

Centers for permanent healthcare education: an analysis on the experience of social players in the north of the state of Paraná¹

Pólos de educação permanente em saúde: uma análise da vivência dos atores sociais no norte do Paraná

Polos de educación permanente en salud: un análisis de la vivencia de los actores sociales en le norte del estado brasileño de Paraná

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ABSTRACT

The policy of continuing healthcare education (CHE) aims to develop healthcare workers. With the objective of analyzing the process of implementing and developing the policy in Paraná, a qualitative study involving the six regions of this state is being concluded. This paper relates to the results from the northern region, focusing on the "experiencing CHE" category. In December 2006, two focus groups were conducted involving representatives from management, training, attendance and participation. The data underwent thematic content analysis. The first CHE encounters aroused feelings of mistrust and resistance, and the center was understood as a means of enabling courses and funding sources. There was a diversity of interests and little negotiating capacity. During the process, the study participants began to talk, reflect and participate. Their teamwork was a positive experience. This experience allowed them to recognize the power of CHE for linking and mobilizing different players.

Keywords: Continuing healthcare education. Healthcare policy. Healthcare work. Continuing education.

RESUMO

A política de Educação Permanente em Saúde (EPS) destina-se ao desenvolvimento dos trabalhadores da saúde. Pretendendo analisar o processo de implantação e desenvolvimento da política no Paraná, uma pesquisa qualitativa, envolvendo as seis regiões do estado, está sendo concluída. Este artigo refere-se aos primeiros resultados da região norte, focalizando a categoria "vivenciando a EPS". Em dezembro de 2006 realizaram-se dois grupos focais, envolvendo representantes da gestão, formação, atenção e participação. Os dados foram submetidos a análise temática de conteúdo. Nas primeiras aproximações com EPS surgiram sentimentos de desconfiança e resistência e o polo foi compreendido como meio de viabilizar cursos e fonte de financiamento. Observaram-se diversidade de interesses e pouca capacidade de negociação. No transcorrer do processo, os integrantes do estudo começaram a conversar, refletir e participar. Experimentaram positivamente o trabalho em equipe. Esta vivência permitiu reconhecer a potencialidade da EPS em articular e mobilizar diferentes atores.

Palavras-chave: Educação permanente em saúde. Política de saúde. trabalho em saúde. Educação continuada.

RESUMEN

La política de Educación Permanente en Salud (EPS) busca el desarrollo de los trabajadores de la salud. Tratando de analizar el proceso de implantación y desarrollo de la política en Paraná, una pesquisa cualitativa comprendiendo las seis regiones del estado se está concluyendo. Este artículo se refiere a los primeros resultados de la región norte enfocando la categoría "viviendo la EPS". En diciembre de 2006 se realizaron dos grupos focales, abarcando representantes de la gestión, formación, atención y participación. Los datos se sometieron a análisis temático de contenido. En las primeras aproximaciones con EPS surgieron sentimientos de desconfianza y resistencia. El polo se comprendió como medio de viabilizar cursos y fuente de financiación. Se observó diversidad de intereses y poca capacidad de negociación. En el transcurso del proceso los integrantes que participaron del estudio empezaron a conversar, reflexionar y participar. Experimentaron positivamente el trabajo en equipo. Esta vivencia permitió reconocer la potencialidad de la EPS en articular y mobilizar diferentes actores.

Palabras clave: Educación permanente en salud. Política de salud. Trabajo en salud. Educación continua.

INTRODUCTION

In 2004, through the Ordinance no. 198/2004 of the Brazilian Department of Health, a National Policy of Continuing Healthcare Education (CHE – EPS, in Brazil) was instituted as a strategy from the Brazilian Unified Health System (SUS) to train and develop employees in this area (Brazil, 2004). The CHE (EPS) policy aims to transform professional practices and the organization of work itself, taking as reference the health needs of populations and the organization of sector management (Brasil, 2007a).

In order to develop this policy, there was the creation of Centers of Continuing Healthcare Education (CHE or Peps, in Brazil), and management teams composed on a “quadrilateral” basis that were constituted by: health state and municipal managers; instructors to work with institutions providing courses to health employees; health services represented by the employees in the area and by the social control or social participation movements in the health system (Brasil, 2004).

For Ceccim (2005^a), CHE can be defined as a pedagogical action with focus on daily health work practice and leads to auto-analysis and reflection on the process. CHE grows in the multi professional sense and in collective construction through experiences with new knowledge which can create new practices. Thus, “the policy of permanent healthcare congregates, articulates and puts in action/network different agents, providing everyone with a protagonist place in the conduction of local health systems” (Ceccim, 2005b, p.977).

In Paraná, for a bigger decentralization of the policy of CHE, twenty two Regional Centers of Permanent Healthcare Education were implemented in the regions covered by the Regional Health State Departments. After this implementation, each region – north, northeast, west, southern center, general fields and east – was in charge of the formation of an Expanded Center of Permanent Healthcare (Paeps in Brazil), expanding the discussions and actions of the CHE (Paraná, 2006).

After the spaces of discussion had been conquered, qualifying the individuals involved in the CHE proposal became a priority. In this sense, from the second semester of 2004 on, the Brazilian Department of Health (Ministério da Saúde – MS), in a partnership with the Brazilian National School of Public Health (ENSP), started an education process to train CHE instructors in the whole country (Ceccim, 2005).

Three years after the implementation of the CHE policy in Paraná – taking into account all the articulations and actions developed in the groups of discussion until the first semester of 2006 – knowing this process became important, especially at the moment the Ordinance n° 198/2004 of the Brazilian Department of Health was being revised. This process resulted in the publication of Ordinance 1.996 of the Brazilian Department of Health on the 20th of August, 2007. This ordinance establishes the current directions for the implementation of the National Policy of Permanent Healthcare Education (Brasil, 2007b).

With the objective of analyzing the process of implementation and development of the CHE policy in Paraná, a piece of research was proposed and has been developed. In its primary step, it comprises the six regions of the state – north, northwest, west, southern center, general fields and east – and, in its secondary step, it comprises the city of Londrina. The completion of the research – including both steps– was planned for March 2009. This article presents data from the north zone, considering that the research, whose data are systematized and analyzed, began in that area.

Methodological Route

This research makes use of the qualitative approach. According to Minayo (2006), the qualitative approach is concerned with a level of reality that can not be quantified, and deepens in the world of meanings of actions and human relations.

Focus groups were used as a method for data collection, and in order to moderate them, a script with questions that stimulated collective reflection and was allowed to be used in wheels of conversation was created. This script was validated by an expert and this data collection technique was selected because it favors the collective building of knowledge.

The guiding questions were developed in order to instigate a wide-ranged discussion, covering topics such as: the process of implementation of the centers, the understanding of the CHE policy, actions implemented, and the prospects for the future of the CHE policy.

As this article is related to the north zone of the state, the selection of participants was made by the coordinators of the five Preps (16, 17, 18, 19 e 22) that are part of the north Paeps. The researchers required individuals who had been treated in the centers since its implementation. There were four participants per Preps, in order to contemplate the different segments of the "quadrilateral" focus. This process resulted in the participation of the following individuals: six state managers, three teachers who represented the healthcare training institutions, five health workers who represented the health services, and two representatives of social control.

The data collection was carried out in Cornelio Procópio, head office of the 18th Regional Division of the State Health Department, in December 2006, in two focus groups. Each group comprised the representation of the five Preps and of the distinct segments represented in the centers. This option did not aim to obtain and analyze the speech by segments, but to allow the expression of parts in order to understand the whole in a CHE wheel of conversation.

The material from both groups was transcribed and analyzed by thematic analysis. As Bardin (1979, p.105) “ the theme is the unit of meaning that naturally emerges from an analyzed text, according to certain criteria related to the theory that guides the reading.”

According to Goldim’s guidelines (2000), the participants were identified by codes in order to ensure the confidentiality of their identities. In order to do so, each focus group was identified with the letters A and B, and its respective participants were numbered (A1, A2,...B1 etc.), considering the order they were presented in the groups.

The analysis was developed in three stages. At first, the material was organized and record units, units of context and categories were defined. In the second stage, the analysis of gathered material was deepened, and, in the third stage, the full analysis was consolidated.

From this process six categories emerged, and that resulted in a preliminary report. The categories "approximation with the CHE" and "formation of centers and articulations" described the process of implementing the five Preps and the Paeps in the north of the state. In the category "experiencing CHE" we can find two different feelings regarding the first contacts with the policy: understanding CHE and the experience in the centers. In the category "activities developed at the centers," we described the CHE actions carried out at the center and the development of a CHE teachers’ training course in the region. In the categories' “perceptions on the CHE process "and "future of the CHE policy", difficulties, needs, contributions and insights on the future of the CHE policy are expressed.

This article focuses on the category "experiencing CHE", an option considered relevant to start revealing the results of this research. The data from the remaining categories are being reanalyzed together with the data from the other five regions of Paraná, with the purpose of being made public later. This study followed the ethical principles defined in Resolution 196/96 (Brasil, 1996), and the project has been approved by the Ethics and Research Committee of the Universidade Estadual de Londrina (the State University of Londrina).

Results and discussion

In the category "experiencing CHE," the collective discourse of the individuals revealed: different feelings in the first contacts with the policy, the understanding of CHE, and experiences at the centers. These phenomena are presented in the following subcategories from which we have highlighted representative speeches.

Feelings emerged in the first contacts with the CHE project.

In the proposal of the CHE policy, while working with wheels of conversation there should not be an obligatory vertical command. Everyone can participate in the discussions. In the wheels, all agents may raise needs and collectively develop strategies that intend to interfere in the training and development of health workers (Brasil, 2005a). As the hegemonic practices in the process of health

work are individual and fragmented, this way of collective construction of actions to solve the problems emerged in the daily life seems to be something complex.

In their first contacts with the CHE, and also having little knowledge of the policy, the individuals reported that they had feelings of distrust, and, even, discredit on the process. These feelings were followed by resistance to the new, as demonstrated in the following speeches:

"There wasn't an understanding of the collective construction [...] there wasn't the understanding that this construction should happen. It is easier to receive something ready than to build it" (B3);

"This resistance that many people have against the centers and Permanent Healthcare Education, I think [...] is fear of change [...]. I think it's [...] fear of the unknown [...]" (A7).

Rosa (2003) states that the new almost always represents a threat to the order, to what has been established, already absorbed and accommodated, therefore, sometimes it is received with restrictions. The author also adds that this resistance is not related to the change itself, but to all the work that every change triggers, which consists in revisiting yourself. Morin (2002) also stresses that the new can cause rejection in individuals who, attached to certain theories, become unable to accept what is new.

In the field of CHE, the new stands out. There are no ready recipes and steps to follow. Thus, CHE will always be dealing with the unknown (Matumoto, Fortuna, Santos, 2006). But, despite the risks this contact with the unknown may represent, it is essential to be open to the new (Freire, 2006).

Receiving the new has become possible as the individuals experienced the CHE. Through participation in discussion groups, they reported that, gradually, these feelings and attitudes were changing, and some changes, even timid, took place in different workspaces. This can be emphasized by the following speech:

[...] We feel that some Regional Health Divisions have complained a lot that the PREPS have only come to disturb (our work) and it is not fair. It came to help us to work collectively, to make us leave those little boxes where we used to work in and that's where we can really work with demands, today we feel the work / service has better quality [...]. (B2)

The individuals' perception, experience and admission of existing discomforts related to their health practices that may effectively promote changes in the process of work (Ceccim, 2005a).

Understanding CHE and experiencing the centers / wheels of conversation

Since the CHE policy was instituted, events have been carried out in the Paraná in order to disseminate and clarify the proposal. Despite the fact that the individuals involved in the research highlighted the importance of these events to contribute to understand that the CHE was something that was not ready, but should be collectively built, difficulties resultant from local demands to understand the CHE not only as an instrument to carry out projects and courses, but as a process related to changing practices persisted:

"I thought it was a space in which we were going to have these partners, training; the city manager, the state manager to discuss and approve of the projects. That was my first idea" (A2);

"The biggest difficulty is to think that Permanent Education is not just a project, a course [...] The practice has to be changed" (A5).

These difficulties may be resultant from the individuals' experiences with offers of traditional courses, common in several program areas or in health care and surveillance policies. This type of training adds knowledge to renewed practices for the individuals to improve their skills and allow opportunities for them to get updated in order to perform their tasks with responsibility, which may be used, including, to learn the CHE. This process is part of the context of health workers. However, the CHE provides a new approach.

The Permanent/Continuing Healthcare Education (CHE) means learning at work, where teaching and learning are incorporated into the daily life of the organizations and the work itself. It is proposed that the training processes for health workers take as reference the health needs of individuals and populations, of healthcare management and social health control, and that they have as objective the transformation of professional practices and of their own work organization. It is

also expected that these processes are structured with basis on the problematization of the work process (Brasil, 2004, p.5).

Failure to grasp the objectives of the CHE by the various agents involved in the health system has made the operational space centers of this policy, initially, to be understood as bureaucratic structures created by the government to transfer financial resources.

This understanding has led institutions to get involved with the centers motivated by the opportunity to meet their immediate interests, and by the expectation that this space could make it possible for them to get financial resources for their projects:

"[...] I didn't understand what was going on, but I understood that there was a large financial interest on the part of the segments that were involved" (B7)," everyone was focused on the financial aspect" (A9);

"[...] what raised the interest of the city in the training process was the financial incentive [...] this was one of the points that made the city participate [...]" (B5).

The financial aspect was also one of the motivations for the representatives of other segments to participate. However, throughout the process, as the segments had their interests met, their representatives moved away from the centers, which demotivated the participation of other segments. A speech related to the removal of educational institutions is shown below:

[...] There is a distance from the centers because the educational institutions have implemented several courses outside the centers and they say that they are running these courses and they don't have any more time to participate in actions of the center[...]. It's because they have already got their part and some other sectors, especially the city halls, ended up [...] sort of getting away from the project. (B1)

That has not only happened in the centers analyzed in this study. Campos et al. (2006) reported that the lack of a systematized process to monitor the activities has made the centers to be seen as a source fund raising and financing projects. The same authors show the need of a decentralization of financial resources, i.e., to have a "fund-to-fund" transfer - from the National Health Fund to the Municipal or State Health Funds. This would facilitate projects' financing, however, it would not guarantee the follow-up of the activities implemented, which should be included in the projects through indicators of process and result evaluation, and their analysis should be in the final report.

Besides the financial aspect, there were other interests that motivated the participation in the centers.

"I think there were several interests that converged to the composition of the center. For example: the city wanted to train its employees without having this vision of service training, the training institutions wanted to sell their courses and enable the implementation of projects[...], the social control wanted its training [...], with the students who wanted more active participation, but also wanted to be trained [...]." (B1)

Merhy (1997) argued that when we arrive somewhere such as a Health Center, which has thirty employees, for example, we necessarily meet a deeply complex dynamics, considering the set of self-governments in operation and the interplay of interests organized as social forces. Within the centers, this was not different. There were several and, many times, contrasting interests that reflected the diversity of intentions and characteristics involved in collective work.

This diversity of interest and little capacity of negotiations among the individuals has arisen, in the wheels of conversation, authoritarian attitudes in a democratic space, as shown by:

"As if we were in a process of dictatorship and democracy [...].One makes a completely democratic discourse, but when it is time to make it effective, it must be 'this way'! We feel a bit used in this process, where you are invited to discuss, where you are invited to propose and then you are invited to legitimate. And ... look, you got acquainted to everything, but it has to be this way [...]." (B9)

The set of agents with individual and collective different interests within the centers, is affected and affects the proposal to change practices that was made by the police of CHE. According to Giovanella (1989), the social individuals, when incorporated in the State, become social agents, and if they work in health, they become health agents. In their actions, they make use of their capacities, and power, what turns them into social forces. In the development of health actions, a relationship

among the agents is created, a force field, which represents the tension generated by the different agents as they face an action proposed by any of them. The combination of these force fields defines the space where decisions, conflicts and health actions themselves take place.

According to the individuals involved in the study, the conflicts of interest present in the wheels of discussion, were not, in general, seen as part of the process of implementation of this policy, therefore, they were contested. Conflicts are often repudiated for causing turbulence and annoyance within the individuals; it is through them, however, that differences in a society that is committed to produce homogenization become evident.

Campos (2007) notes that conflicting processes are part of people's daily lives, and learning how to face them is a way to expand the capacity to analyze oneself, the others and the context, and, consequently, to increase the possibility to act in these situations. Thus, as conflicts are faced, "they bring with themselves the possibility of inclusion and production of change, moving people away from a conservation zone to a zone of transformation " (Brasil, 2005b, p.100).

Sharing and reflecting upon actions collectively makes it possible for people to share positive experience and to ease frustrations. Thus, as the participants could understand the proposal of the CHE, throughout several meetings organized in the centers; they began to participate, to listen, to talk and to respect the others' ideas.

"I remember that at first the staff wouldn't come. From the time they started listening [...], I felt that they really began to participate, to discuss more, and to really bring the real problems [...]." (A9)

"I remember a certain time in the meeting, everyone was losing their patience, nobody was used to talking. Ah! Let's divide the budget [...]. And, deep inside, I think that each one of us wanted that. Let each one take care of his/her life [...]. And now after these four years [...] we talk." (A1)

When they started dealing with daily problems, they started to be more interested in the wheels of conversation process. Vasconcellos (1995) states that learning requires the object of knowledge to have some meaning to the individual, being, therefore, part of his/her reality. Cavalcanti (1999) adds that adults are more likely to learn something that contributes to their professional activities or to solve real problems, which means that the strongest motivations for adult learning are internal; the ones related to: satisfaction by work done, better life quality, and elevation of self-esteem. Within this framework, the policy of CHE may be considered one of the instruments that drives the construction of learning spaces, for which the participants bring: their experiences, barriers emerged from work processes and the real health needs of the population; and build their knowledge collectively.

Through dialog, positive statements related to the commitment to work and to the CHE emerged, as expressed in:

"The one who is committed to work [...] certainly identify him/herself with permanent health education " (A8);

"[...] When we talk about centers, I don't think of courses, I think of reflection momentes "(B9).

For Freire (2001), the act of committing oneself means to be able to reflect, act and reflect. The commitment helps the subject to expose his/her way of being and thinking politically and shows his/her engagement with the reality. When experiencing it, the man abandons neutrality, which only reflects the fear of commitment (Freire, 2006), a very close position to what Merhy (2005) called the "pedagogy of implication."

The individuals involved in this research reported that the centers provided experiences of teamwork processes:

[...] What I found most interesting was teamwork; that was what motivated me the most. We from social control, state management, city management, everyone together, trying; no one knew anything, [...] everybody had difficulties to understand, it was growing, from general services workers to the medical doctor, everyone heard the same thing [...] (B5).

Although, in these movements, some difficulties may come out, once, in a team, several relations of affection, as well as power, work, social and cultural relations are arisen, and they create different

ways of thinking and acting (Brasil, 2005b); it is necessary to insist, because as horizontal work takes place in a team, it's possible to break hegemonic concepts (Adams, Mishima, 2001).

Teamwork provides individuals with complementary skills and knowledge to commit themselves to achieve a common goal, defined by negotiations and agreements among the ones involved in the process (Ribeiro, Pires, Blank, 2004; Almeida, Mishima, 2001; Piancastelli, Faria, Silveira, 2005). This allows the elaboration of pedagogical, social and therapeutic projects that are designed to meet the real health needs of a person / family / group / population within the Brazilian Unified Health System - SUS (Brasil, 2005b).

Farah's study (2006), carried out with professionals of the family health team and professionals of federal, state and regional spheres, also recognized in CHE an opportunity to strengthen the SUS (Brazilian Unified Public Health System).

The result of this study and the experiences lived and reported by the individuals involved here confirm Ceccim's statement (Ceccim, 2005b), as it recognizes the capacity of the CHE policy to articulate and mobilize different agents, giving all of them the role of protagonists/individuals in the conduction of health systems within the Brazilian Unified Health System - SUS. The same author, together with Merhy and Feuerwerker, values the political aspect of the CHE by stating that its implementation is essential for the consolidation of the Brazilian Unified Health System - SUS (Merhy, Feuerwerker, Ceccim, 2006).

Final Remarks

When writing this article, an effort was made to present the dynamics of the social agents' experience in the centers of CHE in northern Paraná. However, due to the variety of information generated in this process, it would not be possible to record all the events.

In the centers/ wheels of conversation, the individuals experienced discomfort, made conflicts explicit and lived experiences that provided conditions to overcome the initial understanding that these spaces were a mere source to raise funds to finance projects. This process has also enabled them to perceive the CHE as a process that is related to change in practice, possible to be implemented based on the problematization of the work process.

These experiences also allowed the recognition and respect for differences by providing opportunities to listen, talk – and dialog.

There was, above all, the recognition of the CHE's ability to articulate and mobilize agents - managers, trainers, health workers and individuals involved in social movements and social control – who, by bringing their experiences to the spaces of the center, gave this strategy the meaning of a possibility for/or collective construction of knowledge.

It is essential to notice that during the research at the centers in Paraná, and later, in the data collection in the north zone, important events happened involving the CHE policy.

With the Covenant for Health Care in 2006, managers, represented by the Conselho Nacional de Secretários de Saúde (Conass) – (National Council of Health Departments) and the Conselho Nacional de Secretarias Municipais de Saúde (Conasems) – (National Council of Municipal Health Departments), discussed the importance of the centers to be consolidated in the Brazilian Unified Health System (SUS). This movement, together with the recommendations of the 3rd National Conference on Management of Work and Health Education (3rd CONAGETES) - resulted in the content of Ordinance no. 1996 from August 20, 2007 of the Brazilian Department of Health, which replaced the assignment of the Center for Permanent Committees of Health Learning-Service Integration (Polo pelas Comissões Permanentes de Integração Ensino-Serviço em Saúde) - (Cies), as stated by the Federal Law 8080/90 (art. 14), related to the CGRS- Colegiados de Gestão Regional em Saúde (Health Regional Management Collegiates). That was a way to put into practice the assignment aimed to regionalize and create hierarchies in the Brazilian Unified Health System (SUS) in a single system network, based on comprehensiveness, decentralization and popular participation.

The changes introduced by this project indicate a positive prospective to improve the National Policy of Permanent Healthcare Education - one of the major strategies to strengthen the Brazilian Unified Health System (SUS).

Collaborators

The authors Sônia Cristina Stefano Nicoletto, Fernanda Freitas Mendonça, Vera Lúcia Ribeiro de Carvalho Bueno, Eliane Cristina Lopes Brevilheri, Daniel Carlos da Silva e Almeida, Lázara Regina de Rezende took part of this research from the elaboration of the project to the final draft of this article. The authors Gisele dos Santos Carvalho e Alberto Durán González participated from the data collection phases to the final draft of the article. The author Marcio José de Almeida followed the research from the elaboration of the project to the final draft of the article as the coordinator of Grupo de Pesquisa em Desenvolvimento de Recursos Humanos em Saúde (GPDRHS/ CNPq) – (Research Group of Human Resources Development in Health), from which all the authors of this article are members.

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