Saúde e Pesquisa
DOI: 10.17765/2176-9206.2024v17n1.e12186

Qualitative indicators of permanent health education: collaborative creation in a health region

Indicadores qualitativos de educação permanente em saúde: criação colegiada em uma regional de saúde

João Pedro Soares Bossan[1*], Mariana Pissioli Lourenço[2], Poliana Avila Silva[2], Michelle Aparecida Siqueira Fazoli[1], Guilherme Malaquias Silva[1], Vanessa Denardi Antoniassi Baldissera[3,]

[1] Nurse, Master's Degree in Nursing, Graduate Program in Nursing, State University of Maringá (UEM), Maringá (PR), Brazil, [2]Nurse, Doctorate in Nursing from the Postgraduate Program in Nursing at the State University of Maringá, Maringá (PR), Brazil, [3] Nurse, Doctorate in psychiatric nursing from the University of São Paulo (SP), professor of the Postgraduate Program in Nursing at the State University of Maringá, Maringá (PR), Brazil.

***Autor correspondente**: João Pedro Soares Bossan – *Email*: bossanjoao@gmail.com

ABSTRACT
Systematizing the experience of creating qualitative indicators for permanent health education in a health region in the state of Paraná, Brazil. Method: Qualitative research, following the "systematization of experience" approach, conducted with healthcare professionals in a health region. Data collection took place from March to June 2021 through materials produced during meetings and researchers' records. The data were organized based on the assumptions of systematization of experience and analyzed through the lens of Freire's critical pedagogy. Results: Five indicators were constructed in a participatory manner. Difficulty in conceptualizing them was observed, with conceptual distance as a barrier and the development within a permanent education process as a facilitator, where the experience provided exemplification. Conclusion: The systematization of experience contributed to the critical analysis of the process, revisiting themes, and identifying potentialities and weaknesses, allowing for the development of future activities in a qualified manner.

Keywords: Continuing Education. Regional Health Planning. Health Management. Public Health. Management Indicators.

RESUMO
Sistematizar a experiência de criação de indicadores qualitativos de educação permanente em saúde em uma regional de saúde do estado do Paraná. Método: pesquisa qualitativa, nos moldes da Sistematização da Experiência, desenvolvida com servidores de uma regional de saúde. A coleta de dados ocorreu de março a junho de 2021 por meio dos materiais produzidos durante os encontros e registros dos pesquisadores. Os dados foram organizados por meio dos pressupostos da sistematização da experiência e analisados sob a luz da pedagogia crítica de Freire. Resultados: 5 indicadores foram desenvolvidos, construídos de forma participativa. Observou-se dificuldade em os idealizar, tendo como entrave o distanciamento conceitual e como facilitador o desenvolvimento dentro de um processo de educação permanente, em que a vivência proporcionou exemplificação. Conclusão: a sistematização da experiência contribuiu para a análise crítica do processo, revisitando os temas e identificando potencialidades e fragilidades, permitindo que próximas atividades sejam desenvolvidas de forma qualificada.

Palavras-chave: Educação Continuada. Regionalização da Saúde. Gestão em Saúde. Saúde Pública. Indicadores de Gestão.

INTRODUCTION

Educational processes in the health sector throughout the national territory have undergone various transformations over the years, influenced by international organizations, pedagogical trends, and the ideological and intellectual currents of the time. There is a growing focus on professional demands, gradually moving away from alienated practices with an exclusive focus on service and institution[1,2].

Historically, professional training has been limited to capacity building in specific health policies and programs, often occurring in a detached and rigid manner through traditional teaching, reinforcing the individualization of knowledge in the workplace[2].

In response to the constant need for training and updating of professionals[3], supported by the divisions created for professional qualification by the Ministry of Health and by the pedagogical and ideological currents of the period, as well as the suggestion of the Pan-American Health Organization for developing countries, the National Policy for Permanent Health Education (PNEPS) was created in 2004. It proposes a restructuring of educational practices in the health field, based on activities in the professionals' daily work and the realities they experience. Through reflection on practice, the aim is to qualify it, revealing solutions to problems experienced in daily life[4-6].

Beyond the necessary change in the health workplace, permanent health education (PHE) reinforces ethical-methodological characteristics for contextualized and problematized transformation. These issues are essential to realize the PNEPS premises as a potentializer of meaningful learning and a reorganizer of health system practices[7].

Evaluation and monitoring of health services are essential activities for their continuous improvement, adherence to quality criteria, user safety, and verification of their conformity and response to actions taken. To ensure quality criteria in services, professionals use available tools, such as standardizations, various pre-established performance criteria, and health indicators[8,9].

The use of indicators, although well-diffused and potentially transformative when used appropriately, still faces challenges in its implementation. This is especially true because of the predominance of quantitative indicators over qualitative ones, data collection and form filling without critical analysis by professionals, lack of knowledge about them, and a shortage of time to use them, among other factors[4,10,11].

Given the complexity of health services, a more effective performance of these strategies materializing PHE actions can enhance the planning of the management, especially when focused on actual contexts from the perspective of the actors experiencing them. Therefore, the objective of this study was to systematize the experience of creating indicators for Permanent health education in a health region in the state of Paraná, Brazil.

METHODOLOGY

This is a study of the systematization of experiences[12], characterized as an epistemological approach to participatory action research in health[13] as an inducer of knowledge. It focuses on a participatory activity developed with professionals from a health region (HR) in the state of Paraná, aiming to construct qualitative indicators for permanent health education.

Participatory action research can be understood as one in which the researcher embeds themselves and interacts with the researched reality, working alongside the involved actors and directly engaging with the study's subject, institution, or researched community. It involves sharing systematized information about the studied context, delving deep into the research

problem in collaboration with the participants, and seeking to solve it[13].

This method aims to organize information resulting from a lived experience/field project and critically analyze it, extracting lessons and knowledge from it. The primary objective of a systematization process is the generation of new knowledge, allowing the practice to be qualified based on insights derived from the practice itself in a cyclical process of enhancement[13,14].

The systematization of experience comprises five stages, namely: Definition of the starting point - organizing aspects related to systematization; Delimitations - defining and surveying fundamental points for systematization by identifying intervention areas and organizing information for critical unveiling; Description of the Experience - reporting the activities carried out; Critical Analysis - synthesizing and deriving opinions, critiques, and value judgments about the experience; Presentation of Results - disseminating the systematization[13,14].

The study location resulted from a request from the health management service in question after noting the lack of indicators in the field of CHE in the institution that were faithful to the conceptual principles of the policy. Due to the COVID-19 pandemic and its progression, in-person meetings were prevented so that they took place remotely.

The participants in the meetings for the construction of CHE indicators were members of the HR's management team, i.e., managers from various sections, divisions, and areas that make up the HR's structure, who voluntarily agreed to participate in the research. In cases where there was an impossibility on the part of management agents, they could nominate a staff member responsible for their sector to participate in the meetings.

As an exclusion criterion, not belonging to the institution's staff or not having availability to attend synchronous remote meetings was adopted. In total, 32 professionals participated in the research. It is worth noting that the selection of participants was a criterion established by the institution, as it was better positioned to determine which individuals had creative potential and a closer relationship with the indicators to be created.

To construct the indicators, four collective meetings and 11 meetings with individualized HR sessions were held remotely from March to June 2021, guided by critical and participatory educational practices[15]. Collective meetings were organized according to the availability of the staff, who received an access link to a virtual room where activities, debates, and co-creations took place. The same occurred with sectoral meetings, but these were conducted exclusively with one or two representatives from a sector, while collective meetings were held with representatives from all sectors.

The data analysis material consisted of products resulting from collective activities, researchers' notes, organizations between institutions, and the created indicators. The analysis of the data followed the principles of Paulo Freire's critical education[15,16].

For the use of materials, all participants, before the activities, filled out the Informed Consent Form (ICF), and its completion was done through the submission of a link in electronic form.

The project has approval from the Research Ethics Committee with Human Beings of the State University of Maringá, No. 4.883.094 (CAAE: 49920721.4.0000.0104), and an agreement was reached in a meeting of the Regional Interagency Committee (CIR) of an HR in the state of Paraná. Throughout all stages of this research, the Guidelines for procedures in research at any stage in a virtual environment of the National Commission for Ethics in Research were followed.

This work is part of a dissertation project titled "Construction of Qualitative Indicators for Permanent Health Education: a systematization of the experience."

RESULTS

For the presentation of the results, it was chosen to limit the presentation of findings to the stages exclusive to the creation of CHE indicators themselves. Before this, meetings were held addressing teamwork, the importance of effective communication in the workplace, recognizing different responsibilities within the HR divisions, the relevance of performed activities, as well as the objective of creating an environment conducive to dialogue, reception, and the exchange of experiences.

Although the previous stages are essential for the obtained results, for replicating the approaches to creating qualitative CHE indicators, it is believed that the directive information to be presented is sufficient.

DEFINITION OF THE STARTING POINT

The starting point was defined as the beginning of the practical experience, alongside the participating actors, disregarding periods before this, such as organization, agreements between institutions, rearrangements due to the pandemic situation, among other aspects. Despite the crucial role of the stages before practice, the main contributions come from the activity itself, conceptual constructions and deconstructions, strategies used to mitigate and overcome adversities, methodological adaptations, and the productions that result from them.

The construction of indicators took place after a long period of negotiations and agreements between the university and the service. Some obstacles hindered the development of the activity, such as schedule incompatibility, demands from the service and the educational institution, the COVID-19 situation, and adaptations and planning for remote activities.

The entire operation was conceived envisioning immersion in a permanent health education process, proposing that, in addition to creating CHE indicators, professionals would experience reflection and collective effort to solve shared problems in their daily work, learn and teach, and feel valued. It was believed that this way, the activity would bring to reality the concepts and demands that would necessarily be discussed regarding PNEPS and its application, facilitating the creation of indicators.

Four collective meetings and 11 individual meetings with sections of the researched service were conducted. For this research, the starting point is in the third collective meeting, which specifically addressed CHE and the creation of indicators, as well as in the 11 individual meetings.

DELIMITATIONS

The lines of action used, namely, the methodological strategies and their actions to achieve the objective, were collective agreements, individual meetings, approval through forms, and group discussions. The issue identified by the professionals of HR was the absence of indicators that effectively portrayed an educational process in line with the assumptions of PNEPS, in addition to conceptual unfamiliarity with the policy by some institution collaborators. There were numerical indicators, which only measure whether or not actions were taken, and not the effective impacts and their meanings.

DESCRIPTION OF THE EXPERIENCE

Creation of Permanent Health Education Indicators

Due to the complexity of the topic, the organizers proposed creating a presentation that would provide theoretical and scientific support for the participants in the creation of CHE indicators. These indicators would be conceived by the HR professionals themselves based on reflections on tasks and complexity identified in previous stages and meetings. On this day, 22 employees attended.

The theoretical presentation began with the contextualization and theorization of perrmanent health education. It briefly presented its history and conceptual improvement, encompassing all its main milestones up to what is currently used for public health policy development. At the end, attendees were encouraged to share their perceptions on the topic voluntarily. It was observed that almost unanimously, participants reported unfamiliarity with PNEPS and its practical and theoretical framework.

After the introductory and conceptual period, the organizers began explaining the activity in which the first indicators would be proposed by the participating team. To facilitate communication, two groups with six participants each and two with five participants each were formed, attempting to keep the highest number of members from the same section in the same group.

Following the division, instructions were given on how the activity would take place: to start the discussion, participants were encouraged to discuss the duties/information about the section they worked in, and classify them according to their degree of difficulty and need for monitoring, in decreasing order.

Once their time ended, they were asked to reflect individually and create indicators that presented a possibility of educational action within the team that could transform/potentialize the selected activity; and that would help to solve problems collectively for that specific task

The indicator should reveal the debate from previous activities, the presentation and reflection on permanent health education, and educational demands in the service. At this point, the guidance given was to detach from quantitative aspects since the numerical observation of permanent health education activities would not necessarily imply resolutions to daily issues and needs.

With individual reflections complete and their time up, participants were invited to speak, clockwise within the tables, about the selected task and the indicator created. For recording these proposals, the CHE coordinator of the HR, who assisted in organizing and participating in the activities, documented the proposed indicators.

As the activity progressed, participants exclusively created service indicators, showing whether the work performed in the role was adequate and if the selected task was well-executed. However, they did not demonstrate a process of educational, dialogical, reflective, collaborative action seeking improvement and problem-solving.

When the problem was identified and it was noticed that the main objective of the task was not achieved, it was necessary to devise another plan for the primary activity of this organization. The creation of qualitative CHE indicators was essential, as quantitative indicators approved within the institution's own instances already monitored the service, but these were not entirely faithful to the educational policy proposed by the Ministry of Health.

Considering this, the researchers concluded the activity and reorganized the initial plan. It was agreed that individual meetings would be held with each section at scheduled dates and times. During the period when professionals awaited the meetings, they were suggested to reflect and, after closer engagement with the topic, ideate the indicators. To stimulate them, suggestions for permanent health education activities that emerged during group discussions were sent:

> Identification of problems/needs in sections/areas through participatory methods by the service's own workers;
> Participatory solutions from workers for the identified problems/needs in their section/area;
> Dialogical spaces in the section/service for evaluating individual and collective responsibilities;
> Sharing of knowledge

through participatory means;
Incorporation of new knowledge/practices into daily work after participatory agreement.

At the end of the listed actions, the following question, accompanied by a statement, guided the creation of indicators: "Does this indicator point to the results/quality of my section's work, or does it indicate if I am learning, teaching, and changing while improving the work?" If the answer points to the results and quality of the service, this indicator does not qualify as a PHE indicator.

Sector-Specific Meetings

On scheduled dates and times, remote meetings were initiated. In general, participants reported difficulties in conceptualizing qualitative indicators, particularly when the indicator was expected to depict a PHE process rather than the service provided.

Successive meetings took place, and researchers consolidated the information and options for indicators that were brought up. In some groups, participants did not come with predefined ideas but were prompted with triggering questions to encourage reflection.

At the conclusion of the groups, participants had suggested five indicators, already grouped when similar. They were informed that they would receive, via email and cell phone contact, a form for adjustment and evaluation of the created indicators.

Researchers organized the indicators and questions related to their adjustment in a brief and easily understandable online form, checking individual acceptance and suggestions for improvement. It is worth noting that, alongside the indicator, there were important comments for understanding, which were made during meetings with small groups.

The indicators were presented separately, and, immediately below, there were four evaluation alternatives: "unsatisfactory," "partially satisfactory," "satisfactory," and "highly satisfactory," followed by an open box for comments with the description "suggested changes."

The form was sent to all participants who went through the collective activity of creating PHE indicators, with an additional week provided for responses. Out of the 22 participants present at the meeting, 15 responded to the form.

For the organization of results and verification of satisfaction with the production, the satisfaction percentage was calculated by multiplying the total number of participants who selected the option by 100 and dividing the result by the total number of participants (15). The result is expressed in the table below.

Box 1. Adaptation of qualitative continuing health education indicators for a health region in the state of Paraná, Brazil, 2021

Indicators	Satisfaction percentage	Suggested changes
Weekly meetings with each department to identify problems/needs for presentation in the briefing.	**0%** Unsatisfactory **26,7%**Partially satisfactory **53,3%** Satisfactory **20%**Highly satisfactory	● Monthly meetings; ● Bi-weekly meetings.
Weekly briefing with representatives from each department to identify needs/problems within the sectors. * During these moments, possibilities for solving the identified issues will be discussed.	**0%** Unsatisfactory **26,7** %Partially satisfactory **46,7%**Satisfactory **26,7%**Highly satisfactory	● Monthly meetings; Bi-weekly meetings; ● Elect someone responsible for monitoring the activity;
Collective construction of an integrative framework for recording the problems/needs of each sector and department. * All sessions have access and can provide suggestions. * A representative may be elected to update the framework during the weekly meeting. * In the integrative framework, one column with the department's name, another with the identified needs/problems, and another with strategies for solving the items.	**0%** Unsatisfactory **13,3%**Partially satisfactory **53,3%**Satisfactory **33,3%***Highly* satisfactory	● Elect someone responsible for monitoring the activity and how to carry out this monitoring; ● Replace "department and section" with "division, section, and/or unit."
Completion of an individual assessment tool and presentation for discussion in a monthly meeting. * The space of the weekly meeting can be used; * There is flexibility for evaluation before the one-month deadline, considering that the assessment should occur from the moment the problem is identified.	**0%** Unsatisfactory **20%**Partially satisfactory **53,3%**Satisfactory **26,7%**Highly satisfactory	● Difficulty in understanding how this will unfold; ● The Regional Health Directorate should hold a monthly meeting with the heads for the discussion of activities and demands.
Reflection on one's practice after weekly meetings and notes on changes/transformation of behavior and work processes in meetings.	**0%** Unsatisfactory **13,3%** Partially satisfactory **60%** Satisfactory **26,7%** Highly satisfactory	● Change the frequency to bi-weekly.

Source: The authors, 2021.

It is observed that the focus given to the indicator proposals aims at reflecting on processes through meetings and discussions about the challenges faced in daily life. Furthermore, co-participation and joint creation were proposed as a strategy to enhance educational opportunities, as well as identify and address critical situations.

It could be observed that the indicators were not, in their entirety, evaluated as "unsatisfactory," being mostly classified as "satisfactory." The main suggestion for change was in the frequency of activities, which, according to the responses, should be more spaced out to become feasible and compatible with the service's availability. Additionally, the second most prevalent suggestion was to appoint someone responsible for monitoring the implementation of these activities.

Approval of the Indicators and Relevant Aspects for Implementation.

The meeting began with a brief introduction of the journey taken, presented verbally by the organizers. Each meeting with the RS team was reviewed, recalling its objectives, achievements, reflections, proposals, difficulties, among other aspects. The participants were invited to give their opinions on the project's development, especially regarding their learnings up to that point.

The indicators were presented again in a virtual display, still without the suggested changes, aiming to recap the production developed by them. Additionally, considering that there might be participants who did not respond to the questionnaire, it was important to make them aware of what was proposed in the initial stage of colleagues' suggestions.

After the individual presentation of each indicator, the researchers showed the suggested changes proposed by the questionnaire respondents. At this point, it was an opportunity for other participants to express their opinions on the proposed changes.

During this occasion, it was confirmed that the initially proposed frequency was unfeasible in the perception of the employees. Due to the routine and workload, weekly activities might not be feasible, making the indicators unworkable. All meeting participants agreed upon the unfeasibility.

The indicators were reviewed one by one, checking which suggested changes and proposals the organizers made. The analysis of each indicator was only finalized after all participants confirmed their agreement with the proposed changes.

Only one of the indicators had no changes in its wording, containing only suggestions for selecting an individual who would be responsible for monitoring the activities. Therefore, the wording of the indicator remained unchanged, and its aspects were discussed for understanding.

Box 2. Reorganization of the indicators after collective debate among participants, Paraná, Brazil, 2021

Old indicator	Change	New indicator
Weekly meetings with each section to identify problems/needs of each sector for presentation in the briefing.	- Frequency: Monthly or bi-weekly.	Bi-weekly meetings with each section to identify problems/needs of each sector for presentation in the briefing.
Weekly briefing with representatives from each section to identify the needs/problems of the sectors.	- Monthly meetings(2); - Bi-weekly meetings (1); - Elect someone responsible for monitoring the activity.	Monthly meetings with representatives from each section to identify the needs/problems of the sectors.
Collective construction of an integrative framework for recording problems/needs of each sector and section.	- Elect someone responsible for monitoring the activity and how to conduct this monitoring(3); - Replace "sector and section" with "division, section, and/or unit."	Collective construction, carried out by all professionals in the sector, of an integrative framework for recording the problems/needs of each division, section, and/or unit.
Completion of an individual evaluation instrument and presentation for discussion in a monthly meeting.	- Difficulty in understanding how this will unfold; - The Regional Health Directorate should hold a monthly meeting with the leadership for discussion of activities and demands.	-
Reflection on their practice after weekly meetings and notes on changes/transformation of behavior and work processes in meetings.	- Change frequency to biweekly(2).	Reflection on their practice after bi-weekly meetings and notes on changes/transformation of behavior and work processes in meetings.

Source: The authors, 2021.

After the debates and adjustments to the indicators were concluded, the final stage for their approval began. As the indicators must be verifiable, understood, and have their data source clear, the organizers prepared a table with the necessary information to make these aspects clear.

Therefore, the indicators were being inserted into the table simultaneously with their agreement, with the fields "definition" and "interpretation" already described earlier, passing only through the scrutiny of the workers present regarding their validity on this occasion.

Box 3. Indicators and their definitions, interpretations, and data sources, Maringá, Paraná, Brazil, 2021

N.	Indicator	Definition	Interpretation	Data source
1	Bi-weekly meetings with workers from the division, section, and/or unit to identify the problems/needs of each sector.	Conducting bi-weekly meetings within the divisions/sections/units for discussions about identified problems/doubts.	It reflects sharing through dialogue about the issues identified in the daily work.	Minutes/attendance lists of meetings
2	Monthly meetings with representatives from each section to present the needs/problems of the sectors.	Meeting, after discussions and meetings within the sectors themselves, about the discussions and problems raised, aiming at sharing solutions and assistance.	It reflects an intersectoral effort to qualify the activities performed by professionals within the institution.	Minutes/attendance lists of meetings
3	Collective construction, carried out by all professionals in the sector, of an integrative chart for recording the problems/needs in each division, section, and/or unit.	Visual, collective, and shared tool aimed at recording and exposing problems and situations that can be improved within the divisions/sections/units, guiding bi-weekly meetings.	It allows professionals, already knowing situations to be addressed in meetings, to reflect in advance and not forget topics to be discussed.	Updating and manipulation of the chart
4	Evaluation instrument for actions developed in each division, section, and/or unit and presentation for discussion in monthly meetings.	Instrument that encompasses individual and collective activities in each sector, enabling the organization of evaluation and discussion in meetings.	It expresses the movement of reflection on practices, enabling the organization and qualification of them.	Own instrument to be created collectively
5	Reflection on their practice after bi-weekly and monthly meetings and notes on changes/transformation of behavior and work processes in meetings.	Transformation of individual and/or collective practices after reflection on them and identified problems.	It reflects the effectiveness of continuing education and the result of established processes.	Individual reflection, which can be included in the evaluation instrument for actions developed in divisions and sections

Source: The authors, 2021.

It can be observed that the indicators were easily identified as auditable since there is a culture and necessity within the institution to record actions involving meetings between collaborators in minutes, providing a physical record that can be verified.

As for the interactive board, participants found the suggestion suitable for facilitating discussion and easy identification of visualized problems. The clear exposure of problems allows them to be analyzed by everyone in the department, not remaining reserved only for those who identify them. This facilitates collaboration with other team members, combining efforts to resolve problematic situations.

The difficulty in evaluating this indicator lay in selecting someone responsible for evaluating the board since only its completion would not be verifiable due to its interactive nature, constantly being rewritten, reformulated,

having information added, and other details subtracted.

Therefore, in conjunction with the assessment, monitoring, and implementation of the other indicators, it was agreed again that, as these are issues directly related to continuing education in the institution, the evaluation and monitoring of implementation would be the responsibility of the collaborator involved in CHE at the HR. He would assist all departments/ units and divisions in the initial phases of implementation.

CRITICAL ANALYSIS

The identified barriers reflect what is experienced on digital platforms: difficulties with connection, low-quality audio, absence or low resolution of participants' images, the impossibility of using materials together, difficulty in organizing ideas because of the disorganization that the above factors can cause, distractions, and interruptions caused by the participants' location, among other challenges.

Regarding CHE, a major challenge was that most participants lacked basic knowledge of the topic. In practice, this greatly hindered the proposal's ultimate goal of creating CHE indicators for the 15th HR.

After the theoretical presentation of the policy aspects, there was an unsuccessful attempt to create indicators. It can be observed that professionals did not fully understand the attributes of PNEPS, especially its application in indicators.

Returning attention to this meeting, it is believed that greater emphasis on policy aspects could have been given, exemplifying indicators that responded to it, addressing the topic with more participatory strategies, stimulating creativity and reasoning, and extending it more on this crucial basis for the intended goal.

Thus, ignorance, combined with the novelty of the proposal and the fragility of the training action, became a weakness of the activity. However, the organizers intelligently addressed the difficulty, as they reorganized the activity, proposing reflection, evaluation, and approval of the indicators.

Individual meetings with each section allowed those who might not express their opinions due to insecurity or fear to do so more openly. When it comes to indicators to be used by the community, the opinion of all participants was crucial.

The approval of the instrument through a strategy similar to an assembly, where everyone was encouraged to respond and express their opinions, also proved to be, from the researchers' perspective, a successful strategy for achieving the team's main goal.

The return after a distancing from the produced material can lead to a reassessment, taking into account the opinions of other colleagues and thus qualifying the individually created indicators. It is worth considering that EPS is essentially collaborative, so collective creation can make them experience processes that could be utilized in future EPS moments.

In conclusion, the creation by the executing members themselves who experienced the indicators was a strengthening and driving factor for them. The creation by professionals essentially attributes value and meaning to them since they were forged by those who will bring them feedback, applicability, adherence or not, etc.

DISCUSSION

The indicators, representing an overcoming of a limit situation, can be identified as a feasible novelty, a new tool developed after overcoming a knowledge/practice, characterizing itself as a creation after a reflective and dialogical exercise. They represent new knowledge, a new material created: unprecedented and possible[16].

The development and expanded perception of educational processes, characteristic of CHE, were also verbalized. The sense of opportunity in everyday environments, in the day-to-day work, is an important outcome, as the understanding of the PNEPS can potentiate processes, identifying educational actions as opportunities to overcome limits, and not just respond quantitatively to institutional demands.

The creation of the indicators highlighted in the research was approved in partnership with the participants, thus establishing changes in the work routine, qualifying CHE through collectivity. This is associated with the PNEPS for a contextualized and problematized transformation of practices, serving as a potentializing device for learning in the health system [7].

The context of education within the health field comprises organizing knowledge in the involvement of teaching practices and curricular guidelines that translate into the formation guaranteeing the comprehensiveness of care, encouraging individual autonomy [4].

This is because building new knowledge in the practical field of work encourages participants to reflect, allowing them to apply their acquired knowledge more assertively. In this context, participatory, dialogical, and valorizing educational practices stand out[17].

The indicators listed through collectivity meet the needs and issues; this planning leads to greater autonomy and protagonism in decision-making, facing changes, elaborating programs and policies, and eliciting greater guidance and control of actions [18].

Thus, these measures of qualitative indicators of CHE are used to reassess, replan, and reorganize service activities so that they provide support for decisionmaking, aiming to improve the quality of health services provided [8].

About this statement, PNEPS brings a proposal for redefining the construction of knowledge for health workers, considering the necessary changes guided by critical reflection on daily life, and modifying the learning process in a participative and collaborative manner [19]. Thus, it transforms practices for overcoming limiting knowledge barriers in the work environment. It is worth mentioning that participatory educational practices, where the learner is the focus of the process, also present positive results when applied to the population [20].

PNEPS provides aid in the execution of CHE actions in all areas; however, despite being suggested in the daily lives of those involved, the defined operationalization guidelines do not meet the need for a participative, problematizing CHE, developed through horizontal and dialogical relationships facing daily demands for practice transformation [7,21].

Participatory decision-making in CHE corroborates the critical awareness of knowledge gaps, which arise at all times, capable of expanding perspectives on issues and guiding those involved to grasp other ways of solving organizational demands, thus qualifying professionals [22,1].

It is noteworthy that efforts to qualify professionals for the realization of the health system and practices have been implemented by health education practices inserted in the realities of healthcare environments. Thus, the insertion of educational health practices in regional and municipal management planning and the development of actions that provide spaces for teaching and learning are still incipient in management planning, requiring greater dialogue and knowledge for its execution [23].

With this, it is intended to indicate that, by making professionals aware of the constructive possibilities of group work, the consequent overcoming of problems, and the meaningful learning with impact on the service, formal or non-formal educational actions can be better utilized, ceasing to be just necessary moments to meet preestablished goals.

The thinking of educators only gains meaning from the thinking of learners, both mediated and illuminated by reality, established

through dialogue. The thinking of the former cannot exist without the latter, nor can the imposition of thinking on the other, reinforcing a domineering and creativity-suppressing practice, pruning the potential to act, create, and be subjects of their actions [24].

Listening is an indispensable attitude in teaching. By listening, the educator allows their discourse to adapt to the reality of learners, breaking the unidirectional horizontality of announcements. It is by listening that one experiences speaking with and not speaking to, which trains, mitigates exploitable competencies, and thus oppresses [25].

CONCLUSION

An effective process of reconstruction, review, analysis, presentation of difficulties, and potentialities of the developed action is observed, leading to the concrete realization of the systematization of the experience as intended.

Throughout the course of the activity, several obstacles were observed, among which the remote access during the pandemic, the need for articulation, the creation of bonds and a welcoming and dialogical space with professionals, the ideation of active methodologies in this process, the difficulty in building the conceptual theory of the public policy of continuing health education, and consequently, the construction of qualitative indicators of continuing health education itself.

It is noted that as the activity progressed and its flexibility for adaptation to the demands of the students was demonstrated, adversities could be addressed alongside the learners/participants. The creation of a participatory collaborative environment of "co-construction" proved to be a facilitator for overcoming problems.

The use of active methodologies was, from the organizers' perspective, a catalyst for achieving the objective, as the construction of indicators should essentially be done collectively. The sequential construction, not in a single meeting but gradually, as a process, facilitated participants in feeling uninhibited, secure, and comfortable when discussing the indicators.

It was observed that the indicators created collectively are in line with the national policy of continuing health education. They express a process of reflection in collective communion, promoting intra- and extra-sectorial integration, allowing different experiences and suggestions of problems to be presented and reflected upon.

The indicators essentially propose a reflective and collective process aiming at improving professional practices, as they are based on resolutions and presentations of issues with other professionals working within the institution. Thus, they corroborate with the essentiality of continuing health education: being a meaningful education in the daily work, promoting dialogicity/interprofessionalism; and being directed towards the qualification of practices and consequently health outcomes and management.

The results of this study demonstrate the need to enhance health educational actions due to the professionals' lack of knowledge in the management of theoretical and practical aspects of the PNEPS. Additionally, it shows the possibility of qualifying policy indicators with their assumptions and, in this way, improving institutional processes.

It is recommended that more studies focused on the analysis of indicators of continuing health education be developed for qualifying the field of knowledge, as well as improving and adapting them to the assumptions of PNEPS.

REFERENCES

1. Silva KL da, França BD, Marques R de C, Matos JAV de. Análise dos discursos referentes à educação permanente em saúde no Brasil (1970 A 2005). Trab educ saúde [Internet]. 2019;17(2):e0019222. Available from: https://doi.org/10.1590/1981-7746-sol00192

2. Jesus JM de, Rodrigues W. Trajetória da Política Nacional de Educação Permanente em Saúde no Brasil. Trab educ saúde [Internet]. 2022;20:e001312201. Available from: https://doi.org/10.1590/1981-7746-ojs1312

3. Machado MH, Ximenes Neto FRG. Gestão da Educação e do Trabalho em Saúde no SUS: trinta anos de avanços e desafios. Ciênc saúde coletiva [Internet]. 2018 Jun;23(6):1971–9. Available from: https://doi.org/10.1590/1413-81232018236.06682018

4. Brasil. Ministério da Saúde. Secretaria de Gestão do Trabalho e da Educação na Saúde. Departamento de Gestão da Educação na Saúde. Orientações para monitoramento e avaliação da Política Nacional de Educação Permanente em Saúde. Brasília, DF, Ministério da Saúde, 2022. Disponível em: https://bvsms.saude.gov.br/bvs/publicacoes/orientacoes_monitoramento_politica_nacional_educacao_saude.pdf. Access in: 06 Jan. 2023.

5. Campos KFC, Sena RR de, Silva KL. Permanent professional education in healthcare services. Esc Anna Nery [Internet]. 2017;21(4):e20160317. Available from: https://doi.org/10.1590/2177-9465-EAN-2016-0317

6. Gonçalves CB, Pinto IC de M, França T, Teixeira CF. A retomada do processo de implementação da Política Nacional de Educação Permanente em Saúde no Brasil. Saúde debate [Internet]. 2019 Aug;43(spe1):12–23. Available from: https://doi.org/10.1590/0103-11042019S101

7. Rossetti LT, Seixas CT, Castro EAB de, Friedrich DB de C. Permanent education and health management: a conception of nurses / Educação permanente e gestão em saúde: a concepção de enfermeiros. Rev. Pesqui. (Univ. Fed. Estado Rio J., Online) [Internet]. 2019 Jun; 11(1):129-34. Available from: https://seer.unirio.br/cuidadofundamental/article/view/6513

8. Bitencourt GR, Ferreira AFM, Amaral MHSP, Renault SMG, Silva JO, Santos KM. Uso de indicadores na avaliação do serviço de educação permanente: reflexão dos pilares da qualidade. Rev. baiana enferm. [Internet]. 2020 Nov.;35. Available from : https://periodicos.ufba.br/index.php/enfermagem/article/view/36844

9. Báo ACP, Amestoy SC, Moura GMSS de, Trindade L de L. Quality indicators: tools for the management of best practices in Health. Rev Bras Enferm [Internet]. 2019 Mar;72(2):360–6. Available from: https://doi.org/10.1590/0034-7167-2018-0479

10. Bustamante V, Onocko-Campos R, Silva AA, Treichel CA dos S. Indicadores para avaliação de Centros de Atenção Psicossocial Infantojuvenil (Capsi): resultados de uma pesquisa-intervenção. Interface (Botucatu) [Internet]. 2020;24:e190276. Available from: https://doi.org/10.1590/Interface.190276

11. Looyd RC. Quality health care: a guide to developing and using indicators. 2nd ed. Boston: Jones and Bartlet, 2019.

12. Holliday OJ. Sistematização de Experiências: aprender a dialogar com os processos. Lisboa: Publisher CIDAC, 2008.

13. Peruzzo CMK. Pressupostos epistemológicos e metodológicos da pesquisa participativa: da observação participante à pesquisa-ação. Estudios sobre las Culturas Contemporáneas, 2017(3)23. Available from: https://www.redalyc.org/jatsRepo/316/31652406009/31652406009.pdf

14. Holliday OJ. O que é sistematizar. 2ª ed. Brasília: Ministério do Meio Ambiente, 2006. p. 21-28.

15. Chavez-Tafur J. Aprender com a prática: uma metodologia para sistematização de experiências. Rio de Janeiro: Assessoria e Serviços a Projetos em Agricultura Alternativa, 2007.

16. Freire P. À Sombra Desta Mangueira. 12ª ed. São Paulo: Publisher Paz e Terra, 2019a.

17. Sokem JA dos S, Bergamaschi FPR, Watanabe EAMT, Renovato RD, Ferreira AM. Evaluation of an educational process about prevention of pressure injury. CienCuidSaude [Internet]. 2020 Feb.17 [cited 2023Oct.6];190. Available from: https://periodicos.uem.br/ojs/index.php/CiencCuidSaude/article/view/49917

18. Ferreira J, Celuppi IC, Baseggio L, Geremia DS, Madureira VSF, Souza JB de. Planejamento regional dos serviços de saúde: o que dizem os gestores?. Saude soc [Internet]. 2018 Jan.;27(1):69–79. Available from: https://doi.org/10.1590/S0104-12902018170296

19. Brasil. Ministério da Saúde. Portaria nº 198/GM de 13 de fevereiro de 2004b. Institui a Política Nacional de Educação Permanente em Saúde como estratégia do Sistema Único de Saúde para a formação e o desenvolvimento de trabalhadores para o setor Saúde e de outras providências. Diário Oficial da União. Brasília: Ministério da Saúde; 2004. Disponível em: https://www.nescon.medicina.ufmg.br/biblioteca/imagem/1832.pdf Access in: 06 Oct. 2021.

20. Alves CAC, Sarinho SW, Belian RB. Vídeo educativo participativo para humanização da assistência em saúde. Saude e pesqui. 2023 Apr./Jun.;16(2). Doi: https://doi.org/10.17765/2176-9206.2023v16n2.e11320

21. Brasil. Ministério da Saúde. Secretaria de Gestão do Trabalho e da Educação na Saúde. Departamento de Gestão da Educação na Saúde. Política Nacional de Educação Permanente em Saúde: o que se tem produzido para o seu fortalecimento?. Brasília, DF, 2018. Disponível em: https://bvsms.saude.gov.br/bvs/publicacoes/politica_nacional_educacao_permanente_saude_fortalecimento.pdf Access in: 15 Set. 2020.

22. Macedo KD da S, Acosta BS, Silva EB da, Souza NS de, Beck CLC, Silva KKD da. Active learning methodologies: possible paths to innovation in health teaching. Esc Anna Nery [Internet]. 2018;22(3):e20170435. Available from: https://doi.org/10.1590/2177-9465-EAN-2017-0435

23.Ferreira L, Barbosa JS de A, Esposti CDD, Cruz MM da. Educação Permanente em Saúde na atenção primária: uma revisão integrativa da literatura. Saúde debate [Internet]. 2019 Jan;43(120):223–39. Available from: https://doi.org/10.1590/0103-1104201912017

24. Freire P. Pedagogia do Oprimido. 71ª ed. São Paulo: Publisher Paz e Terra, 2019b.

25. Freire P. Pedagogia da Autonomia: saberes necessários à prática educativa. 63ª ed. São Paulo: Publisher Paz e Terra, 2020.

Received: 24 oct. 2023
Accepted: 20 jan. 2024