



FACTORS ASSOCIATED WITH CONTINUING EDUCATION PRIORITIES AMONG HEALTH WORKERS

FATORES ASSOCIADOS ÀS PRIORIDADES DE EDUCAÇÃO PERMANENTE ENTRE TRABALHADORES DA SAÚDE

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ABSTRACT: The objective was to identify priority themes for continuing health education among workers of the Health Care Network and the associated factors. This was a cross-sectional study conducted with 215 health workers in a municipality in the central-west region of Brazil. Data were collected using electronic instruments between June and July 2022, based on themes listed as needs in the State Health Plan, and were submitted to inferential statistical analysis. "Reception with risk classification," "first aid," "management of situations of violence, crisis, and psychotic episodes," and "high-risk pregnancies" were identified as themes of common interest among the workers. Associations were found between age group, length of service, educational level, and work shift and the priority themes. Younger professionals, with shorter length of service and educational levels ranging from secondary to higher education, prioritized the themes "first aid," "reception with risk classification," and "management of situations of violence, crisis, and psychotic episodes" across different levels of care.

KEYWORDS: Unified Health System. Education, Continuing. Health Human Resource Training.

RESUMO: O objetivo foi identificar as temáticas prioritárias para a educação permanente em saúde entre trabalhadores da Rede de Atenção à Saúde e os fatores associados. Trata-se de um estudo transversal, com 215 trabalhadores da área da saúde atuantes em um município do centro-oeste brasileiro. Realizou-se a coleta com instrumentos eletrônicos, entre junho e julho de 2022, a partir dos temas elencados como necessidade no Plano Estadual, sendo submetidos à análise estatística inferencial. "Acolhimento com classificação de risco, "primeiros-socorros", "manejo de situações de violência, crise e surto psicótico" e "gestações de alto risco" foram temas de interesse comum apontados pelos trabalhadores. Verificou-se a associação entre faixa etária, tempo de serviço, nível de escolaridade e turno de trabalho e temáticas prioritárias. Profissionais mais jovens, com menos tempo de serviço e com escolaridade entre nível médio e superior, priorizaram os temas "primeiros-socorros", "acolhimento com classificação de risco" e "manejo de situações de violência, crise e surto psicótico" nos diferentes níveis de atenção.

PALAVRAS-CHAVE: Capacitação de Recursos Humanos em Saúde. Educação Continuada. Sistema Único de Saúde.

INTRODUCTION

The Brazilian National Policy for Continuing Education in Health (In Portuguese, *Política Nacional de Educação Permanente em Saúde* - PNEPS), established in 2004, is a strategy for transforming professional practices and work organization, becoming an institutional intervention device for the Brazilian Health System (*Sistema Único de Saúde* - SUS).¹ As learning in/through work, continuing health education (CHE) represents a pedagogical proposal and a learning policy for dealing with the complexity of health production, professional training and work development.²

PNEPS is supported by pillars such as meaningful learning, which is developed in pedagogical experiences in healthcare services that promote reflection on the practices learned and their constant updating.¹ It takes into account aspects such as changes in the epidemiological profile, the organization of healthcare services and the ecological and health awareness of the actors involved, strengthening the health reform movement and the SUS implementation.³

CHE has been highlighted as a national policy aligned with the SUS principles. In this regard, it has repercussions on learning relationships, the inter-institutional pedagogical process, social control of health and inter-federative relations. However, PNEPS implementation has occurred differently across the country, depending on several factors such as the context in which states and municipalities are inserted and the regionalization level.⁴

For instance, Mato Grosso do Sul state faces limitations due to the fact that 78.6% of municipalities do not have specific CHE sectors. Furthermore, 53.6% do not have institutions that train healthcare professionals with secondary or higher education. Despite this, the development of a State Plan for Continuing Education has progressed in the last decade and has proven to be a decentralized process. This occurred because it was discussed in macro and micro health regions, allowing the involvement of stakeholders and contributing to improving the resolution of healthcare services offered to the population.⁵⁻⁶

CHE is recognized as an emancipatory practice with the potential for the integration and consolidation of knowledge, professional redefinition, expansion of self-management capacity, and self-assessment and strengthening of health actions in the territory.⁷ However, there is still a need to advance in the field of investments in educational processes and overcome obstacles in changes to work spaces and reorganization of practices, based on gaps that exist between the real scenario and the health system ideologies.

Another important point to be highlighted is the fact that educational actions developed with health workers are often based on instrumental education, which is fragmented and disconnected from the daily work context. Thus, another challenge is to develop educational actions with health workers in a reflective, participatory, continuous way, focusing on their needs.³ In view of this, the question is: what are the thematic priorities for continuing education from workers' perspective in the Healthcare Network of a small municipality in Mato Grosso do Sul and their associated factors? The priority topics for CHE actions among workers in the Healthcare Network and associated factors were identified.

METHODOLOGY

STUDY DESIGN

This is a cross-sectional study with a quantitative approach, which used the STrengthening the Reporting of OBservational studies in Epidemiology criteria for its construction. This study is part of a

global project entitled “Development and implementation of continuing education strategies with workers in the Healthcare Network”, approved by the *Universidade Federal de Mato Grosso do Sul* Research Ethics Committee, under Opinion 5,472,063 of 2022.

CONTEXT

The research was conducted in a small municipality located in the countryside of Mato Grosso do Sul state, in the Brazilian Midwest. The municipality has an estimated population of 33,547 inhabitants. It is a healthcare hub for a microregion that encompasses five municipalities (where a total of 82,916 inhabitants reside) in northern Mato Grosso do Sul, responding to the demands for emergency care, surgical procedures and referrals for specialized care.

PARTICIPANTS

The participants were health workers from the municipality, from the three healthcare levels (primary, secondary and tertiary) and different establishments, such as Family Health Units, Psychosocial Care Centers, Specialized Assistance Services, Mobile Emergency Care Services, hospitals, among others. There were no restrictions related to positions (specific training in the health area or not) or length of experience. Workers linked exclusively to private healthcare services, self-employed workers and those who were not working during the data collection period, i.e., on vacation, leave or leave, were excluded from the study.

SAMPLE SIZE

According to the Brazilian National Registry of Health Establishments (In Portuguese, *Cadastro Nacional de Estabelecimentos de Saúde* - CNES), the municipality under study had 826 health workers at the time of data collection. Of these, 706 (85.47%) worked in healthcare services or establishments that provide care through the SUS. A total of 145 workers were excluded, who were registered as linked to private services (hospitals, clinics and laboratories), as self-employed or to services such as regional health centers, Military Fire Departments and Hemotherapy Centers, and 22 workers who appeared in duplicate in the CNES registry. A total of 539 health workers were eligible.

To calculate the sample size, performed using the GPower 3.1.9.7, the formula for the chi-square test was adopted from contingency tables. For this purpose, the following values were considered: effect size equal to 0.25 (classified between small and medium), which indicates the possible differences in proportions between groups compared in the analysis; α error equal to 0.05 (5%); test power equal to 0.80 (80%); and 5 degrees of freedom. The minimum sample calculated was 205 participants. The sampling was non-probabilistic.

COLLECTION INSTRUMENTS

In data collection, an instrument for sociodemographic, occupational, health establishment and educational activity characterization developed by the researchers was used. An instrument for identifying continuing education needs among health workers was also developed, based on the Mato Grosso do Sul State Plan for Continuing Education in Health 2019-2022.⁵ The topics were listed in 32 main areas, which were included in a form prepared by the researchers and asked professionals to assign a

degree of need to address the topic according to their daily routine. When completing the instrument, respondents assessed the listed topics and indicated one of four possible answers indicating the degree of need to address the topics in CHE activities: “extremely necessary”; “very necessary”; “slightly necessary”; and “not necessary”. The 32 topics are listed in Chart 1.

Chart 1. Priority topics for continuing education in health according to the State Plan for Continuing Education of Mato Grosso do Sul 2019-2022.

nº	Topic
1	Reception with risk stratification in primary and hospital care
2	Management of high-risk pregnant women
3	Protocol for care for pregnant women, postpartum women and newborns
4	Strengthening adherence to prenatal care, postpartum care, normal delivery, and partner adherence to prenatal care
5	Syphilis management during pregnancy
6	Encouragement of breastfeeding
7	Nutrition in the first years of life
8	Family planning
9	Singular Therapeutic Project
10	Process management
11	Referral and counter-referral
12	Flow of user care at the network's care points
13	Flowcharts and bed management in healthcare services
14	Flow of care for patients in emergency situations
15	Deepening trauma care
16	First aid for drivers, community health workers and educational institutions
17	Patient safety
18	Management of crisis situations and psychotic outbreaks
19	Management of situations of violence
20	Prevention actions in mental health, alcohol and other drugs
21	Ethnic and cultural issues of the indigenous population
22	Risk stratification of chronic diseases
23	Health education strategies based on epidemiological data focusing on self-care, adherence to medication and dietary treatment, physical activity, shared care groups, prevention and health promotion
24	Use of work technologies to promote health
25	Care for people with ostomies
26	Management of people with disabilities (hearing and visual), people with syndromes (such as autism) and their families
27	Care management tools such as genogram, ecomap and Singular Therapeutic Project
28	Advanced Life Support
29	Care flow for people with mental suffering or disorders and users of crack, alcohol and other drugs
30	Harm reduction policy
31	Information systems and notification forms
32	Policies for screening and starting cancer treatment

DATA COLLECTION PROCEDURES

Data collection took place electronically between June and July 2022. The collection instruments and the Informed Consent Form were included in Google Forms® and sent to workers with the support of managers. To this end, they were forwarded to the institutional email address, as well as via messaging application, with weekly reminders sent until the sample was reached.

VARIABLES

The variables of interest for this study consisted of the perception of the need to address the topics for CHE activities. The perception of the need to address these topics was categorized as “extremely necessary” and “lesser need”. The other variables were “age group”, “sex”, “skin color”, “marital status”, “education level”, “position”, “length of service”, “work shift”, “weekly working hours”, “labor regime”, “work establishment”, “participation in training course” and “affinity for type of educational activity”.

Based on the “workplace” variable, the “care level” variable was created, with the following grouping: primary care – Family Health Unit, Health Academy, Family Health Support Center and Vector Control Coordination; secondary care – Polyclinic, Specialized Assistance Service, Mobile Emergency Care Service, Psychosocial Care Center mode I, Zoonosis Control Center, Health Surveillance and Municipal Health Department; and tertiary care: hospitals.

BIAS

The aim was to control the inclusion of participants in the study, according to the proportions of health workers linked to establishments, in order to obtain subsamples compatible with the study population. Throughout electronic data collection, contacts were made with the Municipal Department of Public Health of the municipality and with the heads of the establishments, in order to encourage the participation of workers according to the need to achieve proportionality in the sample composition in relation to the population of each establishment. Delimiting the time for data collection to one month was able to ensure greater data coherence in relation to the healthcare context experienced by workers.

STATISTICAL METHODS

Absolute and relative frequencies were used to describe the sample according to sociodemographic and occupational variables of health establishments and related to educational activities, according to the healthcare level. Moreover, descriptive analysis was performed to express the frequencies of “extremely necessary” and “lesser need” in relation to each CHE topic by care level, in order to present a ranking of the six priority topics listed by the professionals based on the frequency of the “extremely necessary” category and expressed by care level.

Pearson’s chi-square test was applied to verify the bivariate association between the perception of the need to address each topic investigated and healthcare level. An analysis of the association between the perception of the need to address CHE topics and sociodemographic, occupational and educational activity-related variables was also performed using Pearson’s chi-square test, linear trend chi-square test and Fisher’s exact test, in the Statistical Package for the Social Sciences version 20. Prevalence Ratios and respective 95% Confidence Intervals were calculated using the Open Epi website (www.openepi.com/Menu/OE_Menu.htm). Finally, p-values equal to or less than 0.05 were considered for association.

RESULTS

The sample effectively reached was 215 participants. Of these, 102 (47.4%) worked in primary healthcare, 53 (24.7%) in secondary healthcare and 60 (27.9%) in tertiary healthcare. In general, workers were predominantly female (74.4%), brown (55.8%), with higher education (39.1%), nursing technicians

(19.5%), with length of service between two and five years (74%), weekly workload of 40 hours (73.5%) and statutory regime (51.2%). As for positions, according to care level, the most frequent were community health workers (47.1%), Municipal Department of Public Health (39.6%) workers and primary, secondary and tertiary care nursing technicians (38.3%), respectively.

Regarding strategies for educational activities, the specific type most preferred by workers was the lecture (primary care (25.5%); secondary care (15.1%); and tertiary care (25%)), followed by the discussion circle, in primary care (14.7%), and simulation in practice in secondary care (9.4%), in tertiary care (15%). Most professionals at each care level opted for other types of educational activities (such as seminars, workshops and case studies) or a combination of different types: 38.2% in primary care; 62.3% in secondary care; and 33.3% in tertiary care.

Table 1 presents the frequencies of the categories “extremely necessary” and “lesser need” for the topics investigated, according to healthcare levels. Furthermore, the priority topics for each care level were identified, arranged below in decreasing order of the response “extremely necessary”: 18, 19, 2, 16, 14 and 7 in primary care; 1, 19, 4, 11, 18 and 2 in secondary care; and 18, 16, 1, 17, 2 and 14 in tertiary care.

Table 1. Classification of topics for continuing health education by workers at different care levels. Mato Grosso do Sul, Brazil, 2022.

nº	Primary care (n = 102)		Secondary care (n = 53)		Tertiary care (n = 60)		p-value *
	EN	LN	EN	LN	EN	LN	
	n (%)	n (%)	n (%)	n (%)	n (%)	n (%)	
1	40 (18.6)	62 (60.8)	39 (73.6)	14 (26.4)	47 (78.3)	13 (21.7)	0.046
2	68 (66.7)	34 (33.3)	35 (66.0)	18 (34.0)	45 (75.0)	15 (25.0)	0.477
3	58 (56.9)	44 (43.1)	34 (64.2)	19 (35.8)	39 (65.0)	21 (35.0)	0.507
4	55 (53.9)	47 (46.1)	36 (67.9)	17 (32.1)	40 (66.7)	20 (33.3)	0.134
5	59 (57.8)	43 (42.2)	35 (66.0)	18 (34.0)	39 (65.0)	21 (35.0)	0.512
6	62 (60.8)	40 (39.2)	34 (64.2)	19 (35.8)	41 (68.3)	19 (31.7)	0.626
7	64 (62.7)	38 (37.3)	28 (52.8)	25 (47.2)	37 (61.7)	23 (38.3)	0.467
8	58 (56.9)	44 (43.1)	32 (60.4)	21 (39.6)	39 (65.0)	21 (35.0)	0.593
9	40 (39.2)	62 (60.8)	21 (39.6)	32 (60.4)	26 (43.3)	34 (56.7)	0.866
10	36 (35.3)	66 (58.5)	22 (41.5)	31 (58.5)	24 (40.0)	36 (60.0)	0.707
11	48 (47.1)	54 (52.9)	36 (67.9)	17 (32.1)	33 (55.0)	27 (45.0)	0.047
12	46 (45.1)	56 (54.9)	34 (64.2)	19 (35.8)	33 (55.0)	27 (45.0)	0.071
13	47 (46.1)	55 (53.9)	23 (43.4)	30 (56.6)	24 (40.0)	36 (60.0)	0.752
14	65 (63.7)	37 (36.3)	31 (58.5)	22 (41.5)	44 (73.3)	16 (26.7)	0.235
15	59 (57.8)	43 (42.2)	27 (50.9)	26 (49.1)	43 (71.7)	17 (28.3)	0.067
16	66 (64.7)	36 (35.3)	30 (56.6)	23 (43.4)	47 (78.3)	13 (21.7)	0.044
17	55 (53.9)	47 (46.1)	30 (56.6)	23 (43.4)	46 (76.7)	14 (23.3)	0.013
18	70 (68.6)	32 (31.4)	36 (67.9)	17 (32.1)	48 (80.0)	12 (20.0)	0.237
19	69 (67.6)	33 (32.4)	38 (71.7)	15 (28.3)	41 (68.3)	19 (31.7)	0.871
20	62 (60.8)	40 (39.2)	34 (64.2)	19 (35.8)	38 (63.3)	22 (36.7)	0.903
21	32 (31.4)	70 (68.6)	12 (22.6)	41 (77.4)	23 (38.3)	37 (61.7)	0.198
22	54 (52.9)	48 (47.1)	28 (52.8)	25 (47.2)	34 (56.7)	26 (43.3)	0.884
23	57 (55.9)	45 (44.1)	27 (50.9)	26 (49.1)	34 (56.7)	26 (43.3)	0.798
24	57 (55.9)	45 (44.1)	27 (50.9)	26 (49.1)	35 (58.3)	25 (41.7)	0.725
25	47 (46.1)	55 (54.7)	24 (45.3)	29 (54.7)	29 (48.3)	31 (51.7)	0.942
26	56 (54.9)	46 (45.1)	33 (62.3)	20 (37.7)	39 (65.0)	21 (35.0)	0.403
27	38 (37.3)	64 (62.7)	24 (45.3)	29 (54.7)	28 (46.7)	32 (53.3)	0.425
28	51 (50.0)	51 (50.0)	27 (50.9)	26 (49.1)	40 (66.7)	20 (33.3)	0.096
29	60 (58.8)	42 (41.2)	33 (62.3)	20 (37.7)	38 (63.3)	22 (36.7)	0.829
30	44 (43.1)	58 (56.9)	30 (56.6)	23 (43.4)	29 (48.3)	31 (51.7)	0.281
31	49 (48.0)	53 (52.0)	27 (50.9)	26 (49.1)	33 (55.0)	27 (45.0)	0.693
32	63 (61.8)	39 (38.2)	33 (62.3)	20 (37.7)	40 (66.7)	20 (33.3)	0.810

Legend: EN – extremely necessary; LN – lesser need; *Pearson’s chi-square test; n – absolute frequency; % - relative percentage frequency. Source: prepared by the authors.

Table 2 shows the association of priority topics with sociodemographic and occupational variables.

Table 2. Associations of priority topics for primary care and secondary care according to sociodemographic and occupational variables. Mato Grosso do Sul, Brazil, 2022.

Sociodemographic and professional variables	Primary care					
	Topic 16 - First aid applied to drivers, community health workers and educational institutions					
	EN		LN		p-value	PR (95%CI)
n	%	n	%			
Length of service						
Up to 2 years	16	84.2	3	15.8	0.047**	1.55 (1.12 – 2.15)
3 to 5 years	14	50.9	9	39.1		1.12 (0.74 – 1.71)
6 to 10 years	10	83.3	2	16.7		1.54 (1.07 – 2.21)
More than 10 years	26	54.2	22	45.8		1
	Secondary care					
	Topic 1 - Reception with risk stratification in primary and hospital care					
	EN		LN		p-value	PR (95%CI)
	n	%	n	%		
Education level						
High school	12	85.7	2	14.3	0.042**	1.62 (0.98 – 2.66)
Higher education	18	81.8	4	18.2		1.54 (0.94 – 2.52)
Graduate studies	9	52.9	8	47.1		1
	Topic 2 - Management of high-risk pregnancy					
	EN		LN		p-value	PR (95%CI)
	n	%	n	%		
Education level						
High school	11	78.6	3	21.4	0.036**	1.91 (1.01 – 3.58)
Higher education	17	77.3	5	22.7		1.88 (1.02 – 3.46)
Graduate studies	7	41.2	10	58.8		1
	Topic 18 - Management of crisis situations and psychotic outbreaks					
	EN		LN		p-value	PR (95%CI)
	n	%	n	%		
Age range						
20 to 29 years	9	90.0	1	10.0	0.034**	1.73 (1.13 – 2.66)
30 to 39 years	10	76.9	3	23.1		1.48 (0.91 – 2.39)
40 years or older	13	52.0	12	48.0		1
Race/color						
Brown or black	17	56.7	13	43.3	0.045*	1
White	19	82.6	4	17.4		1.46 (1.01 – 2.10)
Type of educational activity						
Discussion circle	1	33.3	2	66.7	0.016***	1
Lecture	7	87.5	1	12.5		2.62 (0.52 – 13.28)
Simulation with practice	3	60.0	2	40.0		1.80 (0.31 – 10.39)
Video lesson	0	0.0	3	100.0		---
Group discussion	0	0.0	1	100.0		---
Other types/associations	25	75.8	8	24.2		2.27 (0.45 – 11.39)
	Topic 19 - Management of situations of violence					
	EN		LN		p-value	PR (95%CI)
	n	%	n	%		
Age range						
20 to 29 years	10	100.0	0	0.0	0.023***	1.67 (1.21 – 2.29)
30 to 39 years	10	76.9	3	23.1		1.28 (0.83 – 1.98)
40 years or older	15	60.0	10	40.0		1

Legend: EN – extremely necessary; LN - lesser need; PR - Prevalence Ratio; 95%CI - 95% Confidence Interval; *Chi-square test; **Chi-square test for linear trend; ***Fisher's exact test.

In tertiary care, there was an association between work shift and topic 1, with higher proportions of prioritization observed in the day shift (Table 3). Regarding topic 16, there was an association with education level, with a higher prevalence of prioritization among those with elementary education,

compared to those with graduate degrees (Table 3). The association between work shift and topic 18 was not confirmed by the association measure (Table 3).

Table 3. Associations of priority topics for tertiary care according to sociodemographic and occupational variables. Mato Grosso do Sul, Brazil, 2022.

Sociodemographic and professional variables	Tertiary care					
	Topic 1 - Reception with risk stratification in primary and hospital care					PR (95%CI)
	EN		LN		p-value	
Work shift	n	%	n	%		
Morning	4	80.0	1	20.0	2.13 (0.78 – 5.77)	
Afternoon	3	37.5	5	62.5	1	
Daytime (morning and afternoon)	16	94.1	1	5.9	0.021*** 2.51 (1.02 – 6.19)	
Nighttime	20	83.3	2	16.7	2.42 (0.98 – 5.99)	
Other	4	66.7	2	33.3	1.78 (0.61 – 5.12)	
Topic 16 - First aid applied to drivers, community health workers and educational institutions						
Education level	EN		LN		p-value	PR (95%CI)
	n	%	n	%		
	Elementary school	2	100.0	0	0.0	1.86 (1.12 – 3.07)
High school	22	84.6	4	15.4	0.041** 1.57 (0.92 – 2.67)	
Higher education	16	84.2	3	15.8	1.56 (0.91 – 2.68)	
Graduate studies	7	53.8	6	46.2	1	
Topic 18 - Management of crisis situations and psychotic outbreaks						
Work shift	EN		LN		p-value	PR (95%CI)
	n	%	n	%		
	Morning	4	80.0	1	20.0	1.60 (0.70 – 3.63)
Afternoon	4	50.0	4	50.0	1	
Daytime (morning and afternoon)	13	76.5	4	23.5	0.029*** 1.53 (0.73 – 3.21)	
Nighttime	23	95.8	1	4.2	1.92 (0.95 – 3.85)	
Other	4	66.7	2	33.3	1.33 (0.54 – 3.26)	

Legend: EN – extremely necessary; LN - lesser need; PR - Prevalence Ratio; 95%CI - 95% Confidence Interval; *Chi-square test; **Chi-square test for linear trend; ***Fisher's exact test.

DISCUSSION

The data obtained in this study show that the management of high-risk pregnancies (2) remained a priority in CHE at all three care levels. Experiencing care during pregnancy allows us to understand that monitoring encompasses the entire Healthcare Network, starting with reproductive planning, prenatal care and postpartum care.⁸ Prenatal care is generally initiated and monitored by the primary care team, and if the pregnancy is or becomes high-risk (due to the identification of some clinical condition or risk factor), monitoring should also be carried out by professionals working at other points in the network.

In the case of high-risk pregnancies, monitoring is shared by secondary care, which is permeated by challenges, such as poor access to the care network, medications, tests and resources.⁹ A study aimed at describing the organization of maternal and child health clinics using the healthcare planning methodology found low numbers of continuing education activities, and in the first stage, there had been zero meetings between teams to develop a care plan, case management, integrated training and technical-scientific meetings between professionals to discuss clinical guidelines, technical documents and updates.¹⁰ In the second year, these actions occurred three to four times, which, although demonstrating improvement, is still insufficient to meet the needs for improving healthcare services.

A statistically significant association was found between professionals with secondary and higher education and the need for educational activities on the management of high-risk pregnancies. To overcome such obstacles, CHE could be a strategy for implementing improvements in the service, especially because acute moments can occur even in consultations with normal risk at all care levels, which requires the team to have technical competence for early identification and rapid and appropriate management in order to reduce cases of maternal and child death and promote health.

Still regarding prenatal care, vertically transmitted infectious diseases, such as syphilis, are investigated during pregnancy, which requires rapid diagnosis and treatment in order to prevent *Treponema pallidum* transmission.¹¹ Syphilis management during pregnancy (5) is an indicator of the quality of care, since congenital syphilis infers the fragility of prenatal care, highlighting the need to improve professional qualifications and the provision of supplies for diagnosis and adequate treatment.¹² Therefore, actions to prevent congenital syphilis are linked to the guidelines provided by healthcare professionals during prenatal care and to the adherence of pregnant women to monitoring, citing serological screening and, if infected, the management of effective treatment as soon as possible.¹³

The Notifiable Diseases Information System highlighted 86,111 cases of gestational syphilis reported in Brazil during 2023 and the estimated percentage rate of 34 cases per 1,000 live births.¹⁴ In view of this, there is an urgent need for public policies and government programs to provide health education with a focus on prevention and health promotion,¹³ updating professionals on screening, diagnosis, management and drug treatment.

Regarding the identification of priority topics by participants from the three care levels, the management of crisis situations and psychotic outbreaks (18) was also highlighted, having a significant association with secondary care professionals aged between 20 and 29 years. These findings corroborate a study carried out in São Paulo through workshops, which concluded that the asylum culture rooted in healthcare services is not easily replaced and that CHE can favor dialogue and the rethinking of health practices.¹⁵

It is worth highlighting that, in a psychotic crisis, patients' critical judgment is compromised, and disorganized behavior may accompany the condition.¹⁶ Since a person suffering from a psychotic episode does not have the ability to resolve or cope with it on their own, this situation is considered a psychiatric emergency.¹⁷ Care for individuals experiencing psychotic crises must be provided in the environment where they are at the time of the crisis, as there is no exclusive location for care in these situations,¹⁸ which corroborates the need to train professionals at the three care levels.

Early identification of signs of mental disorders can be a strategy for promoting health and preventing psychotic crises. Hence, primary care professionals, because they are closer to the community and have bonding as one of their care goals, are in a privileged position to detect mental disorders.¹⁹ However, the deep-rooted stigma surrounding mental illness makes it difficult to take action on the issue, which hinders patient management.¹⁹ Thus, matrix support to maximize actions and services in the area of mental health should be considered as a continuing education strategy¹⁵, allowing professionals working at different network levels to discuss their difficulties and learn through collaboration.

In tertiary care, a study that sought to understand nursing practices when dealing with psychiatric patients in an emergency hospital highlighted weaknesses and stigmas, such as the feeling of fear, concern and vulnerability of professionals, while providing assistance to this user, as well as the use of chemical and mechanical containment practices as the only alternative for moments of crisis.²⁰ Furthermore, it reveals a deficiency in professional qualification, which points to the need for training in the care of psychiatric patients, supporting the findings of this study.

The stigma attached to psychiatric patient care is a reflection of a humanization policy that is not widely incorporated by professionals. In this sense, continuing education regarding the reception with risk stratification in primary and hospital care (1) was shown to be a priority in secondary and tertiary care, and in the latter, a significant association was obtained with greater need described by daytime professionals. The Emergency Care Network determines that low-severity demands be received within the scope of primary care, indicating the responsibility of this care level regarding the care of acute or chronic-acute complaints in the area covered by the unit in which it is located.²¹ That said, users still suffer from lack of information and appear in primary care services with simple complaints in Secondary Care Units, causing losses in the network flow.²² This fact brings to light another priority highlighted in the present study to be discussed at two care levels: the flow of care for patients in emergency situations (14).

Continuing education in first aid for drivers, community health workers and educational institutions (16) is necessary at primary care levels, especially for professionals with zero to two years of experience or six to ten years of experience, and at tertiary care levels, for workers with education up to elementary school. This fact corroborates a study that showed that training in first aid is still incipient, leading to insecurity and difficulties in providing adequate care.²³ Since teaching environments are located within the territory of Basic Health Units, as well as where individuals develop interpersonal relationships for a long period of time, it is essential that this topic be addressed.

The management of situations of violence (19) was listed as a priority in primary and secondary care, especially for professionals aged between 20 and 29 in secondary care. It is known that situations of violence involve multifaceted situations. Thus, there are several perspectives regarding the possible causes. Through a comprehensive approach, psychological factors, personal relationships, among other internal and external factors, can be verified.²⁴ Another point worth highlighting is the violence that professionals themselves suffer while providing care. Violence in the workplace is considered an important risk factor, as it has negative impacts on occupational health, citing as consequences professional apathy, low productivity, substance abuse, as well as risk of depression and suicide.²⁵

If a professional feels coerced or under threat, the quality and safety of the care provided will be compromised.²⁶ Therefore, it is conjectured that, in addition to working on ongoing education on how to approach cases of urban violence, which are increasingly significant, it is also important to offer tools to cope with violence experienced in daily work.

It was possible to verify the association of some factors with priority topics such as “first aid”, “reception with risk stratification” and “management of situations of violence, crisis and psychotic outbreak” at the different care levels. The identification of factors such as age group, education level, length of service and work shift allows us to infer that, in addition to differences observed in the prioritization of topics regarding the care level, there are also differences between professionals at the same level, but who have different sociodemographic and occupational characteristics, which should be taken into account for the planning and implementation of CHE actions.

In this study, younger professionals, with less time in the service and with a high school or college education, prioritized the topics “first aid”, “reception with risk stratification” and “management of situations of violence, crisis and psychotic outbreak”. This finding may indicate insecurity of these professionals due to the shorter time or lower training level in the health area in relation to topics that suggest situations of urgency or crisis, which require qualification. This weakness is not exclusive to this investigation, and is supported by a study that analyzed primary healthcare professionals’ knowledge about violence against women, finding young professionals who had not had content on how to deal with situations of violence within the professional training on the topic offered by the health institution.²⁷ Likewise, the difference in prioritization according to work shift may suggest differences in training needs,

depending on the demands and service profile that workers most often face, and the period in which they work.

Health workers identify important topics in their daily lives. However, the literature indicates weaknesses in CHE actions regarding the adequacy of significant topics for professional practice. In primary healthcare, there is repetition of topics or even disagreement between the topics and the reality of the services.²⁸ In the field of psychosocial care, the need for training in mental health and reference to specific topics emerges mainly due to the incipient training of workers in the area.²⁹

In general, in the health area, we are faced with a rigid work process model that leaves little room for the subjective aspects of practice and the care setting. As a consequence, the ethical and political dimension of CHE is little used.³⁰ Dissatisfaction is heightened by the lack of integration of flows and management between the Healthcare Network points and the confrontation of work overload, which creates obstacles to comprehensive healthcare.³¹ In this sense, managers must encourage learning at work to become a routine practice in services, freeing up space in the agenda for workers to share difficulties between the different points of care and educate themselves through the sharing of experiences and information.

PRACTICAL IMPLICATIONS

CHE, as a transformative practice in health work, presupposes that workers are integrated into the process of planning continuing education actions. In this sense, the results of this study favor the practice by placing the worker as a subject in the educational process, identifying the educational needs observed in daily work, which can support educational actions that favor meaningful and empowering learning.

CONCLUSION

The topics “reception with risk stratification”, “first aid” and “management of situations of violence, crisis, psychotic outbreak and high-risk pregnancy” were priorities among workers at different healthcare levels. It was possible to verify the bivariate association of some factors (age group, length of service, education level and work shift) with priority topics such as “first aid”, “reception with risk stratification” and “management of situations of violence, crisis and psychotic outbreak” at different care levels. Identifying such nuances allows educational actions to be planned according to the profile of professionals and with topics of personal interest based on local reality, which can allow the achievement of significant learning.

Although limited to one municipality, it is suggested that the experience of consulting health workers before planning CHE actions allows for a deeper understanding of the local reality and respect for the PNEPS principles, when considering experiences, and may constitute a possibility of increasing adherence to the proposed activities. Hence, future debates should include educational interventions based on the local needs listed and changes in behavior and professional satisfaction resulting from the actions implemented.

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