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Original Article

Theoretical orientation and practice scenarios on occupational therapists training in primary health care: professors perspectives[1]

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Abstract: Objective: This article aimed to describe and analyze the theoretical guidance and practical scenarios in the training of occupational therapists in Primary Health Care (PHC). Method: This is a qualitative research, which presents the perspectives of 17 teachers from nine occupational therapy courses in the state of São Paulo. Results: We categorized subjects associated to the study objective and present two categories: theoretical orientation - which includes the study of the referential Alma Ata (1978); Health Reform; critical understanding of the Unified Health System, the PHC and the profession specificity in this field involving understanding of the devices used by the teams occupational therapist and their working tools, social vulnerability understanding, everyday life and institutional context involving services and their management. The Practice Scenarios has been identified a plurality of services and drawings management where theoretical activities practices are developed, pointed out the difficulty of conducting training for this professional field. Moreover, the absence of workers on PHC hinders health care and also impairs the students training from different professional areas. Conclusion: The professional category must value since training, the learning of new care technologies compatible with their knowledge and occupational therapeutic resources towards the population's access to different practices for comprehensive health care, including the care of occupational therapy in PHC.

Keywords: *Occupational Therapy, Training of Health Professionals, Work in Health, Primary Health Care.*

Orientação teórica e os cenários de prática na formação de terapeutas ocupacionais na atenção primária à saúde: perspectivas de docentes

Resumo: Objetivo: O objetivo deste artigo é descrever e analisar a orientação teórica e os cenários de prática na formação de terapeutas ocupacionais na Atenção Primária à Saúde (APS). Método: Trata-se de uma pesquisa qualitativa, que apresenta as perspectivas de 17 docentes de nove cursos de terapia ocupacional do Estado de São Paulo. Resultados: Foi realizada categorização de temas associados ao objetivo do estudo e, para este artigo, apresentamos duas categorias: Orientação teórica – que compreende o estudo do referencial de Alma Ata (1978); da Reforma Sanitária; da compreensão crítica do Sistema Único de Saúde, da APS e da especificidade da profissão nesse campo, que envolve o entendimento dos dispositivos que contemplam o terapeuta ocupacional nas equipes e de suas ferramentas de trabalho, e a compreensão sobre vulnerabilidade social, vida cotidiana e contexto institucional, que envolve os serviços e sua gestão. Já em relação aos Cenários de Prática foi identificada uma pluralidade de serviços e desenhos de gestão, nos quais se desenvolvem as atividades teórico-práticas, o que apontou uma dificuldade para realizar a formação para esse campo profissional. Além disso, a ausência de trabalhadores na APS dificulta o cuidado em saúde e também prejudica a formação de estudantes de diferentes áreas profissionais. Conclusão: Cabe também

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à categoria profissional valorizar, desde a formação graduada, o aprendizado de tecnologias de cuidado compatíveis com os seus saberes e recursos terapêutico-ocupacionais em direção ao acesso da população a diferentes práticas para o cuidado integral à saúde, incluindo-se o cuidado da terapia ocupacional na APS.

Palavras-chave: *Terapia Ocupacional, Formação de Profissionais de Saúde, Trabalho em Saúde, Atenção Primária à Saúde.*

1 Introduction

International studies on Occupational Therapy in Primary Health Care (PHC) address the lack of funding, training and limited understanding of the role of the occupational therapy in the PHC (WOOD; FORTUNE; MCKINSTRY, 2013) and identify few research investigating the role of the professional assistance in this context (DONNELLY et al., 2014). Also, even the profession is not strongly disseminated on the level of care, the PHC is seen as an opportunity for occupational therapy, since it contributes to population care in a holistic perspective (MUIR, 2012).

In Brazil, even though the training and practices of occupational therapists have been in territorial and community settings since the late 1970s and the 1980s and 1990s, with experience in Basic Health Units (ROCHA; SOUZA, 2011; BARROS; LOPES; GALHEIGO, 2007), only in the 2000s we saw more reflections emerging on the role of the occupational therapist in the PHC, as shown by the literature study by Bassi, Malfitano and Bianchi (2012). The authors sought to know the discussion of training and intervention in PHC recorded by the occupational therapy, finding 21 full papers in specific journals in the country and they identified a growing trend of discussion on this topic in the papers, which also reflect a concern among PHC professionals.

In this context, we have identified changes in the graduation, which undergoes changes from Resolution No. 4, on January, 12 1983 that by introducing the new Minimum Curriculum for Occupational Therapy courses in the country, it was guiding a training for professional practice in the three health care levels, already approaching the occupational therapy and the PHC (BASSI, 2012; SOARES, 1991). On the 1990s, there were discussions on legislation of the training and evaluation of Brazilian higher education. These discussions are due mainly to the Law of Guidelines and Bases of National Education LDBEN (BRASIL, 1996), which ended with the Minimum Curriculum for higher level courses in Brazil and established the flexibility curriculum.

Thus, after the discussions of the training of different professions working in the health sector and LDBEN, the graduation of occupational therapists was regulated by the National Curriculum Guidelines for Undergraduate Course in Occupational Therapy, established by the National Education Council (CNE) in 2002, with the publication of resolution nº 6 (BRASIL, 2002). These Guidelines, in its Article 3, shows

> The profile of the graduated professional, occupational therapist, with a generalist, humanist, critical and reflective training. Professionals are trained to professional practice in all its dimensions, based on ethical principles in the clinical and therapeutic course and prevention of occupational therapy practice (BRASIL, 2002, p. 1).

The curriculum guidelines of 2002 have been guiding reviews and adjustments in the Pedagogical Political Projects of occupational therapy courses, recently changing the training of future professionals (PIMENTEL; OLIVER; UCHÔA-FIGUEIREDO, 2011). In this context, the publication of curriculum guidelines pointed to the need for general and specific training of professionals to be able to work in different contexts, according to local realities and services of different levels of care, including PHC, as a possible training, research and extension scenario to the area (OLIVER et al., 2012; BRASIL, 2002).

In practice, these changes are finding challenges due to the history of vocational training be held in the rehabilitation of spaces and the singularities of services to comply with a logic care and not necessarily being involved with ordering the training of professionals. Also, there are difficulties regarding the definition of their general character, as this would not only be a generalist in the health field, but a generalist able to work in different areas, such as in social, education, work and generation income, and in the culture (PAN, 2014).

Regarding the occupational therapists work in the PHC, there is the professional contemplated in devices, depending on the composition of their teams, can contribute to the comprehensive care in PHC. These devices are integrated into the Family Health Strategy (FHS) and the entire health care network, where the occupational therapist can compose the teams in Basic Health Units (BHU); the Support for Family Health Centers (NASF) (BRASIL, 2008), and the Office teams in the Street (CnR) (BRASIL, 2012a) and Home Care (HC)/ Best at Home Program (BRASIL, 2013).

Before the insertion possibilities in this care level to reflect on occupational therapy in PHC, Rocha, Paiva and Oliveira (2012) argued on the need for greater clarity and perception of the object of study, the intervention processes, technologies and possibilities of occupational therapy in this field, both in theoretical and academic areas such as training and professional practice. Together with these needs, the first - and maybe the greatest challenge - is to expand the spectrum of interventions and build the work processes of occupational therapy based on territory, with the collective and individual subjects, and PHC devices. This is necessary because the professional training is still essentially centered on the individual (SOUZA, 2012).

In this sense, it is essential to know more deeply the different training experiences for and in the PHC, as well as the theoretical propositions of the actors who are involved in training processes. At the same time, it is necessary to sensitize professionals in activity to reflect, through research and theoretical constructs, their professional practices in the PHC (OLIVER et al., 2012). This publicness of experience in the PHC will be one way to subsidize the training of professionals to intervene in this context (SOUZA, 2012).

Thus, the purpose of this article is to describe and analyze the theoretical guidance and practical scenarios in the training of occupational therapists in the PHC. They should be understood, discussed and related to the National Curriculum Guidelines for Occupational Therapy Courses (BRASIL, 2002) and the reflections on this professional area.

2 Method

The study is characterized as descriptive and exploratory with a qualitative approach, seeking to analyze the multiple realities (SAMPIERI; COLLADO; LUCIO, 2013) expressed by 17 teachers, characterized in Table 1, and responsible for the training of occupational therapists for the PHC of five public courses and four private courses in occupational therapy, in the state of São Paulo.

The State of São Paulo has the largest number of active courses in the country with 14 occupational therapy courses, five public courses and nine private courses, a total of 43 public and private courses in operation in Brazil in 2015. This state also develops the oldest public course in the country, in operation since 1956 (PALM, 2012; BRASIL, 2015a).

The construction of field data was by the initial identification of the country courses in Palm (2012) and through the portal e-MEC (BRASIL, 2015a), and the development of a research instrument: The Interview Guide with the Teacher responsible for training for PHC. This script was previously built with the contribution of seven judges who have experience in the field of research, teaching and professional practice related to the fields of PHC, health professionals and occupational therapists training.

From authorization to participate in the research of nine of fourteen occupational therapy courses in operation in the State of São Paulo in 2015, each coordinator of the nine courses were contacted and they indicated teachers who performed the training of occupational therapists to PHC, leading to 17 teachers participate in the study.

The data construction process was conducted in educational institutions of research participants. Thus, after reading and signing the Consent and Informed Form (TCLE), 17 interviews were recorded in audio recorder with a total of 11 hours and 26 minutes. These interviews were transcribed, reviewed, organized and stored in the database. The transcripts were sent to participants via e-mail to enable the analysis of its contents and, if necessary, modify something that was relevant. Only two teachers recommended changes in transcription, but there were no significant changes to the content of their initial contributions.

Finally, a thorough reading of the database was performed, and the processing of material constructed in the field and the categorization of subjects linked to the objective of the study, in a system of empirical categories formulated as they were found reading the interviews (BARDIN, 2011).

For this article, the following categories were selected: theoretical guidance - essential content of graduate training occupational therapist for PHC

Table 1. Characterization of teachers as the year of graduation, title and bonding time to the education in the PHC.

Year of graduation of the OT teachers	Participants[2]	Post-Graduation of higher level	Teaching time in HEI and time linked to PHC training	Public or Private HEI/ year of the course creation
1979	Teacher 6	Ph.D. in Social Psychology – 1999	31 years/16 years	HEI C public/1956
1980	Teacher 17	Ph.D. in Medicine (Mental Health)- 2000	13 years/13 years	HEI D public /2002
1981	Teacher 15	Ph.D. in Philosophy of Education – 2012	17 years/10 years	HEI I private/1998
1983	Teacher 8	Ph.D. in Production Engineering – 2004	10 years/8 years	HEI D public /2002
1985	Teacher 7	Ph.D. in Public Health – 2000	29 years/29 years	HEI C public /1956
1986	Teacher 2	Ph.D. in Psychology- 2009	5 years/5 years	HEI A public /2006
1988	Teacher 1	Ph.D. in Preventive Medicine – 2012	1 years/8 months	HEI A public /2006
1997	Teacher 5	Ph.D. in Public Health – 2014	1 month/1 mês	HEI B public /1978
1999	Teacher 3	Ph.D. in Public Health – 2013	8 months/8 months	HEI B public /1978
2001	Teacher 4	Ph.D. in Public Health – 2008	10 years/10 years	HEI B public /1978
2001	Teacher 9	Ph.D. in Education – 2013	2 years/2 years	HEI E public /2003
2002	Teacher 14	Master in Health Psychology – 2011	2 years and 6 months/1 year	HEI H private/2006
2002	Teacher 12	Human Resource Management Specialization - 2008	7 years/6 months	HEI H private/2006
2005	Teacher 11	Specialization in Teaching in Higher Education - 2009	6 years /3 years	HEI G private/2005
2007	Teacher 13	Specialization in Assistive Technology - 2012	3 years /3 years	HEI H private/2006
2008	Teacher 10	Ph.D. in Special Education – 2015	1 year and 6 months/6 months	HEI F private/2012
2010	Teacher 16	Master in Public Health - 2013	1 ano/6 months	HEI I Private/1998

and monitoring of the students in practice settings, and the influence of PHC services management methods in training graduate occupational therapists.

The data built were analyzed based on the National Curriculum Guidelines for Undergraduate Program in Occupational Therapy (BRASIL, 2002) and the theoretical and methodological references of occupational therapy and Public Health, and health research and scientific evidence produced in the area of training and occupational therapy.

The research was submitted to the Ethics Committee in Research of the Federal University of São Carlos, UFSCar, by the principles of Resolution 466 (BRASIL, 2012b) with a favorable opinion of its performance (Protocol: 990.200, 04/14/2015).

3 Results and Discussion

3.1 Theoretical guidance: essential content to graduate training of Occupational Therapist for PHC

Among the theoretical contents, the teachers established the training both knowledge related to the field of Public Health as the specific center of

occupational therapy as essential. They highlighted the important international reference of Alma Ata (1978), the Study of Health Reform and institutionalization of SUS as theoretical elements and structuring practices for care in PHC.

> *First, to know what is primary, both the international movement, the issue of Alma Ata, the history of the formation of the SUS* (Professor 1 - HEI A).

There were also ways recommended for the training of the occupational therapist in the area of critical understanding of the SUS and the PHC.

> *I think it is essential you take the student to have an understanding of the system as a whole, less than an idea that the SUS is for a population that has no access to other forms of health* [I think this is still a predominant idea in many courses, that working in the SUS is working with people who have no money to buy other things] *which puts in there thinking a certain way of seeing this population and the work itself. So, I think to put the student in touch with what is the SUS, the story that nurtured the SUS, the principles that have been made from a certain criticism of the previous model. SUS is not just a system point of view of its working institutions and such, but as a citizenship project, it is a project that gestated from a critique of society, to put it that way* (Professor 7 - HEI C).

As pointed out, it is necessary to know the influences and the organization of the SUS and the PHC, since, in certain situations, this lack of health professionals and users does not favor the recognition of their due importance as still happens in Brazil (CAMPOS et al., 2008).

Understanding the difficulties and challenges of a universal public health system for its organization and operation is not different to the training context of occupational therapists to PHC, as discussed below:

> *Knowing the public health policy,* [study the SUS and identify our role in each place], *understanding how the services are structured in fact, for example, when we work with some communities, they cannot understand the difference between the Emergency Care and BHU service, for example, often we as professionals also do not know this difference* (Professor 12 - HEI H).

For a solid and critical understanding of PHC in the SUS, it is necessary a theoretical study in depth about public policy, on society and social control, as we can identify in the following statements:

> *The discussion on the issue of health policy and an understanding of public policy is essential, a theoretical understanding, an understanding that makes us understand what is the place of health in this society that has this contradiction of a marketing and prevalent message of the private health system and the constitutional of universal right of the health right... The study of the functioning of society, the study of the professional role in society* (Professor 4 - HEI B).

> *I think students need to have a political training, knowing what are the guidelines for the health organization in the city, how the social control is done, necessary to have a knowledge of the history of public health and SUS* (Professor 15 - HEI I).

The understanding of popular education and knowledge of the territory is added to the training for PHC, as proposed in the reports below.

> *Using the popular education, knowing this territory, knowing the culture of this territory to develop actions with the population, the community. Thinking territory, as a tool that we use in health, which is the territorial* (Professor 8 - HEI D).

> *Thinking the subject in the territory, the issues he lives with his pathology, the difficulties, which are not always focused on the disease, his relationships with people in the neighborhood, his social role* (Professor 15 - HEI I).

Also, the PHC addresses the most common problems in the community, providing prevention, care, and rehabilitation. It integrates care when there are more than a health problem and deals with the context in which the disease exists and influences the response of people to his health problems. The health care in the PHC is close to the context of people, a better position to assess the role of multiple and interactive determinants of disease and health (STARFIELD, 2002).

For this the PHC approach, it is necessary to promote the training of occupational therapists, understanding of different subjects also indicated by Professors.

> *I think the word host is essential in the basic care more than anywhere else. The longitudinally is a huge challenge, and I think it is one thing to think also as a very important tool in primary care* (Professor 7 - HEI C).

> *Understanding the continuity of care, community and family care, teamwork, the user's need, intersectionality and the concept of comprehensiveness* (Professor 1 - HEI A).

Therefore, it is important to understand that there is no discharge in the PHC care processes because the user´s relationship with the team will be strengthened all the time since it is responsible for the health of a family and the longitudinal care (SOUZA, 2012).

Regarding the training, it is a serious mistake to base operations and training in the PHC only in the aspects of the public health area, since occupational therapy has much to contribute as a specific center, especially concerning supporting the teams in care the families of greater risk and vulnerability through cross-sectoral coordination, listening, the relationship, dialogue, about the care and use of what is available to perform care in PHC. Thus, care to be performed can be called specific, but non-specialist. This means that the specific nature of the profession is not lost in the PHC, and instead, it is maintained and constantly reflected (SOUZA, 2012).

However, for the construction of this specificity, it is also observed that the PHC and occupational therapy have an incipient literature, but with a trend towards the greater accumulation of research, specific interventions, and development (BASSI; MALFITANO; BIANCHI, 2012). This situation confirms the following report:

> *On the occupational therapy, we have little literature; I feel that we have more items on CBR and working with people with disabilities than in mental health in primary care* (Professor 1 - HEI A).

In the small but the growing number of publications on occupational therapy in PHC, it is worth highlighting the specificities of this professional group, which is constituted as an emerging professional performance area (BAISSIA; MAXTA, 2013).

It should be noted that the knowledge of epidemiology, Anthropology, Public Health, Psychosocial Rehabilitation references and Community-Based Rehabilitation (CBR) have been the theoretical and methodological references of educational processes and practices in occupational therapy in PHC (OLIVER; AOKI; CALDEIRA, 2013; CALDEIRA, 2009).

Also, the professors specified the professional core of occupational therapy and listed the essential content of training, as we can see below.

> *Within occupational therapy, working every day, the use of time, significant occupations* (Professor 1 - HEI A).

> *Bringing concepts that sound expensive as in everyday life, such as the occupational life of these subjects and think that in the territory* (Professor 3 - HEI B).

> *Another thing I think is very important is the issue of training in the understanding of what is daily life and activities of daily living* (Professor 5 - HEI B).

The daily life appears as content for the training of occupational therapists in PHC, since this level of care is an essential part of care for the health of the population, while that everyday life is the object of study and occupational therapy intervention (SILVA; MENTA, 2014).

It is possible to understand that the occupational therapy concerns on what people do, how they use time, where they go, what are their wishes, as the social context facilitates or hinders the engagement of people in different activities, finally how to build the daily lives of the subjects. Each routine is private and is built according to the uniqueness and the reality experienced in the social context (SALLES; MATSUKURA, 2013). Thus, understanding the construction and the transformation of everyday life may be as therapeutic-occupational resources for care in PHC in the graduate training.

The professors reported on different content required training for PHC, which it may be connected to both the general and specific nature of the area as the history of the profession and its interventions for physical rehabilitation and mental health.

> [On the internship in physical disability] *For the student to be in the PHC PHC, I think he needs to bring everything he has. He has to bring what he knows of group dynamics, on mental health, what he knows about family relationships that he knows of the activity, what he knows on orthosis, what he knows on Bobath, body manipulation, what he knows of clinical settings. It is a mosaic, a composition. Moreover, this composition can only be possible on the user's needs* (Professor 6 - HEI C).

> *I can know what is OT, but I have to know what is the profession, then I see that the occupational therapist will equip the autonomy of the subject also* [PHC] *will create living spaces and well-being, we will promote cinema, but we have to know how to listen to depression, it is a biopsychosocial care, but with much respect for the cultural* (Professor 17 - HEI D).

This general construction is essential for the training, because it will be based on the specific practices of occupational therapist within the PHC service, in home environments and community settings (BAISSIA; MAXTA, 2013). Thus, the occupational therapist in PHC is responsible for planning, management, coordination and evaluation of specific actions of occupational therapy developed in PHC services, at home, and in the community. Thus, it develops care actions among different populations, such as those with disabilities, psychological distress, changes in human development, social vulnerability and/or have difficulty in carrying out their daily activities, whether leisure, employment or movement, and social interaction, among others (ROCHA; PAIVA; OLIVEIRA, 2012).

The essential contents of training are different, and these are articulated to the understanding of the public health policies of PHC and devices of this level of care, which include the presence of the occupational therapist, for example in the BHU, the NASF, the Office in the street and Home Care. Moreover, as the teachers reaffirm, it is necessary to know the working tools of this field, as the matrix support, the clinic expanded and the Singular Therapeutic Project (STP).

> *Understanding the PHC devices that OT is inserted from the ministerial order, which would be the NASF, the office on the street and home care. It is essential to understand what OT is matrix support because this is the concept that we are being asked to take for Primary Care. Knowing what the Family Health Strategy territory is, and integrity, extended clinic, field and core reference team, Singular Therapeutic Project* (STP), *for example, what is the uniqueness of the OT about this concept. In building the STP, we think how to organize an occupational therapy intervention plan* (Professor 3 - HEI B).

> *The student has to be aware of ministerial programs to be able to enter as a professional. The student must have an idea about the health-disease-care, about the clinic, expanded on the STP. Being aware of what are the health facilities, how is the management of the equipment, knowing the network, how care is within the network* (Professor 2 - HEI A).

In Brazil, there is an expanded understanding of the PHC assignments, established in Ordinance Nº 2488 of 2011 (BRASIL, 2011). This expansion has been accompanied by greater integration of different professionals in PHC devices, which expands the new forms of action and take care of the professional, and inserts its technologies to this level of care (ROCHA; PAIVA; OLIVEIRA, 2012).

This is due to the PHC bringing a double burden of complexity: challenges professional categories working in health to restructure its training model to align the professional profile to the population´s needs in the PHC, and requiring clear definition of the specific skills of each profession, so that the boundaries of the area are respected, promoting people´s access to such expertise of an inter-professional way (ROCHA; PAIVA; OLIVEIRA, 2012).

Another aspect mentioned by the teachers was the training in occupational therapy for PHC and the interface with the theoretical and practical field of social, occupational therapy.

> *I always try to say the differences have an OT in the PHC, what is the OT core of this space of the PHC, which is such a generalist that has blurred the boundaries* (Professor 3 - HEI B).

> *So, it is hard to discuss what is social, what is primary health care, because they have similar content, the student has to understand that there are things that are specific to one area and another, but they have to understand the possible links between these two fields* (Professor 8 - HEI D).

The problem of heterogeneity of conceptualization of the social field in occupational therapy and superposition with another operation field - which has received great emphasis on practical training in health, the PHC - have repercussions on the theoretical and practical training. Thus, it is worth understanding that the territory and social vulnerability are not enough to define a professional technical action. Thus, it is necessary to analyze in depth the objectives and methods of intervention in the social field and PHC, and also the knowledge and expertise to guide the actions in each area (LOPES; PAN, 2013).

In this perspective, the occupational therapy can help to develop actions to minimize and/or

resolution of situations of vulnerability and social risk in each territory covered in the PHC, based on territorial and cross-sectoral actions directed to individual and collective needs (ROCHA; PAIVA; OLIVEIRA, 2012).

Another essential content training for PHC was related to labor and management groups. According to Ballarin (2015), learning is fundamental to work with groups, since it is expected that the occupational therapist has an accumulation of specific skills to understand, organize and coordinate groups, acting as a member of a team, as a manager or assistance in health, education or social contexts.

> *In the Primary Health, you work with groups, you work with the community, this ability is also very important. It also stems from the ability to work in a multi-professional team* (Professor 5 - HEI B).

Thus, the various individual or group activities used by occupational therapy in PHC have as purpose, both the knowledge and the opportunities available for the reorganization and transformation of daily life, seeking to promote maximum participation in personal and social life (ROCHA; PAIVA; OLIVEIRA, 2012).

3.2 The Monitoring of (the) students in practice settings and the influence of PHC services management arrangements in graduate training of Occupational Therapists

The description of the professors on the monitoring of the students in the real scenario of the PHC favored the understanding of these strategies in this theoretical and practical component and its relevance to the training of occupational therapists in PHC.

The inclusion of students in PHC scenario is having weaknesses arising from various difficulties in establishing a partnership between health services and the school, which has hindered effective construction of the learning process in different courses that operate in this care context (CORÁCIO et al., 2014).

Also, this challenge is in recent productions on the training of occupational therapists to the mental health area due to lack of resources and the difficulty in establishing partnerships between HEIs and services. However, the teaching service integration is strategic for the training of occupational therapists, especially by the power to experience the challenges and contradictions that provide services to the highest exercise practice. Moreover, this integration demand for a professional to contribute to finding solutions that meet, the assistance priorities of both the territory as SUS and public policy in addition to the training needs (LINS; MATSUKURA, 2015a, b).

Regarding the integration of teaching and service in the PHC, the professors mentioned that this scenario training is a vulnerable space.

> *We are in the most vulnerable areas, in some family health units* (Professor 1 - HEI A).

> *We are in a unit that is a socially/culturally neighborhood considered impaired because it has to traffic* (Professor 9 - HEI E).

> *We have the internship that is specific in the Basic Health Unit in a very impoverished area of the city* (Professor 11 - HEI G).

> *As for the monitoring of students, I have tried to sensitize them to this context* [referring to the vulnerable context]. *How to care for people* (Professor 15 - HEI I).

> *The practice place is in the territory, here near the University, which is a very vulnerable area regarding access* (Professor 16 - HEI I).

The teachers did not indicate theoretical references of their reflections on this subject and, to this understanding, we agree with Castel (2008) that when talking about social issues, he stated that the vulnerability is the result of the establishment of a system of relations between the degradation of the economic and social situation, and the destabilization of the lifestyles of the groups, which are face to face with social problems.

Castel (2008) considered that the social space consists of areas marked by vulnerability or integration, where people live. Thus, in the integration area there is an ongoing work and strong social support network; in the vulnerability zone, there is a relationship between job insecurity and weakness in the social support network; in the disaffiliation zone, there is lack of work and social relationships, and in the assistance zone, there is an explicit expulsion of work and the difficulty of social integration. This author emphasized that the precariousness of work produces the process that

powers the social vulnerability and produces, at the very end, unemployment and disaffiliation, and the state becomes the main support and the main protection to vulnerability.

Oliveira and Furlan (2008) also stated that the concept of vulnerability by Castel is useful to think about how health practices have been organized - and can be organized - in the territories and services of these participants. Thus, the study of this concept supports the development of educational processes in PHC, as this level of care is close to the social life of people.

Therefore, it is important to reflect on the graduate training for PHC, as it leads students to PHC service and makes them realize a reality which sometimes is distant. This approach may result in the construction of a care hygienist in students by the meeting between people from different backgrounds, being necessary to discuss this training at the graduation (CECCIM, 2014), with solid theoretical discussions about what are the realities and the vulnerability experienced by the population and by students during training.

This hygienist care can be caused as Freire (1983) called it as cultural invasion, in which a subject that invades the historical-cultural space of the other overrides their worldview to individuals through authoritarian relationships. Thus, the way out of this perverse process would promote communication and dialogue, in a way that they cannot be broken by the relationship between thought-language-context or reality; then there should be more communication between the university and the population, this contact of students with PHC services and its territories.

As a result of this contact with students with different areas of the PHC, some professors highlighted this scenario as a possible promoter in the training because it causes contact with popular knowledge; thinking of health as a public right; the need for cross-sectoral joints, and expansion of the concept of health.

> *Another aspect is you coming into direct contact with the popular knowledge of community health workers, with an interdisciplinary team that is thinking problems that not always OT thought about it* (Professor 3 - HEI B).

> *In fact, the SUS is recent, but we observe little effort in its defense. I think this is an important issue in the training of occupational therapist who is seeing the other students from other areas; we are in the front. At least that is what I see here* (Professor 15 - HEI I).

> *We have a partnership with CRAS which is very recent; there was a meeting last week between the responsible psychologist of CRAS and us* [the OT internship in PHC] (Professor 10 - HEI F).

> *It is funny. At first, we had a very focused service, thinking of health, but very physical. Moreover, now we can now extend this look of occupational therapy for overall health. Thinking about the functionality and the appropriation of the individual of that space* (Professor 13 - HEI H).

Before the appointed considerations, we see that student learning provided by the production meetings between them and the people, families, and communities. These meetings, according to Bravo, Cyrino and Azevedo (2014), enable the exchange of knowledge, perceiving the other as having distinctive knowledge, essential way to the development of skilled care in PHC.

These meetings are ratified as important by the professors.

> *What I find essential is to know how to relate to each other. How to have a date, a real date. Moreover, I am calling a true meeting exactly how Merhy speech, I mean, that meeting that affects both, the two are affected; it is not a thing* (Professor 7 - HEI C).

> *We must have empathy and for that, it is necessary to have experience in the community and respect for diversity* (Professor 17 - HEI D).

The meetings are mediated by the professor or preceptors monitoring in the context of practical training in PHC, where they can cause the training of student political role, as emphasized in the following statements:

> *You have to be very clear* [in OT internship of PHC] *the role of what the SUS is, and the political role that health professionals have in the training of students, it is not a favor they are doing, it is helping to qualify such assistance and is by these professionals, it is a part of teaching. The teacher has to play a role with the students and with the teams* (Professor 1 - HEI A).

The monitoring of students is done by the professors, tutors and technicians linked to HEI, and in that sense, the professors report their experience.

> *We show together with the students how the service of the OT is* [for the FHS team] *through cases, the activities of daily life, autonomy within the house, get around alone, so we show that we are not the physiotherapist, we have a core knowledge. There is no presence of occupational therapists in the service network in primary care; the professors are who play the role of professors* (Professor 1 - HEI A).

> *I work with students more within the unit, providing support to services and actions, then we have groups within the basic unit.* [We work] *at home, in the territory, and within the unit. There are not preceptors, I am there about 4 years in the internship and do not have much time for other things because the internship is very time consuming* (Professor 2 - HEI A).

> *The course understands the PHC space as an important place in training, we understand that we are lack of resources to implement a more effective way, because it ends up counting only with our human resources, two professors involved and one technique, but we do not have occupational therapist on the network and we have no occupational therapists linked, for example, the* [HEI D] *that can be preceptor* (Professor 8 - HEI D).

> *We select some cases to the individual treatment plan with the students; we share tasks, this involves not only our students, but it also involves the entire unit – there are the health agents and the trio management, medical, nurse, dentist, nursing assistants. All ends up participating enough of our interventions in the unit. They have the responsibility* (OT of the NASF), *to be bureaucratic, but they are also part of our strategy as the internship* (Professor 9 - HEI E).

> *Students do not do any action that does not pass me by* [teaching], *or I have no knowledge. I divided that those going in that house, patient profile with the student profile, the groups also all the actions were undertaken by them, they have to come up with what action they will develop. The monitoring of students is direct in-home care every day I go to a student in a house, and so I am going slowly at all* (Professor 10 - HEI F).

Monitoring is also performed by the teachers. It is observed that the presence of this figure in the context of training of occupational therapists is scarce because even to the small insertion of these professionals in PHC. This aspect is highlighted in the statements:

> *There are 6 OT in PHC, two in NASF and 4 in the health districts in the FHUs. Students have very different training depending on the teacher because that teacher will be in that unit that can be totally different from each other. The differences and uniqueness between the units are very important, and I value them, but the training opportunities, they need to be a little more equalized, I think it is a limitation and other limitation is that, in fact, as there is no an action plan of the OT in the network* [and in the PHC], *the preceptorship plan, it is also fragile because then we have governesses who participate very actively in the process, and other, participate less* (Professor 3 - HEI B).

> *We have 2 OT in the NASF of the BHU* [where the internship happens] *it is enough, but* [they do not supervise the students]. *The technique of* [HEI C], *which has this role to supervise. We do not have a partnership with the OT with the NASF; we have a partnership with the NASF. Thinking of inter-professional work* (Professor 6 - HEI C).

Facing the monitoring process, the professors identified challenges such as:

> *The FHS team does not know what is OT* (Professor 1 - HEI A).

> *Within a basic unit, there is no place for the occupational therapist* (Professor 2 - HEI A).

> *In the PHC network of the municipality, we have no occupational therapists* (Professor 17 - HEI D).

> *Our problem is because there are two-hour classes, so, then, what the student can do is to be in contact, which is also important, the first practices are experiences. This relationship with the user, the bond, we cannot do much, I miss this space so we can make this bond between theory and practice with the student* (Professor 16 - HEI I).

> *We question the students* [about OT in the PHC]*: Make home visits in patients with no object of practical activity, is it occupational therapy? So, these issues appeared more and it was very rich, very productive* (Professor 11 - HEI G).

> *There was no OT in the PHC, which made it very difficult also our entry and thus by more than there were these limitations, I think that during the process that I remained in supervision* [as a teacher] *and everything was very profitable, the issue of the occupational therapy* (Professor 11 - HEI G).

According to Corácio et al. (2014), there is a difficulty in the process of training of professionals working in the health area: a) to the insufficient number of service professionals, there is not an effective participation in the training of students; b) the technical-political organization of the health units creates conditions for extended absences without replacement of professional services. Also, there are difficulties in the structure of services that hinder to meet the training needs of professionals: the student cannot see the system work, cannot see resoluteness, and they see an excessive demand on the service (CORÁCIO et al., 2014).

Training requires a change in the practices of PHC teams, that is, the way how the work process is being structured, as one of the "critical nodes" to change the techno-assistance health model in Brazil. Moreover, for this reason, it is important that the training is articulated in the decision-making process in public health policies (CORÁCIO et al., 2014).

Thus, the monitoring process is complex due to the diversity of social contexts and services. This reality requires the efforts of many orders, so there is equalization of interests and perspectives on training of occupational therapists, both from HEI, with professors and students, as technical, the preceptors, the community and the municipal health management, which shares the space of its services with the training of many health professionals and enables hiring professionals to the PHC area.

In view of the above, it is also necessary to point out the modalities of management of the services the student receive in practical contexts in PHC, due to the closeness between decentralized governance of the SUS and the education of health professionals' processes being also based on the challenge of public management of the health sector to order training policies, as seen in the SUS (CECCIM; FEUERWERKER, 2004).

The professors participating in the research identified three types of management services (Public Administration, Social Organizations and Foundations of HEI), in which practical training and work internships of occupational therapy students in PHC are developed. However, they did not generate a discussion on the different forms of management of PHC services undertaking the training of students and the development of care in PHC. The absence of debate between the HEI - promoting training of health professionals and the management of systems and services, and who perform health care - it is one of the weaknesses also presented by Ceccim and Feuerwerker (2004).

One of the management modes is the public administration of PHC services and one of the teachers pointed out the presence of joint construction space for the training of occupational therapy students, even in the context of their speech, having reported the breakdown of these spaces due the political and administrative continuity, as the result of political control in the city.

> *The organization of services is through a direct administration. We basically have two forums, which produce a joint production between the educational institution and the PHC services, one of which is the meeting of preceptors, that monthly we do with all preceptors dividing this meeting in which part of the schedule is intended for educational discussions, evaluation of students, joint construction of menus and themes, etc. And another part is used for continuing education for preceptors developing themes they choose to develop people in training* (Professor 3 - HEI B).

> *The management of PHC is through a direct administration* (Professor 10 - HEI F).

Another mode of administration of PHC services presented by professors was the management of Social Organizations (SO) mode that is characterized by devolution of services to the non-state sphere (CARNEIRO JUNIOR; ELIAS, 2006), which causes contradictions to the implementation of SUS.

> *Management of health centers, family health strategy, it is carried out by social organizations unfortunately* (Professor 11 - HEI G).

> *The management of services is via SO* (Professor 13 - HEI H).

> *The municipal management is mixed, there are some people in the municipality who are hired via public tender, directly from the city, and there is an institution that also ends up making outsourced contracts of some employees. The NASF professionals are employed by the institution, so they are not from public tenders*

> *by the town hall, other professionals that make up the primary care team is through this social organization* (Professor 9 - HEI E).

> *I think in the particular case of the municipality, there is the presence of the SO, which, incidentally, is now going through a hell of a crisis, that is the issue of the SO for the various districts. History shows that these SO often had no participation in the construction of SUS, they were not part of an understanding of a project as SUS. So they cannot come to this perspective* (Professor 7 - HEI C).

The management of the PHC municipalities of HEI C, D and H is carried out by the Foundations of HEI, which also administer health services and school health centers, as a form of service to meet both the training demands of their health care students as well as the health care demands of the population of their territories.

Many services of the academic institutions are structured according to their internal logic and, more linked to the demands of research, extension, and education than the real demands, to work as reference and counter reference to the SUS service network (CAMPOS et al., 2000). On this, one of the professors reported an aspect of the historical origin of this management model.

> *In the beginning, when the trading between the HEI and the municipality started, I had this idea that the university knows how to do. Because many SO today are connected to universities or educational institutions, this initial idea I saw it too be gestated in instances where I attended some years ago* [1980-1990] (Professor 7 - HEI C).

Management by SO is a reality in different scenarios of practice, as shown by the professors.

> *Management is via direct administration. However, I think the trend is that some services are for administration of SO* (Professor 1 - HEI A).

> *The thing is that the public health is organized by Social Organizations increasingly evident in the municipal policy. The Municipal Health Council is quite backward, most advisers have little knowledge of SUS, there is no popular participation, students are unaware of the existence of the Council. Moreover, then the population, of course, they want to have health insurance, it is the dream of every Brazilian. Even university students, most of them unknown and/or never attended a meeting; they even do not go to a health service* (Professor 15 - HEI I).

The management by the SO is focused on the management model and the State of unaccountability to build programs and policies to meet a significant portion of conquered social rights. This polarization between direct administration and state irresponsibility dulled the search for alternatives, while respecting the principles and guidelines of the Health Reform and SUS, to be able to overcome the health care problems and would ensure effectiveness, quality and efficiency of the services provided by SUS, as well as the training of health professionals (PAIM; TEIXEIRA, 2007).

In the occupational therapy area, Lopes et al. (2008) identified the following problems in the training: the need to discuss with the management the increase of technicians, occupational therapists, to implement social policies, in addition to the frequent alternation in public administration being a major difficulty for maintenance projects, agreements and partnerships for education, which is compounded with the privatization of services.

In this sense, the training of health professionals has remained out of the organization´s management and the critical debate on the structuring of care systems. Thus, new mechanisms will be needed to fight for public planning and management so that services can be SUS learning scenarios and for the SUS (CECCIM; FEUERWERKER, 2004).

There is a need to review the relationship between the HEI and the PHC services so that the training process can take place with the strengthening of the curriculum and health care. In this regard, the guidelines for the celebration of Organizational Contract Public Action Education-Health (COAPES) can strengthen the integration between education, community services and, under the SUS. The COAPES are recent management strategies, which seek to ensure access to all health facilities under the responsibility of healthcare manager as setting practices for training in the undergraduate and health in residences, and establish responsibilities of the parties related to the operation of the teaching-service-community integration (BRASIL, 2015b). Moreover, it is also necessary to review the issue of bonus and welfare coverage promoted by the professional service, which is responsible for the students in the practical field of PHC (CORÁCIO et al., 2014).

4 Conclusion

This study indicates the need to extend the academic and professional reflection on the indicated theoretical assumptions, such as the reference of Alma Ata (1978); the study of the Health Reform; critical understanding of the SUS and the PHC, and its characteristics as care level of continuous care and social policy, and also the specificity of the profession in the PHC, which involves understanding of the devices that reference the participation of occupational therapist in professional teams of PHC and its working tools already in graduate training. Associated with such content, there are critical and solid grasps of the causes and effects of social vulnerability and the multiple possibilities of understanding and transforming everyday life, as well as the institutional context in which the services from its management to the composition of the professional staff. These theoretical content could be elements to be incorporated in the necessary discussions on the review of the National Curriculum Guidelines for the occupational therapy area, in which the theoretical and practical training for PHC could be better sized and explicit.

There were a plurality of services and PHC management projects identified, in which they develop the theoretical and practical articulation strategies, which also makes up the mosaic of difficulties to carry out the training for this professional field. The reality of services indicates different understandings of professional practice at this level of care, which makes the health care of the population and also impairs the training of students from different professional areas. In this sense, there is greater damage to occupational therapy due to the insertion of a small number of these workers in the PHC.

It should be noted that the management of services encompasses macro-politics of questions about the role of the State in carrying out the social and the presence of different types of PHC service management causing repercussions also in the training of occupational therapists activities policies, which, by exploratory nature of this study, it was not possible to measure, demonstrating the need for further research to show this problem.

Thus, it is also up to the professional category (students, teachers, workers and representative bodies), their politically and technically commitment, so there are training processes according to the health needs of the population, equitable PHC services, and the occupational therapist values the implementation of care technologies compatible with their knowledge and occupational therapeutic resources towards the universal access of the population to different practices of comprehensive health care, as from the PHC.

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[2] All participating professors are women. The presence of women in the profession is marked historically and, as it could not be different, they are the majority in the course of practical training of occupational therapists.