI is developed by only a part of the university[15].

Even though these authors criticize this teaching model, they agree that TWI is an important strategy to promote reflections and effective proposals for intervention in the social reality and in health services.

METHODOLOGICAL ASPECTS

This descriptive-exploratory case study aimed to know the reality of the integration between teaching-service according to the reports of educators who participate in the process.

The study setting was the Butantã Health District School (BHDS) in São Paulo. It is located in the Middle Eastern Health Coordination and constitutes a partnership between the São Paulo Health Secretary and the University of São Paulo through the Medical School (FMUSP), College of Nursing (EEUSP) and College of Public Health (FSPUSP), with a view to joint management, teaching and research in the region.

The study participants were six people, two coordinators of undergraduate programs (medical and nursing programs), three undergraduate professors and one linked to the São Paulo Health Secretary who was responsible for the authorization of internships at the study site. All participants had a bachelor's degree and were distributed as following in the undergraduate programs: three professors at the Medical program, two professors at the nursing program, and one who taught at the Social Work program. All participants had taken complementary education, while four reported specialization courses (Management of Health Unit, Public Health and Medicine); three had a master's degree (Collective health, Nursing, Public Health); four had doctoral degrees (Pathology, Pediatric nursing, Collective health); two reported medical residence (Family and Community Medicine, General Clinic); two post-doctoral graduates (Preventive medicine, Medical Clinic) and one was a free lecturer (Pathology).

Data were collected through semi-structured interviews, which were recorded on cassette tapes and then transcribed. Collective Subject Discourse (CSD)[16] was used for data analysis. The CSD technique proposed by the authors consists of organizing data from discourse that make it possible to recover a given universe of people's stock of representations on a given topic. CSD is a "discursive collectiveness" whose content is composed by what is said by an individual and by his(er) "group companion" updated by him. The discourse is submitted to content analysis and decomposed into the main ideas that are present in individual or collective discourse. A synthesis is then elaborated and aims to provide a discursive reconstitution of the social representation[16].

This study is in agreement with Resolution 196/96 and was approved by the Research Ethics Committee at the São Paulo Health Secretary (process N. 0204/2005). After its approval, permission to carry out the study jointly with the Technical Health Supervision at the Butantã School was granted. A free and informed consent term was used and participants received information and clarified their doubts regarding the study. They spontaneously agreed to participate and were guaranteed confidentiality, so that their privacy was protected.

RESULTS AND DISCUSSION

The opinion of educators regarding the integration between teaching-service at the BHDS

Four main ideas (MI) contained in the educators' discourse were identified during the analysis of interviews and are presented as follows:

MI 1 – The teaching-service integration occurs by a unilateral initiative through a movement of the academia to incorporate service professionals in training programs and put students' activity into operation at the services in the region.

There are... nurses who are not professors and are hired to work in the field with the task of connecting actions in the teaching program with the practice in the health unit. They also encourage workers to put in practice teaching actions, they gather groups or elaborate actions in the field that will serve in the future as teaching opportunities... they are those who make this connection, who read the characteristics and the work in the unit, try to enlarge or establish some actions that allow for practical

classes. There is collaboration from the Health Unit as they provide some community agents to stay with the students, but this collaboration is more focused on following up the actions than on developing or proposing joint actions. So, they are integrated but in a perspective of following up the actions carried out.

MI 2 – There is an active integration between teaching and service through the hiring of professionals with a teaching profile and ongoing discussion, between workers and the university, regarding the teaching program.

It has always been proposed to discuss questions raised during household visits and try to elaborate joint actions during internships, that is, to take along some worker from the service, so that these actions remain over time after students leave the health unit... the Community Agents are those who most have accompanied us. Before we begin the interviews, we discuss with them how they relate with the health conditions of residents and then why this educative project has been developed, we encourage them to follow up the household visits. Some professionals participate in the Basic Care Committee, where there is a representative of the preceptors of each health unit who participates in the discussions and the elaboration of content and how courses are administered. The physicians at the Units help to develop a course jointly with professors who have some connection with the Basic Health Unit or with the Teaching Health Center or yet with outpatient clinics from the Hospital das Clínicas. Attempts have also been made to select physicians with a teaching profile to work with these teams and their work has been organized so to take into account the student's presence.

MI 3 – The teaching-service integration between has contributed to improve care.

Nowadays, the integration between academia and service is a little better; I hope it's even better in the future. Actually, what has been seen is that, when the service is transformed in an academic environment, it also improves care. Since a professional is responsible for students, they ended up studying more because there is someone who is going to ask, question what will be done. The professor has a critical view on the literature and procedures and the preceptor has a more complete view of the care delivered because he is the one who is in the front line. This exchange of information is very enriching for both sides and should be done is the majority of places where the university can be a partner.

MI 4 – There are teaching activities but there is no integration between teaching and service.

There's something lacking in this discussion about integration. The university gets there at the internship stage... and that's it; there's one more person at the Health Unit. You can't say workers are integrated in the teaching process; it is more like, the workers follow up the teaching project and students follow up the activities performed. There isn't integration; there isn't a joint project. Sometimes, there are discussions when students got into the consultations and nurses propose to explain why they did what they did. Professionals from the service also participate a lot in the elaboration of courses.

The data analysis revealed that the Main Ideas contained in the educators' discourse regarding the teaching-service integration are diverse and based on different theoretical perspectives. For some educators, the teaching-service integration does not exist, while others believe there is integration between teaching-service when the health service professional is hired to work at the health unit because (s)he "enjoys" receiving students. Another idea that emerges is related to the fact that the students' presence at the health service improves professionals' quality and education.

The intersection between basic health network/university was sometimes appointed as: participation of physicians from the BHU in the elaboration of courses and teaching, hiring of physicians with a teaching profile, participation of nurses in the curricular re-orientation, discussion of cases with community health agents.

The contribution of the integration between teaching-service to construct a Health Surveillance model in the educators' perspective

In this category of analysis, where we looked at the contribution of the teaching-service integration to change health care delivery in the region, two important Main Ideas emerged from the educators' discourse.

MI 1 – There is incipient participation of University in the implementation of Health Surveillance and it happens by implementing some actions and by addressing this topic during courses.

The contribution of the university in changing the health service model has been little discussed... the integration is still incipient. The university has a lot to contribute with the work that takes place on the front line... The network can be used as an instrument for training in the field. The participation of the university has been seen in the education of students... the content of Health Surveillance is in the curriculum, preparing students in theory and working with these issues in the field...what has been aimed for is to teach a new model of not

only treating the disease but promoting health, preventing diseases and also healing. If Basic Care is not addressed in the first years of the program, students only learn about the healing model because, from the second year on, they already attend patients at the hospital. The earlier students are exposed to integral care, the easier they will see the three things in a more organized way, as professionals. Thus, it has been attempted to change the paradigm these students are being educated in.

MI 2 – The, University has not participated in the implementation of the Health Surveillance model because there is no guidance from the mayor office and it is not its role.

The problem is that, sometimes, there is no information… The mayor office does not clearly inform things…there isn't any information regarding the creation of COVISA (Health Surveillance Coordination) and many have never heard about it. The Health Surveillance perspective has never been heard of, not in the last mandate and even less in this one. Physicians from the health units are not participating in the process, so it's difficult to teach students something the professionals themselves don't know. Regarding the participation of the university in the implementation of this model, first, the academia has no chance or power to implement a health model, because a health model is to put in practice a policy and elaborating a policy includes a negotiation that meets much more political interests that needs… the University doesn't have this power.

Therefore, the discourses indicate that the participation of the University in the implementation of the Health Surveillance model is limited and restricted to the development of a teaching project in the undergraduate program to prepare future professionals for an enlarged practice. Educators also appoint that changing the care model depends on a political project that rarely is constructed jointly with the BDHS. It is worth mentioning that some educators report that their participation in the BDHS has a technical-pedagogical profile and excludes political praxis from their competence.

FINAL CONSIDERATIONS

The cooperative work between the University and the health network anticipates a better-qualified care delivery, due to the presence of professors supervising students, focus on meeting the health needs of the local population by several professional categories, which is the result of research.

Another important aspect raised to approximate teaching and service institutions refers to the valorization, by the academia, of the teaching role performed by professionals at the service[17]. In the current scenario of Brazilian public policies, a new program to value the teaching function performed by these professionals is about to be launched. It is an inter-ministerial program including the Ministries of Health and Education called Program of Education by Working in Health (PET-Health), which aims to promote groups of tutorial learning in the Family Health Strategy[18]. PET-health can be an important counterpart for preceptors and an important factor in the approximation of the teaching and service institutions.

The consolidation of innovative practices in real scenarios requires an essential step: the transformation of the work process and coherence between the project of the services and the educative proposal in its political, technical and methodological dimensions, so that these initiatives involve levels of health services management, university and population. Thus, working on the reality, seeking to transform the established work process and promote deep changes in relations requires that the commitment and decision to be part of the process is institutional and not only a commitment and decision taken by isolated actors. The work at the service necessarily includes negotiations with the local political power, especially in the context of municipalization of health, which is currently in course in Brazil. In this perspective, a judicious work to establish priorities, construct interventions and continue actions, are essential in the study site, and these processes require effective participation of several actors[17].

The reorganization of care based on the HS model implies new roles, new relations and new practices at all levels of the system. These changes can be favored by policies (financing, management, remuneration) that have been considered by SUS managers. However, given the characteristics of change – values, attitudes, practices – it has to be essentially constructed in the local place, performed by professionals, population, educators and students[17].

The need to continue investing in the construction of new teaching-service-community relations, sensitize managers, universities and community leaderships with a view to qualify them is evident.

The aim should be to expand opportunities and create effective spaces for discussion and conversation between the university, services, community leaders and health councils, encouraging a discussion on the role all these actors play in professional education and care reorganization.

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