Permanent Health Education in primary care: Concepts and practices as perceived by workers

Carolina Luiz Ferreira da Silva, Tatiane Martins Jorge

ABSTRACT

This study aimed to investigate how primary healthcare teams understood the concept of Permanent Health Education (PHE) and how it has been practiced in their contexts. Two primary healthcare (PHC) teams – a PHC team and a family health team – of a municipality in inland São Paulo, Brazil, were selected by drawing lots to participate in the study. Participants were health workers, encompassing each team's high- and mid-level professionals. Data were collected with an online questionnaire whose 14 items were divided into two parts – one with professional profile information and the other with questions relevant to the study –, administered in the last bimester of 2020. The collected material was gathered and analyzed with the topic content analysis method described by Bardin and Minayo. Based on the two larger study topics – PHE knowledge and practice –, three cores of meaning were identified in the material: "PHE as continuing education", "Institutional and personal challenges to changes", and "Administrative support and team initiative". Despite the limitations of the study regarding the sample size and data collection instrument, its results are homogeneous with other published studies. PHC teams confuse the meaning of PHE and develop such practices with a continuing education approach; consequently, they face barriers to planning PHE practices. The results are also similar to those found in research in the literature concerning team engagement to put PHE into practice.

Keywords: Permanent education, Primary health care, Public health, Public policy, Knowledge.

INTRODUCTION

Primary healthcare (PHC) is people's first level of contact with health systems; it coordinates and organizes the population's comprehensive healthcare. Hence, it is expected to be accessible to them and present solutions to their various needs – which requires the employment of various tools capable of leveling the work process, focusing on the importance of different care professionals sharing the problem-solving process[1].

Permanent Health Education (PHE) was instituted in Brazil in 2004 as a public policy and an important qualification tool to work in PHC. Its objective is to stimulate, strengthen, and follow up on the professionals' training, helping transform health practices to meet the fundamental principles of the Unified Health System (SUS, in Portuguese)[2].

Since the PHE National Policy was implemented, PHE practices have been developed and benefitted educational institutions and health services, improving assistance and training human resources[3,4,5].

The PHE process is a political action in which protagonists at the services creatively provide care in different forms based on their everyday practices, transforming the circumstances[6]. PHE ensures qualified administration and assistance as it is incorporated into each unit's routine, solving problems through critical collective thinking and the availability of necessary tools to change work practices[7,8]. In other words, PHE can lead to reflections on assistance and administration and improve them, transforming the work process and thus providing improvements to users.

PHE methodology is based on problem-posing education, whose objective is to significantly change everyday practices through integrality, teamwork, workers' and users' autonomy, and citizenship[9]. According to Davini[10], problem-posing pedagogy enables greater dialogue among professionals and between them and the users.

The literature reports that the current scenario of PHE practices in the various health services has become increasingly technical

University of São Paulo. Medical School of Ribeirão Preto, Ribeirão Preto, SP, Brazil

https://doi.org/10.11606/issn.2176-7262.rmrp.2023.196780

and verticalized[11,12]. Professionals usually have difficulties understanding PHE as a gradual change in the work process; thus, they reduce it to formal educative measures instituted by the administration to technically present new equipment or government programs[13]. Moreover, PHE has been constantly related to terms such as training and continuing education[14] – which, however, does not necessarily connect with the reality of health services. Instead, it is based on technical knowledge, focused on courses and training, which characterizes it as a continuation of the academic model[15]. Therefore, it is not sufficient to meet the growing needs in PHC imposed by the advancements in SUS implementation[16].

Given the above, it is important to invest in research to understand, assess, and follow up on the development of education initiatives in health services to verify whether practices have drifted from PHE concepts and which obstacles hinder its implementation[17,18].

This study aimed to understand how workers in two PHC teams in a municipality in inland São Paulo view PHE.

METHODOLOGY

Study type

This is a cross-sectional, descriptive, analytical, predominantly qualitative study, conducted according to the Consolidated Criteria for Reporting Qualitative Studies (COREQ)[19].

Study environment/setting

The study was conducted in Ribeirão Preto, a city in inland São Paulo located 314 km from the state capital. It has an area of 650 square kilometers (km^2) and a population density of 999.3 persons per km^2. The 2020 estimates indicate a city population of about 711,825 inhabitants[20].

The municipality is divided into five health districts – West, North, South, East, and Central –, each of them with a district health center, some community health centers, and some family health centers. Altogether, there are 41 community health centers and family health centers[21].

Participants

The study sample comprised workers from two PHC health teams.

Sampling and sample size

The teams that participated in this study were chosen by drawing lots. This stage excluded community health centers that were under renovation and the five district health centers. Three health centers were picked from each district. The first ones selected from each district were contacted via e-mail to verify whether their teams were interested in participating in the research, to which they were not obligated. A total of five health centers and their teams agreed to participate. However, only two – a family health team and a PHC team – took measures for data collection.

All health professionals in the teams were invited to participate voluntarily in the study, regardless of their time of service. Administration and cleaning/maintenance personnel were not invited.

The sample comprised 11 health professionals – three from the PHC team (a physician, a nurse, and a nurse assistant) and eight from the family health team (a physician, a nurse, a nurse assistant, and five community health agents. It is important to point out that the participating PHC team did not have any community health agents.

The characterization of the sample indicated a predominance of women (92.3%). Their age ranged from 25 to 71 years, with a mean age of 44 years and a median age of 42 years. They had been working in their centers for 1 to 28 years (a mean of 10 years and a median of 8 years).

Questionnaire

The collection instrument was an online questionnaire – which was used instead of an interview because the collection took place in November and December 2020, while there were restrictions imposed by the new coronavirus pandemic.

The questionnaire had 14 items divided into two parts – the first one addressed the respondents' profiles, and the second one had questions related to the study. The first part sought information on

age, professional training, position in the team, and the time they had been working in their centers. The second part, focused on the study topic, addressed the concept of PHE and whether the team held specific PHE meetings. In the case they held such meetings, other issues were approached, such as their frequency, duration, and format, what strategies they used, how they chose the topics and the identification of factors that facilitated the practice. If they did not hold PHE meetings, the subsequent questions verified their perception of barriers to the practice and suggestions to implement it. Questionnaire administration was not pretested.

The instrument was applied directly with the participants as the lead researcher visited the two health centers, respecting the health measures taken to prevent COVID-19.

Due to the small sample size, the quality of the responses was not addressed in terms of either the respondent's professional category or the type of health center.

Data analysis

The two researchers gathered, read, and analyzed the questionnaire responses with the topic content analysis method described by Bardin[22] and Minayo[23].

It is recommended that in qualitative studies, researchers first skim the material to have initial contact with the content and get acquainted with it. In this stage, named topic preanalysis, the researcher refers to their objectives and hypotheses to verify whether the collected data are representative, relevant, homogeneous with the larger study topic, and thoroughly cover the subject. Then, they begin forming the analysis corpus to explore the material and identify some indicators to form the cores of meaning in the study, which in turn is interpreted in the last phase of the study.

Ethical aspects

The study was authorized by the Municipal Department of Health of Ribeirão Preto and the selected health centers. The project was approved by the Human Research Ethics Committee of the Hospital das Clínicas of the Faculty of Medicine of Ribeirão Preto, (evaluation report nº. 4.189.365, CAAE nº 35606020.2.0000.5440), complying with the Regulating Guidelines and Norms for Human Research in Resolution no. 466/2012 of the National Health Council of the Brazilian Ministry of Health.

RESULTS

Based on the two larger study topics – PHE knowledge and practice –, three cores of meaning were identified in the material: "PHE as continuing education", "Institutional and personal challenges to changes", and "Administrative support and team initiative", which are presented and interpreted below.

PHE as an opportunity for technical development

Only two out of the 11 professionals presented definitions such as:

"From my perspective, permanent education is a review of work processes and concepts (...)".

"Meetings with team members to discuss topics relevant to primary healthcare work".

Almost all participants associated PHE with updated knowledge and courses on various topics:

"It's an update of knowledge".

"It means to get always updated and never stop".

"Always getting updated".

"Constant courses for the team's learning and development".

"Courses to learn about different topics".

"Learning about various topics – e.g., participating in courses.

These reports of the two teams demonstrate that the concept of PHE is linked to the opportunity to acquire technical knowledge – which is closer to the idea of continuing education.

Other reports on the structure and format of the meetings reinforce the confusion between PHE and continuing education:

"Brief oral presentations in large rooms at the health center".

"Instructions are given via application messages".

"One topic a week, chosen by the team".

"Daily, lasting about 15 to 20 minutes".

Understanding PHE as a stagnant moment in the professionals' routine diminishes the encompassing meaning of the term, often distorting its concept.

Institutional and personal challenges to changes

Participants were asked whether PHE was carried out in the centers, and both the PHC team and the family health team gave diverging responses. Moreover, only three out of the 11 professionals gave affirmative answers.

The participants' reports pointed out both institutional and personal barriers to the practice of what they considered PHE:

"The leaders do not encourage it".

"There is not enough time. The team is always too busy".

"There is not enough time because the health center lacks human resources".

"Health professionals are overloaded".

"Our schedule is full".

"Great demand for health attention".

"Unwillingness".

"Uninterest".

"People's unwillingness".

Most comments blamed the administration for PHE unfeasibility. These reports are knowingly legitimate, as SUS professionals are overloaded. However, the reports also pointed out personal barriers, demonstrating that some team professionals resist promoting health education initiatives.

Administrative support and team initiative

Regarding PHE structure and implementation, participants referred to both structural factors (e.g., planning, schedule, and organization) and motivational factors, as presented below:

"It has to be a goal, included in the health center's work process".

"A specific time must be set apart for all professionals to participate frequently".

"The schedule must have a specific day per month set apart for these meetings".

"It's necessary to organize the schedule and raise the team members' awareness".

"It requires the whole work team".

"It has to be planned".

"There must be encouragement".

"The team has to be willing".

Thus, administrative support and team initiative helped implement PHE, minimizing institutional and personal barriers pointed out by participants.

DISCUSSION

The reports of both the PHC team and family health team participants show that PHE has been confused with continuing education, which corroborates the literature[24-26]. Such confusion of terms reveals a difficulty in understanding the concept of PHE[11,12], which poses a barrier to the processes of change. Difficulties understanding the term reflect directly on the practice at the centers, which is often carried out with traditional and technical teaching methods[12].

Cardoso et al. (p. 1493)[7] gave the following literal description: "PHE is grounded on active methods of knowledge, as opposed to transmissive ones" – i.e., PHE explores problem-posing education, enabling greater interaction between professionals and the community[27]. Continuing education, on the other hand, is related to educational activities that

sequentially and cumulatively transmit scientific technical content in a traditional model, with a preestablished schedule[28]. Thus, the concept of "updating knowledge", as pointed out in this study, does not necessarily indicate the occurrence of PHE because it is more related to continuing education. PHE initiatives must not be minimized to only technical training and/or knowledge update; rather, they must be related to the work process[29].

The point is not to deny the importance of continuing education, as it is useful in many contexts. However, PHE must be related to the health services' practical aspects and the workers' and population's needs[29].

Within each team, the participants' perceptions diverged regarding the occurrence of PHE as a work process in the health centers – which may be due to the nonuniform understanding of the PHE theoretical framework.

Participants also referred to a variety of meeting durations and frequencies. Some authors[30,31] state that PHE effectiveness depends on planning, with the whole team participating in its organization, and periodical activities proposed in advance. Other scholars on the subject believe the ideal is that PHE be included in each professional's working hours and preferably conducted during team meetings, on fixed days. However, PHE effectiveness is ensured not only by systematic meetings but also by the very experience[32,33]. Health professionals must be encouraged to make critical reflections about reality to transform social structures[34].

When asked about meeting formats and PHE strategies, they mentioned brief oral presentations in large rooms at the health centers and application messages with one topic per week – which reinforces that professionals see PHE as continuing education. The resources used to develop PHE must go beyond meetings and training. Team cooperation and shared healthcare to discuss clinical cases and unique therapeutical projects are examples of strategies that can be used to substantially help them acquire new knowledge and provide better care to the population[35]. Learning is more significant when it is based on everyday problems[17].

PHE is an educational instrument of social change. Therefore, implementing the educational process depends on dialogue and openness to collective reflection[31]. Studies report the need for giving priority to active listening in PHE, using strategies that encourage dialogue and discussions. Collective dialogue must preferably take place in circles to ensure greater participation of those involved and enable different interactions between them[7,36,37].

Most participants reported both institutional and personal barriers to PHE implementation. Overwork and the lack of time and interest were reported as hindrances to the process. Studies in the literature with different scenarios indicate the same challenges of educational practices – i.e., some professionals' lack of participation and interest, overwork, lack of infrastructure, devalued knowledge of mid-level professionals, difficulties understanding more active learning methods[6], lack of PHE-qualified professionals, lack of professionals' adherence, lack of planning by the health center administration, employee turnover (which hinders bonding with the team), and focus on fragmented work between different professionals[8]. The workers' degree of commitment is an important factor to overcome the barriers, especially regarding innovative, interactive, and integrative actions combining theory and practice[29].

Concerning what needs to be done for PHE to take place, the participants reported administrative support and team initiative. Most of them cited "planning" and "defining a specific day in the schedule", which corroborates the literature. Carotta, Kawamura, and Salazar[38] referred to planning and the inclusion of PHE meetings in the team's work routine as important actions to structure and implement PHE. According to Peres, Silva, and Barba[39], PHE should be based on needs identified by the workers and supported and supervised by a PHE center.

This study revealed that PHE is not practiced as proposed by its National Policy. Despite the investments in health education practices, they have not been used in health services' daily routine[40]. Therefore, health teams and municipal departments of permanent education must constantly address and discuss PHE, while administrators and universities must make efforts regarding both the health services and health professionals' training to redirect PHE practices.

It is necessary "to transcend linearity and occasional and limited actions, set to be carried out in specific places with preestablished contents and strategies"[29] (p.777).

Participants did not report facilitating factors for PHE practices. This may have happened either because of difficulties understanding the meaning

of the term or the absence of such practices in the experience of most professionals in these teams.

This study had some limitations, such as the number of participating teams and the use of a questionnaire, instead of an interview or the observation of the reality they experienced. Hence, further studies are needed with more participating teams and other methods to obtain results.

There are barriers to be identified and overcome by professionals, administrators, educational institutions, and the population. Knowing and exploring the meanings of PHE presented in its National Policy guide protagonists to critical reflections and improvements in the work process of each health service. Hence, the scientific community, health professionals, SUS users, and students may find this study useful.

CONCLUSIONS

The study aimed to understand how health workers of two PHC teams perceive PHE in their work process and demonstrated that PHE concepts are confused with continuing education. Team professionals diverged on events described as PHE, and both participating health teams highlighted hindering factors.

Institutional and personal challenges were also pointed out, such as not regularly scheduling PHE practices, overwork, and the lack of time and interest in PHE.

The literature on the topic shows homogeneous results presented by research. The hindering factors pointed out by participants in this study had already been addressed in other ones, which proposed possible solutions in terms of planning, team engagement, and qualification of professionals in PHE concepts and practices.

Thus, the present study considers the importance of observing how PHC workers see and practice health education public policies. Given the sample limitations, developing similar studies to improve and better use PHC public policies is important.

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Contributions:
CLFS and TMJ equally contributed to the conceptualization and writing of the research project, data analysis and interpretation, article writing, critical review of relevant intellectual content, and approval of the final version for publication. Only the first author participated in data collection.

Corresponding Author:
Carolina Luiz Ferreira da Silva
carolina.luiz.silva@alumni.usp.br

Editor:
Ada Clarice Gastaldi

Received in: Apr 19, 2022
Approved in: Feb 23, 2023