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PERMANENT HEALTH EDUCATION FROM THE BASIC CARE MANEGEMENT PERSPECTIVE

EDUCAÇÃO PERMANENTE EM SAÚDE NA PERSPECTIVA DE GESTORES DA ATENÇÃO BÁSICA

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ABSTRACT

Qualitative research that aims to analyze the knowledge and application of the Permanent Health Education policy, from the perspective of Primary Care managers in a city in the interior of São Paulo. The data were collected from 25 professionals, through semi-structured interviews. The data analysis took place using Bardin's content analysis technique (1979). The results were organized into two categories: Permanent Health Education: conceptual dimension and Permanent Health Education: challenges to operationalize PHE. These results showed that, in the conceptual field, there is a clear verbalization that professionals know about EPS; however, the space for discussion is poorly articulated, poorly organized and does not occur continuously. As for the challenges to operationalize Permanent Education in Health, it is concluded that it is necessary to invest in the implementation of this policy in order to create spaces and develop and improve the collective construction of reflections on the practice of work, which results in the use of the policy as another management tool.

Keywords: Health Education. Permanent Education in Health. Health education.

RESUMO

Pesquisa qualitativa com o objetivo de analisar o conhecimento e aplicação da política de Educação Permanente em Saúde, na perspectiva de gestores da Atenção Básica de um município do interior de São Paulo. Os dados foram coletados junto a 25 profissionais, por meio de entrevista semiestruturada. A análise dos dados aconteceu por meio da técnica de análise de conteúdo de Bardin (1979). Os resultados foram organizados em duas categorias: Educação Permanente em Saúde: dimensão conceitual e Educação Permanente em Saúde: desafios para operacionalizar a EPS. Estes resultados mostraram que, no campo conceitual, há a verbalização de forma clara de que os profissionais conhecem a EPS; contudo, o espaço para discussão se dá de forma pouco articulada, pouco organizada e não ocorre de maneira contínua. Quanto aos desafios para operacionalizar a Educação Permanente em Saúde, conclui-se que se faz necessário o investimento na implementação desta política de forma a criar espaços, desenvolver e melhorar a construção coletiva de reflexões da prática do trabalho, o que resulta no uso da política como mais uma ferramenta de gestão.

Palavras-chave: Atenção Básica. Educação Permanente em Saúde. Ensino em Saúde.

INTRODUCTION

The discussion around work processes, the organization of health services, the implementation of organizational policies and cultures linked to the employees who represent the Unified Health System (SUS) has been a complex and challenging path to the appreciation and improvement of conditions of the integrative work of these professionals. The teams that today represent Primary Care, formed by a powerful and rich multidisciplinary approach to the contribution of knowledge, make it possible for health units to be increasingly prepared for the multiplication of information and education (SEIDI *et al.*, 2014).

In order for the health service to be qualified and able to care for patients in a broad, organized way, with comprehensive care, some attributes are more than necessary in maintaining this right: an organized work process, equipment, sufficient number of professionals to services offered on site, input materials, adequate space for practice, in addition to educational actions and activities that allow the professional to make exchanges and develop in an integral way (FERRAZ *et al.*, 2005).

When you have health professionals inserted in the daily reality of their practice environment, with freedom to act and interfere in work proposals, suggesting changes that can improve the whole, it is considered that the public server feels part of the process. This way of perceiving, acting and reflecting on what is happening can be understood as an opportunity for education, in fact, to develop as a dynamic process in the construction of knowledge (WEYKAMP *et al.*, 2016).

In this sense, Permanent Education in Health (PHE), established by the Ministry of Health through Ordinance No. 198/2004, suggests this practice as a policy for the development of educational actions in a decentralized, informal way, involving all professionals in health for a qualified exchange, in which no one would assume that they have enough knowledge that they could not learn, nor a collaborator who did not have the minimum amount of information they could pass on and teach (SIGNOR *et al.*, 2015).

Within its possibilities, the idea is that this process can contribute to the training of professionals, enhance health policies, develop the collaborator in some practices, strengthen the Unified Health System (SUS), change paradigms and work culture built in time, bring the management closer to the team, better understanding of the service of each actor in that environment and involve the management in the unit's problems (SIGNOR *et al.*, 2015).

So that these actions take place in a way that contributes to the qualification and development of the entire team, Continuing Education in Health needs to be linked to a process of educational proposals that debate and problematize work and its practice based on daily life. The actions are based on the assumption that the interaction is democratic, participatory and with the protagonism divided between workers, users and social control. This moment must be seen as an integral part of the management of daily health work (SILVA *et al.*, 2017).

More than that, Permanent Education in Health can reveal how complex and articulated the different and daily problems in practice environments are, demanding proposals and strategies from professionals that need articulation with the management of the system (SANTOS; PEDROSA; PINTO, 2016).

From this perspective, this study sought to know and understand the perception of managers of Primary Care in relation to the practices of Continuing Education in Health.

METHODOLOGY

Qualitative and descriptive research, supported by content analysis, carried out in the city of Rio Claro, in the interior of São Paulo, with professionals in charge of managing teams from Basic Health Units (BHS) and the Family Health Strategy (FHS), comprising 25 participating professionals, who were approached after approval by the Research Ethics Committee (REC) with human beings of the Federal University of São Carlos (UFSCar), under the CAAE number: 03489418.9.0000.5504,

on 12/09/2018, and advise number: 3,067,600. These participants had at least five years of experience within SUS and had been working as a unit coordinator for at least one year.

Data collecting took place through semi-structured interviews, based on the guiding question: What is your conception of Continuing Education in Health and how has it been developed in your practice? The interviews were recorded through footage taken with semi-professional cameras, ensuring data fidelity for transcription and subsequent data analysis. The transcription was made only by the main researcher, presenting and converting the interviewees' speeches in full, in the way they were given, remembering that everything that was said is important and has meaning within the object of the research.

Data from this research were analyzed using the Content Analysis technique. This technique is based on studying the collected material, analyzing the speeches and their characteristics and understanding the knowledge that the interviewees bring about the subject. Data analysis took place until they were exhausted. The technique is further subdivided into three stages: pre-analysis, material exploration, treatment and interpretation of collected information (BARDIN, 1979).

DEVELOPMENT

After analyzing the material, it was possible to establish two thematic axes: Permanent Health Education: Conceptual Dimension and Permanent Health Education: challenges to operationalize the EPS.

Continuing Health Education: Conceptual Dimension

With the collected testimonies, it is identified that the process of Continuing Education in Health that takes place in Primary Care Health units is done in a fragmented way. The understanding around how the PHE actions are performed is strict and restricted in some teams to take place during the weekly meetings, which in this case are always held on Fridays, or are conditioned to the requests of team members when problem occurs in the unit or there is question about a procedure.

Health Unit managers in Primary Care are seen as the reference for all the work developed in these environments. Their performance goes beyond providing good service to the population, as this professional is responsible for managing a space formed by a multidisciplinary team. Therefore, their concern is also with the organization of work, health promotion and prevention, the management of internal conflicts and health education activities (BARBOSA; FERREIRA; BARBOSA, 2012).

> [...] *If we are aware of things, we do it all the time, it happens that we do not identify how* [...] (E24).

A possibility of a broader understanding regarding the importance of Permanent Education in Health can be given by its affection and similarity pointed out by some authors with Popular Education, proposed by Paulo Freire. This is because both strategies work with the idea of giving meaning to contents and working with the student in a liberating way, showing the real applicability of that knowledge in their social interaction, giving them the autonomy necessary for their independence (CECCIM, 2005).

Some professionals say they have a deeper knowledge of Continuing Education in Health and how the process should work, however, when they explain how they put this understanding into practice, it is clear that they have a confused conception of the idea and how they are doing the EPS with their teams (LIMA; RIBEIRO, 2016).

> [...] *Continuing Education is a teaching process with the team, which can be worked according to the reality of each health unit.* [...] (E2).

The professional's appointment showed that the practice of Continuing Education in Health takes place in their territory only in moments of lack of knowledge of the team or one of its collaborators, systematizing the process and conditioning the need to qualify for the work, without a more in-depth discussion of work processes, giving only the coordination the protagonist role in the discussion.

There is no manual for making Continuing Health Education in motion within the clinical setting, and this is the interesting part of the process. In the increment of this work, we can point out as devices to build the PHE within the health practice environment: the meeting of multidisciplinary teams, which is weekly, the matrix support carried out with the Support Centers for Family Health - NASF, institutional support, unique therapeutic project and shared consultation for the discussion of clinical cases (LIMA; ALBUQUERQUE; WENCESLAU, 2014).

However, some professionals in fact described doing this process in a very structured way, taking into account the problem-based education processes, articulating spaces for this exchange with the team to take place throughout the period and crediting the PHE policy as a consonant in the improvement from work.

> [...] *PHE is a day-to-day sequence, it is a transformation in work. PHE has been translating this need for training and work improvement*. [...] (E21)

> [...] *I think PHE is a continuous process, there is no beginning, middle and end, we are improving according to the management.* [...] (E3)

Professionals who were articulated and users of Continuing Education in Health, at all times in the daily routine of the unit, highlighted that employees arrive with agendas for team meetings, in addition to seeking knowledge and pertinent information in the coordination role to clarify their doubts. For one of the respondents, the proximity to the team that the PHE practice provided was clear.

The coordinators' responses made it clear that these educational actions developed or encouraged by the team are very different from the concepts practiced by Permanent Education in Health. Respondents did not say in their responses or did not make clear the existence of a pedagogical standard or a clear methodology for the moments when they said the PHE happened. However, it is notorious to say that the vast majority said they are willing to make a culture of the practice, having seen the efforts that the management has made in the municipality to make these professionals aware of the exercise of PHE in the daily routine of Primary Care (LIMA, RIBEIRO, 2016).

> [...] *It's about improving what you've learned, it can be done by anyone* [...] (E22).

> [...] *It's a teaching-learning process, according to the problems that appear on a daily basis* [...] (E14).

The gain that empowered employees of Permanent Education in Health deliver to the other public servers of a multidisciplinary team is exponential. Just as knowledge is liberating, the transformation towards reality and the work process, provided from good meetings and discussions relevant to the reality in health, is still the main reason to believe in this policy. Professionals engaged with the reality of the territories, participating in the debate processes around the Ministry of Health's programs, inserted in management councils, that is, occupying spaces that propose discussions to improve their conditions and, consequently, the population, contribute so that, in fact, we have participatory health management, and PHE has a fundamental role in this (LIMA; ALBUQUERQUE; WENCESLAU, 2014).

It is evident that, for some professionals, this process is still seen as something that is not of all importance in the daily routine of the unit. Its viability takes place according to the demands that arise at the place of practice and a mechanized process is necessary for the discussion of work

processes to take place. For some professionals, the Continuing Health Education process takes place when a member of the team asks for space in the team meeting to discuss a situation that is different from the routine.

It is necessary to make investments so that this practice becomes something routine, so that the understanding of Continuing Education in Health becomes comprehensive and the ways to stimulate the process as well. It is an education model in which all professionals must be inserted, motivated and aware of their co-responsibilities in the interaction. Bringing this policy to a broader discussion of the work process involves the importance and also the appreciation of professionals in a position of coordination, since it is their role to motivate and build spaces for team interaction.

Continuing Education in Health: Challenges to Operationalize PHS

The testimonies showed that the activities of Continuing Education in Health are conditioned to begin when these coordinators start them, highlighting again that the process is mechanized. More than that, the attitude of these managers shows that the team's understanding is that this interaction, exchange, conversation, organization of meetings, among other PHE activities, only happen in the presence and also with the consent of the heads.

> [...] *We are often there on a day-to-day basis, there is a problem or some doubt, we end up gathering everyone in a corner and teaching people, clearing up any doubts*. [...] (E14)

> [...] *I think the experience of each one there is valid, teaching each other, sometimes what I experienced, the team did not experience.* [...] (E23)

When we condition these interviewees on the role of unit management, taking responsibility for all work processes within the clinical environment, including education, it is notorious to say that they assume this function for their daily attributions, however, they centralize the process and the lack of decentralization in activities is clear. In this sense, once again, Permanent Health Education actions are perceived as fragmented, influenced by the lack of a broader understanding of the coordinators about the process (LIMA; ALBUQUERQUE; WENCESLAU, 2014).

Continuing Education in Health takes on a fundamental role in consolidating SUS and in its strategy as a trainer and management tool, both for municipalities and for the Federal State. Within its human resource management policy and also crediting this tool with a better discussion within the work processes, there is an improvement in the expectations of the adaptation of these professionals based on the real needs of the population regarding their lack of access to knowledge and an improvement in the posture of the public servant who participates in this training process (OLIVEIRA *et al.*, 2011).

When coordination takes on several functions within the health unit, since these professionals are also the eye of municipal management within these spaces, we know that other external influencers end up hindering not only a work process, but also several. Reduction of staff, coverage area, scarce physical resources, among other factors, were pointed out at that time. Even with all these difficult points for action, workers demand the articulation of the coordinator so that, at least weekly, a space of time is reserved to discuss the daily life.

> [...] *Regardless of my being there as a nurse and coordinator, all subordinates actively participate in the process.* [...]

This statement by the team is again close to the context of Paulo Freire's popular education, when we need to think about filling bottlenecks in the training of professionals who are in that space, especially with regard to practice. It even sounds like a necessity or even that the process should happen more often. This is because the vast majority of professionals made it clear that the space in

which there is the possibility of this exchange is restricted in team meetings, that is, only on Fridays (MANCIA; CABRAL; KOEICH, 2004).

Continuing Education in Health often enables an expansion and greater experience of professionals in clinical practices, allows a qualification of teamwork, an appreciation of collective spaces, co-management with other workers and an even closer relationship between the coordinators and the other participants (FERREIRA *et al.*, 2019).

Even though there is space on one day of the week for a practice that, in the understanding of these professionals, is the time of Continuing Education in Health, the practice still needs to divide the time of two hours, from 2 pm to 4 pm, with other matters pertaining to the meeting of team. In other words, regarding the attribution of the coordinator to the management post, his time is still very restricted to the administrative needs of the unit and its bureaucracies (SILVA, 2002).

> [...] *When a nursing technician has a doubt in the care, she comes to me and clears the doubt, we end up discussing something about a patient* [...] (E5).

Again, the discourse that claims to be a bureaucratic process to carry out Permanent Education in Health is empty. From the moment that actions are taken automatically, in which any location and situation is favorable to carry out PHE, it is removed from the mind that it is broader, more meticulous, time-consuming, or any other adjective that labels the process as complicated to practice. The idea is that PHE is always multidisciplinary, decentralized and ascending, that it is a tool that enables greater dialogue between those involved, management, councils, it is a process of change, but fundamental for the recomposition of care practices (MANCIA; CABRAL; KOERICH, 2004).

The main difficulties mentioned by the research subjects in applying PHE in professional practice are illustrated by the speech of respondent 1: “Our challenges are great, from the number of employees, the coverage area, the resistance to change, the immobilized training of employees”. This scenario is seen positively and with contours of possibility for E7: “Implementing is a process, right? But I think we are evolving despite the difficulties”, complemented by E17 who informed us “I think the main difficulty is the acceptance of everyone on the team”.

It is necessary to take advantage of these moments in which the worker is willing to carry out the PHS so that his process becomes part of the daily actions of each individual within the unit. When the exchange is inserted, the problematization of cases, training for work, the reflection of their actions, the professional tends to take on the co-responsibility within the construction of an educational process, alleviating for the management all the attributions that the service has. conditions. By dividing the tasks, everything becomes more systematized and less bureaucratic (MANCIA; CABRAL; KOERICH, 2004).

CONCLUSION

As for most health professionals and also for the participants of this study, the understanding of the process of actions in the practice of Continuing Education in Health is far from the potential that the policy has as its premise. The inclusion of other ways to implement moments of health education for the team, using continuing education and poorly targeted meetings, directly affects the attribution of the few moments in which the discussion around work processes is conditioned.

The lack of time in daily life for greater interaction between the unit coordinator and the rest of the workers makes it difficult to reflect on the day-to-day of the organizational environment, always leaving the possibility to build and reframe the knowledge, missing the most suitable opportunity for the action-reflection-action process. This fragments the actions when they are organized by the interviewees, leaving the possibility of learning that would be organized with little adherence and low relevance.

More than bringing Permanent Health Education to these territories, it is necessary to monitor the management in the work routine of these spaces, presenting to the team how this process takes

place and interferes in their activity, and how it can be important for the organization of the service of all involved. In addition, coordinators need to receive more attention in terms of prior knowledge of the PHE policy and a frequent update on processes that can be attributed to the systematic implementation of PHE.

It is necessary to take advantage of the excellent relationship that the interviewees demonstrate to have with the teams, which already refer to these professionals as being possible facilitators of the PHE process at work, so that this new moment of dazzling practice is actually constructive.

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