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ORIGINAL ARTICLE

PERMANENT HEALTH EDUCATION AS A POSSIBLE PRACTICE: AN EXPERIENCE IN PRIMARY CARE[1]

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ABSTRACT

Objective: to describe the process of needs analysis, execution and evaluation of an educational program in Primary Health Care, in the logic of Permanent Health Education (PHE). **Method:** action research with mixed approach, developed between 2014 and 2016, with health workers. Data collection occurred in focus group meetings, educational program workshops and questionnaire application. The qualitative data were submitted to discourse analysis of the collective subject, and quantitative data were submitted to descriptive statistical analysis. **Results:** the prioritized need was impaired communication in the work environment; and, during the implementation of the educational programme, participants agreed agreements to overcome the identified problems, such as the creation of dialogue spaces and defined communication flows. They were satisfied to participate, and it was noticed that the educational program had a positive impact on the work. **Final considerations: the** objective of describing the entire Process of PHE was achieved. There was a greater stimulus for a movement of transformation in the work process, in reference to the improvement of communication in the professional dimension of care management, from a dialogical and critical paradigm, capable of resignifying the teaching-learning process at work. As a product, there is a more effective way to operate PHE.

Keywords: Health policy. Education. Health human resource training. Primary health care.

INTRODUCTION

A movement that is currently observed is the valorization of subjectivity in health work processes as a strategy to reconfiguration the care model(1), evidencing the need for practices that promote the involvement of workers, since this action influences organizational identity and the increase in the resilience of professionals(2).

A study on ethical issues in health highlights that, although we expect the values of organizations to be the same values reproduced in care practices, what actually occurs is the coexistence of a logic to promote organizational efficiency and effectiveness and another, based on the relationship between professional and service user. Underlying these logics are different sets of values that often clash, such as the value of profit and the value of life. The proposal is that conflicts in moral structures be addressed by the organization and not between individuals or groups that work there(3).

Bringing this reflection to our federative organization, it is worth mentioning that there is, in Brazil, the National Policy of Permanent Education in Health (PNEPS) since 2009. There is a wide discussion about the consequences of this policy in the daily work in health, focusing on what would be its purpose of sustaining the principles of the Unified Health System (SUS).

On the one hand, it is understood that there is room for changes initiated in the microcosm of organizations through Permanent Health Education (PHE) with movements of disruptions of the instituted, insertion of creativity and elevation of autonomy to the subjects. In this

[1]This study was the result of the doctoral thesis: Zinn GR. Permanent Education in Health: from a political guideline to a possible practice [thesis]. São Paulo: University of São Paulo; 2015. 147 p. Available at: http://www.teses.usp.br/teses/disponiveis/7/7140/tde-11052015-154630/pt-br.php and from the master's dissertation: Lecca, CGG. Implementation and evaluation of an educational program in accordance with the guidelines of the national policy on continuing education in health. [dissertation]. São Paulo: University of São Paulo; 2017. 121p. Available in: https://www.teses.usp.br/teses/disponiveis/7/7140/tde-27042018-153006/en.php

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sense, PHE is seen as a promoter of a critical attitude in acting, thinking, conceiving, proposing, analyzing and predicting. This emancipatory perspective is, however, opposed to the limits of investments in educational processes and structural obstacles that limit changes in work spaces. Thus, PHE is seen as another educational process with a new nomenclature, but which reproduces the old clothing within health organizations[4].

In view of this scenario, it is worth remembering the following question about the PNEPS[5:920]: "how to train subjects committed to managing work problems in the face of the structural difficulties of the SUS?"

In the PNEPS, the paths of transformation of the SUS work are based on three pillars: the micropolitics of living work, the wheel method and the significant learning. However, in times of strong advance of neoliberalism, it is necessary and urgent to rescue an PHE that is able to articulate the "utopia" of health as the right of all from the expansion of the gaze, in other words, to overcome the micropolitical actions of daily work to reach the political spaces and collective articulations that strengthen the movement of health reform and the realization of the SUS, as printed in the Constitution[5].

A literature review study on PHE in primary care showed that the educational actions developed with health workers are based on an instrumental, fragmented and disjointed education of the context of daily work, which translates into a practice based on the concept of continuing education. The challenge is to realize the development of these workers in a reflective, participatory, continuous and focused on local needs. In addition, it is essential to understand PHE by the professionals and managers involved[6].

The cartesian heritage present in our daily lives makes us expect concrete and quantifiable results to recognize and value human actions. In this sense, the realization of this research contributes to the overcoming of the challenges mentioned in the previous paragraph and to present a concrete product with the potential to instrumentalize management for the practice of PHE.

In this context, this study is justified as a contribution to the demonstration of a possible way to operate the PNEPS in daily health work, based on the answer to the following question: how to develop and evaluate the PHE process, from its survey and analysis of educational needs to its evaluation? The proposed objective was to describe the process of needs analysis, execution and evaluation of an educational program in Primary Health Care (PHC), in the logic of PHE.

METHODOLOGY

An action research was conducted with a mixed approach in a municipality in the interior of São Paulo, where one of the three administrative health regions is located, as suggested by the managers. Data were collected in four Basic Health Units (UBSs), two of which were traditional and two were partially implemented by the Family Health Strategy (ESF), in which participants joined. The research was developed in two stages:

Stage I – Five focus group meetings were held between March and November 2014. In the first meeting, the main potentialities and weaknesses experienced in the day-to-day work were identified; at the second meeting, the problems were analyzed regarding the feasibility of local intervention; at the third meeting, priority problems were listed for initiating educational interventions; in the fourth meeting, the planning of the educational intervention was collectively developed; and finally, at the fifth meeting, the evaluation was made about the experience of participating in the groups. The inclusion criteria of the participants was to be a health worker in the municipality and working in the health units of the administrative region indicated for the research. The support occurred randomly after a wide invitation; workers who were on vacation or away from work were excluded. Six nursing techniques and five resident nurses of Primary Health Care (PHC) participated in the study; there was no number of other health workers. The focus groups occurred in a single location, with the participation of these nursing professionals who worked in the four UBSs mentioned above. As a product of these meetings, the priority theme identified to be worked on educational actions was Impaired Communication.

Stage II – Workshops were held to implement the educational program entitled Reflecting the practice of communication in the work environment, between June 2015 and July 2016. In this stage and to obtain greater support, the workshops took place separately in each of the four units represented in stage I. In each UBS, two meetings were held for the workshops. At the first meeting, the professionals collectively identified the main communication-related challenges in their unit and signed agreements to overcome the problems. The second meeting took place two months after the first, so that there was time to experience the agreements established. At this time, the professionals discussed the changes achieved and the need for adjustments in the agreements. The second workshop was completed with the satisfaction assessment, and perception of impact of the program, with the application of adapted questionnaires. The inclusion criterion of the participants in this stage was to be a health worker of the four UBSs, represented in step I. Among the 204 workers in these health units, 125 (61.3%) joined the study. The following participants were: community health agents (23.2%), auxiliaries and technicians (22.4%) and nursing interns (1.6%), nurses (9.6%), physicians and dentists (9.6%), residents of different professional areas (3.2%), oral health assistants (1.6%), psychologist (0.8%), nutritionist (0.8%) and administrative staff (4.8%).

The qualitative data were submitted to collective subject discourse (CSD) analysis. For this reason, there is no identification of the participants, but rather the discourse that represents the collectivity. The quantitative data were submitted to descriptive statistics.

The research was approved by the Research Ethics Committee, under protocol: 435,413 and authorized by the Municipal Health Department (SMS) of the municipality where the work was carried out. The premises of Resolutions 466/12 and 510/16 were respected. The consolidated criteria for reporting qualitative research (COREQ) followed.

RESULTS

Survey and analysis of educational intervention needs

As results of the focus group meetings, we identified the weaknesses and potentialities found in daily work that were categorized according to the dimensions involved in the management of care[7] as follows:

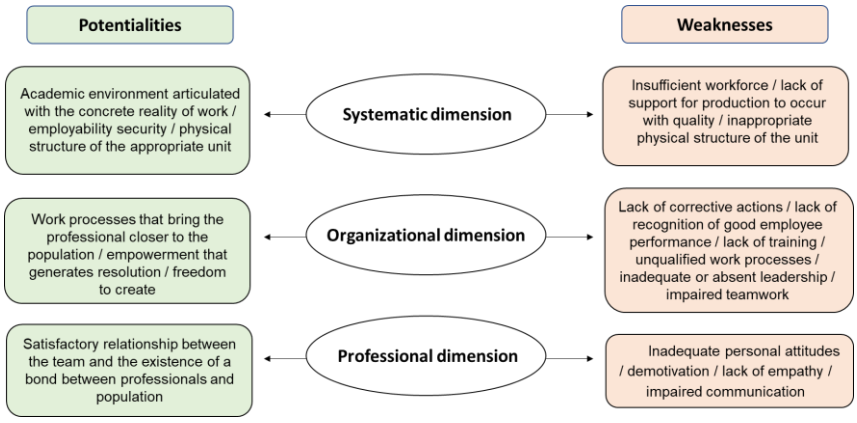

Figure 1. Categories of analysis resulting from the survey and analysis of educational action needs. Sorocaba, 2014.
Author: own.

After categorization, the problems were analyzed regarding the feasibility of local intervention. In the professional dimension, all the problems found were considered viable for educational intervention in the work environment, with potential for overcoming. In the organizational dimension, the problems raised were considered partially viable for intervention, since some of them involve management attitudes. In the systemic

dimension, the problems were considered, in their entirety, unfeasible to be submitted to local educational intervention, since they are at another level of governability.

Regarding the identification of the priority problem for an educational intervention, the participants considered the theme *Impaired Communication*, and developed, together, the educational planning, which was the basis for the elaboration of the program *Reflecting the practice of communication in the work environment.*

As an evaluative result of participation in this first stage of the research, the following central ideas and CSD were obtained as results:

Central Idea A: Collaboration, interaction and achievement

> CSD: I participated in the meetings with the purpose of developing a research that aims to contribute to improvements in the planning of educational interventions. I realized that to change attitudes, we do not need to wait only for the actions of those who manage, but rather, build, together, ways of doing different and better. The research assistance also allowed the expression of experiences and problems. I was able to perceive the perspective of the other participants, and thus create a work instrument capable of putting into practice the strategies discussed.

Central Idea B: Action-trigger as a power trigger

> CSD: My attitude as a worker and future manager has undergone and will undergo changes from these meetings of great learning and that have brought additions in my personal and professional life. The people who participated in the group already want to make a difference, and these meetings were like "injections of spirit" to motivate me more. I feel touched and with expectations. I developed greater interest in the work issues and improved my communication strategy with the team and the population. I can bring to my unit a promising future in the participation of all management teams.

Execution of the educational programme

Among the 125 participants in stage II of the research, only six (4.8%) professionals participated in both workshops. During this period, there were absences of professionals due to licenses, absences and transfer to other units, especially due to the dengue epidemic that occurred in the municipality, which made it impossible to participate more effectively in the educational/reflective process.

In each of the four units in which the educational program was carried out, adaptations of the initial planning were necessary, due to the size of the teams, availability of management and profile of each group. Collective discussions were conducted about possible agreements to improve communication in the work process. It is worth mentioning that the participants of this second stage considered the theme of the relevant educational program, even if they did not participate in the moment of needs survey.

The agreements were translated into the following CSDs, with their central ideas and description of the outcomes achieved:

Chart 1. Central ideas and Collective Subject Discourse (CSD), resulting from the execution of the educational program, Reflecting the practice of communication in the work environment. Sorocaba, 2016

Central idea: **Organization of the information wall**
CSD: I need to turn the information wall into an organized and up-to-date place. Whether it's the wall next to the attendance register, in which each of us must make a commitment to remove outdated information, such as the wall of each room in the unit, in which the professional responsible for the room must be responsible for updating and organization. I will use different colors, on the papers, pins or drawings, as a strategy to help in the differentiation of information.
Outcome: The agreement was reached practically in its entirety, but the issue of using different colors to organize the murals was not reached. People began to pay attention and organize the information contained therein, however, still unable to integrate this attitude into the daily work process. This agreement was maintained with the aim of further improving the dissemination of important information through this means of communication.
Central idea: **Use of technology to share information**
CSD: I consider it important to use WhatsApp® technology as a strategy to share new and urgent information.
Outcome: The agreement was not successful, due to managerial issues of banning cell phone use during working hours.
Central idea: **Defined communication flows**
CSD: Upon receiving the information, I must evaluate the content and verify the importance and need to pass it on to the team, like the information acquired in meetings and courses. Another important issue in the flow of information is the establishment of

standardization and schedule, that is, establishment of dates for the transmission of information and its execution, whether directed to the team or the population. In the case of information for teams, nurses from different shifts must meet and define what will be transmitted in a standardized way and, in relation to the population, it is important to organize the flows.
Outcome: The agreement was partially reached, as the daily demands of work did not allow the creation of a routine for transmitting information, however, the team recognized the importance of this agreement to improve the work process. So, the agreement was maintained, and the team proposed to continue organizing to achieve this goal.
Central idea: **Proactivity in the search for information**
CSD: I need to take a personal stance of knowing the rules of each sector of activity and of the service in general. I must seek information from a proactive act. Once I've sought out the information, whether it's a protocol or a guideline, I must plan its execution, put it into practice, and share the information. It is necessary to take responsibility for knowing the role of my co-worker and the information necessary for my professional practice. Such a search standardizes and brings security to the worker and the user, who will always be attended in the same way, receiving the same information, regardless of the professional who transmits it..
Outcome: The agreement was partially reached. It was identified by the team as a transforming factor of reality and was maintained as a change goal. The difficulty for its execution was identified by the team as a result of the work overload, the fragility in communications and the different attitudes, facing the different demands of the users.
Central idea: **Empathic attitude**
CSD: I need to develop in myself the ability to empathize and respect others and, in this way, relate kindly, whether with a smile or the mention of "good morning". This attitude is important towards the team, towards the users, towards the service.
Outcome: The agreement was partially reached, as it also depends on the transformation of personal attitude. There was the justification of work overload as an element that makes this attitude difficult. The agreement was maintained as a goal, because despite the difficulty of reaching full scope, it was considered important in the work process.
Central idea: **Dialog spaces**
CSD: It is necessary that there are moments of conversation about the work, and that, in these spaces, I participate with commitment and interest. Establishing the periodicity of these moments is essential for them to happen.
Outcome: The agreement was partially reached. It was highly valued by the team and considered a moment of transformation and appreciation of people in the work process. They considered it a moment of transmission of information and team learning. This agreement was maintained and seen as strengthening interprofessional work.
Central idea: **Necessary care for moments of encounter**
CSD: I suggest some care so that meetings or information transmission are successful. As for informational issues, it is necessary to have a professional responsible for transmitting this information and an adequacy of the language, especially when it comes to guidelines for the population, as well as developing the habit of validating the information transmitted, that is, verifying what the other understood from my message. It is important to read the memos and information as a group, rather than just passing them along. Regarding conversation spaces, it is essential to have a partnership between nurses from different shifts to lead the groups and anticipate the topics to be addressed in the workshops.
Outcome: The agreement was partially reached, again justified by the workload, reduced scales and accumulation of tasks. However, the gains from the meetings held, brought the concern to make them better prepared. And with that, attention to improving communication and interpersonal relationships were perceived.

Author: own.

It is noteworthy that, with the exception of the use of WhatsApp®, all other agreements were reached, even partially.

Evaluation of the educational program

Regarding the satisfaction assessment, the results are presented in the following table:

Table 1. Satisfaction evaluation in the participation of workshops of the program *Reflecting the practice of communication in the work environment*. Sorocaba, 2016.

Satisfaction Scale Items	% response per point from the Likert scale						Descriptive statistics	
	n	**TD**	**D**	**N**	**A**	**TA**	***M***	***SD***
01. The workshops were important for my professional growth	125	0	2.4	20.8	**59.2**	17.6	3.92	0.69
02. I was able to reflect on new ways of qualifying my work	124	0	3.2	11.3	**75.8**	9.7	3.92	0.58
03. The objectives of the workshops were achieved	125	1.6	10.4	**48.8**	33.6	5.6	3.31	0.80
04. The contents of the workshops can be applied in practice	125	0	3.2	8.8	**65.6**	22.4	4.07	0.66
05. These workshops helped to improve my daily activities	125	0	4.8	19.2	**62.4**	13.6	3.85	0.71
06. I don't know how to use the content covered in my professional practice	125	21.6	**55.2**	17.6	4	1.6	2.09	0.83
07. The content covered will help to improve my professional performance	125	0	4.8	14.4	**65.6**	15.2	3.91	0.70
08. The content addressed corresponded to the objectives proposed for the workshops	125	0	4	26.4	**59.2**	10.4	3.76	0.69
09. The content covered was adequate to my needs	125	0.8	8	26.4	**60**	4.8	3.60	0.74
10. I felt free to express myself during the workshop	125	2.4	10.4	12	**55.2**	20	3.80	0.96
11. There was interaction between the participants	125	1.6	8	10.4	**64.8**	15.2	3.84	0.84

To be continued...

12. The discussion took place in a logical sequence	125	1.6	4	13.6	**64.8**	16	3.90	0.77
13. I had no difficulty understanding the content covered	125	0	2.4	3.2	**64.8**	29.6	4.22	0.62
14. The instructor demonstrated knowledge about the content	111	0.9	0	4.5	**68.5**	26.1	4.19	0.60
15. The workshops were helpful for me to develop new skills	111	0	2.7	28.5	**60.4**	8.4	3.74	0.64
16. I feel more prepared for professional practice	111	0.9	3.6	31.5	**56.8**	7.2	3.66	0.71
17. The instructor showed respect for the manifestations of the participants	111	0	0.9	2.7	**63.1**	33.3	4.29	0.56
18. The instructor showed interest in the participants' learning	111	0	0	2.7	**64.9**	32.4	4.30	0.52
19. The instructor was objective in his explanations	111	0	0	3.6	**64**	32.4	4.29	0.53
20. The instructor conducted the workshop safely	111	0	0	1.8	**60.4**	37.8	4.36	0.52
21. I was interested in participating in the workshop	111	1.8	4.5	6.3	**64.9**	22.5	4.02	0.80
22. The topic addressed is not important for my practice	111	23.4	**48.6**	12.6	14.5	0.9	2.21	0.99
23. The objectives of the workshops corresponded to the needs of the practice	111	0	2.7	9.9	**72.1**	15.3	4.00	0.60
24. The workload was sufficient for the proposed discussions	111	6.3	19.8	29.7	**38.7**	5.5	3.17	1.02
25. The time dedicated to practical activities was sufficient	111	6.4	14.5	27.2	**46.4**	5.5	3.30	1.00

Legend: n: total number of respondents**, TD:** totally disagree**, D:** disagree**, N:** neither agree nor disagree, **A:** agree**, TA:** totally agree**, M:** mean**, SD:** standard deviation

Table 1 shows that the average satisfaction of professionals in participating in the workshops is positive. They consider, in particular, that the workshops provided reflections for the qualification of the work. As for the perception of impact of the workshops, the results follow:

Table 2. Program impact perception *Reflecting the practice of communication in the work environment*. Sorocaba, 2016.

Impact Perception Scale Items	**% response per Likert scale point**						**Descriptive statistics**	
	n	**TD**	**D**	**N**	**A**	**TA**	***M***	***SD***
01. I use it frequently in my current work, which was discussed in the workshops	125	1.6	5.6	8.8	**65.6**	18.4	3.94	0.80
02. I take advantage of the opportunities I have to put into practice what was discussed in the workshops	125	0	2.4	11.2	**71.2**	15.2	3.99	0.60
03. I remember the discussions held in the workshops	124	0.8	4	16.2	**66.1**	12.9	3.86	0.71
04. When I apply what I learned in the workshops, I perform my work faster and with better results	123	0	4.9	26	**54.5**	14.6	3.79	0.75
05. The quality of my work has improved in activities directly related to the theme of the workshops	124	0	7.3	27.4	**50.8**	14.5	3.73	0.80
06. The quality of my work improved even in those activities that did not seem to be related to the theme of the workshops	124	0	7.3	35.5	**47.5**	9.7	3.60	0.76
07. My participation in the workshops served to increase my motivation to work	124	1.6	10.5	18.5	**57.3**	12.1	3.68	0.88
08. My participation in these workshops increased my self-confidence. (I now have more confidence in my ability to run the job successfully)	124	1.6	12.1	34.7	**41.9**	9.7	3.46	0.89
09. After my participation in the workshops, I have more often suggested changes in work routines	123	1.6	13	28.5	**47.2**	9.7	3.50	0.90
10. These workshops I took made me more receptive to changes at work	124	0.8	4.8	20.2	**63.7**	10.5	3.78	0.73
11. The workshops I took benefited my co-workers	122	0.8	3.3	32	**50.8**	13.1	3.72	0.76

Legend: ***n***: total number of respondents, **TD**: totally disagree, **D**: disagree, **N**: neither agree nor disagree, **A**: agree, **TA**: totally agree, **M**: mean, **SD**: standard deviation

It is highlighted in table 2 that the professionals perceive that the contents of the workshops were used in the workplace and were able to take advantage of the opportunities to put into practice what was discussed in the workshops.

The following scheme was elaborated to represent the insertion of PHE in the different micro and macrostructural spaces in the health field, based on the experience from this study:

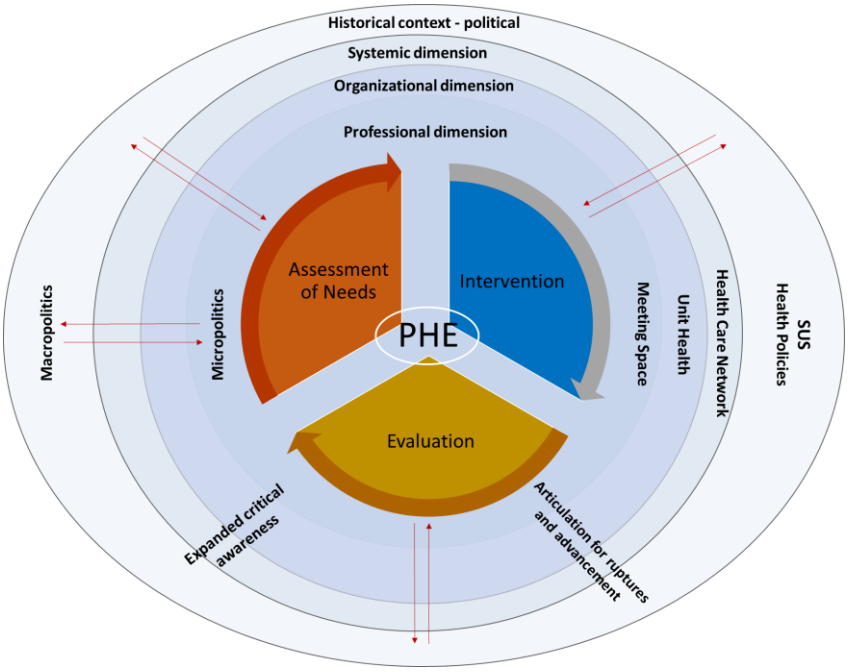

Figure 2. Micro and macrostructural spaces for PHE insertion in the health field. Sorocaba, 2021. Author: own

DISCUSSION

The research demonstrated that PHE is a possible practice and mobilizes attitudes of collective transformation. However, the need for PHE movements to be appropriated as a practice at different levels of management to implement their power, and not only in the micropolitical space, stands out. Movement analogous to the proposal, experienced in the study, is the cycle of systole and diastole of the heart, in its left ventricle. For the work process to be oxygenated and stay alive, two moments are necessary: the moment of diastole – referring to the reflection on the work (leaving the scene and discussing, researching, reflecting one's own practice); and the moment of systole: the act itself (daily work practice) that, once oxygenated by diastole, keeps the work alive, not dead.

The movements permeate all dimensions of care management, because, on the one hand, in the micropolitical space of the encounter this movement is essential and brings concrete changes, as demonstrated in the present research; on the other hand, the absence of articulation at broader levels of governability may restrict the oxygenation movement of living work.

Following the stages of this research, it is concluded that the survey and the analysis of the needs of educational interventions is one of the moments neglected in the practice of PHE in institutions. This study demonstrated that its realization is essential, since the engagement of managers in the analysis of training needs and instructional planning is fundamental for the success in increasing individual performance, teams and the entire organization[8].

We chose to develop this stage in a participatory way from the focus group meetings, because the more the work relationships are based on the dialogue, the greater the integration of health care actions[9]. Thus, discussing the issues that require intervention in the health work process increases the possibility of integration in the implementation of the proposed interventions, which represents greater power in the transformation process.

A question that is presented in this study and that coincides with the reality of many health services is: who will continue the built planning? Not always those who participate in the survey and analysis of needs and construction of the implementation plan, will be involved in carrying out the intervention. Hence the need for a well-structured process that results in a social

representation of the scenario experienced, so that the people who will continue the educational/reflective movements feel part, even if they have not participated in the beginning of the process.

Another highlight in the survey and needs analysis is the moment of meeting and discussions, which already has in itself potential for transformation. It is observed that the focus groups constituted opportunities for reflections that triggered changes in attitudes at work, even before the execution of the planned intervention. In addition, the return to the group of discussions and agreements held at each meeting, for recognition, validation and modification of what has been proposed, intensifies the empowerment of people and the democratization of decisions, as well as creates a process of recording PHE actions.

The results pointed to the need for intervention on impaired communication at work, a relevant theme in the scenario, with a strong Cartesian and authoritarian heritage. A study that aimed to analyze communication as a domain of collaborative interprofessional practice in health, in the context of the work process of PHC teams, highlighted as antidialogical aspects of communication, unilateral information in the work process, use of digital technologies and little meeting space. These aspects prevent communicative action as praxis[10]. The inclusion of diverse educational methodologies contributes to the sensitization of professionals to safe communication practices and minimizes ineffective communication[11].

Besides, opportunities in the technological dimension of health are evidenced, especially for the expansion and recognition of light and light-hard technologies, in which communication plays a prominent role in relationships[12]. The incorporation of information and communication technologies is a viable strategy for the qualification of work and management processes in health services in the SUS[13]. Specifically in primary health care, reflecting communicative practices in the context of light and light-hard technologies is central to triggering quality communication throughout the Health Care Network (RAS).

Regarding the implementation of the educational intervention plan, the research pointed out concrete challenges of making PHE a possible practice. As barriers, the following stand out: 1. absence of formal spaces for discussion at work that, when they exist in the form of team meeting space, are replaced by other demands or underutilized in their potential for collective construction; 2. lack of structure to deal with extraordinary health demands, such as the dengue epidemic, which was concomitant with the moment of the research, and which will always be present in the human reality, as there is today the pandemic of Covid-19; 3. inadequate dimensioning of the health workforce, with frequent changes of people in their functions to cover diverse needs; 4. initial resistance of people to participate in moments of discussion and collective construction, partly due to disbelief in the effectiveness of these meetings, partly due to work overload.

However, despite the barriers, the implementation of PHE movements was possible in the micropolitical space, culminating in the progress in the processes of change, as demonstrated in the results. Team meetings and other formal or formal moments of exchange can be understood as elements of the public sphere, since they aim to construct interprofessional agreements, that is, the co-management of social political commitments incorporated in the health work process[9].

In order to meet this reflection, the need for nursing leaders to support the development of the team's management, leadership, policy and decision-making skills was verified, in order to strengthen the provision of services and develop education and evidence-based practice[14]. Changes in the management model, an element inherent to the PNEPS proposal, are emphasized when thinking of PHE practices as strategic elements in shared health management and the search for quality and safety of health care.

This brings us to the issue of health management, in which the Triad of PHE, safety and quality is permeated by barriers, such as changes in managers, management priorities, organizational structure, fragmentation of the work process, devaluation of support services, specific educational practices and without professional integration and, consequently, with impacts on motivation, satisfaction and engagement in the processes of change[15].

The collegiate spaces, the support of managers, the monitoring of actions at the place of their realization and the paradigm shift based on the culture of PHE, safety and quality, from interdisciplinarity, are strategic needs for the strengthening of this triad. For this, participatory management models, based on horizontal power relations, are a prerogative for safe and quality care[15].

It is worth rescuing the dimensions involved in the management of care, presented by Cecilio[7], which fit in a relevant way to look at the different layers, in which the joints for transformation must occur, without succumbing to failure. The dimensions are: *professional* – meeting between health professional and user who refers to the micropolitics of work; organizational – includes the technical and social division of labor; and *systemic* - set of services, presenting different levels of technological incorporation and levels of complexity, with numerous flows necessary for a process of integral care. It is pointed out as one of the limitations of this research the performance of PHE, only in the professional dimension.

Regarding the moment of evaluation, it is worth mentioning that this is also a neglected moment in the practice of PHE. It is necessary to develop new studies to deepen the understanding of the elements that connect the evaluation criteria, because the concept of learning is multidimensional, and the processes that involve acquisition, retention, generalization, transference and performance after training interventions are complex and poorly studied[16].

Financial investments in TD&E stocks are very significant and require valuation and accountability. In Brazil, the adoption of adaptations of the integrated and soda evaluation model (MAIS) and the integrated model for assessing the impact of training at work (IMPACT) has supported research on the effectiveness of training and educational programs in various contexts([17]. It is necessary to evaluate and record the moments of PHE in health work. In this study, the reaction of participants in the PHE movement was quantified, with high satisfaction results.

The evaluation of knowledge in this situation is not relevant, after all, a structured model is not used to improve specific contents, so it is not appropriate to evaluate knowledge before and after the educational intervention. These are educational/reflective moments open to new possibilities for the construction of collective knowledge.

Another limitation of this study was the lack of application of the transfer support assessment, however, it is worth emphasizing the importance it has for the implementation of the changes built in the PHE process. It is in the support of the transference that the strength that the systemic macro issues have in the feasibility of sharing the knowledge constructed and reflected from the PHE, for the daily practice of health work. It is necessary to sensitize managers to the importance of supporting training[17]. Even if this is a view of the Area of TD&E, one can appropriate this reflection in the context of PHE, that is, support in the organizational and systemic dimensions is essential for the success of educational/reflective movements that occur in the professional dimension.

Finally, the impact assessment, which is essentially important to demonstrate how much educational investment in health work brings concrete results, especially in health indicators, would need continuity for effective measurement, which is also a limitation of the present study. Given the period we had to carry out the research, we chose to evaluate the perception of the impact on daily work, after the PHE movement developed, from the perspective of the participants. The results indicated a positive perception, with opportunities to practice what was discussed in the workshops and their use at work.

FINAL CONSIDERATIONS

In order to meet the objective of this research, the description of the needs analysis, execution and evaluation of an educational program, in the logic of PHE, demonstrated that, despite the challenges, this process is possible, and promotes dialogical and collaborative practices in daily health work.

The prioritized need was impaired communication and, during the execution of the educational program, the participants agreed agreements to overcome the identified problems. There was a perception of a positive impact on

the work process and they felt satisfied to participate in the PHE movement.

As a contribution, we present the steps for a possible practice of PHE that can be applied in other realities of health work with the appropriate adaptations. We highlight the need to break the neglect of the survey and analysis of needs and the evaluation of PHE movements, in addition to giving voice to these movements so that they are increasingly strengthened and expanded to other dimensions of health care management and, thus, sustain its essence of being an instrument for strengthening the SUS.

EDUCAÇÃO PERMANENTE EM SAÚDE COMO PRÁTICA POSSÍVEL: UMA EXPERIÊNCIA NA ATENÇÃO PRIMÁRIA

RESUMO

Objetivo: descrever o processo de análise de necessidades, execução e avaliação de um programa educativo na Atenção Primária à Saúde, na lógica da Educação Permanente em Saúde (EPS). **Método**: pesquisa-ação com abordagem mista, desenvolvida entre 2014 e 2016, com trabalhadores da saúde. A coleta de dados ocorreu nos encontros de grupo focal, oficinas do programa educativo e aplicação de questionários. Os dados qualitativos foram submetidos à análise de discurso do sujeito coletivo, e os dados quantitativos, à análise estatística descritiva. **Resultados**: a necessidade priorizada foi a comunicação prejudicada no ambiente de trabalho; e, durante a execução do programa educativo, os participantes pactuaram acordos para superação dos problemas identificados, a exemplo da criação de espaços de diálogo e fluxos definidos de comunicação. Sentiram-se satisfeitos em participar, e percebeu-se que o programa educativo causou impacto positivo no trabalho. **Considerações finais**: o objetivo de descrever todo processo da EPS foi alcançado. Houve maior estímulo para um movimento de transformação no processo de trabalho, em referência ao aprimoramento da comunicação na dimensão profissional da gestão do cuidado, a partir de um paradigma dialógico e crítico, capaz de ressignificar o processo de ensino-aprendizagem no trabalho. Como produto, tem-se um modo mais efetivo de operar a EPS.

Palavras-chave: Política de saúde. Educação. Capacitação de recursos humanos em saúde. Atenção primária à saúde.

EDUCACIÓN PERMANENTE EN SALUD COMO PRÁCTICA POSIBLE: EXPERIENCIA EN ATENCIÓN PRIMARIA

RESUMEN

Objetivo: describir el proceso de análisis de necesidades, ejecución y evaluación de un programa educativo en la Atención Primaria de Salud, en la lógica de la Educación Permanente en Salud (EPS). **Método**: investigación-acción con enfoque mixto, desarrollada entre 2014 y 2016, con trabajadores de la salud. La recolección de datos tuvo lugar en los encuentros de grupo focal, talleres del programa educativo y aplicación de cuestionarios. Los datos cualitativos fueron sometidos al análisis de discurso del sujeto colectivo, y los datos cuantitativos, al análisis estadístico descriptivo. **Resultados**: la necesidad priorizada fue la comunicación perjudicada en el ambiente de trabajo; y, durante la ejecución del programa educativo, los participantes pactaron acuerdos para superar los problemas identificados, a ejemplo de la creación de espacios de diálogo y flujos definidos de comunicación. Se sintieron satisfechos de participar, y se percibió que el programa educativo causó impacto positivo en el trabajo. **Consideraciones finales**: el objetivo de describir todo el proceso de EPS fue alcanzado. Hubo mayor estímulo para un movimiento de transformación en el proceso de trabajo, en referencia al perfeccionamiento de la comunicación en la dimensión profesional de la gestión del cuidado, a partir de un paradigma dialógico y crítico, capaz de resignificar el proceso de enseñanza-aprendizaje en el trabajo. Como producto, se tiene un modo más efectivo de operar la EPS.

Palabras clave: Política de salud. Educación. Capacitación de recursos humanos en salud. Atención primaria de salud.

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