SELEÇÃO PARA O CURSO DE MESTRADO PROFISSIONAL
TURMA 2020 – TURMA MULTIPROFISSIONAL

PRIMEIRA ETAPA – PROVA DE INGLÊS

Prezado(a) candidato(a),

Inicialmente lembramos que você deverá colocar o seu código (o mesmo utilizado na lista de presença) para que a sua prova não seja identificada. Após a correção, a Banca identificará cada candidato, relacionando o código ao nome.

Trechos dos seguintes artigos em inglês compõem essa prova:

Texto 1) Vieira-Meyer APGF et al. **Variation in primary health care services after implementation of quality improvement policy in Brazil**. Fam Pract. 2019 Aug 21. pii: cmz040. doi: 10.1093/fampra/cmz040.

Texto 2) Nargis N et al. **Socioeconomic patterns of smoking cessation behavior in low and middle-income countries: Emerging evidence from the Global Adult Tobacco Surveys and International Tobacco Control Surveys**. PLoS One. 2019 Sep 6;14(9):e0220223. doi: 10.1371/journal.pone.0220223. eCollection 2019.

Texto 3) Carvalho WMDES, Teodoro MDA. **Health professionals' education: the experience of the School for the improvement of the Unified Health System in the Federal District of Brazil**. Cien Saude Colet. 2019 Jun 27;24(6):2193-2201. doi: 10.1590/1413-81232018246.08452019.

Marque com **X** a melhor alternativa para cada questão.

COPIE A RESPOSTA NA TABELA A SEGUIR.

Boa prova!

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CÓDIGO DO CANDIDATO: _____

PERGUNTA	RESPOSTA			
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TRECHOS DO TEXTO 1

Brazil is the most populous country in the world with a public, universal and entirely free health care system. The Brazilian Unified Health System (SUS), created in 1988 with the principles of universality, equity and integrated care, provides primary, secondary and tertiary health care (1). In 2004, the SUS established a primary health care (PHC) strategy at the municipality (a city or town with its own local government) level, entitled Estratégia Saúde da Família (Family Health Strategy; FHS). This strategy is run by the municipalities and provides a broad range of PHC services delivered by a multidisciplinary team composed of a physician, a nurse, a dentist, a nursing assistant, a dental assistant and community health workers (2). Each team is responsible for the health of the population living in an assigned geographical area, comprising ~1000 families (4000 people) (3). The Family Health Team (FHT) professionals work under the aegis of PHC principles; providing basic health care, promoting health activities and preventing diseases, as well as referring those in need to other levels of care (e.g. secondary and tertiary health care). In 2017 ~40 000 FHTs covered 5398 of the 5565 municipalities in Brazil, providing care for roughly 63.2% of the Brazilian population (4). Brazil is internationally recognized for its development of PHC at the local level (5), where the municipalities are responsible for the implementation of the PHC.

Historically, the FHS has struggled with access, quality and service coordination (6–8). Over the past decade, several initiatives have been designed to improve PHC quality in Brazil, such as the evaluation for quality improvement (AMQ), and the FHS improvement project (PROESF) (9). These programs have not provided the anticipated improvements, however.

Most recently, a national program was initiated to systematically evaluate structure, process and outcomes for improving PHC access and quality (Programa Nacional de Melhoria do Acesso e da Qualidade da Atenção Básica, PMAQ) (10,11).

[...]

In this study, we found that PHC quality, measured by work process and infrastructure CI variables, improved between 2012 and 2014 in Brazil. Infrastructure quality progress occurred in an equitable manner, with the largest improvements among those with the lowest initial quality. Improvements (work process and infrastructure) were not consistent; however, in that there was substantial variation by city size and country region/location, which may indicate these factors are mediators. Though the PMAQ, a Brazilian financial reward program to improve PHC, is a national program, municipalities manage PHC. Thus, it could be expected that national public policies have differing impact, where city size and location variables mediate the implementation and or the results of the policy. These factors are important when planning national policies administered at a local level.

This is the first study to evaluate PHC quality using PMAQ validated CI variables data. Composite variables are measurements based on multiple data items (14), allowing for examination of improvements in a wide range of areas. However, there are some limitations to the study. Only PHC teams that offered to be evaluated were included in PMAQ and in this study. Nevertheless, the number of FHTs evaluated and their distribution in the country (>50% of the PHC teams located in >70% of municipalities) suggests that these improvements are representative of a large portion of the country. The attributes of a high-performing PHC system are well documented in the literature, including access, continuity, team-based care that is comprehensive and whole-person centred, creation of population focused accountability, coordination and service integration and patient engagement (15). These attributes were not directly evaluated in this study, as the data did not allow for direct inference on them.

(Adapted from: Vieira-Meyer APGF et al, 2019)

PERGUNTAS REFERENTES AO TEXTO 1

1) No segundo parágrafo, os autores falam de iniciativas pensadas para melhorar a atenção primária, como o AMQ e o PROESF. Em relação ao sucesso desses programas, os autores afirmam que:
a) eles alcançaram seus objetivos antecipadamente
b) eles não resultaram nas melhorias imaginadas anteriormente
c) estes programas não foram criados para melhorar a atenção básica
d) estes programas deram resultados positivos antecipadamente ao esperado

2) O quarto parágrafo afirma que a qualidade da atenção primária foi mensurada:
a) de forma equitativa
b) pelo trabalho consistente das variáveis equitativas
c) pelas variáveis de processo de trabalho e infraestrutura
d) de acordo com o tamanho do município e sua região/localização

3) Um dos fatores evidenciados no quarto parágrafo como importantes para o planejamento de políticas nacionais executadas em nível local é:
a) o atributo de alta performance
b) o progresso equitativo da qualidade
c) o impacto da recompensa financeira no sucesso das políticas públicas
d) a mediação de variáveis como tamanho e localização do município na implementação da política

4) De acordo com o quinto parágrafo, as limitações para esse estudo estão relacionadas:
a) aos números e às distribuições das equipes no país
b) ao número pequeno de equipes que participaram do PMAQ
c) às melhorias observadas que representam uma alta parcela do país
d) às inclusões no PMAQ apenas das equipes que pediram para serem avaliados

5) A palavra “struggled”, no segundo parágrafo, pode ser melhor traduzida como:
a) tem tido dificuldade
b) procurar libertar-se
c) tentar duramente
d) contorcer-se

6) No quarto parágrafo, no trecho “This strategy is run by the municipalities and provides a broad range of PHC services delivered by a multidisciplinary team composed of a physician, a nurse, a dentist, a nursing assistant, a dental assistant and community health workers” a expressão ‘is run by’ é melhor traduzida por:
a) é corrida por
b) é seguida por
c) é executada por
d) é abandonada por

7) De acordo com o quarto parágrafo, a qualidade da atenção primária:

a) melhorou no período de 2012 a 2014
b) cresceu de forma consistente entre as variáveis estudadas
c) foi influenciada por variações substanciais no trabalho do profissional
d) teve avanço equilibrado nos aspectos de trabalho, estrutura e processo

TRECHOS DO TEXTO 2

Smoking is often more prevalent among those with lower socio-economic status (SES) [1,2] and has been found to be a leading contributor to socio-economic disparities in mortality and health in European countries [3–5] and in the United States [6]. Smoking can create a disproportionately larger health and economic burden on those with lower SES. This is often due to the higher proportion of income they spend on purchasing tobacco products as well as on treating tobacco-induced diseases. The loss of productivity and income caused by tobacco-attributable morbidity and premature mortality is also a major contributor to the economic burden on lower-SES tobacco users [2]. This socio-economic pattern in smoking and its health and economic consequences are particularly visible in high-income countries, with emerging evidence in the context of low- and middle-income countries (LMICs).

Using the World Health Organization World Health Survey of 70 countries from 2002 to 2003, for example, Fleischer and colleagues observed that current smoking prevalence was generally higher among men of lower education, with exceptions to this pattern in several countries in sub-Saharan Africa [7]. Based on data from the Global Adult Tobacco Survey (GATS) in 13 LMICs, Palipudi and colleagues found higher use of tobacco among individuals of lower education and wealth status, with exceptions in Mexico, Turkey and China [8]. A more recent study based on data from the Demographic and Health Surveys in 54 LMICs found evidence of socio-economic inequalities in tobacco use in most countries among men and women [9].

Socio-economic inequalities in smoking can be driven by disparities in both initiation and cessation of smoking across different SES. This paper is focuses on the socio-economic patterns in quitting behaviour of smokers in LMICs.

[…]

Based on the analysis of eight LMICs, that had conducted GATS and the ITC survey during the same year, this study provides limited evidence to support the hypothesis that the probability of successful quitting is greater for smokers with higher SES as defined by household income, wealth and education. However, with respect to employment, the findings indicate that smokers without employment (e.g. students, homemakers, retirees, and the unemployed) have greater probability of successful quitting. Abdullah and Yam (2005) similarly observed that being in the “student/retired/others” category was associated with quitting among Hong Kong Chinese smokers [38].

The evidence that smokers who are not employed are more likely to quit than their employed counterparts seems counterintuitive from the perspective of environmental pressure to not smoke. Non-employed smokers are not subject to smoke-free policies in workplaces [52]. They do not face the social pressure not to smoke that working individuals tend to face from their co-workers. It is unlikely the case that smoking bans are more widely adopted and better enforced in other venues including homes than in workplaces in LMICs.

It is also unlikely that the employment status of individuals would be sensitive enough to capture the effect of household wealth on individuals’ decision to smoke. Wealth index is an indicator of household level economic status, which is accumulated over time. On the

other hand, employment status is indicative of current individual economic status, which is inherently more transitory than household wealth. However, for students or homemakers, employment status is not necessarily reflective of household income status.

(Adapted from: Nargis N et al, 2019)

PERGUNTAS REFERENTES AO TEXTO 2

8) No segundo parágrafo é informado que a prevalência do tabagismo é maior:
a) nos 70 países estudados pela Organização Mundial de Saúde (OMS)
b) geralmente em homens de menor nível educacional
c) em países como México, Turquia e China
d) na região da áfrica subsaariana

9) De acordo com o primeiro parágrafo do texto, o tabagismo está associado:
a) ao maior status socioeconômico (SES)
b) às disparidades socioeconômicas e educacionais na Europa
c) ao aumento no tratamento de doenças induzidas pelo tabagismo
d) aos maiores encargos econômicos e de saúde para aqueles com menor status socioeconômico

10) O foco do texto 2, de acordo com o descrito no terceiro parágrafo, refere-se aos:
a) padrões socioeconômicos de tabagistas em países de baixa renda
b) padrões socioeconômicos de tabagistas em países de baixa e média renda
c) padrões de comportamento de tabagistas de países com baixa renda que deixam de fumar
d) padrões de comportamento de tabagistas de países com baixa e média renda que deixam de fumar

11) Em relação aos resultados da pesquisa apresentados no quarto parágrafo, é correto afirmar que:
a) o nível socioeconômico deve ser sempre medido pela renda familiar, riqueza e educação
b) o nível socioeconômico e as atividades laborais não têm nenhuma influência na probabilidade de um tabagista parar de fumar
c) há evidência limitada para dar suporte a hipótese de que parar de fumar é mais provável em tabagistas com nível socioeconômico mais alto
d) tabagistas sem emprego (exemplo: estudantes, donas de casa, aposentados e desempregados) tem maior dificuldade de parar de fumar

12) No quinto parágrafo, no trecho “The evidence that smokers who are not employed are more likely to quit than their employed counterparts seems counterintuitive from the perspective of environmental pressure to not smoke”, a palavra “Counterintuitive” significa:
a) confirmar intuição
b) contraintuitivo
c) confirmatório
d) provável

13) No quinto parágrafo, na frase "It is unlikely the case that smoking bans are more widely adopted and better enforced in other venues including homes than in workplaces in LMICs", a palavra "unlikely" significa:

a) pouco provável
b) não gostar
c) provável
d) gostar

14) A expressão "on the other hand", encontrada na sexto parágrafo na frase "On the other hand, employment status is indicative of current individual economic status, which is inherently more transitory than household wealth" pode ser melhor traduzida como:

a) na contramão dos fatos
b) da mesma forma
c) pelo outro lado
d) pela outra mão

TRECHOS DO TEXTO 3

The debate surrounding permanent health education (PHE) emerged in the 1970s within the Pan American Health Organization's (PAHO) Human Resources Development Program. According to a PAHO report, the majority of countries in the Americas would need to make sweeping changes to their health systems in order to achieve health for all by the year 2000. To this end, the report proposed that health professionals' training should be the responsibility of health systems and pointed to PHE as one of the pathways for promoting professional development, improving working practices, and strengthening local healthcare services[1,2].

In Brazil, the creation of the Unified Health System (Sistema Único de Saúde - SUS) and Article 200 of the Constitution - which provides that "It is incumbent upon the unified health system, in addition to other duties, as set forth by the law: to organize the training of personnel in the area of health"[3] - laid the ground for the development of policy in the area of health professionals' training. In 2004, in furtherance of its constitutional duties, the Ministry of Health issued Ministerial Order 198/GM/MS, creating the National Policy for Permanent Health Education (Política Nacional de Educação Permanente em Saúde - PNEPS)[4].

[...]

Through the organization of staff education activities, EAPSUS has materialized into an organizational entity with its own identity and purpose, which may be defined as a government school.

The term government school gained a certain level of normativity, at least potentially, when it was included in the Constitution by Constitutional Amendment 19 of 1998 as a result of administrative reform. This amendment provided for the creation of government schools, defined as institutions specifically created to provide training for public employees in furtherance of the requirements for career progression. Paragraph 2 of Article 39 provides that the Union, states, and Federal District shall establish government schools to promote training and development of public employees[26].

(Adapted from: Carvalho WMDES, Teodoro MDA. 2019)

PERGUNTAS REFERENTES AO TEXTO 3

15) De acordo com o relatório mencionado no primeiro parágrafo, pode-se afirmar que:
a) a melhoria das práticas profissionais fortalece os serviços de saúde em toda a região
b) propõe que o treinamento dos profissionais de saúde deve ser de responsabilidade dos serviços de saúde
c) a maior parte dos países americanos não precisa de mudanças nos seus sistemas de saúde para atingir a meta saúde para todos no ano 2000
d) a maior parte dos países americanos precisa apenas de mudanças simples nos seus sistemas de saúde para atingir a meta saúde para todos no ano 2000

16) Entre as melhorias antecipadas com Educação Permanente em Saúde (PHE), a única que **NÃO** é mencionada no primeiro parágrafo é:
a) fixação dos profissionais em seus locais de atuação
b) promoção de desenvolvimento profissional
c) fortalecer os serviços de saúde locais
d) melhorar as práticas de trabalho

17) De acordo com o último parágrafo, as Escolas de Governo são:
a) escolas para treinar profissionais que querem ser funcionários do governo
b) escolas de ensino superior responsáveis pelo treinamento em saúde no Brasil
c) instituições criadas na constituição de 1988 para auxiliar na formação de quadros para o governo
d) instituições criadas especificamente para fornecer treinamento a funcionários públicos, para promover os requisitos para progressão na carreira

18) O trecho do primeiro parágrafo “The debate surrounding permanent health education (PHE) emerged in the 1970s within the Pan American Health Organization’s (PAHO) Human Resources Development Program.”, a palavra “surrounding” pode ser traduzida como:
a) em torno de
b) limitado a
c) ambiente
d) baixo

19) Na frase “It is incumbent upon the unified health system, in addition to other duties, as set forth by the law: to organize the training of personnel in the area of health”, presente no segundo parágrafo, pode-se afirmar que:
a) a formação de pessoal na área da saúde não é um problema
b) compete ao SUS organizar a formação de pessoal na área da saúde
c) a maior atribuição legal do SUS é organizar a formação de pessoal na área da saúde
d) não há base legal para que o SUS tome para si a função de organizar e formar pessoal na área da saúde

20) Na frase “Through the organization of staff education activities, EAPSUS has materialized into an organizational entity with its own identity and purpose, which may be defined as a government school” a expressão “through” pode ser melhor traduzida como:
a) pensando na
b) mesmo com
c) por meio da
d) apesar da