The National Permanent Health Education Policy: dental surgeons' perception of Primary Health Care

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ABSTRACT

Taking as a reference the National Permanent Health Education Policy (NPHEP), which seeks the training of workers according to the needs of the population, management and professionals, the objective of this study was to know and analyze the perception of the dental surgeon (DS) of the Family Health Strategy (FHS) on NPHEP. This is a descriptive, cross-sectional and observational quantitative study, with a sample composed of 173 DS active on Primary Health Care Unities from the City of Fortaleza/CE. The data were collected by means of a semi-structured questionnaire. The categorical data were expressed as absolute and percentage frequencies, and were analyzed by means of the chi-square test. Evaluating the socioeconomic profile, the majority of the respondents were women (74.6%), married (72.8%), with an average income of 7 to 10 minimum wages (49.1%). As for the NPHEP, 51.2% knew it partially, and Permanent Health Education (PHE) was evaluated as regular by 48.8% and as good by 33.3%. It is noteworthy that the understanding of PHE as a contributing factor of professional training was positive for 97.7% of respondents. It was observed that greater participation in the activities of PHE favors the positive evaluation of the NPHEP. This policy is still unknown by many DS of the FHS. The PHE activities carried out in the city of Fortaleza are considered regular by most of the professionals interviewed. Aiming to advance with the PHE, the participants reinforce the importance of actions in the perspective of reflection by/at work in primary health care, seeking changes in the work process in health and consequently the improvement of health care provided to the population.

Descriptors: Education. Family Health Strategy. Oral Health.

1 INTRODUCTION

With the implementation of the Unified Health System (SUS) the human resources policy began to be based on clear principles, in which health professionals should be able to provide more effective, equitable and quality care[1]. In the Constitution of 1988, article 200 establishes that it is the responsibility of the SUS to order the formation of human resources in the health area[2]. For this, some strategies were implemented, seeking to make SUS a teaching-learning network.

In the early 1980s, the Pan American Health Organization launched the proposal for Permanent Health Education (PHE), whose purpose was to guide the health workers' training process[3,4], which should be initiated during undergraduate courses and perpetuated throughout the professional's life.

The National Permanent Health Education Policy (NPHEP) was the strategy launched by the Brazilian Ministry of Health (MS), through Ordinance nº 198/GM/MS on February 13, 2004, for the training and development of workers for the sector[5]. The implementation of NPHEP aimed at training and development of health professionals, proposing that the process of training of workers take place taking as reference the population's health need, management and social control in health[4,6]. Among its objectives is the construction of a teaching-learning network in the work exercise in SUS, aiming at training and developing workers, always observing the health needs of users[7].

Among the characteristics of the PHE proposal, meaningful learning is one of the most important, based on the pedagogical proposal of Paulo Freire[8], with work based on problematization, using the data experienced in the daily lives of professionals and taking into account their pre-existing knowledge and conceptions[3]. Therefore, the practice scenarios now serve as a space for problematization, dialogue, reflections and consensus building, in which it is possible to promote a health service with more quality[3,9], which favors the training of professionals with an adequate profile and ability to learn, work in teams, communicate, critically reflect and enhance humanistic qualities[10].

Following the guidelines for the organization of PHE activities, the municipality of Fortaleza/CE created, through Ordinance nº 160/2006 of the Municipal Health Secretariat (SMS), the Municipal Health School System (SMSE)[11] with the purpose of strengthening the idea of an integrated system of education, service and research. This system stands out for its breadth, involving higher and technical education institutions, public and private and all health units, which makes the experience one of the widest in the country[12], characterized by offering courses in order to improve the services and training of professionals. In 2013, the SMSE started to be called Coordination of the Management of Health Education and Work (COGTES), reaffirming the importance of working the PHE in the municipality.

Given these considerations and understanding the relevance of education at work for the transformation of health services, this study was carried out, pioneer in the city of Fortaleza/CE, with the objective of knowing and analyzing the perception of the DS of the Family Health Strategy (FHS) on NPHEP.

2 METHODS

This is a cross-sectional, quantitative, descriptive, observational epidemiological investigation, since it analyzes the data through the systematic observation of their characteristics, without intervention in the variables[13].

The study had as scenario, the city of

Fortaleza, capital of the state of Ceará, located in the Northeast of Brazil, with 108 Primary Health Care Units (PHCU), divided into six Regional Secretariats according to the characteristics and similarities of their population and territory. It is noteworthy that the city of Fortaleza is the fifth largest capital of Brazil, with a population of 2.447.409 inhabitants, presenting a Health Care Network organized from Primary Health Care (PHC)[11].

The target population of this research was composed by the DS of the FHS of the municipality. For the definition of sample size were considered sampling error of 5%, confidence level of 95% and percentage of observation (p) of 50%, apex of statistical confidence for sample calculations of binary data, when the frequency of the study variable is unknown. Considering the population of 284 DS, according to the Primary Care Information System (SIAB) in February 2014, a sample size of 164 was reached. Considering the possibility of potential losses, 173 DS were evaluated.

The inclusion criterion was that the DS should have been working at the FHS for at least two years. Professionals who were away from their job at the FHS were excluded because they were acting in management, secondary care, due to vacation or leave at the time of data collection. Participants who did not answer at least 70% of the survey instrument questions were also excluded.

Data were collected through a semi-structured questionnaire, applied to the DS of the FHS by two researchers. Previously, the researchers discussed the object of study and the data collection instrument in order to align the conduct of the work. The questionnaire was validated by a team of subject matter experts, and then pilot-tested for possible changes. The pilot study questionnaires had their data discarded from the final survey results.

Professionals were interviewed at the PHCU they worked at or at team meetings held by the Municipal Health Secretariat. Data collection took place from August 2014 to August 2015.

The questionnaire was divided into two parts: the first one, with 13 questions about the identification of professionals, and the second one containing 14 questions regarding perceptions about PHE. Data were tabulated in Microsoft Excel® and exported to *Statistical Packing for Social Sciences* (SPSS) version 17.0 software for *Windows*. Categorical data were expressed as absolute and percentage frequencies and analyzed by means of the chi-square test. Numerical data were expressed as mean and standard deviation and analyzed by means of the Kruskall-Wallis test (non-parametric data, Kolmogorov-Smirnov test).

A confidence index of 95% was considered exposing the prevalence ratios and respective confidence intervals of statistically significant comparisons. The variables were distributed into frequency and proportion. Associations were made between the dependent variables "knowing PNEPS" and "evaluation of NPHEP" and the other variables.

The study was carried out according to the requirements of Resolution Nº 466/2012 of the National Health Council, with approval of the project by the research ethics committee of the Federal University of Ceará, with the opinion nº 526.915 (CAAE 25677613.8.0000.5054).

3 RESULTS

A total of 173 DS of the FHS were interviewed, with a mean age of 38,8 ± 8,6 years and training time of 16±7,4 years. Most respondents were female (74.6%), married (72.8%), with average income between 7 and 10 minimum wages (49.1%). It is noteworthy that in 2014 the minimum wage was R$724,00, with the dollar value of 2,40 reais; thus, the minimum wage was equivalent to US$ 301,66.

In 2015, the minimum wage was R$ 788,00, with the dollar value of 2,69 reais; thus, the minimum wage showed devaluation and amounted to US$ 292,93.

Regarding the location of the regional, 28.9% worked in the Regional Secretariat VI. In relation to the employment relationship, the majority had another job (53.8%), and the clinical practice was exercised by 77.4% of the participants.

With regard to undergraduate training, most of them took it in a public institution (67.6%). It is noteworthy that almost all professionals (97.1%) have a postgraduate course, the majority (91.3%) in the level of specialization, being 71% in Dental Clinic and 60% in Collective Health (table 1).

It is observed that 51.2% of participants partially know the NPHEP. The fact that the policy is aimed at professionals, users and managers was highlighted by 82% of professionals. It was also recognized that the NPHEP aims to guide users and managers, make technical-scientific updating and transformation of practices (67.5%) (table 2).

Regarding the promotion of PHE activities, 48.3% of respondents reported that they were conducted, however 63.4% indicated that there is no exact frequency of execution. For 37.9% of the DS, activities should occur on a monthly basis. Most have already participated in PHE (89%) and 52.2% believe that the proposed activities partially include the integration between theory and practice (table 2).

The infrastructure was considered partially adequate for the activities proposed by 53.5% of the participants. PHE was rated as regular and good by 48.8% and 33.3%, respectively (table 2).

The understanding of PHE as a contributing factor in vocational training was 97.7%, and the negotiated exposition methodology was suggested as the most appropriate (61.6%), while it was reported as the most used (67.3%). %) (table 2).

No association was observed between age, time since graduation and performance time in the FHS with the dependent variable "NPHEP knowledge". However, there was a significant association between this dependent variable and having attended postgraduate courses in the area of Collective Health – 83.3% of the DS postgraduate in Collective Health reported to know the said policy. It was also observed that 56.3% of the professionals who know the NPHEP understand the active methodologies as the main method to be used in the development of the activities of PHE (table 3).

It should be pointed out that the courses in Family Health, Public Health, Health Management, Regulation and Audit and Legal Dentistry were grouped as postgraduate courses in Collective Health. Post-graduation in clinical studies included the areas of Periodontics, Pediatric Dentistry, Orthodontics, Prosthesis, Surgery, Dentistry, Implantology, Endodontics, Special Patients and Radiology.

The more PHE activities are performed, the more positive is their assessment (table 4). There was also an association between the contribution of PHE to the training of health professionals and the fact that it is rated as excellent or good. All professionals who consider PHE as excellent or good recognize their contribution to vocational training (table 4). There was no significant association between the evaluation of PHE and the frequency of activities or the indication of a methodology.

DS were asked what the specific themes to follow the PHE activities are, and the most cited were professional update on Dental Emergencies with Basic Life Support, Special Patients, Pharmacology, Health Education, Health Surveillance, Mental Health and FHS.

Table 1. Socioeconomic characterization of the sample's dental surgeons

Variable	N	%
Gender		
Female	129	74.6%
Male	44	25.4%
Marital Status		
Single	28	16.2%
Married	126	72.8%
Divorced	9	5.2%
Separated	6	3.5%
Other	4	2.3%
Monthly Income (minimum wages)		
Up to 7	35	20.2%
7 to 10	85	49.1%
10 to 15	39	22.5%
15 to 20	8	4.6%
More than 20	1	0.6%
Regional Secretariat in which he/she works		
I	22	12.8%
II	22	12.8%
III	32	18.6%
IV	21	12.2%
V	26	15.1%
VI	50	28.5%
Have another job		
Yes	93	53.8%
No	80	46.2%
Which job		
Clinic	72	77.4%
Public service	12	12.9%
Other	9	9.7%
Training institution		
Public	117	67.6%
Private	56	32.4%
Hold a post-graduate degree		
Yes	168	97.1%
No	5	2.9%
Post-graduate level		
Specialization	157	91.3%
Further training	58	33.7%
Master's degree	21	12.2%
Doctorate	1	0.6%
Post-doctorate	-	-
*Area of post-graduate degree**		
Clinical	110	71.0%
Collective Health	93	60.0%

* Possibility to select more than one option

Table 2. Knowledge on the National Permanent Health Education Policy

Variable		N	%
Know NPHEP	Yes	33	19,2%
	No	51	29,7%
	Partially	88	51,2%
Target public of NPHEP	Higher level professional	1	0,6%
	Medium level professional	34	20,4%
	All professionals, users and manager	137	82,0%
	Manager	9	5,4%
	Other	2	1,2%
Objective of NPHEP	Guide users	1	0,6%
	Guide managers	5	3,0%
	Technical and scientific updating	38	22,5%
	Transformation of practices	27	16,0%
	All previous objectives	114	67,5%
	Any of the previous	-	-
	Other	1	0,6%
The municipality promotes PHE	Yes	83	48,3%
	No	7	4,1%
	Partially	74	43,0%
	I don't know	9	5,2%
Current frequency of PHE activities	Monthly	6	3,9%
	Quarterly	3	2,0%
	Six-monthly	10	6,5%
	Annual	11	7,2%
	No exact frequency	97	63,4%
	I don't know	26	17,0%
Ideal frequency for PHE activities	Monthly	64	37,9%
	Trimestral	39	23,1%
	Six-monthly	37	21,9%
Have participated on PHE activities	Yes	153	89,0%
	No	11	6,4%
	I don't remember	4	2,3%
	I don't know	4	2,3%
There is integration between theory and practice in PHE activities	Yes	52	32,7%
	No	24	15,1%
	Partially	83	52,2%
Adequate infrastructure to carry out PHE activities	Yes	49	34,0%
	No	17	11,8%
	I don't know	1	0,7%
	Partially	77	53,5%
Evaluation of PHE	Great	7	4,3%
	Good	54	33,3%
	Regular	79	48,8%
	Bad	19	11,7%
	Awful	3	1,9%
Contribution of PHE to vocational training	Yes	168	97,7%
	No	5	2,3%
*Adequate methodological strategy suggested by interviewees**	Active	57	34,8%
	Expositive	21	12,8%
	Expositive and negotiated	101	61,6%
	Other	14	8,5%
*Methodological strategy used in PHE**	Active	25	15,4%
	Expositive	68	42,0%
	Negotiated expositive	109	67,3%

* Possibility to select more than one option

Table 3. Association between knowledge of National Permanent Health Education Policy and other variables

	Knowledge on NPHEP						
	Yes		No		Partial		P-value
Age (years)	43.2 (±8.9)		36.8 (±9.6)		38.2 (±7.3)		0.686[a]
Time of graduation (years)	19.3 (±8.0)		15.4 (±6.6)		15.0 (±7.3)		0.944[a]
Time in PHE (years)	8.9 (±3.6)		7.8 (±3.8)		8.6 (±4.5)		0.191[a]
Have post-graduate degree	33	100.0%	50	98.0%	85	96.6%	0.530[b]
Type of graduate studies							
Specialization	30	90.9%	47	92.2%	80	90.9%	0.966[b]
Further training	10	30.3%	18	35.3%	30	34.1%	0.889[b]
Master's degree	7	21.2%	3	5.9%	11	12.5%	0.110[b]
Doctorate	-	-	1	2.0%	-	-	0.303[b]
Post-doctorate	-	-	-	-	-	-	1.000[b]
Post-graduate area							
Clinical	13	43.3%	37*	82.2%	60*	75.0%	*0.001[b]
Collective Health	25*	83.3%	23	51.1%	45	56.3%	*0.013[b]
Target public of NPHEP							
Higher level	1	3.1%	-	-	-	-	0.120[b]
Medium level	9	28.1%	8	17.0%	17	19.3%	0.456[b]
Professionals, users and managers	26	81.3%	41	87.2%	70	79.5%	0.536[b]
Managers	1	3.1%	2	4.3%	6	6.8%	0.673[b]
Other	1	3.1%	-	-	1	1.1%	0.454[b]
Objective of NPHEP							
Guide users	1	3.0%	-	-	-	-	0.126[b]
Guide managers	0	0.0%	2	4.2%	3	3.4%	0.519[b]
Technical and scientific updating	6	18.2%	10	20.8%	22	25.0%	0.689[b]
Transform practices	6	18.2%	6	12.5%	15	17.0%	0.731[b]
All	22	66.7%	34	70.8%	58	65.9%	0.837[b]
Any	-	-	-	-	-	-	1.000[b]
Other	-	-	1	2.1%	-	-	0.281[b]
Contribution of PHE to vocational training (Yes)	32	97.0%	48	98.0%	86	97.7%	0.956[b]
Adequate methodological strategy suggested by interviewees							
Active	18*	56.3%	11	24.4%	28	32.9%	*0.013[b]
Expositive	2	6.3%	8	17.8%	11	12.9%	0.332[b]
Negotiated expositive	14	43.8%	27	60.0%	58	68.2%	0.052[b]
Other	2	6.3%	4	8.9%	8	9.4%	0.861[b]
Methodological strategy used in PHE							
Active	8	25.0%	8	17.8%	9	10.8%	0.155[b]
Expositive	18	56.3%	18	40.0%	32	38.6%	0.210[b]
Negotiated expositive	18	56.3%	30	66.7%	60	72.3%	0.256[b]
Other	3	9.4%	0	0.0%	2	2.4%	0.057[b]

p<0.05, Kruskal-Wallis / Dunn; Bp <0.05, chi-square test; * p<0.05 x other groups

Table 4. Association between evaluation of National Permanent Health Education Policy and other variables

	Evaluation of Permanent Health Education										p-value
	Great		Good		Regular		Bad		Awful		
	n	%	n	%	n	%	n	%	n	%	
Municipality promotes PHE											
Yes	6*	85.7%	43*	81.1%	27	34.2%	3	15.8%	0	0.0%	<0.001[a]
No	0	0.0%	1	1.9%	1	1.3%	5*	26.3%	0	0.0%	
Partially	1	14.3%	9	17.0%	49*	62.0%	10*	52.6%	2*	66.7%	
I don't know	0	0.0%	0	0.0%	2	2.5%	1	5.3%	1*	33.3%	
Current frequency of PHE's activities											
Monthly	0	0.0%	4	8.2%	1	1.4%	0	0.0%	0	0.0%	0.538[a]
Quarterly	0	0.0%	2	4.1%	1	1.4%	0	0.0%	0	0.0%	
Six-monthly	2	28.6%	3	6.1%	3	4.2%	1	6.7%	0	0.0%	
Annual	0	0.0%	5	10.2%	4	5.6%	2	13.3%	0	0.0%	
No frequency	5	71.4%	28	57.1%	49	69.0%	11	73.3%	2	66.7%	
I don't know	0	0.0%	7	14.3%	13	18.3%	1	6.7%	1	33.3%	
Contribution of PHE in professional training (Yes)	7	100.0%	54	100.0%	77	98.7%	16*	84.2%	3	100.0%	0.003[a]
Adequate methodological strategy suggested by interviewees											
Active	2	28.6%	15	28.8%	28	37.3%	7	36.8%	2	66.7%	0.640[a]
Expositive	1	14.3%	4	7.7%	12	16.0%	2	10.5%	0	0.0%	0.645[a]
Negotiated expositive	7	100.0%	31	59.6%	47	62.7%	10	52.6%	1	33.3%	0.189[a]
Other	1	14.3%	3	5.8%	4	5.3%	5*	26.3%	0	0.0%	0.041[a]

*p <0.05. chi-square test; * p <0.05 x other groups

4 DISCUSSION

Most respondents were female, a fact that corroborates the study by Matos, Toassi and Oliveira[14] in 2013, which presents the feminization of health professions, as a solid growth of the female population in professions formerly performed by men, such as Medicine and Dentistry. The fact that most respondents work in regional VI is justified because it has the largest number of professionals in the oral health teams.

It is stressed that more than half of respondents had, besides working at the FHS, another source of income, and 77.4% also worked in the office, which justifies a high percentage of professionals with postgraduate degrees in clinical areas.

The data presented here corroborate another study[15] that defines Dentistry as a profession with a strong focus on private practice and technical requirement. However, the training needs have changed over the years and nowadays the need for professional performance in the public service is noticeable, where besides the technique, other competences and skills – such as humanization and the ability to work in a team – are necessary.

It was observed that the NPHEP is still unknown by many SUS workers, despite being published in 2004. Tesser *et al*.[9] also found

ignorance by most professionals. It is noteworthy that PHE is a national policy for the training and development of health workers, enabling the development of education, as well as the expansion of the resolution capacity of services[4]. Although they do not know details about this policy, DS understand their objectives and know their target audience which is very positive for their strengthening.

It has been recognized that the municipality promotes PHE activities, but the lack of frequency of activities weakens the education process. Miccas and Batista, in 2014[16], emphasized that PHE should have a continuous character, different from Continuing Education, which is based on punctual and fragmented actions, using traditional teaching methodology, characteristics that can make learning difficult.

It is noteworthy that the city of Fortaleza provides the FHS professionals with 8h per week of their workload of 40h per week intended for the development of PHE activities, however it is perceived the need for greater regularity of them. Almost 90% of DS have participated in PHE activities, highlighting the importance of learning to have meaning. As activities become associated with the daily actions of the services, activities become more effective[3]. It is emphasized, furthermore, that the traditional methodology will hardly provide the integration between theory and practice, with active methodologies being the most indicated in the pursuit of meaningful learning[17.18].

The use of problematizing methodologies with discussions about the demands of the territory, as well as the needs of professionals and users should be used in PHE activities. Ordinance nº 278 GM-MS of February 27, 2014, states that a NPHEP guideline is the promotion of meaningful learning through the adoption of active and critical methodologies[19]. Conducting traditional courses that do not consider work-learning or the context of the place do not add value to the daily routine of services[20]. However, it is still possible to observe the use of this type of methodology in various services[16].

The active methodology seeks to work with problems for the development of teaching-learning processes, valuing learning to learn[17]. Despite the scientific evidence[17] on the great effectiveness of PHE work through active methodologies, the present research found that DS still understand traditional methodologies as the best option for performing PHE activities, a fact that may justified by the completion of undergraduate courses until 2000 by most professionals, when traditional methodologies predominated.

For the PHE activities to happen satisfactorily, besides the use of an appropriate methodology, there must be an adequate physical and structural condition, with a specific place for its development. However, there was a weakness of the municipality in the matter of infrastructure for the development of PHE activities. It is considered important that the municipality of Fortaleza provides adequate physical structure and equipment to develop quality activities for students and educators.

Most respondents rated the PHE of the municipality as regular, which should serve as an alert for managers to check the main weaknesses and highlight the positive points, seeking to increase the degree of satisfaction of professionals. PHE is considered a contributing factor to vocational training, thus increasing the quality of services. Corroborate this statement Montanha and Peduzzi[3], who highlight the implementation of SUS based on the concept of comprehensive health. participatory management and teamwork, emphasizing the

training of workers as an essential condition for the construction of a quality service for the population.

A significant association was observed between the fact that the professionals had post-graduate degrees in Public Health and considered the active methodologies as the most appropriate for the performance of PHE activities. The professionals with training in this area have more knowledge about the NPHEP, due to the emphasis on discussions on this topic, highlighting that many courses are made possible through actions provided by the said policy[21].

Most DS believe that active methodologies are most appropriate because they know about NPHEP. Therefore, the active methodology is an educational conception that stimulates reflection processes, in which the student has an active and co-responsible posture in relation to their learning[3.18.22]. It is noteworthy that the dialogued expository methodology can be used as an active methodology, provided that the educator and the students actually make it dialogued.

It is also emphasized that there is a confusion between PHE, which works meaningful learning, centered on the daily work process, highlighting interdisciplinarity and using active methodologies for its development, and Continuing Education, characterized by the transmission of punctual and fragmented knowledge focusing on professional categories[9.23].

When associating the evaluation of PHE in Fortaleza/CE with the other variables, a statistical association was observed with the municipality promoting PHE activities, the contribution of PHE in the training of professionals and the choice of the appropriate methodology.

It is suggested that performing more PHE activities will provide professionals with a better experience of NPHEP, which influences their positive evaluation. For Lino *et al*.[24], PHE should be part of the health workers' thinking and doing, providing their professional and personal growth, as well as contributing to the organization of work processes through the problematization of reality. Carrying out PHE activities is fundamental for the execution of health services more efficiently[25].

The understanding of the importance of PHE for vocational training provides a positive evaluation of it, and it is possible to glimpse how important the articulation between them is. In the study by Mendonça *et al*.[22], it was observed that understanding about the PHE allowed professionals to understand the importance of the policy in the work process, enabling the visualization of paths to develop it.

The discussion on the use of appropriate methodology needs to be broadened among workers, managers and the population. Using an inappropriate methodology could compromise the PHE process and contribute negatively to the evaluation of this PHE. It is suggested the active problematizing methodology as the most appropriate, with it the previous knowledge of the students are considered and the teaching-learning process happens in a significant way, which promotes the establishment of a quality health service[3.8.9].

Finally, regarding the perceptions of professionals about the needs of PHE activities, several factors may influence, such as special interest in a particular task, interest in continuing to learn, some deficiency in their previous training, their satisfaction with management, among others. others[25-27]. It is necessary to evaluate the needs of workers, taking into account the needs of managers and the population, seeking to associate them with each other and, thus, PHE will become more

effective in the construction of health services.

5 CONCLUSION

NPHEP is still unknown to many FHS dental surgeons. However, most professionals understand the importance of this policy for the training of professionals of the Unified Health System. The PHE activities performed in the city of Fortaleza are considered regular by most of the professionals interviewed.

Aiming to advance with PHE in the municipality investigated, the research participants reinforce the importance of PHE actions from the perspective of reflection by/at work in Primary Health Care, seeking changes in the health work process and, consequently, the improvement of health care provided to the population.

It is important that managers can together with FHS teams plan PHE activities, having active methodologies as a tool for the development of PHE, recognizing in this process the protagonism of workers, as well as the manager and the community.

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RESUMO

A Política Nacional de Educação Permanente em Saúde: percepção dos cirurgiões-dentistas da Atenção Primária à Saúde

Tomando-se como referência a Política Nacional de Educação Permanente em Saúde (PNEPS), que busca a formação dos trabalhadores de acordo com as necessidades da população, gestão e profissionais, o objetivo desse estudo foi conhecer e analisar a percepção do cirurgião-dentista (CD) da Estratégia Saúde da Família (ESF) sobre a PNEPS. Trata-se de um estudo quantitativo descritivo, transversal e observacional, com amostra composta por 173 CD atuantes nas Unidades de Atenção Primária em Saúde do Município de Fortaleza/CE. Os dados foram coletados por meio de questionário semiestruturado. Os dados categóricos foram expressos na forma de frequência absoluta e percentual, sendo analisados por meio do teste qui-quadrado. Avaliando o perfil socioeconômico, a maioria dos entrevistados foi do gênero feminino (74,6%), casado (72,8%), com renda média de 7 a 10 salários mínimos (49,1%). Quanto à PNEPS, 51,2% a conheciam parcialmente, sendo a Educação Permanente em Saúde (EPS) avaliada como regular por 48,8% e como boa por 33,3%. Destaca-se que a compreensão da EPS como fator contribuidor da formação profissional foi positiva para 97,7% dos entrevistados. Observou-se que maior participação nas atividades de EPS favorece a avaliação positiva da PNEPS. Essa política ainda é desconhecida por muitos CD da ESF. As atividades de EPS realizadas no município de Fortaleza são consideradas regulares pela maioria dos profissionais entrevistados. Visando avançar com a EPS, os participantes reforçam a importância das ações na perspectiva da reflexão pelo/no trabalho na atenção primária à Saúde, buscando mudanças no processo de trabalho em saúde e consequentemente a melhoria da atenção em saúde prestada à população.

Descritores: Educação. Estratégia Saúde da Família. Saúde Bucal.

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