JHGD
Journal of Human Growth and Development
CDH
www. jhgd.com.br

ORIGINAL ARTICLE

Assessment of permanent education by the team of the expanded center for family health and primary care

Wellen Góbi Botacin[a], Lorena Ferreira[b], Marly Marques da Cruz[c], Edson Theodoro Dos Santos Neto[d], Carolina Dutra Degli Esposti[e]

Open acess

[a]Programa de Pós-Graduação em Saúde Coletiva. Universidade Federal do Espírito Santo (PPGSC/UFES). Avenida Marechal Campos, 1468, Bonfim, Vitória, Espírito Santo, Brasil;

[b]Programa de Pós-Graduação em Saúde Coletiva. Universidade Federal do Espírito Santo (PPGSC/UFES). Avenida Marechal Campos, 1468, Bonfim, Vitória, Espírito Santo, Brasil;

[c]Departamento de Endemias Samuel Pessoa, Escola Nacional de Saúde Pública, Fundação Oswaldo Cruz, Rua Leopoldo Bulhões, 1480, Sala 601, Bairro Manguinhos, Rio de Janeiro, Brasil;

[d]Programa de Pós-Graduação em Saúde Coletiva. Universidade Federal do Espírito Santo (PPGSC/UFES). Avenida Marechal Campos, 1468, Bonfim, Vitória, Espírito Santo, Brasil;

[e]Programa de Pós-Graduação em Saúde Coletiva, Universidade Federal do Espírito Santo (UFES), Avenida Marechal Campos, 1468, Bonfim, Vitória, Espírito Santo, Brasil;

Corresponding author
wellen37@hotmail.com

Manuscript received: may 2023
Manuscript accepted: august 2023
Version of record online: december 2023

Abstract

Introduction: the National Policy for Permanent Health Education is a strategy for training workers in the Brazilian Unified Health System.

Objective: we sought to evaluate the implementation of the Permanent Health Education Policy from the perspective of professionals from the Expanded Center for Family Health and Primary Care in the city of Vitória, Espírito Santo.

Methods: this is a case study, quantitative and qualitative research, with triangulation of methods. A Logic Model and an Analysis and Judgment Matrix were prepared based on document analysis and scientific literature.

Results: 49 questionnaires were applied and 28 interviews were conducted with health professionals with at least one year of experience in the position. A descriptive analysis of the quantitative data (absolute and relative frequencies) was performed using SPSS version 21.0, and thematic content analysis of the interviews was conducted using MAXQDA (22.0.1), with the results being applied to the matrix, following the score for each classification level of the criteria provided for in the Governance, Technical Quality, and Sustainability dimensions.

Conclusion: the full degree of implementation of the policy was obtained in the view of the teams, with facilitating factors such as the good performance of the Technical School of Health.

Keywords: health evaluation, health policy, primary health care.

Suggested citation: Botacin WG, Ferreira L, Cruz MM, Neto ETS, Esposti CDD. Assessment of permanent education by the team of the expanded center for family health and primary care. *J Hum Growth Dev. 2023; 33(3):341-353.*
DOI: http://doi.org/10.36311/jhgd.v33.15281

Authors summary

Why was this study done?
The National Policy of Permanent Health Education was created in Brazil in 2004 with the aim of contributing to the qualification of health professionals in the Brazilian Unified Health System. Its implementation undergoes adjustments, in the various scenarios, according to contextual factors. The Teams of the Expanded Center for Family Health and Primary Care have been important both for the expansion of health care and for their qualification from Permanent Education actions. Thus, this study on the implementation of the Permanent Health Education Policy, in the view of these teams, was justified both by the need to evaluate its characteristics and the factors that interfere with the implementation of the policy in a municipal context, and by the necessary discussion on the contribution of the teams of the Expanded Family Health and Primary Care Center in this process.

What did the researchers do and find?
A Logical Model and an Analysis and Judgment Matrix were developed, fed with data obtained from the application of questionnaires and interviews. The results showed that the policy is implemented in the municipality. Moreover, the role of these professionals in terms of policy and actions was highlighted, emphasizing their importance even before the possibility of dismantling these teams.

What do these findings mean?
In the view of the Teams of the Expanded Center for Family Health and Primary Care, the factors facilitating the implementation of the policy are related to the good performance of the Technical School and Health Professional Training of the municipality, the good participation of professionals in these actions, and the positive results for the professional and for the service. Obstacles to this process include low management involvement, lack of sufficient resources for actions, and lack of monitoring. As an example of a suggestion for improvement, the guarantee of a time booked in the agenda of professionals to participate in Permanent Health Education actions emerged. Thus, the results show that, for the implementation to be continued and improved, there is a need for adjustments.

INTRODUCTION

Adequacy in the training of health professionals, especially for Primary Health Care (PHC), is an essential aspect for the transformation of their practices. Permanent Health Education (PHE) is a tool that aims at this transformation, since it provides a guided learning of work practice. In this context, the professionals of the Team of the Expanded Center for Family Health and Primary Care (eNASF-AP) have been acting in a relevant way to carry out PHE actions.

The Family Health Strategy (FHS) is the model for the reorganization of PHC in Brazil and it has been undergoing improvements and achievements since 1994[1]. In 2008, the incorporation of eNASF-AP became a milestone that contributes to the achievement of positive results regarding the support it offers to the FHS[2].

The increase in the areas of professional activity and the integration between workers from different backgrounds enhances PHC and helps in its solving capacity, expanding access and comprehensiveness of care. This is done by interprofessionality, intersectorality, matrix support, and shared care and actions involving and considering the particularities of users and community[2].

The spaces of PHE are appropriate for the problematization and elaboration of new ways of caring, favoring the change of the work practice of professionals, making them critical and reflective and promoting qualified care. However, obstacles are still present, such as the difficulty in understanding its concepts and the performance of actions disconnected from the practical reality of the service[3-14].

The National Policy of Permanent Health Education (PNEPS), created by Ministry of Health Ordinance no. 198, of February 13, 2004, is characterized as a strategy for the training and development of workers in the Brazilian Unified Health System (SUS). Its objective is to modify and qualify health care, as well as organize actions and services, training processes, and pedagogical and health practices[15].

It is understood that the implementation of this policy contributes to the qualification of professionals and a better organization and performance in the SUS health care network. The GM/MS Ordinance no. 1,996, of August 22, 2007, established changes in the policy to promote improvements in its execution[16].

It should be noted that the same policy can present different results, since the context of its implementation influences its execution and results[17]. One must evaluate policies in a local context, such as in the Permanent Health Education Policy (PEPS), as well as the perspective of health professionals acting on it, such as in eNASF-AP. This study aims to evaluate the implementation of the Permanent Health Education Policy in the Primary Health Care of Vitória, capital of Espírito Santo, Brazil, in the view of professionals from the Team of the Expanded Center for Family Health and Primary Care.

METHODS

Study Design

This is a quantitative-qualitative evaluative research, with the methodological strategy of case study with triangulation of methods, aiming to evaluate the implementation of PHEP in Vitória, capital of Espírito Santo, in the view of the professionals of eNASF-AP. This study is part of the project: "Evaluation of the implementation of the Permanent Health Education Policy in the view of the Teams of the Expanded Center for Family Health and Primary Care".

Study Location and Time

The municipality of Vitória is part of the Metropolitan Health Region of the state of Espírito Santo (ES), located in southeastern Brazil (figure 1). It has a population of approximately 350 thousand inhabitants and has 95 teams working in PHC and covering 339,750 (93.83%) people, 269,100 (74.32%) of these with FHS coverage. The Health Care Network of the municipality covers six regions and 29 Health Territories/Basic Health Units (BHUs). This segmentation contributes to the

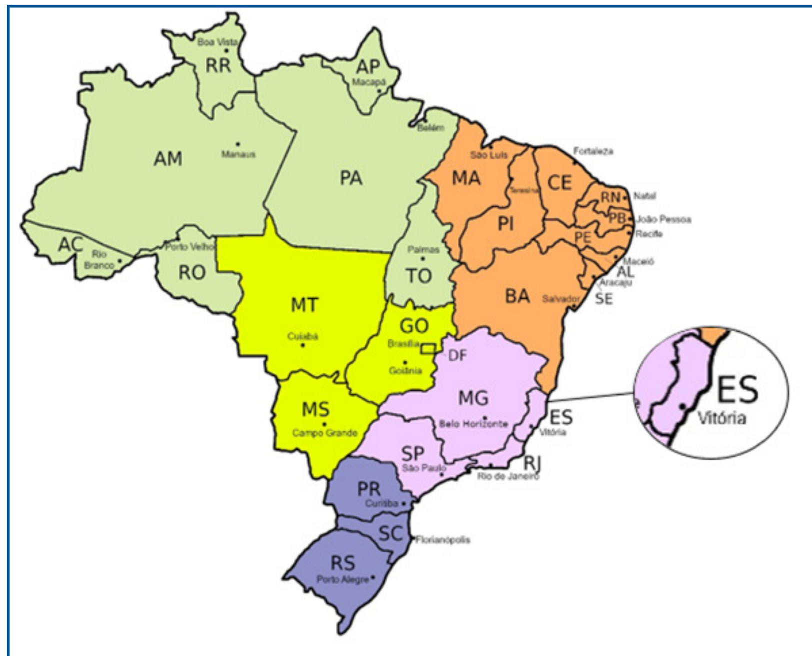

Figure 1: Map and location of the municipality of Vitória-ES, Brazil.
Source: Infoescola (2022)[18].

decentralization of services, an important principle of SUS that assists in issues related to local planning and the recognition of the needs of the population according to their characteristics[19,20].

The PHC in this municipality has eight eNASF-AP, which support the FHS of 13 BHUs located in five of the six health regions. These teams provide clinical, health, and pedagogical care to the professionals of the supported teams. They total approximately 60 professionals and are formed by the following categories: Social Work; Psychology; Physical Education; Pharmacy; and Speech Therapy. The municipality has the Technical School and Health Professional Training (ETSUS), which carries out research, teaching, and technical cooperation actions for the qualification of human resources, PHE actions, and services provided by SUS[20].

In the first stage of the research, a Logical Model (ML) of PHEP was developed, adapted from Ferreira[10] and updated based on official documents on the municipal and state SUS management process and on the scientific literature (figure 2).

The selected components were: Planning, which addresses the documents, plans, and articulation with actors and institutions in the execution of permanent education; Political Articulation of actors and institutions responsible for monitoring, planning, and implementing continuing education; Coordination, which provides for the presence and use of resources and governance actions; and Conceptual, Technical, and Practical Guidance, establishing the dissemination of the concept of Permanent Education, professional and technical qualification.

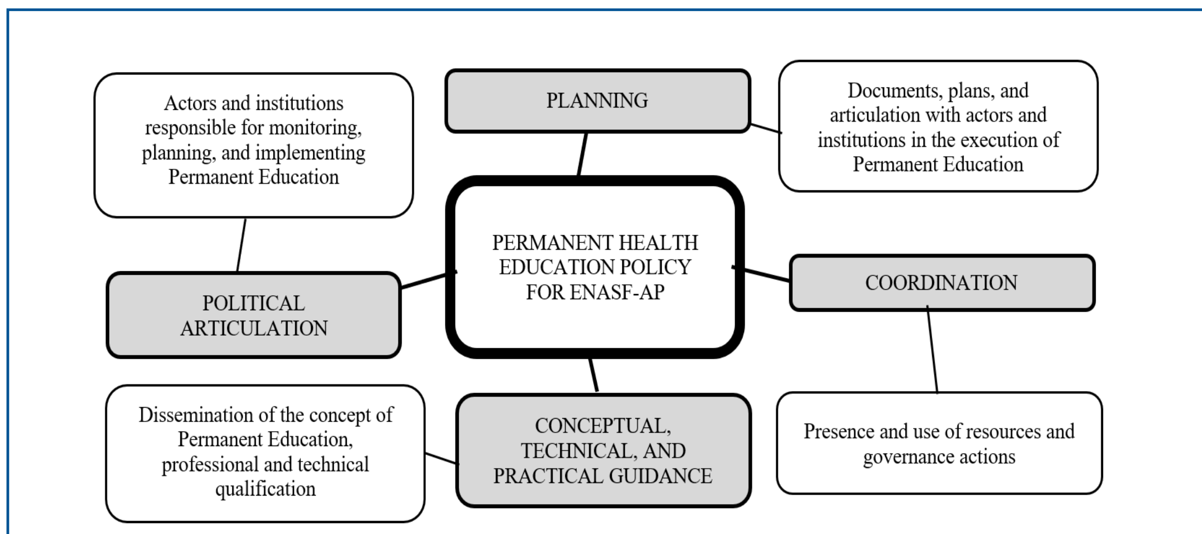

Figure 2: Logic Model of Implementation of the Permanent Health Education Policy for the Team of the Expanded Center for Family Health and Primary Care in the municipality of Vitória-ES, 2022
Source: adapted from Ferreira et al. (2020)[10].

This LM of implementation of PHEP for eNASF-AP allowed the construction of an Analysis and Judgment Matrix (AJM) of the policy. An evaluation matrix allows the recognition of the parameters necessary to answer the research question and assist in the evaluation[21]. The AJM presented here has been adapted[22] and prepared from information obtained in documents and literature on the subject.

The matrix has three dimensions: Governance; Technical Quality; and Sustainability. These dimensions and their subdimensions, indicators, and criteria were formulated based on the document analysis of PHEP and eNASF-AP, in the Governance Model of Health Care Networks[23], in scientific publications, in the document "National Policy of Permanent Health Education: what has been produced for its strengthening?[24]," and in the Practical Guide to Public Policy Evaluation[25]. The first dimension, called Governance, encompasses two subdimensions: Coordination, which highlights the partnership and articulation between the various actors and institutions in the implementation of PHE actions, including ETSUS; and Participation, which governs the participation of ETSUS in the training of professionals.

The second dimension, Technical quality, is subdivided into Formation and Professional performance, which refer, respectively, to the participation of professionals in the training and actions of PHE and in the evaluation of these educational processes regarding the training of professionals.

Sustainability, third dimension of AJM, has a Technical subdimension, which consists in the evaluation of the partnership between management and professionals in the PHE actions, in the planning and execution of these actions, in the availability of resources for this purpose, in the integration between the professionals themselves, evaluating whether they generate changes in professional practices and whether the actions help solving the demands. Figure 3 presents AJM with its dimensions, subdimensions, and respective criteria and indicators, classification, and reference standard.

From the sum of the score obtained, the degree of implementation of PHEP will be determined according to figure 4.

Dimension	Subdimension	Criteria or Indicators	Classification	Standard
Governance	Coordination	Performance of ETSUS Vitória in the development of PHEP in the municipality	4.Always act 3.Sometimes act 2.Almost never act 1.Never act	Always
		Partnership/articulation of the different actors and institutions involved in the implementation of PHEP in Vitória	4.Always articulate 3.Sometimes articulate 2.Almost never articulate 4.Never articulate	Always
	Participation	Participation of ETSUS Vitória in the training processes	4.Always participate 3.Sometimes participate 2.Almost never participate 1.Never participate	Always
Technical quality	Training	Health professionals in the training processes and practices of PHE	4.Excellent 3.Adequate 2.Poorly adequate 1.Inadequate	Excellent
	Professional Performance	Use of instrument for evaluating training processes	4.Always has 3.Sometimes has 2.Almost never has 1.Never has	Always
		Training for working in PHC	4.Always provides 3.Sometimes provides 2.Almost never provides 1.Never provides	Always

Sustainability	Technical	Partnership of municipal management with health professionals in PHE actions	4.Always articulate 3.Sometimes articulate 2.Almost never articulate 4.Never articulate	Always
		Planning and execution of PHE actions in the view of FHU health professionals	4.Always has 3.Sometimes has 2.Almost never has 1.Never has	Always
		Availability of resources (physical, material, financial, or human) in the FHU for PHE actions, in the view of health professionals	4.Sufficient 2.Poorly sufficient 2.Insufficient 1.Very insufficient	Sufficient
		Integration between local management and health care professionals	4.Always has 3.Sometimes has 2.Almost never has 1.Never has	Always
		Change in professional practice	4.Always 3.Sometimes 2.Almost never 1.Never	Always
		Resolution of local demands	4.Always 3.Sometimes 2.Almost never 1.Never	Always

Figure 3: Analysis and Judgment Matrix of the Permanent Health Education Policy, in the view of the Team of the Expanded Center for Family Health and Primary Care of Vitória-ES. Vitória, 2022
Source: adapted from Akerman and Furtado (2016)[21].

Classification levels of PHEP implementation in the view of eNASF-AP			
Incipient (≤ 25%)	Intermediate (26 to 50%)	Satisfactory (51 to 75%)	Comprehensive (≥ 76%)
Of the total 48 points, up to 12 points	Of the total 48 points, from 13 to 24 points	Of the total 48 points, from 25 to 36 points	Of the total 48 points, from 37 to 48 points

Figure 4: Degree of implementation of the Permanent Health Education Policy, in the view of the Team of the Expanded Center for Family Health and Primary Care of Vitória-ES. Vitória, 2022
Source: adapted from Ferreira (2019)[22], Silva *et al*. (2005)[26], and Alves *et al.* (2010)[27].

Study Population and Eligibility Criteria

To respond to the matrix, data were collected by triangulation of quantitative and qualitative methods. In the first stage, quantitative, participants were selected based on the following inclusion criteria: working in eNASF-AP of Vitória for at least a year. Professionals who did not formally belong to eNASF-AP, even if they had the same professional training and worked in PHC, and professionals on vacation or leave at the time of data collection were excluded. An adapted self-administered questionnaire[21] was used, with closed questions about the participation of professionals in PHE activities, the results achieved by these actions, and the existence of changes in the professional practice in the day-to-day of PHC.

In the second stage of the study, qualitative, the selection criteria were: participation in the quantitative stage of the study and having answered the self-administered questionnaire; at least two professionals from each of the five categories present in the eNASF-AP of the municipality; and representativeness in all five health regions covered by eNASF-AP. Professionals on leave or vacation at the time of data collection were excluded.

In this stage, individual semi-structured interviews were conducted, using a guide script containing the following themes: concept of PHE and its relationship with Permanent Education; involvement of actors and institutions in the articulation and implementation of PHE actions; facilitating factors and obstacles that affect the implementation of PHEP; and monitoring and evaluation of these actions.

For the selection and identification of the participants of this stage, the snowball technique was used, with the indication of an individual by other individuals[28] and maintaining the necessary care to obtain a heterogeneous sample.

Data Collection

At first, the application of the questionnaire was carried out in person at the BHUs of the municipality, between November 2019 and March 2020. Subsequently, because of the Coronavirus Disease 2019 (COVID-19) pandemic, and following the recommendations on social isolation[29], the collection started to be carried out remotely using the Google Forms application, between August 2020 and January 2021. The interviews were conducted by two trained researchers, on the day and time of each participant's preference, using communication tools such as Google Meet and WhatsApp.

Data Analysis

The analysis of quantitative data was done by descriptive statistics, with calculation of absolute and relative frequencies using the Statistical Packages for the Social Sciences (SPSS) v. 21.0 (Inc, Chicago, USA). The audio of the interviews of the qualitative stage was recorded and transcribed in its entirety and its content was analyzed according to thematic content analysis[30,31], with assistance from the software of qualitative data analysis MAXQDA® 22.0.1. The results were later applied to the AJM.

Ethical Aspects

The research was approved by the Research Ethics Committee of the National School of Public Health Sergio Arouca under opinions no. 2,464,885/2018 and Nº. 4,228,002/2020, and followed all ethical precepts. Participants signed the free and informed consent form printed in two copies, during the face-to-face data collection, or answered it via Google Forms, during remote data collection.

RESULTS

Of the 60 professionals who were members of the eNASF-AP in the municipality, 49 (81.7%) participated in the initial quantitative stage. In the second stage, with a qualitative approach, 28 professionals from eNASF-AP participated.

Most participants were women (n=44; 89.8%) and aged between 40 and 49 years old (n=20; 40.8%). There was a predominance of social workers (n=14; 28.6%), followed by pharmacists (n=12; 24.5%), psychologists (n=09; 18.4%), physical education professionals (n=8; 16.3%), and speech therapists (n=06; 12.2%), working in the following health regions covered by eNASF-AP: Region 1 (n=06; 12.3%); Region 2 (n=21; 42.8%); Region 3 (n=13; 26.6%); Region 5 (n=05; 10.2%); and Region 6 (n=04; 8.1%). The maximum education level of these professionals was Specialization (n=37; 74.4%). Most of them had a workload of eight hours a day (n=32; 65.4%), held a tenure position (n=43; 87.8%), and were in their current position between 11 and 20 years (n=20; 40.9%) (table 1).

The results will be described according to the level of implementation, according to AJM items, and representing the political-organizational context of the municipality (table 2).

Table 1: Characterization of the professionals of the Team of the Expanded Center for Family Health and Primary Care. Vitória-ES, 2022

	Variables	N	%
Sex (n=49)	Female	44	89.8
	Male	5	10.2
Age (n=49)	30-39	16	32.5
	40-49	20	40.8
	50-59	10	20.6
	60 years or older	3	6.1
Maximum education level (n=49)	Bachelor's degree	1	2.1
	Specialization	37	74.4
	Masters' degree	10	21.4
	PhD	1	2.1
Professional category (n=49)	Social Worker	14	28.6
	Physical Educator	8	16.3
	Pharmacist	12	24.5
	Speech Therapist	6	12.2
	Psychologist	9	18.4
Time in current position (n=49)	1-5 years	15	30.7
	6-10 years	9	18.3
	11-20 years	20	40.9
	21-28 years	5	10.1
Employment relationship (n=49)	Tenure	43	87.8
	Hired	6	12.2
Daily workload in the FHU (n=49)	2 hours	2	4.1
	5 hours	1	2.0
	6 hours	13	26.5
	8 hours	32	65.4
	11 hours	1	2.0

Table 2: Degree of implementation of the Permanent Health Education Policy, according to dimensions and subdimensions of the evaluation, in the view of the professionals of the Team of the Expanded Center for Family Health and Primary Care. Vitória-ES, 2022

Dimension	Subdimension	Criteria/Indicators	Standard (expected score)	Result (achieved score)
Governance	Coordination	Performance of ETSUS Vitória in the development of PHEP in the municipality	4.Always act	4.Always act
		Partnership/articulation of the different actors involved in the implementation of PHEP in Vitória	4.Always articulate	4.Always articulate
	Participation	Participation of ETSUS Vitória in the training processes	4.Always participate	4.Always participate
Technical quality	Training	Health professionals in the training processes and practices of PHE	4.Excellent	4.Excellent

	Professional Performance	Existence of instrument for evaluating training processes	4.Always has	1.Never has
		Training for working in PHC	4.Always provides	4.Always provides
Sustainability	Technical	Partnership of municipal management with health professionals in PHE actions	4.Always articulate	2.Almost never articulate
		Planning and execution of PHE actions in the view of FHU health professionals	4.Always has	2.Almost never has
		Availability of resources (physical, material, financial, or human) in the FHUs for PHE actions, in the view of health professionals	4-Sufficient	2.Insufficient
		Integration between local management and health care professionals	4.Always has	3.Sometimes has
		Change in professional practice	4.Always	4.Always
		Resolution of local demands	4.Always	4.Always
	Total	48 points	38 points - Comprehensive	

Source: adapted from Ferreira (2019)[22], Silva et al. (2005)[27], and Alves et al. (2010)[28].

In the Governance dimension and its Coordination subdimension, the 28 participants in the interviews were unanimous in highlighting the performance of ETSUS in the municipality. Still according to most participants, there is partnership and articulation between actors and institutions in the process of implementing PHEP. In the Participation subdimension, professionals stated that ETSUS participates in the training processes (n=46; 93.9%).

Regarding the Technical Quality dimension, in the Training subdimension all professionals (n=49; 100%) reported participating in training processes and PHE practices inside and outside their work environment. The existence of instruments to evaluate and monitor the training process, an indicator of the Professional Performance subdimension, was reported by only six of the 28 interviewees, while 45 (93.8%) stated that PHE practices enable them to work in PHC.

In the Sustainability dimension, Technical subdimension, 20 of the 28 interviewees affirmed there was no participation of professionals along with the municipal management in the construction of an agenda for PHE actions; 14 professionals stated that there was no planning and execution of PHE actions; and 14 mentioned the availability of two or more resources to carry them out. Still on this subdimension, of the 49 study participants, 18 (36.7%) stated that there is integration between local management and FHU professionals to carry out PHE practices, and 44 (93.6%) observed a change in professional practice after participation in these actions and said that they help in solving local demands of the service.

Table 2 shows the score obtained in each of the AJM criteria and its comparison with the expected standard for evaluating the degree of implementation of PHEP in the municipality. The sum of the score achieved was equal to 38 and allowed classifying the degree of implementation of PHEP as Comprehensive in the view of eNASF-AP professionals in the city of Vitória-ES.

DISCUSSION

The demands for the training of health professionals in PHC are complex, and PHE emerges as a strategy in this scenario. It is considered the organizer of learning processes and recommends, as a consequence, satisfactory results in the actions developed in the field of health[5]. The frequency and space in which PHE actions take place are important factors in defining their capacity to transform the local reality. Because it is based on the problematization

of real and everyday issues of the service, it seeks the transformation of reality. A broader understanding of PHE and the perception of the professional as the subject of their learning are excellent incentives for the change of daily actions[6].

The literature has shown that PNEPS contributed considerably to the approximation of education and health, strengthening SUS. Its pedagogical capacity to favor decentralization and encourage the training of health workers, with the establishment of spaces for knowledge exchange, learning and building of collective knowledge, sharing of experiences, importance of the pedagogical character of the daily life of the service, of multiprofessional work, as well as the participation of management and users of the service, enable transformations in the ways of doing health[11].

The analysis of the Governance dimension showed that ETSUS presented a prominent role and protagonism in the implementation process of PHEP. This school offers a set of different events and educational initiatives based on the needs identified by SUS managers and covers health professionals. The school acts in the municipality as an important institution responsible for the training and development of health professionals by offering actions and training guided by teaching-service integration, contributing to the generation of transformative movements, both individually and collectively, related to health care and professional training[32].

ETSUS, in 2020, had its training calendar suspended due to the COVID-19 pandemic, and even then offered 25 trainings related to COVID-19[20], to prepare workers to act according to the needs of the service, an important principle of PHE. These training processes offered by ETSUS are a powerful tool for the effectiveness of SUS and enable the participation of teachers and health professionals, as well as reflections and exchange of knowledge, providing opportunities for new ways of doing health, although there are still difficulties in its effectiveness[11].

In addition to ETSUS, the partnership with actors and institutions proved to be fundamental for the development of PHE actions for most of the participants in this study. For the consolidation of PHEP and the development of PHE actions, the interrelation between actors and institutions, health and education, the teaching-service integration, and the involvement of PHC professionals, teachers, and students in an intersectoral and interinstitutional way is essential[9,12], and this coparticipation must be constant to actually carry out this joint action between the various spheres.

Concerning the Technical Quality dimension, the participation of eNASF-AP professionals in training processes and PHE practices was excellent, corroborating the literature[4,5] and emphasizing the importance of carrying out PHE constantly and permanently, presenting itself as an important strategy of personal reflection and reading of reality, thus enabling new ways of working in health services[8,14]. This reality is different from the one portrayed in a study conducted with eNASF-AP professionals[6] and with dentists[4], in which PHE actions proved to be scarce and inadequate, carried out punctually, by conventional methodologies and disarticulated from practical reality.

PHE has been occurring in the daily life of health services in numerous ways and initiatives, from the most formal and traditional means of teaching and learning to the non-formal ones, with daily activities that provoke reflections and inspire changes. It is necessary that the obstacles to the implementation of this teaching-learning process, such as the absence of critical-reflective actions and the non-recognition of the competence of professionals, are overcome by encouraging the implementation of actions aimed at practice, so that PHE really happens[7].

The evaluation and monitoring of PHE actions were scarce in the studied context, as shown in the literature[5,13], alerting to the absence and need to create specific instruments that allow monitoring and measuring the effects of the actions carried out, as well as the level of impact of the training processes in accordance with the objectives intended by the policy and services.

Analyzing the Sustainability dimension, according to the studies by Barcellos *et al*. (2020)[5] and Silva and Scherer (2020)[13], the construction of an agenda of PHE actions between municipal management and eNASF-AP professionals almost never happens and there is little integration between local management and service professionals in the development of actions. This fact can be explained by the problems often faced by management: constant political-partisan changes; lack of understanding by managers about the concept and importance of PHE; high demand for services; frequent professional turnover; and scarce involvement in these issues, which significantly affect health work[5,8].

PHE actions proved to be drivers of changes in the practice of professionals, which enhances the resolution of service demands. These findings corroborate a study[4] performed with dental surgeons, which showed that PHE actions are important for the training of professionals and effective in the daily life of the health service, contributing to their performance in the face of the demands of the service. On the other hand, a research with higher education professionals[3] showed that PHE actions have not collaborated significantly to the change in practice, presenting scarce results incapable of modifying the reality of the service.

Regarding the obstacles to the implementation of PHEP, the lack of fully adequate infrastructure for the development of PHE actions highlighted in this study is also discussed in the contexts of the city of Fortaleza-Ceará[4] and in the state of Goiás[5], which show the insufficiency of human, financial, material, and infrastructure resources.

In this study, eNASF-AP professionals considered the material resources as sufficient and available for the PHE actions and highlighted the presence of a meeting room for this purpose. Financial resources were considered non-existent and there was a balance in the responses concerning the human resources available for the implementation of PHE. This is important, since, for the actions to happen properly, become more fruitful and effective, in addition to the adoption of an appropriate methodology, one must rely on satisfactory physical resources and structure[4].

However, although the level of implementation of PHEP was evaluated as comprehensive by eNASF-AP professionals, weaknesses were presented by the

participants regarding the absence of monitoring and evaluation of PHE actions; the incipient partnership between municipal and local management in the implementation of PHE actions; the lack of integration between management and professionals in the planning and execution of actions; and the insufficiency of physical, material, and human resources for this purpose.

Studies conducted in other contexts have also shown that, despite advances, the implementation of PNEPS in municipalities and states still faces many obstacles such as: scarcity of financial, material, and infrastructure resources; lack of support and political interest and political-partisan inconstancy, in which political positions are transfigured according to the structuring of power, centralizing or decentralizing health work; interpersonal relationship difficulties, such as lack of cooperation; problems related to the workflow and role of professionals; high turnover of workers; lack of time and interest from FHS professionals; absence of monitoring and evaluation of PHE actions; and impasses concerning the demand for work and training of professionals, due to the reduced staff of human resources, with work overload of professionals, making it difficult to install a health model that overcomes the curative logic in the still existing health care[5,12,33].

In this sense, PHE actions must recognize the worker as the main agent of the process. PHE should be part of the work of the teams in the service and have the participation of management, professionals, users, and regional and state health articulation, as well as adopting adequate methodologies, thus improving the training of professionals and, consequently, the quality of the service offered to the population[4,6].

Service and learning have an important relationship, because one also learns while working. Work is the central instrument of PHE, as it has been appearing in the discourses of the health field. The Pan American Health Organization shows that PHE can cause changes in professional practice in their daily lives based on their reality. PHE is not a course, lecture, or teleconference, but takes place in the workplace, for work and by work[7].

Training processes must work on themes of interest to the target audience and involve them in the learning process, with a practice of constant development[34], especially when there are doubts and concerns related to lack of knowledge about issues and conduct of daily practice, even in promotion and health education[35]. This contextualization, combined with listening to professionals, their experiences and their involvement in the stages of planning, executing, monitoring and evaluating activities, contributes to improving knowledge and making sense of the contexts of action[35].

Therefore, it is important to investigate PHE actions as well as the implementation of PHEP, since this information can serve as a basis for strengthening health services, causing reflection on the theme and stimulating critical thinking, assisting in strategic planning, in the preparation of plans that include PHE, and in supporting institutions and actors involved in the process of conducting PHE5. Moreover, it provides its valorization in daily work practices by managers and professionals.

The implementation of PHEP in the municipality, upon reaching the Comprehensive classification level, reveals strengths that must be maintained and improved and also highlights the weaknesses that need greater attention, thus seeking to improve the implementation of PHEP, objective of this type of evaluation study, which focuses on implementation. The variation in the implementation of a given intervention is related to the influence exerted by the place of implementation, presenting different results in different contexts[36], a fact that may explain the various results found in the literature.

CONCLUSION

The level of implementation of the Permanent Health Education Policy in Vitória, in the view of the Team of the Expanded Center for Family Health and Primary Care, was classified as Comprehensive.

The Technical School and Health Professional Training of Vitória played a prominent role in this process, and the articulation between the different actors and institutions proved to be satisfactory. There is also an excellent participation of eNASF-AP professionals in PHE actions and its results in changing daily practice, training for action in PHC, and assistance in solving the local demands of the service, which contributed significantly to the level of full implementation of PHEP in the municipality.

Weaknesses can be noted regarding the involvement of municipal and local management in this PHEP implementation process, in the construction of agendas with the participation of eNASF-AP, and in the implementation of PHE actions, in addition to the lack of available financial and human resources and a policy for monitoring and evaluating actions.

We suggest the adoption of a reserved space in the agendas of professionals so that they can participate in PHE actions; the monitoring and evaluation of these actions; greater involvement of professionals, management, and institutions; and ensuring the availability of resources, especially financial and human resources for such purposes.

We hope these results and discussion can contribute to the implementation process of PHEP in this and other Brazilian municipalities, as well as highlight this important theme. Furthermore, we also intend to increase the interest from professionals, institutions, and management for the involvement in planning and implementation of PHE actions, as well as for subsidizing decisions related to PHEP.

The COVID-19 pandemic, in view of the recommendations for social isolation, can be described as a limitation of the study, since it initially made it difficult for researchers to enter the research field and hindered the data collection process. However, this limitation was circumvented with adjustments in the research method.

Authors' contributions

All authors contributed to the manuscript. Wellen Góbi Botacin: participated in data collection, data analysis, statistical analysis, discussion of the results, writing of the text, and final version of the text; Lorena Ferreira: participated in study design, data analysis, discussion of the results, and final version of the text; Marly Marques da

Cruz: participated in the conception of the study and review of the text; Edson Theodoro dos Santos Neto: participated in the conception of the study and final review of the text; Carolina Dutra Degli Esposti: participated in the general orientation of the research, study design, definition of the study design, data analysis, discussion of the results, and substantial critical review of the final version of the text.

Funding

This work was carried out with support from the Espírito Santo Research and Innovation Fundation (Fapes) – (Process nº. 83170561/2018 and 2023-983C0).

Acknowledgements

We thank the Espírito Santo Research and Innovation Foundation (Fapes).

Conflict of interest

The authors declare no conflict of interest.

REFERENCES

1. Melo EA, Miranda L, Silva AM, Limeira RMN. Dez anos dos Núcleos de Apoio à Saúde da Família (Nasf): problematizando alguns desafios. Saúde debate. 2018; 42 (esp): 328-340. DOI: https://doi.org/10.1590/0103-11042018S122
2. Anjos KF, Meira SS, Ferraz CEO, Vilela ABA, Boery RNSO, Sena ELS. Perspectivas e desafios do núcleo de apoio à saúde da família quanto às práticas em saúde. Saúde debate. 2013; 37 (99): 672-680.
3. Almeida TMC, Santos RMM, Sampaio DMN, Vilela ABA. Educação permanente como apoio ao PMAQ-AB. Rev. Enferm. UFPE on line. 2019; 13 (e242036): 1-6. DOI: 10.5205/1981-8963.2019.242036
4. Almeida JRS, Bizerril DO, Saldanha KGH, Forte FDS, Almeida MEL. The National Permanent Health Education Policy: dental surgeons' perception of Primary Health Care. Rev. ABENO. 2019; 19 (3): 13-25. DOI: 10.30979/rev.abeno.v19i3.754
5. Barcellos RMS, Melo LM, Carneiro LA, Souza AC, Lima DM, Rassi LT. Educação permanente em saúde: práticas desenvolvidas nos municípios do estado de Goiás. Trab. educ. saúde. 2020; 18 (2): 1-14. DOI: https://doi.org/10.1590/1981-7746-sol00260
6. Bispo-Júnior JP, Moreira DC. Educação permanente e apoio matricial: Formação, vivências e práticas dos profissionais dos Núcleos de Apoio à Saúde da Família e das equipes apoiadas. Cad. saúde pública. 2017; 33 (9): 1-13. DOI: https://doi.org/10.1590/0102-311X00108116
7. Campos KFC, Marques RC, Silva KL. Continuing education: speeches by professionals of one Basic Health Unit. Esc. Anna Nery Rev. Enferm. 2018; 22 (4); 1–11. DOI: https://doi.org/10.1590/2177-9465-EAN-2018-0172
8. Campos KFC, Sena RR, Silva KL. Permanent professional education in healthcare services. Esc. Anna Nery Rev. Enferm. 2017; 21 (4): 1-10. DOI: https://doi.org/10.1590/2177-9465-EAN-2016-0317
9. Ceccim RB. Educação Permanente em Saúde: descentralização e disseminação de capacidade pedagógica na saúde. Ciênc. Saúde Colet. (Impr.). 2005; 10 (4): 975-986. DOI: https://doi.org/10.1590/S1413-81232005000400020
10. Ferreira L, Ribeiro MS, Oliveira LZ, Szpilman ARM, Esposti CDD, Cruz MM. Validação do modelo lógico de implementação da Política de Educação Permanente em Saúde na Atenção Primária. Trab. educ. saúde. 2020; 18 (2): 1-21. DOI: https://doi.org/10.1590/1981-7746-sol00262
11. Leite ICM, Lima RR. Educação permanente em saúde: uma possibilidade para aperfeiçoar o trabalho em uma Escola Técnica do Sistema Único de Saúde? Research, Society and Development. 2019; 9 (3): 1-10. DOI: http://dx.doi.org/10.33448/rsd-v9i3.2291
12. Oliveira MCB, Metelski FK, Trindade LM. Educação permanente para qualificação do processamento de esterilização de materiais na Atenção Primária: contribuições da integração ensino-serviço. Rev. APS. 2021; 24 (1): 160-167. DOI: https://doi.org/10.34019/1809-8363.2021.v24.16514
13. Silva CBG, Scherer MDA. A implementação da Política Nacional de Educação Permanente em Saúde na visão de atores que a constroem. Interface comun. saúde educ. 2020; 24 (e190840): 1-15. DOI: https://doi.org/10.1590/Interface.190840
14. Vallegas AB, Souza AC, Sanches LS, Alves LA. A educação permanente em saúde no processo de trabalho dos agentes comunitários de saúde. Research, Society and Development. 2020; 9 (4), 1-18. DOI: http://dx.doi.org/10.33448/rsd-v9i4.2962
15. Brasil. Portaria n.º 198, de 13 de fevereiro de 2004. Institui a Política Nacional de Educação Permanente em Saúde como estratégia do Sistema Único de Saúde para a formação e o desenvolvimento de trabalhadores para o setor e dá outras providências. Diário Oficial da União. 2004; 13 fev.

16. Brasil. Portaria nº 1.996, de 20 de agosto de 2007. Dispõe sobre as diretrizes para a implementação da Política Nacional de Educação Permanente em Saúde. Diário Oficial da União. 2007; 20 ago.
17. Tamaki EM, Tanaka OY, Felisberto E, Alves CKA, Dumond Junior M, Bezerra LCA et al. Metodologia de construção de um painel de indicadores para o monitoramento e a avaliação da gestão do SUS. Ciênc. Saúde Colet. (Impr.). 2012; 17 (4): 839-849. DOI: https://doi.org/10.1590/S1413-81232012000400007
18. InfoEscola [internet]. Mapa do Brasil. – [citado 2022 Ago 10]. Disponível em: <https://www.infoescola.com/mapas/
19. e-Gestor Atenção Básica [internet]. Ministério da Saúde. e-Gestor Atenção Básica: Informação e Gestão da Atenção Básica. - [citado 2022 Ago 8]. Disponível em: https://egestorab.saude.gov.br/
20. Espírito Santo (Estado). Secretária Municipal de Saúde de Vitória. Relatório Anual de Gestão-2020. Vitória; 2021. [citado em 28 de janeiro de 2022]. Disponível em: https://www.vitoria.es.gov.br/arquivos/20210531_relgestaoanualsemus2020.pdf?1623090875. (acessado em 28/01/22).
21. Akerman M, Furtado JP. Práticas de avaliação em saúde no Brasil: diálogos. Porto Alegre: Editora Rede Unida; 2016.
22. Ferreira L. Avaliação de Implementação da Política de Educação Permanente em Saúde na Atenção Primária no município de Vitória, Espírito Santo [tese]. Rio de Janeiro: Fundação Oswaldo Cruz; 2019.
23. Brasil. Implantação das Redes de Atenção à Saúde e outras estratégias da SAS. Ministério da Saúde. Secretaria de Atenção à Saúde; Brasília 2014.
24. Brasil. Política Nacional de Educação Permanente em Saúde: o que se tem produzido para o seu fortalecimento? Secretaria de Gestão do Trabalho e da Educação na Saúde. Departamento de Gestão da Educação na Saúde; Brasília 2018.
25. Brasil. Avaliação de políticas públicas: guia prático de análise ex post, 2. Brasília, Casa Civil da Presidência da República; 2018.
26. Silva LMV, Hartz ZMA, Chaves SCL, Silva GAP. Metodologia para análise da implantação de processos relacionados à descentralização da atenção à saúde no Brasil. In: Hartz ZMA, Silva LMV organizadores. Avaliação em saúde: dos modelos teóricos à prática na avaliação de programas e sistemas de saúde. Salvador: EDUFBA; Rio de Janeiro: Fiocruz; 2005.
27. Alves CKA, Natal S, Felisberto, E, Samico I. Interpretação e análise das informações: o uso de matrizes, critérios, indicadores e padrões. Rio de Janeiro: Editora MedBook; 2010.
28. Vinuto J. A amostragem em bola de neve na pesquisa qualitativa: um debate em aberto. Temáticas 2014; 22 (44): 203-220. DOI: https://doi.org/10.20396/tematicas.v22i44.10977
29. Brasil. Recomendação Nº 027, de 22 de abril de 2020. Recomenda aos Poder Executivo, federal e estadual, ao Poder Legislativo e ao Poder Judiciário, ações de enfrentamento ao Coronavírus. Conselho Nacional de Saúde; Brasília 2020; 22 abr.
30. Minayo MCS. Pesquisa Social. Teoria, método e criatividade. Petrópolis: Editora Vozes; 2002.
31. Bardin L. Análise de Conteúdo. São Paulo: Edições 70; 2016.
32. Borges TT, Garbin CAS, Siqueira CE, Garbin AJI, Rocha NB, Lolli LF et al. Escolas Técnicas do SUS (ETSUS) no Brasil: regulação da integração ensino serviço e sustentabilidade administrativa. Ciênc. Saúde Colet. (Impr.). 2012; 17 (4): 977-987. DOI: https://doi.org/10.1590/S1413-81232012000400020
33. Bezerra HMC, Gomes MF, Oliveira SRA, Cesse EAP. Processo educativo do Núcleo Ampliado de Saúde da Família na atenção à hipertensão e diabetes. Trab. educ. saúde. 2020; 18 (3): 1-18. DOI: https://doi.org/10.1590/1981-7746-sol00277
34. Castanha CSC, Tavares LFB, Leone C, Paiva LS, Daboin BEG, Marques NSF et al. Basic life support education: the impact of lecture-demonstration in undergraduate students of health sciences. JHGD., Basic life support education: the impact of lecture-demonstration in undergraduate students of health sciences.J Hum Growth Dev. 2021; 31 (2): 283-290. DOI: 10.36311/jhgd.v31.11509
35. Marinho MNASB, Vieira NFC, Ferreira HS, Pequeno AMC, Sousa IC, Pereira AP, et al. Health in school program: from training processes to practice scenarios. J Hum Growth Dev. 2018; 28 (2): 175-182. DOI: http://dx.doi.org/10.7322/jhgd.147219
36. Hartz Z, Cruz M, Craveiro I, Dias S. Estratégia interinstitucional (IHMT/Fiocruz) para fortalecimento da capacidade avaliativa nos países da CPDL: foco nos estudos de implementação para avaliação do PECS. An Inst. Hig. Med. Trop., (Lisb). 2016; 15 (1): 81-87. DOI: https://doi.org/10.25761/anaisihmt.110

Resumo

Introdução: a Política Nacional de Educação Permanente em Saúde é uma estratégia para formação dos trabalhadores do Sistema Único de Saúde.

Objetivo: buscou-se avaliar a implementação da Política de Educação Permanente em Saúde na visão de profissionais do Núcleo Ampliado de Saúde da Família e Atenção Primária do município de Vitória, Espírito Santo.

Método: trata-se de uma pesquisa quanti-qualitativa, do tipo estudo de caso, com triangulação de métodos. Foram elaborados um Modelo Lógico e uma Matriz de Análise e Julgamento a partir de análise documental e da literatura científica.

Resultados: foram aplicados 49 questionários e realizadas 28 entrevistas com profissionais de saúde com pelo menos um ano de atuação no cargo. Foi realizada a análise descritiva dos dados quantitativos (frequências absolutas e relativas), por meio do SPSS versão 21.0, e a análise de conteúdo temática das entrevistas, com auxílio do MAXQDA (22.0.1), sendo os resultados aplicados na matriz, seguindo a pontuação de cada nível de classificação dos critérios previstos nas dimensões Governança, Qualidade Técnica e Sustentabilidade.

Conclusão: obteve-se o grau pleno de implementação da política na visão das equipes, com fatores facilitadores como a boa atuação da Escola Técnica de Saúde.

Palavras-chave: avaliação em saúde, política de saúde, atenção primária à saúde.

© The authors (2023), this article is distributed under the terms of the Creative Commons Attribution 4.0 International License (http://creativecommons.org/licenses/by/4.0/), which permits unrestricted use, distribution, and reproduction in any medium, provided you give appropriate credit to the original author(s) and the source, provide a link to the Creative Commons license, and indicate if changes were made. The Creative Commons Public Domain Dedication waiver (http://creativecommons.org/publicdomain/zero/1.0/) applies to the data made available in this article, unless otherwise stated.