

CONTINUING EDUCATION IN PRIMARY HEALTH CARE: COMPARATIVE QUANTITATIVE EVIDENCE

Educação permanente em saúde na atenção primária: evidências quantitativas comparadas

Educación continua en atención primaria de salud: evidencia cuantitativa comparativa

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ABSTRACT

This descriptive-analytical and quantitative study aimed to evaluate the perspective of Primary Health Care workers on the practice of Continuing Health Education. Participants included 262 workers from Family Health Units and traditional Basic Health Units. Among the participants, approximately 72% had participated in continuing education activities in the six months prior to the research. Only 43% regularly participated in at least one activity per month. Workers from Family Health Units participated in a greater number of continuing education activities than workers from traditional Basic Health Units and had a better perception of the practical impact of these activities on their work and on interprofessional experience. Many workers did not have access to continuing education activities, especially those from traditional basic units. The need to expand access to continuing health education is highlighted, with special attention to supporting traditional units.

Keywords: Education Continuing. Primary Health Care. Family Health Strategy.

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RESUMO

Estudo descritivo-analítico e quantitativo com o objetivo de avaliar a perspectiva dos trabalhadores da Atenção Primária à Saúde sobre a prática da Educação Permanente em Saúde. Participaram 262 trabalhadores de Unidades de Saúde da Família e de Unidades Básicas de Saúde tradicionais. Dentre os participantes, cerca de 72% participaram de atividades de educação permanente, nos seis meses anteriores à pesquisa. Apenas 43% participavam regularmente de ao menos uma atividade ao mês. Os trabalhadores das Unidades de Saúde da Família participaram de maior número de atividades de educação permanente que os trabalhadores das Unidades Básicas Tradicionais e tiveram melhor percepção sobre o impacto prático dessas atividades em seu trabalho e sobre a experiência interprofissional. Muitos trabalhadores não tinham acesso às atividades de educação permanente, especialmente os trabalhadores das unidades básicas tradicionais. Destaca-se a necessidade de ampliar o acesso à educação permanente em saúde, tendo especial atenção ao apoio às unidades tradicionais.

Palavras-chave: Educação permanente. Atenção primária à saúde. Estratégia saúde da família.

RESUMEN

Este estudio descriptivo-analítico y cuantitativo tuvo como objetivo evaluar la perspectiva de los trabajadores de Atención Primaria de Salud sobre la práctica de la Educación Continua en Salud. Participaron 262 trabajadores de Unidades de Salud de la Familia y Unidades Básicas de Salud tradicionales. Entre los participantes, aproximadamente el 72% había participado en actividades de educación continua en los seis meses anteriores a la investigación. Solo el 43% participó regularmente en al menos una actividad al mes. Los trabajadores de Unidades de Salud de la Familia participaron en un mayor número de actividades de educación continua que los trabajadores de Unidades Básicas de Salud tradicionales y tuvieron una mejor percepción del impacto práctico de estas actividades en su trabajo y en la experiencia interprofesional. Muchos trabajadores no tuvieron acceso a actividades de educación continua, especialmente aquellos de unidades básicas tradicionales. Se destaca la necesidad de ampliar el acceso a la educación continua en salud, con especial atención al apoyo a las unidades tradicionales.

Palabras clave: Educación Continua. Atención Primaria de Salud. Estrategia de Salud Familiar.

INTRODUCTION

The creation of the Secretariat for Labor Management and Education in Health (SLMEH) of the Ministry of Health (MH)¹, and the establishment of the National Policy for Permanent Education in Health (NPPEH)² were milestones in the federal policy for the development of Permanent Education in Health (PEH) in Brazil.

The National Policy for Professional Development in Health (NPPEH) defines PEH as learning at work, where the act of learning and teaching is integrated into the daily experiences of workers in health organizations. PEH utilizes meaningful learning, problem-solving, and reflection on the work process. Its activities should start from the workers' prior knowledge and aim to solve problems faced in real-world scenarios, considering the health demands of individuals and populations³. Thus, PEH aims at the professional development of workers and the improvement of the quality of care provided to users of the health system.

There is a clear alignment between this definition of PEH and the thoughts and theory on youth and adult education of the educator Paulo Freire. The "Paulo Freire" Learning Method advocates that the educator-learner relationship be horizontal, where there is no transmission of knowledge from one to the other, but rather an exchange of knowledge that occurs through a dialogical process, employing active methodologies. The educator should be an encourager of debates and not a simple transmitter of information. The learning process should awaken the learner's critical awareness for the development of a real, not magical or fantastical, perception of their environment and their role in society and their work. The perspective is that, based on the knowledge learned, those involved develop critical thinking, proactivity in decision-making, empathy, and collaborative practices that generate transformations in their life and work context^{4,5}.

Globally, discussions are developing regarding the interface between PEH (Permanent Education in Health) and Interprofessional Education (IPE). According to the WHO, IPE is a practice of PEH and occurs when two or more professionals learn about something or learn from each other in order to improve the quality of services provided⁶. Therefore, due to the characteristics of the work process in Primary Health Care (PHC) within the Brazilian Unified Health System (BUHS), which is strongly based on multiprofessional teamwork, it is believed to be a fertile ground for the development of PEH⁷.

It is recognized that public health systems oriented towards primary health care, such as the BUHS (Brazilian Unified Health System), require workers to have extensive theoretical and practical knowledge of health management, care for families, individuals and populations, addressing the social determinants of health, territorialization, and social participation. This knowledge is not commonly offered in training courses, whether technical or undergraduate, for health professions, and is acquired by workers after their initial training. In this context, PEH (Continuing Education in Health) presents itself as a powerful learning strategy for primary health care workers⁸.

In the Brazilian Unified Health System (BUHS), despite the Family Health Strategy (FHS)⁷ being the priority and substitute model for the expansion and consolidation of Primary Health Care (PHC), at least two types of health establishments still coexist. The Ministry of Health defined Basic Health Units (BHU) as establishments that offer PHC services and actions but do not have Family Health Teams (FHT). Family Health Units (FHU), on the other hand, have at least one SF team, with a minimum workload of 40 hours per week, 5 days a week, for 12 months of the year⁹. BHU and FHU are formed by teams with different backgrounds, especially regarding the medical category. The contrasts in the composition of the teams and in the work processes of these PHC units lead to different experiences for workers and users.

National and international scientific literature on PEH lacks research that uses quantitative methods to describe this practice in primary health care. This study aimed to analyze the knowledge of primary health care workers about the PEH policy of the Brazilian Unified Health System (BUHS) and to characterize collective and interprofessional experiences of PEH in primary health care.

METHOD

This is a descriptive-analytical study with a quantitative approach, carried out in traditional primary health care units and family health units of the public health system of a municipality in São Paulo.

According to the Demographic Census (IBGE, 2022), the municipality had a population of 698,259 inhabitants and, in its primary health care network, had 41 health units, including traditional primary health care units and Family Health Strategy units, distributed across five health districts. Some family health units had more than one family health team. Mixed health units, which simultaneously offer primary and secondary care, were not included in the study in order to avoid the participation of professionals linked to secondary care.

Participants included professionals from the following categories: physicians, nurses, nursing technicians and assistants, dental surgeons, oral health assistants, pharmacists, pharmacy assistants, community health workers, and university-level professionals.

After selecting the professional categories and units that met the inclusion criteria, a total of 1,233 potential participants were identified. The sample size calculation, considering a 95% confidence level, a 5% sampling error, and a homogeneous distribution, estimated a sample of 206 participants. The sampling method used was non-probabilistic convenience sampling. Workers who were absent during the data collection period were excluded.

Only two health units refused to participate in the study. Among the participating units, only the Family Health Unit located in the rural area was not visited. In total, 38 units (92.7%) were visited by the principal investigator, with an average stay of one hour at each location to publicize the research and encourage participation.

In the literature review, no structured and validated instrument was identified that assessed the knowledge, participation, and perception of health workers regarding the National Policy for permanent education in health (NPPEH). Therefore, the researchers developed their own electronic data collection instrument, based on the current public policy on Health Promotion^{10,11}. The instrument was submitted to content validation by a panel of ten judges with recognized expertise in the field of Health Promotion. Researchers with a research line aligned with the theoretical framework of Health Promotion, as indicated in their Lattes curriculum or in scientific publications in the area in the five years prior to the development of the instrument, were considered eligible as judges.

The assessment questionnaire for the instrument intended for judges was built on the REDCap¹² platform and answered remotely, via the internet, through electronic acceptance of the Informed Consent Form. The instrument went through two cycles of evaluation and adjustments before reaching its final version.

The questionnaire was made available to workers through the REDCap platform, after electronic acceptance of the Informed Consent Form. Data collection took place in June and July 2022.

Three hundred twelve (312) workers responded to the questionnaire. Responses from participants who failed to answer more than two questions were considered valid for analysis. Thus, the final sample consisted of 262 workers.

Data analysis and the creation of tables and graphs were performed using Jamovi^{13,14} and Microsoft Excel (2019) software. Statistical tests were selected according to the analytical objectives of each variable. For comparative analyses between BHU and FHU regarding participation in permanent education in health activities and in planning and evaluation meetings, only responses from workers with a minimum of one year of service on their current team were included.

The study was approved by the Research Ethics Committee (CAAE No. 34946520.8.0000.5414; Opinion No. 4.323.233) and authorized by the Municipal Health Department, and it is part of a master's thesis.

RESULTS

Of the 262 participants, two did not indicate the care model of their team. The average age of the workers was 43.6 years, with the youngest being 22 years old and the oldest 70 years old. The average length of service in the current team was 6.3 years, ranging from less than 1 year to 32 years of service. One worker did not indicate whether they held the position of team manager/coordinator. Twenty participants (7.7%) identified themselves as team managers/coordinators, and 239 identified themselves as workers responsible for direct user care (92.3%). The majority of participants worked in Family Health Strategy (FHS) teams (69.6%) and had been in their current team for more than 1 year (79.2%) (Table 1).

Table 1 - Frequency of participants according to length of service in the current team and type of assistance modality, Ribeirão Preto, SP, 2022.

ASSISTANCE MODALITY	PARTICIPANTS				TOTAL	
	LESS THAN 1 YEAR		1 YEAR OR MORE		No.	%
	No.	%	No.	%		
BHU	28	51.9	51	24.8	79	30.4
FHU	26	48.1	155	75.2	181	69.6
TOTAL	54	100	206	100	260	100

Source: Author

All professional categories of interest to the study participated. The largest professional group was the community health workers, representing 32.6% of the total, and the smallest group was the dental assistants, with 1.5% of the participants (Table 2).

Table 2 - Frequency of participants according to professional category and type of assistance modality, Ribeirão Preto, SP, 2022.

Professional category	Assistance Modality				Total	
	BHU		FHU		No.	%
	No.	%	No.	%		
Community health worker	6	7.6	79	43.5	85	32.6
Dental assistant	3	3.8	1	0.6	4	1.5
Pharmacy assistant	4	5.1	5	2.8	9	3.5
Dentist	6	7.6	9	5.0	15	5.8
Nurse	15	19.0	25	13.8	40	15.4
Pharmaceutical	2	2.5	4	2.2	6	2.3
Doctor	14	17.7	28	15.5	42	16.2
Others	2	2.5	13	7.2	15	5.8
Nursing technician/assistant	27	34.2	17	9.4	44	16.9
GRAND TOTAL	79	100	181	100	260	100

Source: Author

Approximately 72% of workers participated in a professional development activity in the last six months, and 43% regularly participated in at least one activity per month. Workers from Family Health Units (FHU) reported participating more in professional development activities, both occasionally (in the last six months) and routinely (at least one activity per month), than workers from Primary Health Care Units (PHCU) (Figure 1).

It was found that 75% of respondents participated in at least one health planning activity in the last six months and that 60% participated in health evaluation activities. Workers from Family Health Units (FHU) reported participating more in health planning and evaluation activities than those from Primary Health Care Units, and all results showed statistical significance (Figure 1).

Knowledge about the National Policy for permanent education in health (NPPEH), its funding, and the coordination of permanent education in the health by the Municipal Health Department (SMS) was widespread among workers, and there were no statistically significant differences between workers from the Family Health Units (FHU) and the Basic Health Units (BHU) (Figure 2).

Interprofessional collaboration in PEH was addressed through two questions. Approximately 71% of workers reported that all professions had the opportunity to participate in PEH activities, and 82% reported that there was effective interaction among professionals. In the Family Health Units (FHU), participants perceived that all professional categories had greater access to PEH and that there was greater interaction among workers when compared to those in the Basic Health Units (BHU). The differences were statistically significant (Figure 2).

Approximately 96% of workers indicated an interest in PEH activities. Furthermore, 81% found it possible to schedule one hour per week for PEH. Neither perception differed significantly different between FHU and BHU. However, the perception of FHU workers regarding the importance of PEH activities for professional practice was more positive (87% FHU vs. 68% BHU) (Figure 2).

Regarding the difficulties in implementing PEH practices, the majority (75%) agreed that the team is understaffed in relation to the workload. There was no significant difference between the two care modalities (Figure 2).

Approximately 60% of participants indicated that other workers did not give due importance to PEH, and this response was similar among the respondents (Figure 2).

When comparing responses regarding the impression that health team managers/coordinators did not value PEH (Parment education in health system), it was found that the majority (66% in BHU and 79% in FHU) disagreed with this statement. The difference was significantly more favorable for FHU (Figure 2).

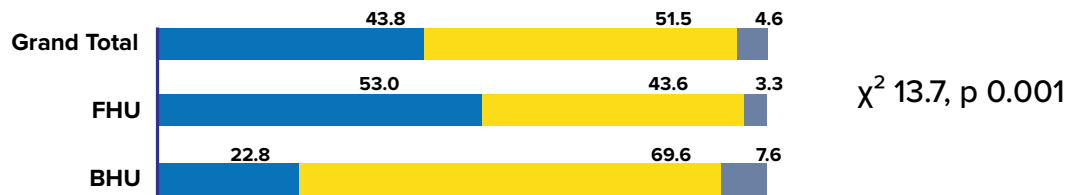
Approximately 81% of workers saw the possibility of including one hour per week in their schedules to practice PEH, and there was no significant difference between the units (Figure 2).

Figure 1 - Comparison between BHU and FHU regarding participation in continuing health education activities and health planning and evaluation meetings (data in percentage), Ribeirão Preto, SP, 2022.

I have participated in at least one continuing education activity in the last 6 months.



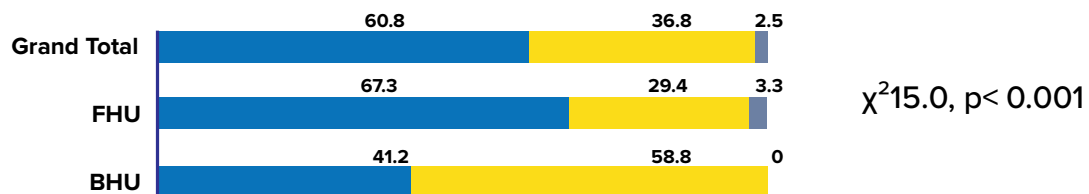
I participate in at least one continuing education activity per month.



I have participated in at least one activity planning meeting in the last 6 months.



I participated in at least one meeting to evaluate activities carried out in the last 6 months.

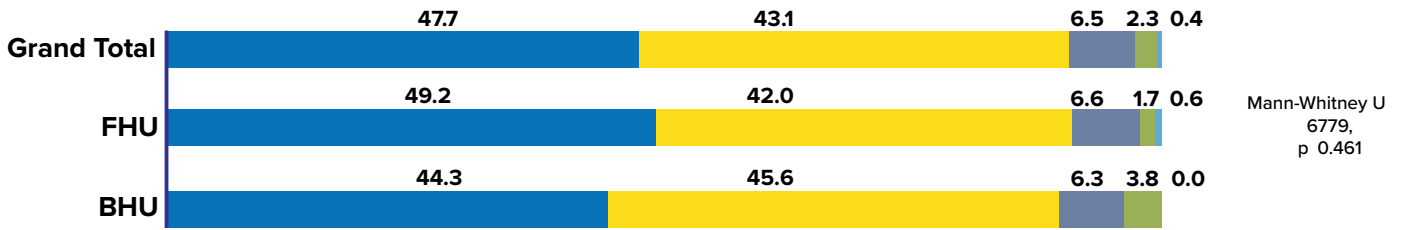


Caption YES NO I DO NOT KNOW

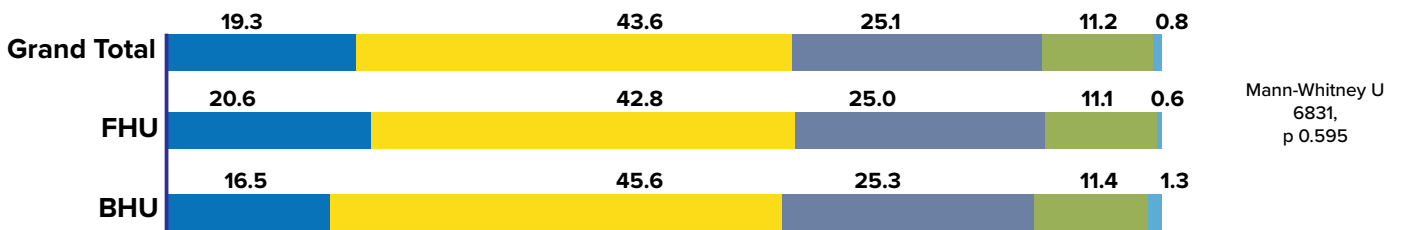
Source: Author

Figure 2 - Comparison between BHU and FHU in relation to general responses to the research instrument (data in percentage), Ribeirão Preto, SP, 2022.

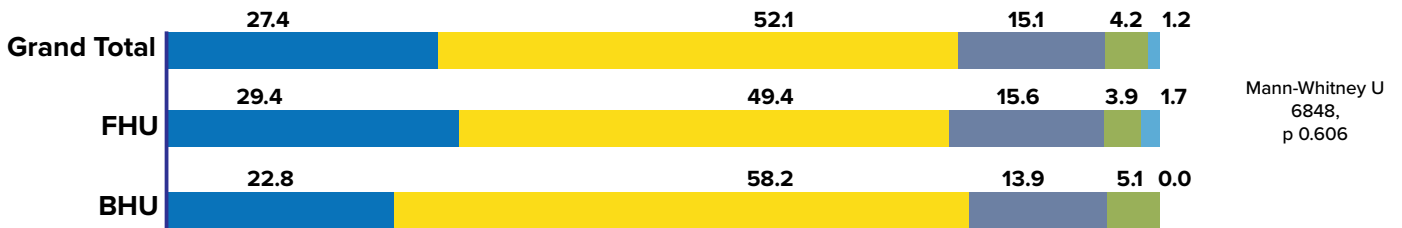
Continuing Education in Health is the subject of a national policy in the area of Health Care in Brazil.



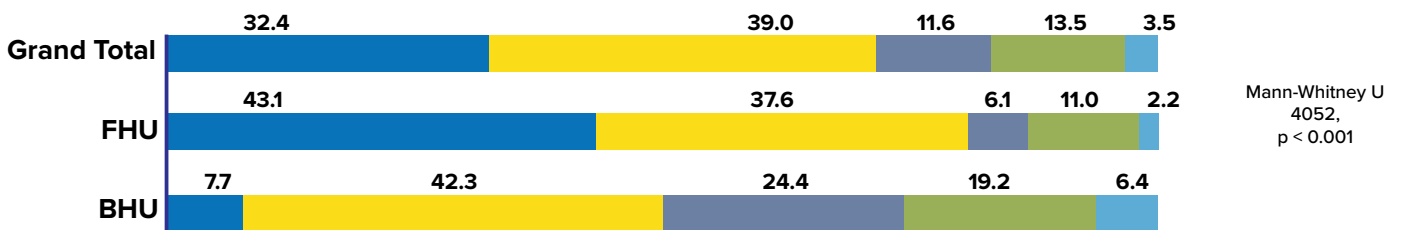
There are financial resources available for states and municipalities to develop continuing health education activities for BUHS (Brazilian Unified Health System) workers.



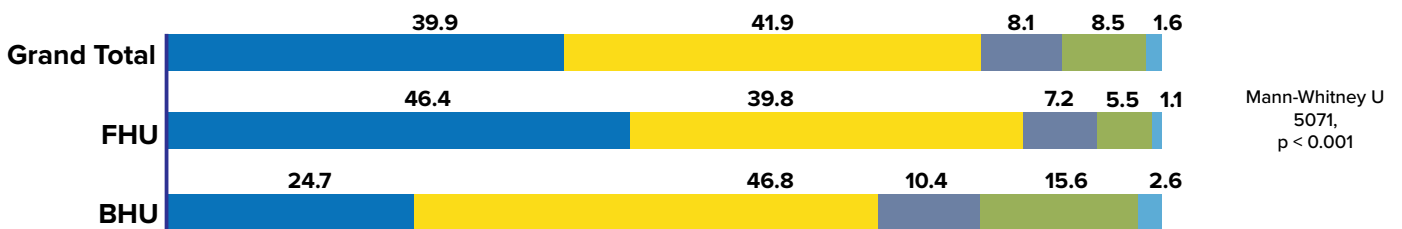
In the Municipal Health Department of Ribeirão Preto, there is a group of workers responsible for developing and conducting continuing education activities for BUHS (Brazilian Unified Health System) workers.



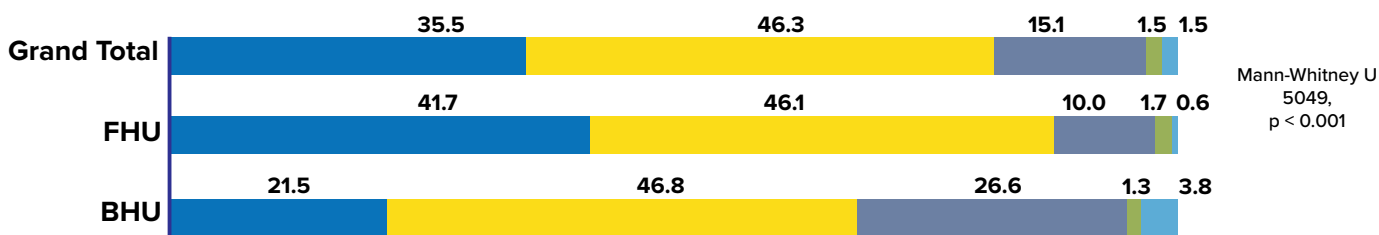
In the continuing education activities at my unit, all employees, regardless of their profession, have the opportunity to participate.



In the continuing education activities at my unit, all employees, regardless of their profession, have the opportunity to interact with each other.



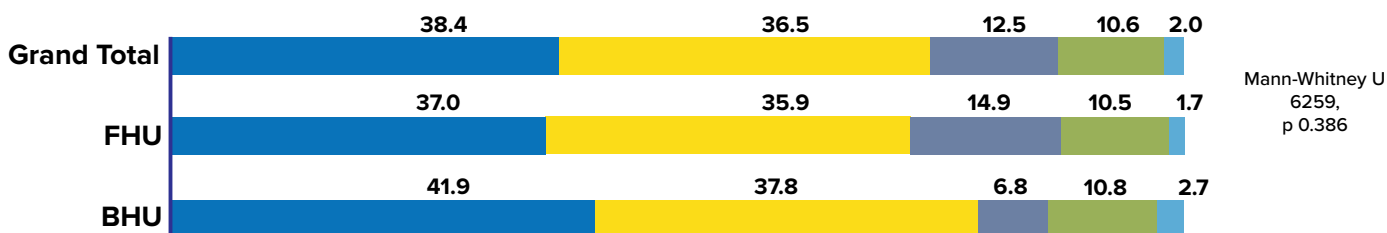
Regarding your opinion on the Continuing Health Education activities in your unit in which you participated, please answer: They were useful and improved the quality of my work.



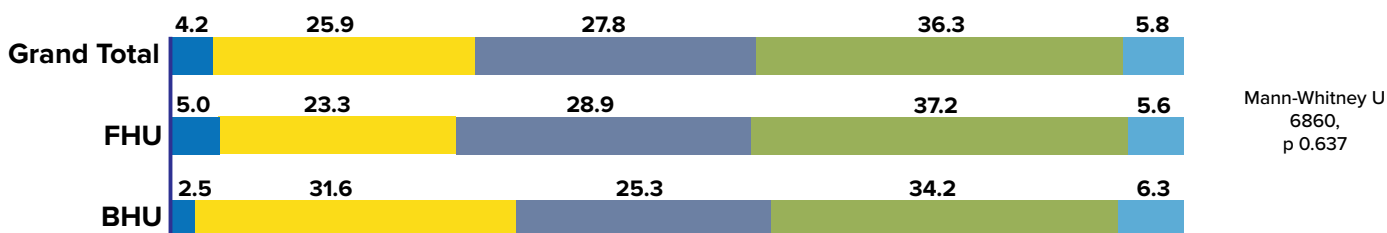
Regarding your opinion on the Continuing Health Education activities in your unit in which you participated, please answer: I think it's important and I'm interested in participating in Continuing Education activities.



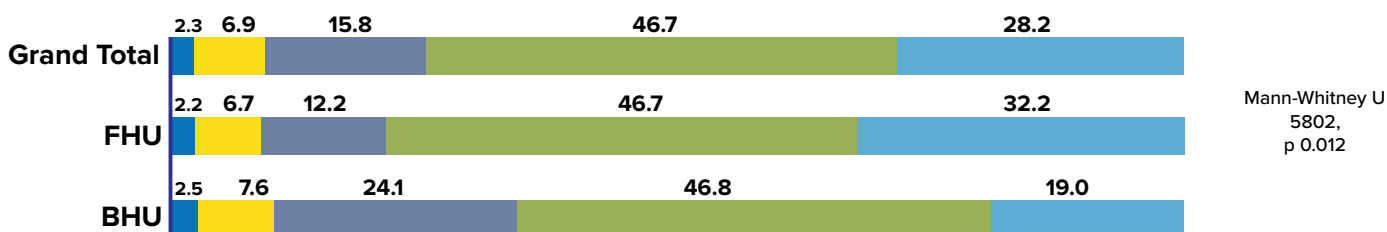
Regarding the difficulties in carrying out Continuing Health Education activities in your unit, please answer: We have fewer workers than would be necessary to care for our patients.



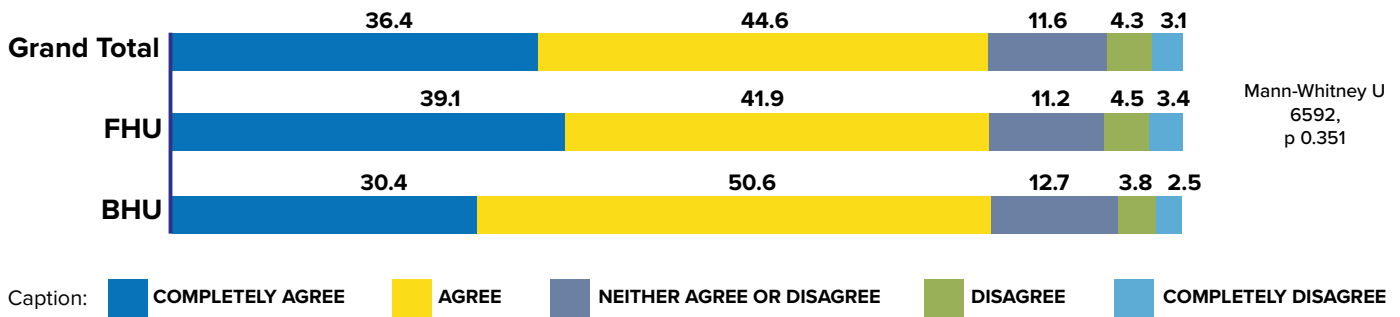
Regarding the difficulties in carrying out Continuing Health Education activities in your unit, please answer: The workers do not value Continuing Education activities.



Regarding the difficulties in carrying out Continuing Health Education activities in your unit, please answer: The manager/coordinator does not value Continuing Education activities.



Regarding the difficulties in carrying out Continuing Health Education activities in your unit, please answer: I think it would be possible to reserve one hour per week in my schedule to participate in Continuing Education activities.



Source: Author.

DISCUSSION

Significant differences were found in the experience of PEH (Parent Education in Health) between workers in Family Health Units (FHU) and traditional Basic Health Units (BHU), with a more favorable situation for the former.

The results indicated that not even half of the participants had the opportunity to participate effectively and routinely in PEH activities, as recommended by the NPPEH. This finding was similar to that of the research on professional training for work in PHC settings¹⁵. Another study found a better evaluation, in terms of staff training, among FHU workers compared to those in other PHC services¹⁶.

A study with primary health care physicians and nurses showed that 72% of primary health care workers stated that their units offered continuing education activities, while 84.7% of professionals from family health units responded positively. Another important finding of this investigation is that workers from units that practice continuing education assigned a High Overall Score to Primary Health Care on the PCATool at a prevalence ratio of 1.73 compared to others (95% CI 1.22 – 2.46, p = 0.002). This was the variable among all those involved in the study that demonstrated the greatest influence on the positive evaluation of professionals¹⁷.

Researchers studying factors that contribute to the implementation of PEH (Parent Education in Health) found that the habit of holding participatory planning meetings by the team is a positive factor for PEH activities¹⁸. This likely explains the results found, indicating greater participation of FHU (Family Health Units) workers in PEH, planning, and health evaluation activities. From this perspective, other authors have described health planning as a critical node in PHC (Primary Health Care), as its absence leads to the following negative consequences: lack of recording and evaluation of health actions, team disaggregation, fragmentation, and discontinuity of health actions¹⁹.

Primary Health Care Units (PHCU) and Family Health Units (FHU) workers reported similar levels of knowledge about the National Policy for Permanent Health Education (NPPEH), despite the relatively short existence of this policy. Conversely, the fact that only slightly more than half of the workers were aware of the possibility of funding for PEH indicates that they do not possess a comprehensive understanding of this public policy. There is often some confusion between the concepts of permanent education and continuing education in health^{20,21}. The concept of PEH began to be debated in Brazil, in conjunction with the Pan-American Health Organization, in the 1980s, and the NPPEH was established less than 20 years ago. It is emphasized that the concept of PEH is considered fundamental to the development and improvement of the BUHS (Brazilian Unified Health System), due to its primary purpose of improving health practices²².

It is noteworthy that one-fifth of respondents were unfamiliar with the municipal PEH coordination office. In these two questions, there was no significant difference between BHU and FHU. This demonstrates the

need for greater integration between this coordination office and the workers, so that the needs of the health teams can be identified and inform the development of the local management's action plan for PEH.

Regarding interprofessional, the perception in Family Health Units (FHU) was more positive than in Basic Health Units (BHU), indicating a possible greater professional interaction in Family Health. The concept of interprofessional education (IPE) emerged in the WHO in 1973 and was addressed in 1978 at the Alma Ata meeting²³. A report published by the WHO defined IPE as a priority for the development and sharing of knowledge among different health professions to meet the health needs of the population, based on teamwork²⁴. Research conducted with primary health care workers identified that interprofessional, expressed through collaborative practice, produces a more friendly work environment, better quality of care, and a feeling of security for professional practice²⁵.

The perception of the applicability of PEH activities was more positive among FHU workers, a result that aligns with the findings of Marin, Marchioli, and Corrente¹⁵. This evidence highlights the fact that the concept of PEH is based on the daily demands of the teams, the pedagogy of problematization, expanded participation, a strategic approach, and interprofessional²⁶. From the results of this study, it can be inferred that FHUs used these precepts more effectively than BHUs in the planning and development of PEH.

Indeed, it is observed that the practice of IPE, as a practice of PEH, constitutes a complex task. The main barriers to IPE are the isolated work of professionals; small teams; a strong hierarchical culture and care centered on the professional instead of being centered on the person being cared for. Another difficulty for its implementation and, consequently, of IPE in health services comes from the training of workers in technical and undergraduate courses, which only recently began discussions on how to develop interprofessional actions in their curricula, that is, this process is incipient²⁷.

Approximately three-quarters of respondents indicated that the team was understaffed in relation to the demands of the population under their health responsibility. No significant differences were found in this regard between the different types of care. Official data from the local BUHS (Brazilian Unified Health System) management indicate low coverage of Primary Health Care (PHC) and Family Health Strategy (FHS) in the municipality, impacting population care and overloading workers²⁸. The excessive workload is an obstacle to achieving PEH (permanent education in health), corroborating the findings of this investigation¹⁸. A study showed that approximately 87% of PHC workers reported attending to more patients than the team was able to handle¹⁶. Furthermore, it indicated that approximately 70% were not adequately trained to perform new procedures or participate in knowledge updates. It concluded that approximately 60% believed they were being asked to perform tasks for which they had not been properly trained¹⁶.

Sikka, Morath, and Leape²⁹ state that engaged and productive workers are essential to health systems. Thus, qualifying workers to provide healthcare is one of the main functions of managers. Workers must find meaning in their activities and feel satisfied with what they produce. Unfortunately, healthcare workers get sick more often, physically and/or psychologically, than those in other professional fields. This is largely due to the insecurity they are subjected to daily and the pressure to produce more and more, in progressively worse working conditions and with lower pay. In turn, managers must ensure an adequate, safe, and respectful environment, which will result in benefits for the population dependent on their care.

A study on the appropriation of PEH by PHC revealed aspects that favored the positive perception of workers regarding this educational practice: the encouragement of critical reflection on work and the pursuit of self-knowledge and professional growth³⁰. Difficulties cited included: work overload and insufficient staffing, lack of planning for PEH initiatives, lack of appreciation for PEH activities by management, inadequate characteristics of the activities developed, and fragmentation of work. Furthermore, the topics designated for PEH were often determined by people outside the units, being decontextualized from the teams' experiences. The use of inadequate methodologies, unprepared facilitators, inaccessible language, and themes distant from reality were identified as unfavorable factors for the implementation of PEH³⁰.

A positive finding for the PEH perspective is that almost all workers responded that they considered it important and were interested in participating in PEH activities. Almost two-thirds of the participants agreed on the lack of appreciation for PEH by other workers. This may indicate an overestimation in the response regarding the value placed on PEH. The lack of appreciation for PEH by managers/coordinators showed a statistically significant difference between FHU and BHU, being more favorable in FHU. This finding may indicate greater integration between FHU managers/coordinators and their teams when evaluating PEH practices. Similarly, qualitative research found concordant opinions on the disinterest of many workers and lack of support from managers for PEH Practices²¹.

A study that evaluated scientific production on PEH highlighted the need for local management to encourage PEH activities that modify relationships between people, work processes, and professional autonomy³¹. The power of PEH to generate changes and transformations in work processes can be highlighted, consequently reflecting positively on the provision of care³².

It is important to deepen the understanding of local realities to comprehend the difficulties faced by teams in carrying out PEH (permanent education in health) and to identify the causes of the differences between traditional FHU (Family Health Units) and BHU (Basic Health Units), in order to increasingly support and motivate teams to use this strategic tool for improving the quality of health services.

CONCLUSIONS

The results show that PEH activities in primary health care in the municipality did not occur as recommended by the NPPEH guidelines. Many workers did not have access to these actions in the six months prior to the survey, and more than half did not even participate in them monthly. A positive aspect was the lack of difference in the declared interest in participating in PEH activities between the care modalities, indicating potential for adherence in both contexts.

FHU workers reported greater access to PEH activities, health planning and evaluation, as well as greater satisfaction. This scenario may be related to the structured planning in the FHS, which favors actions more aligned with the needs of the teams and territories.

To improve the current state of PEH (Permanent Education in Health) practice in the municipality, it is evident that a review of the teams' work processes is necessary, advocating for PEH as a fundamental instrument for improving service quality. In this sense, it is the responsibility of the municipal administration to intensify support for primary health care teams, especially primary health care units, for the planning and regular development of PEH. It is important to strengthen the interprofessional nature of PEH, particularly in traditional primary health care units, to rethink the work process and revisit central concepts and values for the production of care, such as collaborative practice. Training for the managers of these units is recommended due to the strategic role they play, as they can act as facilitators in consolidating this public policy.

PEH (Permanent Education in Health) trains workers to transform the daily routines of healthcare units, raising the standard of care. By focusing on real problems, collaboration among professionals, and the specific needs of each territory, it promotes safer, more critical, and more humanized care for BUHS (Brazilian Unified Health System) users.

Limitations of the research include the absence of some professional categories due to the use of convenience sampling and the impact of the COVID-19 pandemic on worker participation.

This study contributes to the scientific literature by including a significant number of professionals from different categories, in addition to using a specific instrument on PEH (Continuing Education in Health). It highlights striking differences in the work processes of the units, with direct repercussions on the practice of PEH, offering relevant support for local management in defining the care model and improving care in primary health care.

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