Residencies in health: analysis of a state policy for training professionals for the SUS

Residências em saúde: análise de uma política estadual de formação de profissionais para o SUS

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DOI: 10.1590/0103-11042023138111

ABSTRACT Health residencies constitute an important State strategy in regulating the training of professionals for the Unified Health System (SUS) within the scope of work management and health education policy. An investigation was carried out to analyze how the residency policy in the professional health area has been implemented in the state of Pernambuco, Brazil, from 2010 to 2021, in terms of management, characteristics of residency programs, and resources invested. The work is a social research, of the case study type and mixed methods approach, with documental research and government data, which used the Policy Cycle Approach as a theoretical-analytical framework. We developed thematic content analysis based on what was collected, on theory and on the researchers' perspective, identifying the categories: policy actors and governance; expansion of training and funding; priority thematic areas; training in multiprofessional health residencies. We identified management experiences with the participation of different local actors, incremental investment in residency grants, and expansion of multiprofessional residencies in health. The challenge of implementing a health training policy remains, which, based on in-service education, acts as a driving force to advance the SUS.

KEYWORDS Health human resource training. Internship and residency. Unified Health System.

RESUMO *As residências em saúde constituem-se importante estratégia de Estado na regulação da formação de profissionais para o Sistema Único de Saúde (SUS) no âmbito da política de gestão do trabalho e educação na saúde. Foi realizada uma investigação que objetivou analisar como a política de residência em área profissional da saúde tem sido implementada no estado de Pernambuco, Brasil, no período de 2010 a 2021, nos aspectos gestão, características dos programas de residência e recursos investidos. O trabalho é uma pesquisa social, do tipo estudo de caso e abordagem de métodos mistos, com pesquisa documental e dados governamentais, que utilizou como referencial teórico-analítico a Abordagem do Ciclo de Políticas. Foi desenvolvida análise de conteúdo temática com base no que foi coletado, na teoria e na perspectiva dos pesquisadores, identificando as categorias: atores da política e governança; expansão da formação e financiamento; áreas temáticas prioritárias; formação nas residências multiprofissionais em saúde. Foram identificadas experiências de gestão com participação dos diversos atores locais, investimento incremental em bolsas de residência e ampliação das residências multiprofissionais em saúde. Persiste o desafio de implementar uma política de formação em saúde, que, pautada pelo ensino em serviço, atue como força motriz para fazer avançar o SUS.*

PALAVRAS-CHAVE *Formação profissional em saúde. Internato e residência. Sistema Único de Saúde.*

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Introduction

The omission in relation to the work management and health education agenda has brought serious consequences for the Unified Health System (SUS), especially because of the low capacity of the State to guide the training of health professionals. According to Torres et al.[1(11)], "health training is still a critical point of proposals that bet on changing the health care model in Brazil". In order for the training of these professionals to be, in fact, focused on the health needs of the population, there are numerous challenges, especially with regard to regulatory processes.

Since the creation of the Secretariat for Management of Work and Education in Health (SGTES) in the Ministry of Health (MS), in 2003, several actions, strategies and programs have been developed in an attempt to integrate education and work in health. Among these, residency in a professional health area was presented as a higher education strategy in health that brings opposite meanings to those historically attributed to medical residencies, which are configured as a specialization focused on curative and private action[2].

Residency in the professional health area, instituted by Law nº 11.129/2005, as graduate education in the form of in-service education, aims to train professionals for a differentiated activity in the SUS, assuming interdisciplinary construction, teamwork, permanent education and reorientation of technoassistance logics[3-5].

In the process of implementing the health education policy in Brazil, the structuring of residencies in health as a State policy for professional training in the SUS is considered a step forward. However, this training modality is in constant dispute, with cycles of discontinuity and incipient regulation. Inconstancy is observed in regulatory and promotion actions, including in the work of the National Commission for Multiprofessional Residency in Health (CNRMS), the highest regulatory body for this policy in the country, which points to weaknesses in national management. The professional training policy for health workers became vulnerable to changes in management, the discontinuity of investments and the lack of coordination.

In the current context, a series of federal management initiatives have been undertaken in the sense of turning back on strategic issues related to residencies in the professional health area. Distancing itself from a proposal of in-service education, it has edited norms that do not dialogue with the legislation previously produced and still in force, and that do not recognize the actors who work in it or consider the history produced by the social movements that carry out residencies in health in the country.

The productions that deal with education through work, and more precisely about residencies in health, have been growing in Brazil, more strongly since its institutionalization[6], but no studies were identified that analyze the implementation of the policy of residencies in health in the territories. As a result, the need for studies that analyze the residency policy in the context of practice and the characteristics of these programs is reinforced, aiming at the development of the SUS.

It is based on the assumption that the institutionalization and strengthening of the health residency policy in the SUS are an important strategy to consolidate the State's role in regulating the training of health professionals and to improve the policy of work and education management in health. The article aims to analyze how the residency policy in the professional health area has been implemented in the state of Pernambuco, Brazil, from 2010 to 2021, in terms of management, characteristics of residency programs and invested resources.

Theoretical-methodological procedures

This is an exploratory, case-study type of social research which object is an analysis of the

implementation of the residency policy in the professional health area in Pernambuco, Brazil.

The analysis of the implementation process has been highlighted, being considered a crucial stage for understanding government action, revealing the real possibilities of the policy, the established pacts, support, disputes and interests of the actors[7]. Implementation, therefore, is embedded in governance structures, understood as the rules of the game and institutional arrangements that support cooperation, coordination and negotiation[7].

The theoretical-analytical framework used was the Policy Cycle Approach (ACP) proposed by Stephen Ball and Richard Bowe[8,9], English researchers in the area of educational policies, which includes three contexts in policy formulation: the context of influence, the context of text production and the context of practices[8-12]. The three contexts occur simultaneously with high imbrication, making it difficult to separate them, and they can be found within each other[11].

The ACP highlights the complex and controversial nature of the policy, emphasizes the micropolitical processes and the action of local social actors, indicating the need to articulate the micro and macro processes in the analysis of policies[10], being important the clear and objective characterization of the investigated policy, including historical, legislative, contextual, discursive, political, ideological, financial and others data[12]. The present study intends to investigate the state residency policy and its historical characterization, in order to contribute to the analysis of the context of the practice.

A mixed methods approach was used, with documentary research and government data collection. The State Department of Health of Pernambuco (SES-PE) made documents available, such as legislation, reports and minutes, and the following information on residency programs in the professional health area, from 2010 to 2021: institution, program, professional categories, year, accredited openings, funding agency. Data were organized in a Microsoft Excel® spreadsheet.

36 documents relevant to the purpose of the study were selected: D1 to D4 – state plans for continuing health education (4 documents); D5 to D24 – minutes and documents produced by the state forum of the Multiprofessional Residency Commissions in Health (Coremu) (20 documents); D25 to D34 – minutes and documents produced by the State Commission for Health Residencies (10 documents); D35 to D36 – report of state seminars on residencies in health (2 documents).

The analysis was guided by the following question: how the state policy on health residencies was implemented in terms of management and governance, and what are the characteristics of residency programs in the professional health area and their financing. The documentary research also contributed to the understanding of the macro and micro contexts, as well as to identify the instances and social actors involved with the process, which will be subjects in the next phase of the study. Descriptive and thematic content analysis were used.

The importance of analyzing the content and statements that appear in the texts of the political proposal is highlighted, in which it is possible to identify concepts used, different visions of the political strategy adopted, inconsistencies with the context and with the trajectory, giving clues about what is in dispute and the gambles in progress[13].

Thematic analysis followed the following phases: pre-analysis, in which the first contact and the organization of the collected material took place; exploration of the material, classification operation to reach the core of understanding the text; and treatment of the results obtained, inference and interpretation that culminated in a critical and reflective analysis of the collected content[14].

After carrying out all the procedures, an analysis was produced based on the theory and perspective of the researchers, organized into the following thematic categories: actors of

politics and governance; expansion of training and funding; priority thematic areas; training in multidisciplinary health residencies.

This article is part of a research policy analysis study entitled 'Training for the SUS on the political agenda: analysis of residencies in health in Pernambuco', approved by the Research Ethics Committee of the Aggeu Magalhães Institute, opinion number 5.078.594/2021.

Policy actors and governance

Important actors that cross the discussions and practices of residencies in health are identified, such as: federal, state and municipal managers; Coremu and residency program coordinators; tutors; preceptors; health residents; national and state health councils; health workers and their representations organized as professional councils; and educational institutions. The relevance of the following spaces of governance within the scope of residency policy for local actors can be affirmed: the Coremu, the state forum of Coremu, the state commission on residencies in health, the state seminar on residencies in health, the national meeting of residences, the forums of the segments and collective of residents.

Governance can be conceptualized in different ways. For the purposes of this study, it is considered as the act of good governance the relations between the population, the resources and the health services, in order to articulate them in function of the objective of health care and materializing in a responsible structure by the organization of resources, available materials and strategies[15].

The Coremu appears as an important space for shared management and decision-making among the different segments, but which have limitations due to the weaknesses of national legislation, the excessive number of programs and the effective participation of resident professionals. Aiming to enhance the work of Coremu and integrate them, the state forum of Coremu was established, from 2016, coordinated by SES-PE.

According to Cavalcante et al.[16], the forum fills a gap that existed in residencies in the professional health area, a space for dialogue and agreement between the residency commissions and the SES-PE. The following are indicated as initial results:

> [...] expansion of residency openings in strategic areas of SUS PE, specific training for preceptors, qualification of the selection process, offering training for coordinators of residency programs, setting up a working group to discuss training in obstetric nursing and establish ment of state guidelines for the organization of programs and fields of practice[17(19)].

In order to strengthen collegiate management spaces, expanding the participation of other actors, in 2019, at the III State Seminar on Health Residencies, a state residency commission was constituted, as a strategic agenda, in that context, to strengthen the politics in the state and in the Northeast region. Considering that situation, the intention of the actors was not only to build a state commission to intervene in local residency management problems, a structure that did not exist until then in the scope of national politics, but also to put political pressure on the CNRMS and strengthen the representation of organized collectives, such as the segment forums, in the various management spaces.

The following stand out as governance devices: holding annual meetings that discuss residencies in the professional health area, such as the national residency meeting, mobilized by the segment forums; and state health residency seminars. Collective construction and representativeness are key elements of these spaces, in which the discussion on the governance of the residency in health policy aims to

strengthen participatory management, enabling the understanding of different realities and locoregional contexts of residency programs and health services[18].

A critical point in the management and governance of the residency policy at the local level is the finding of the adverse impacts of the lack of functioning of the CNRMS, the fragile national coordination and the precarious regulation of the residency policy in the professional health area. Also noteworthy is the perception that the resumption of the national commission in the authoritarian context experienced in the country would be detrimental to the development of residences in the professional health area, reinforcing the importance of strengthening state policy. The resumption of CNRMS took place in 2021[19],

> [...] without considering the entire historical process accumulated and widely agreed between the actors of this type of training regarding its instruments of regulation, and without dialogue with the actors of the residency movement[20(5)].

There is also the understanding that it is necessary to strengthen the agenda of permanent education and residencies in health in the instances of SUS agreement. It is necessary to advance in partnerships and agreements with the network of health services in the municipalities so that managers understand the importance of in-service training for changing practices and qualification of network workers[21].

The structuring of permanent health education in municipalities and

> [...] the recognition of the state plan for permanent education in health is essential for managers to understand the residency guideline as a strategy for improving practices and strengthening the SUS[20(20)].

In the trajectory of residencies in health in Pernambuco, there are strategies and local arrangements that aim to improve governance practices. The policy was undergoing adjustments and being adapted by the various actors and institutions as new collegiate spaces were created, regulated and experimented with. In the context of practice is where the policy in use is verified, in which it, in fact, becomes effective, and in which secondary adjustments occur, that is, the adaptations and recreations that the actors need to make to deal with the policy itself[22]. Ball[9] highlights that secondary adjustments, which relate actors to policies and the State in different ways, can create, in contexts, policy responses that adjust themselves, but do not create pressures for radical changes, or disruptive responses, that is, responses that try to radically change the structure or abandon it.

In the current context, an important challenge for local actors can be seen, with the recent emergence of decentralized multiprofessional residency commissions – Codemu, an auxiliary body to the CNRMS, which should be constituted by each Federation Unit (FU)[19,23]. Differently from what was developed in the state, this decentralized commission does not foresee in its composition the participation of state and municipal managers, of social control, and still denies the existence and historical role of forums for coordinators, preceptors, tutors and residents.

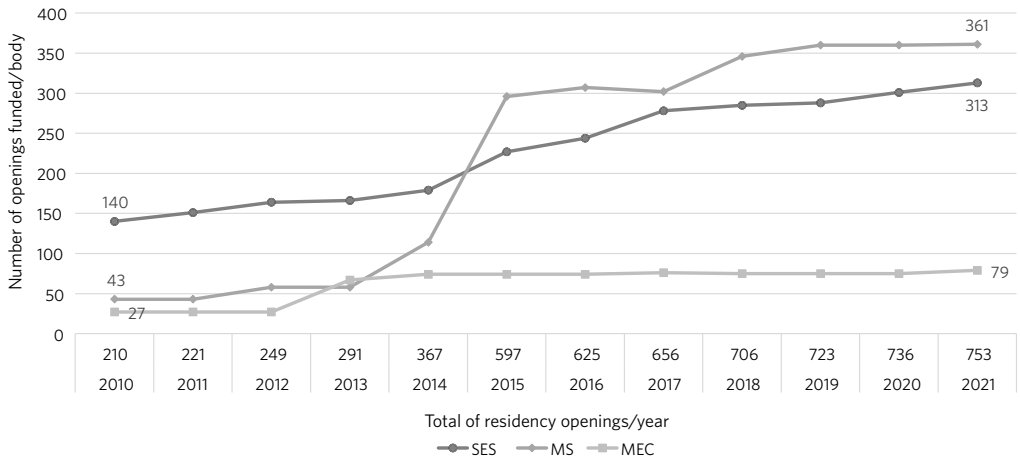
It is observed that the residency policy, comprising the roles and powers of the various actors, took on very specific contours in the state, with regard to the production of spaces for shared management and the role played by state health management, even though some challenges persist. The adaptations and local adjustments to the management of this training policy did not achieve structural changes, nor did they manage, as far as it could be verified, to influence other FUs or even the national manager of the policy under analysis.

Expansion of training and funding

The significant expansion of residency openings in the professional health area observed in the historical series (increase of 258.57%) is the result of MS incentives and the existence of a solid line of financing for residency scholarships with resources from the state treasury, which was decisive from the first programs implemented and in the moments of reduction of federal funding, as evidenced from the year 2016 (*graph 1*).

It appears that SES-PE was, initially, the main funding body, accounting for 66.67% of scholarships in 2010. At the end of the period (2021), its participation was 41.57% due to the progressive increase in federal resources, more expressive from MS, between 2014 and 2015 (*graph 1*).

Graph 1. Evolution of openings in residency programs in the professional health area, by funding body and year, in the state of Pernambuco, Brazil, from 2010 to 2021



Source: Self elaborated.

With an average expansion of 49.36 openings per year, the increase of 230 openings in 2015 stands out, an increase of 62.67% compared to the previous year (*graph 1*). Part of this result is a reflection of MS incentives, which multiplied by seven the number of residency openings financed by the agency for the year 2015 since the beginning of the historical series.

It was observed that adherence to the national scholarship program, with funding linked to the definition of priority areas, was decisive for the expansion of residencies, especially multiprofessional ones, in addition to the participation of the state government, which appears as an important financier of health residency grants throughout the period.

Sarmento et al.[24] point out that, between 2010 and 2015, 320 new residency programs in the professional area of health were approved in different regions of Brazil, with grants financed by the Ministry of Health. The Southeast region was the most covered in the entire country (46.3%), with the Northeast in second place (20.6%)[24]. According to the authors, all states in the Northeast approved

residency projects with MS grants, with the highest frequency observed in 2014. Pernambuco had the highest number of approved programs in this region, with 7.8% of all programs approved nationally, followed by the state of Ceará, with 5.6%, and Bahia with 4.1%[24].

This shows a certain continuity in the local management of the policy, both in terms of governance and in guaranteeing the financing of scholarships, despite the uncertainties related to the national context. However, it is important to highlight the discourse that some residency program coordinators do not get involved in debate spaces or connect to national agendas, perhaps because,

> [...] they are not feeling the impact, due to the fact that SES-PE is supporting most of the scholarships, and other states that are without a strong state policy are suffering, reducing openings and closing residences[25](12).

In addition to financing residents' scholarships, there is a need for resources to promote the implementation of the residency policy, including structural improvements to services and the enhancement of professional preceptors. Some difficulties are glimpsed in the process of expansion of residences, such as the existence of precarious bonds of preceptors, structural and financial difficulties of institutions and municipal health departments, and difficulty in guaranteeing a decentralized pedagogical team such as tutoring and teaching. Therefore, it is observed that, in the cycles of expansion of the residency programs, it was decided to expand the funding of scholarships, however without building mechanisms that guarantee the structure and quality of the programs.

In this sense, it is important to highlight that a training program for SUS workers, in isolation, will not be enough to overcome the challenge of ordering training according to health needs, without seeking conditions for the appreciation of these workers and their job. Thus, the consolidation of the field of work management and health education as a State policy still remains a major challenge for the SUS.

Another obstacle to program expansion is presented as follows: instability related to the Ministry of Education's information system; the misalignment of deadlines for registration, evaluation and approval of programs with public notices for MS funding grants and the implementation of the selection process in the state; and the need to open new Coremu. It was observed that the expansion of programs and residency openings in the professional health area was not accompanied in the same proportion as the opening of new Coremu, which may indicate difficulties in the management and development of these programs.

Priority thematic areas

The 116 residency programs in the professional area of health operating in the state of Pernambuco in 2021 were grouped by thematic areas, using as a reference the organization of the technical chambers of the CNRMS[4,26], adapting it to align it with the discussion of Health Care Networks (RAS) (*box 1*).

Box 1. Distribution of residency programs in the professional health area by thematic area in 2021, Pernambuco, Brazil

Thematic areas	Residency Programs in the Professional Health Area
Hospital care	Multiprofessional in palliative care, Surgical nursing, Nursing in surgical center, Nursing in clinic and surgery, Nursing in diagnostic imaging, Nursing in Heart Transplantation and Mechanical Ventilatory Assistance, Surgery and oral maxillofacianl trauma, Hospital Dentistry, Pharmacy, Nutrition, Multidisciplinary health care interiorization
Specialized health care	Multidisciplinary in elderly health, Nursing in cardiology, Nursing in hematology and hemotherapy, Nursing in infectology, Nursing in nephrology, Nursing in neurology / neurosurgery, Nursing in pneumology, Multidisciplinary in health in nephrology, multidisciplinary in cardiology
Intensivism, urgency and emergency	General emergency nursing, ICU nursing, Pre-hospital nursing, Emergency emergency nursing, Respiratory physiotherapy, Intensive physiotherapy, Hospital physiotherapy with an emphasis on cardiorespiratory, Multiprofessional in urgency, emergency and trauma, Multiprofessional in intensive care
Oncological care	Medical physics, Nursing in oncology, Dentistry with a focus on oncology, Multiprofessional in cancer care and palliative care, Multiprofessional in oncology
Primary care, family and community health	Multiprofessional in family health, Multiprofessional in the interiorization of health care
Collective health	Multiprofessional in collective health, Dentistry in collective health, Multiprofessional in health surveillance
Child and adolescent health	Child health nursing, Pediatric dentistry, Multidisciplinary neonatology
Women's health	Women's health nursing, Obstetric nursing, Multidisciplinary women's health
Functional health / Physical rehabilitation	Nursing in Orthopedics/Traumatology, Multidisciplinary in physical rehabilitation
Mental Health	Psychology, Nursing in psychiatry, Multiprofessional in the psychosocial care network, Multiprofessional in mental health
Animal and environmental health	Veterinary Medicine

Source: Self elaborated.

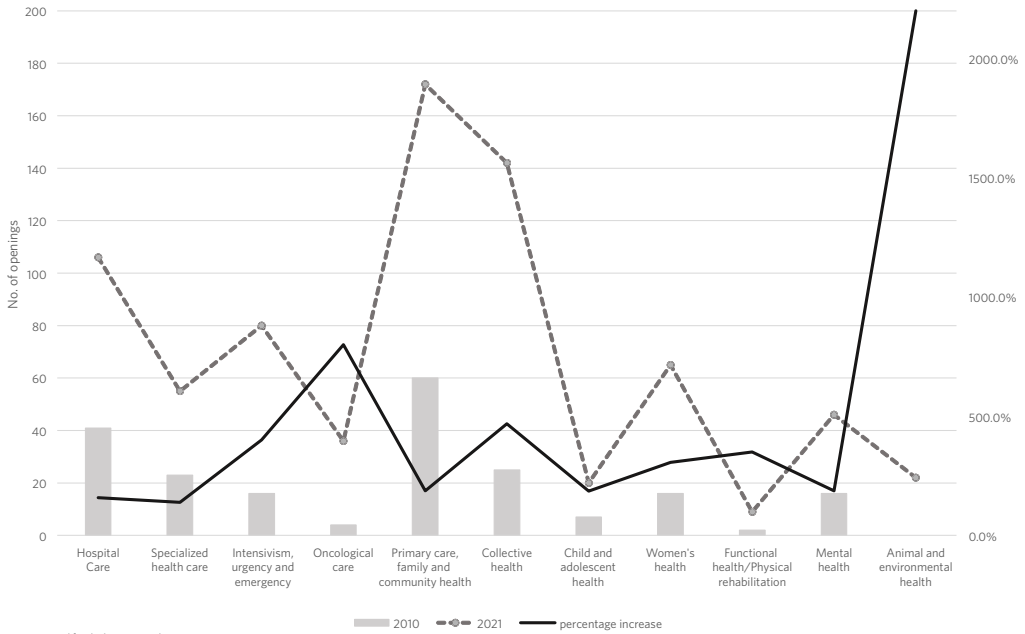
Among the 753 residency openings in the professional health area offered in 2021, the thematic areas with the most expressive numbers were: primary care, family and community health (172); public health (142); hospital care (106); intensive care, urgency and emergency (80); and women's health (65) (*graph 2*). As for the expansion of vacancies in the period from 2010 to 2021, there was a greater proportional growth in the area of animal and environmental health, due to the opening of two programs in veterinary medicine, with 22 openings. Then come the thematic areas of oncology care (800%), collective health (468%) and intensive care, urgency and emergency care (400%) (*graph 2*).

Significant growth was also observed in the thematic areas of women's health (306.25%), mental health (187.50%), primary care, family and community health (186.67%) and child and adolescent health (185.71%). Training aimed at structuring care for chronic diseases can be seen in the variety of programs that were organized in the thematic areas of hospital care and specialized health care over the period (*box 1; graph 2*).

The documents point to the need to expand the training offer in strategic areas to meet the organization of the RAS in the state, highlighting the urgency and emergency networks, maternal and child care, care for chronic diseases, oncological care, psychosocial care, primary

health care, in line with the data presented in the historical series that demonstrate the expansion of residency programs in these thematic areas (*graph 2*).

Graph 2. Evolution of residency openings in professional health area by subject area, Pernambuco, Brazil, 2010 to 2021



Source: Self elaborated.

It can be observed that the discussions carried out in the state in relation to the priority areas for the training of specialists in the professional health area pointed out in the documental analysis materialized, to a certain extent, with the opening of residency programs (*graph 2*). The challenge that presents itself is the effective incorporation of these workers in municipal and state health services in an integrated and regionalized network.

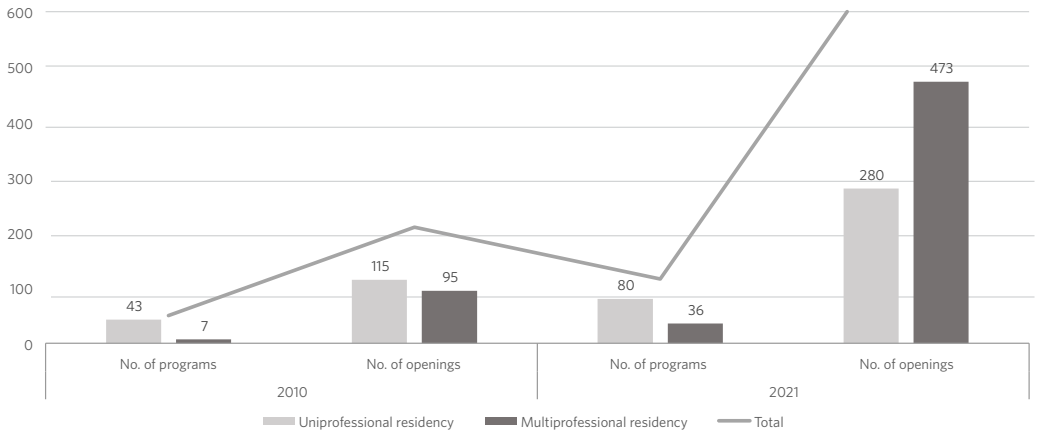
Considering the diversity of programs and their varied insertions in the territory, reflections need to be made so that the training of health professionals is, in fact, focused on the real needs of the population, and for changes to occur in health work processes. This teaching modality has contributed to the qualification of health workers in order to understand the needs of public health and use training strategies to deconstruct the biomedical model that is still hegemonic in the health system[18].

Health residencies were presented, among the policies for training human resources for health, as a State strategy to train professionals with a profile focused on transforming practices, with a new understanding of health and interventions aimed at implementing the SUS[27]. From the expansion of residency programs evidenced in Pernambuco, and the affirmation of the role that this training strategy plays in the structuring of the RAS, the importance of articulating policies within the scope of work management and health education is highlighted, in order to face adequate training and absorption of these workers to work effectively in the SUS.

Training in multidisciplinary health residencies

There was an increase of 397.89% in multidisciplinary residency in health openings in the analyzed period, and an increase of 143.48% in uniprofessional residencies (*graph 3*), culminating, at the end of the historical series, in, respectively, 473 and 280 opening in these programs.

Graph 3. Evolution of residency programs and openings in the professional health area in uniprofessional and multiprofessional modalities in the period from 2010 to 2021, Pernambuco, Brazil



Source: Self elaborated.

When analyzing the expansion of multidisciplinary residencies in health by thematic areas, one observes the opening of programs in areas where there were only uniprofessional programs at the beginning of the historical series, such as hospital care, functional health/physical rehabilitation, specialized health care, oncology care, intensive care, urgency and emergency, child and adolescent health and women's health (*table 1*). In hospital care, despite the expansion of multidisciplinary programs, vacancies in uniprofessional programs are still predominant (*table 1*).

It is important to highlight the role played by multiprofessional residency in the hospital environment. There are still difficulties in consolidating a multiprofessional and interdisciplinary work in the multiprofessional residency developed in hospitals, partly due to the existing limitations in the training of health professionals, corporatism, the relationship of these resident professionals with doctors and the hegemony of the health model centered on individual, curative and private care[28].

Table 1. Number of openings in uniprofessional and multiprofessional residency programs by thematic area in the years 2010 and 2021, Pernambuco, Brazil

Thematic area	Uniprofissional		Multiprofissional	
	2010	2021	2010	2021
Hospital care	41	76	0	30
Functional Health/Physical Rehabilitation	2	4	0	5
Specialized health care	23	30	0	25
Primary care, family and community health	0	0	60	172
Oncological care	4	14	0	22
Intensivism, urgency and emergency	16	51	0	29
Collective health	0	12	25	130
Child and adolescent health	7	14	0	6
Women's health	16	49	0	16
Mental health	6	8	10	38
Animal and environmental health	0	22	0	0
Total	115	280	95	473

Source: Self elaborated.

It is understood that multiprofessional residencies constitute a counter-hegemonic device, which operates resistance strategies against the uncritical reproduction of the worldview that prevails in educational institutions, the technical model of higher education and the model of specialties in medical residency, in order to achieve the goal of tackling social and regional inequalities.

There is still a long way to go in terms of consolidating multidisciplinary residencies as a political strategy, which, while promoting changes within health services, provokes reflections on higher education in health in Brazil. It is noteworthy that the opening of multidisciplinary programs in health is a movement that must go against the logic of training centered in the hospital environment, and that seeks to break with the exclusively biologicist character in the education of health workers, which is still dominant.

That said, the evolution of multidisciplinary residencies in health in the state of Pernambuco can clearly signal the importance of public health education policies, with guidelines and investment. This regulatory role is decisive for health institutions to open programs that meet the training needs of workers, in quantity and quality for the local SUS.

This tendency to expand training through multidisciplinary residencies is in permanent dispute, considering the new national guidelines brought in the wake of a 'resumption' of the CNRMS, through Interministerial Ordinance No. 7/2021[19]. However, with divergent concepts, concentration of power in the Ministry of Education and in the councils of professional categories, the 'new' CNRMS presents a structure and functioning that excludes the actors and representations that are historically organized around residencies in health, mischaracterizing the multidisciplinary training to be developed in the RAS, emphasizing single-professional residencies and the return to hospital-centered and curative logic.

In an excerpt from the document 'Letter from the state commission on health residencies in the state of Pernambuco', it is observed that the segments or representations of the social actors of the residency programs in the state, despite claiming to wait "for a long

time for the reactivation of the CNRMS"[29](1), present a position contrary to the movement led by the Ministries of Health and Education:

> We also emphasize that the referred Ordinance goes against the principles of the National Policy of Permanent Education in Health and mischaracterizes the multidisciplinary training, which values teamwork as a strategy to face the intense process of specialization in the area of health, which deepens the intervention in individualized aspects of health needs, without contemplating the articulation of actions and knowledge[29](1).

In relation to recent changes in the national policy for residencies in the professional area of health, it is understood that

> [...] the measures adopted by the federal government, although they seem to contribute to the residencies, in fact, aim to weaken the principles and guidelines defended by the SUS[20](14).

This reinforces, among local actors, the need to strengthen state policy, through the construction of strategies and actions that enable the day-to-day production of the policy in the reorientation of the training model, and opposing the 'federal management model' positioning itself as a collective. The formation of health practices agents is determined by a set of interests and forces that move, both in the direction of reproduction and transformation of the education and health system, and the challenge that presents itself is to guide them to meet the health needs of the population.

Final considerations

In this work, it was observed that the local movements of collective organization of the spaces of governance of policy about residency in the professional health area contributed to a certain stability in the management and in the financing, despite the different national contexts and the changes in the conception, in the guidelines and in the direction of national policy, especially from 2016 onwards. Local governance spaces, such as the Coremu state forum, the state housing commission and the state seminar, were consolidating themselves as alternatives in the face of the absence of the CNRMS and the lack of conduction of the policy at the national level.

Understanding that the policy is subject to interpretation and re-creation by the actors who work in the territories where it is developed, the research provided clues on how local actors transform the original policy, adapting it. As all scientific production has limitations, when based on documentary research, even though it allows the understanding of the object in its historical context, this study indicates the need for further investigations that deepen the issues discussed here, aiming to obtain a procedural and interpretative understanding of the paths taken and the vision of the various actors in the context of practice.

It can be said that health residencies are presented as a state policy in Pernambuco, consolidating themselves, over the period studied, with innovations in the scope of local management, a significant expansion of openings and funding of scholarships. However, it is still not possible to say whether this local movement managed to produce structural changes in state policy, resisting possible management changes, nor did it influence the national management of the policy. The long-awaited resumption of the activities of the national commission has been received with concern, considering the political context and the lack of representativeness of social actors, and bringing, among other local challenges, the implementation, still in progress, of Codemu.

It was found that the orderly and incremental investment in this type of training contributed to the affirmation of residencies in health as a fundamental part of a health worker education policy for the SUS. Financing lines for residency grants targeted at priority areas resulted in a significant expansion of

training, with emphasis on multidisciplinary residencies. However, in recent years, a certain stability in the speed of expantion has been observed.

Weak national coordination, reduced federal investment in grants, local difficulties in developing programs are some aspects that influence this scenario. It is necessary for professional training policies to be structured in the fields related to work management policy and health education and to consolidate themselves as an important strategy to meet the needs of the SUS and the organization of the RAS. Case studies such as the one presented in this research may indicate paths and possibilities for overcoming difficulties.

The analysis of the thematic areas demonstrates the variety of residency programs training professionals to work in different care networks, and the need for locoregional studies that point out the priority areas for opening new residencies in the professional health area in the state, in order to contemplate major health problems and regional distribution.

The governance strategies developed at the local level to facilitate the offer and expansion of professional training for the SUS are movements of resistance to federal budget cuts and the fragile role played by the Ministries of Health and Education. The development of the policy occurred despite the irregularity in the functioning of the CNRMS, which has the role of regulating and evaluating training at the national level. However, the effective consolidation of the national policy in residency in professional health area, which moves towards fulfilling the challenge of organizing the training of professionals for the SUS, involves the adequate functioning of the CNRMS, not in a cartesian and bureaucratic way, but in a participatory manner and that focuses on strengthening decentralized management.

Higher education in health in Brazil still presents challenges for the training of health professionals to consolidate itself as a driving force for the process of change to advance the SUS. It is in this sense that the implementation of a policy for training health professionals to work in the SUS is reaffirmed, which, based on in-service teaching, has health work as an educational principle.

Collaborators

Santos JS (0000-0002-4784-5639)* contributed to the study design, data collection and analysis, writing of the original manuscript, review and final editing. Santos Neto PM (0000-0001-5665-0924)* contributed to the study design, manuscript review and final editing. ■

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Received on 09/29/2022
Approved on 04/05/2023
Conflict of interests: non-existent
Financial support: non-existent