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DIAGNOSIS OF THE SITUATION OF HEALTH WORKERS AND THE TRAINING PROCESS AT A REGIONAL CENTER FOR PROFESSIONAL HEALTH EDUCATION[1]

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The policy of professional health education has been put into operation by the centers of professional health education in a decentralized way. Aiming to identify the needs of the health sector at a regional level, a survey was carried out to investigate the situation of workers in the public health network of 22 cities in the 10th Paraná Health District, Brazil. Questionnaires and document analysis were used in this qualitative and quantitative exploratory study. Results revealed that 35.6% of the workers did not participate in any educational activities between 2004 and 2006. In terms of work contracts, 78.7% had only one job, 50.2% were government employees, and 25.2% had unstable contracts, showing that the sector incorporated the productivity and flexibility rationales. The conclusion is that the centers of professional education, jointly with teaching and management institutions, need to clearly define policies for the health sector at a regional level.

DESCRIPTORS: human resources; education, continuing; single health system

DIAGNÓSTICO DE LA SITUACIÓN DE LOS TRABAJADORES DE LA SALUD Y EL PROCESO DE FORMACIÓN EN EL POLO REGIONAL DE EDUCACIÓN PERMANENTE DE LA SALUD

La política de educación continuada en salud ha sido ejecutada por los Polos de Educación Permanente, de manera descentralizada. Para identificar las necesidades regionales del sector, se llevó a cabo el levantamiento de la situación de los trabajadores de la red pública de salud de 22 municipios perteneciente a la 10ª Región de Salud de Paraná. La investigación exploratoria, con enfoque cualitativo y cuantitativo, se utilizó de cuestionarios y del análisis documental. Los resultados mostraron que 35,6% de los trabajadores no participó en ninguna actividad de formación entre 2004 y 2006. En relación al vínculo de trabajo, 78,7%, tenían solamente un empleo, el 50,2% eran funcionarios concursados y 25,2% tenían contratos precarios, poniendo de relieve la incorporación de la lógica de productividad y flexibilización en el sector. Se concluye por la necesidad de contar con una política para el sector de la salud a nivel regional, con participación de los órganos formadores y de gestión del sistema de salud.

DESCRIPTORES: recursos humanos; educación continua; sistema único de salud

DIAGNÓSTICO DA SITUAÇÃO DOS TRABALHADORES EM SAÚDE E O PROCESSO DE FORMAÇÃO NO POLO REGIONAL DE EDUCAÇÃO PERMANENTE EM SAÚDE

A política de educação permanente em saúde vem sendo operacionalizada pelos Polos de Educação Permanente, descentralizadamente. Visando contribuir para a identificação das necessidades regionais do setor, realizou-se levantamento da situação dos trabalhadores da rede pública de saúde de 22 municípios da 10ª Regional de Saúde do Paraná. A pesquisa exploratória, com abordagem qualitativa e quantitativa, utilizou de questionário e análise documental para a coleta de dados. Os resultados revelaram que 35,6% dos trabalhadores não participaram de nenhuma atividade de formação entre 2004 e 2006. Em relação ao vínculo empregatício, 78,7%, possui apenas um vínculo, 50,2% são estatutários e 25,2% são contratados de forma precária, evidenciando a incorporação da lógica da produtividade e da flexibilização no setor. Conclui-se pela necessidade de definição clara do Polo de política para o setor de saúde que envolva os órgãos formadores e de gestão do sistema de saúde em nível regional.

DESCRITORES: recursos humanos; educação continuada; sistema único de saúde

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INTRODUCTION

The new dynamics of production has led to intense transformation, especially in the labor area, through the incorporation of new management modes and technology, reorganizing productive processes, reducing work positions in the industry and contributing to the expansion of the service sector[1]. In the health area, as from the 1990s, this process in Brazil was favored by public policies like the Program of Community Health Agents (PACS), agents to fight dengue, among others, which absorbs workers dismissed from other areas without specific qualification. This process, coupled to the sector's commodification, has led to increased turnover in public health services and unstable labor relations, which impede the creation of ties between workers and employers, knowledge on the real health condition of the community and the work team itself[2].

In addition to these, other problems have been discussed since the beginning of the health reform, such as the need to change the care model and health professionals' education, which indicate the gap between professional education and the needs of the Brazilian Unified Health System (SUS), as undergraduate programs keep training professionals without considering the advancement achieved in this area by the public sector, especially in primary care. SUS has progressed more rapidly in this area than changes adopted in education[3].

Several Latin American countries, including Brazil, promoted large reforms in their health systems in the 1990s. However, these changes were focused on financial aspects and management systems, with little emphasis on health workers. This may have contributed to the continuity of many problems in the sector, such as: unequal access and permanence of the predominant health care model[4].

One should analyze the proposal of professional education in the Brazilian health area with this context in mind. This proposal is based on three sectors: public, private and the one covered by health insurance; and at different levels of care: primary, secondary, tertiary and quaternary, in which the organization of work processes is different and possibly mediated by different rationales, in terms of care levels as well as private and public sectors.

The professional education proposal of the Ministry of Health (MH), in contrast to the concept of continuing education that includes post-undergraduate teaching activities and aims to update and acquire new information, is presented as a strategy to restructure and develop health services based on the analysis of concrete situations, with a view to changing values and concepts and transform health service practices. In this perspective, professional education presents a close relation between the educative and health work processes with the use of new teaching-learning methods, especially problematization. It also proposes to be a training/teaching and system management strategy, so as to change the health care process, the elaboration of policies and social control in the health sector[5].

The Regional Center of Professional Health Education at the State University of Western Paraná (PREPS/Western), included in this study, is a reference for the cities belonging to the 10th Paraná Health District (10th RS) and its creation was based on the MS proposal, which has sought to elaborate policies for the training and development of health workers as a strategy to consolidate SUS. These policies are being put into operation in a decentralized way in the entire Brazilian territory, at inter-institutional and regional levels, called Centers of Professional Health Education. Its tasks are: to identify the sector needs, establish inter-institutional and inter-sector negotiations and elaborate policies for the education and development of health workers, among others. The state of Paraná received six enlarged centers in the health macro-regions and 22 regional centers, one in each regional health center[6].

In order to comply with its functions defined by the National Policy of Professional Health Education, the Management Committee at PREPS/Western considered it necessary to perform an initial diagnosis of the human resources existent, in terms of quantity and other aspects regarding education, different levels of formal education, refresher training, qualification, training and courses these workers might have attended after their initial formal education in the studied period.

In this perspective, this study aimed to carry out a survey to know the situation of health professionals working in public health services in the cities included in the scope area of the 10th RS and to identify educational activities attended between 2004 and 2006.

MATERIAL AND METHOD

This qualitative and quantitative exploratory study was carried out through document analysis of

projects approved and put in operation by PREPS/ Western and a survey, whose data were collected by a questionnaire with open and closed questions, distributed to people working in the public health sector of the 22 cities* that compose the 10th RS.

Data collection was carried out between October 2006 and March 2007. Four thousand questionnaires were distributed, which correspond to the total of workers in the health area of the studied cities. Of these, 939 (23.5%) questionnaires were returned, together with the signed free and informed consent term. The research project was approved by the Research Ethics Committee that guides research involving human beings at the State University of Western Parana.

The content of open questions was grouped into thematic units and individuals' discourse identified by a number of order, preceded by the letter "Q". Answers of closed questions were systematized in absolute frequency and percentage. Occupations were grouped based on the methodology that defines occupation in the health area according to its activities and classifies them in three groups: core, related and others. The analysis was based on literature related to the topic under study.

RESULTS AND DISCUSSION

The majority of the participants was female (78%), with secondary school (55.2%), weekly workload of 40 hours (75.9%), with only one work contract (78.7%) and five years of work (55.2%). Participant occupation groups are presented in Table 1.

Occupations in the core group predominate, considering that, from the 50 occupations found, 20 were core activities (68.9%), 25 were related occupations (23.1%), and five were from the others group (3.1%) (Table 1). Among the occupations from the core group, the nursing team (nurse, nursing technician, nursing auxiliary and community health agent – CHA) was a majority (51.5%). Although CHA does not meet the requirement of specific education[9], which is demanded in the core group, it constitutes a new member integrated in the health team, according to social policies implemented by the MS in the 1990s. The diverse composition of the work force in the health area demands effective actions from the government to regulate occupational performance, aiming for the quality of care delivery, which should not depend solely on the market regulation[10].

When we related schooling with occupation, we found that the majority (55.2%) had secondary education and only 1% had a master's degree, the highest educational level found. Considering that the required educational level is primary education, the quantity of CHAs with a bachelor's degree (7.4%) and specialization (2.3%) is noteworthy. This result might be related to the reduced supply of jobs and to structural unemployment itself, which affects all capitalist societies, especially in peripheral countries. One health secretary with secondary education and one coordinator with only primary education were found among the study participants. Many of the professionals with a bachelor's degree had more than one specialization.

Table 1 – Number of workers according to groups of occupations. Cascavel, 2007

Groups	Occupations	N	%
Core (644)	Community Health Agent	258	27.5
	Nursing Auxiliary	115	12.2
	Nurse	73	7.8
	Nursing Technician	38	4.0
	Physician	30	3.2
	Dental surgeon	28	3.0
	Endemics agent	21	2.2
	Dental Assistant's office	17	1.8
	Social worker	11	1.2
	Pharmacist	9	1.0
	Others	44	4.7
Related (217)	Operational assistant	42	4.5
	Administrative Assistant	40	4.3
	Driver	35	3.7
	Keeper	28	3.0
	Administrative technician	16	1.7
	Recreation professional	10	1.1
	Others	46	4.9
Others (29)	Coordinators	15	1.6
	Others	14	1.5
No answer		49	5.2
Total		939	100

The primary care strategy, which is the reorganizing axis of the health system, absorbs the largest number of workers in the health area in the

*Anahy, Boa Vista da Aparecida, Braganey, Cafelândia, Campo Bonito, Capitão Leônidas Marques, Cascavel, Catanduvas, Céu Azul, Corbélia, Diamante do Sul, Formosa do Oeste, Guaraniaçu, Ibema, Iracema do Oeste, Jesuíta, Lindoeste, Nova Aurora, Quedas do Iguaçu, Santa Tereza do Oeste, Santa Lúcia, Vera Cruz do Oeste.

studied population (Table 2). The Municipal Health Secretaries were the main employers. Regarding place of work, the Health Centers (33.2%), Family Health Units (19.3%) and Basic Health Units (17.5%) concentrated the majority of occupations (70%), and represent the reorganization process of the health system operating in Brazil.

Table 2 – Number of workers according to place of work. Cascavel, 2007

Place of work	Occupations			Total
	Core	Related	Others	
Basic Health Unit (BHU)	131	24	6	161
Health Center (HC)	200	82	11	293
Municipal Health Secretary (central level) (MHS)	4	11	4	19
Family Health Unit (FHU)	163	8	-	171
Hospital	56	42	1	99
Health District (HD)	22	17	5	44
HC and FHU	7	-	-	7
HC and other	2	3	-	5
BHU and FHU	5	-	-	5
HC and Hospital	3	-	-	3
BHU and hospital	3	-	-	3
HC and BHU	3	-	-	3
BHU, HC and FHU	1	-	-	1
HC and HD	1	-	-	1
BHU and HD	1	-	-	1
FHU and other	1	-	-	1
HC, MHS, FHU and HD	-	1	-	1
Other*	33	24	-	57
No answer	8	5	51	64
Total	644	217	78	939

*Schools, Outpatient clinic, Emergency room, Integrated Emergency Trauma Care System - SIATE, Blood center, Psychosocial Care Center - CAPS I and III and Mental Health Care Center - CASM.

Although the majority of workers were hired as government employees (50.2%), unstable job positions were evidenced by the existence of temporary contracts (11.7%), other kinds of contracts (7.6%) and not reported types of contracts (5.9%) (Table 3).

The majority of respondents (78.7%) had only one work contract and a minority (9.2%) two to four work contracts. Members of the nursing team (4.2%), the physician (1.5%) and the dentist (0.8%) were among those with two work contracts. Working in shifts favors multiple work contracts and it has become a way to compensate for wage losses, despite risks and harms they cause to care delivery and to workers' health[11].

Following the general trend of the current economy, the health sector also incorporated the rationale of flexible work relations, reducing formal contracts, eliminating limited workloads and increasing the volume of contracts for undetermined periods. Estimates are that approximately 600 thousand health workers do not have legal support and regularity of professional work in Brazil[12].

Table 3 – Number of health workers according to the type of work contract and group of occupations. Cascavel, 2007

Type of contract	Occupations			Total
	Core	Related	Others	
Government employee	276	154	21	471
Hired according to Brazilian labor laws (CLT)	182	22	1	220
Temporary	90	13	3	110
CLT and temporary	8	-	-	9
Government employee and temporary	2	1	-	3
Other*	54	10	3	71
No answer	32	17	1	55
Total	644	217	29	939

*Refers to commissioned positions, cooperative and trainees.

The main challenge of the MS policy called "DesprecarizaSUS", aimed to value workers, is to enlarge the consensus on the concept of unstable work[12]. Unstable work, according to labor unions, is characterized not only by the absence of workers' legal rights and social security, due to indiscriminate outsourcing, inexistent or irregular contracts via cooperatives and commissioned positions to provide direct care to the population[13], but also by the absence of public sector recruitment examination or government employment in SUS[12].

The reduced number of stable workers and the increased number of professionals in temporary positions[13] affect the quality of health care delivery, especially because the latter occasionally participate in the development of health actions, which fragments care and weakens projects based on integrality and equity. Thus, discussion of educational practices linked to professional education projects have to be tied to the context in which policies aiming to enhance the work force in the health area are elaborated.

Training practices that aim to transform health care have been discussed in Brazilian conferences in health and human resources, which are milestones in the definition of policies for the health sector[9]. Thus, different initiatives in the area of health education have been developed, with a special focus on continuing and professional health education actions. While the first aims to contribute to the reorganization of health services, the second aims to transform work

processes focused on the improvement of service quality and on equitable care and access to health services.

In the socialization process that takes place in health institutions, as a practice area and as cultural and educative institutions, different professions are confirmed and completed and the necessary professional practices and competences are molded[6]. The main ways to updating knowledge mentioned by the study participants, in a set of nine options, were: information provided by the institution (26.6%), participation in events (18.3%) and newsletters (13.8%). The least mentioned were: library (4.5%) and scientific journals (4.9%). These results confirm the importance of institutional initiatives to update the knowledge of health workers.

Data on educative activities revealed that 35.6% of the workers did not participate in any activity in the studied period (2004 to 2006). Among those, the largest part belonged to the group of "related" activities (46.5%), followed by the group of "core" activities (31.7%) and "others" (27.6%). Among those who participated in training and updating activities, the majority (40.6%) had attended one to two events in a three-year period, less than a participation/year, which is considered low due to the rapid changes that occur in the health area.

Regarding educational activities promoted by PREPS/Western, 40 activities including courses, events, workshops and training were approved and carried out between 2004 and 2006, 11 activities in 2004, 17 in 2005 and 12 in 2006. In this set of activities, 12 (30%) focused on specific diseases, nine (22.5%) aimed to discuss aspects related to SUS (principles and guidelines or system management) and four activities were related to professional education (10%). Demands from the sectors in the 10th RS determined the Center activities, which aimed to train and/or sensitize municipal teams for specific actions. The adopted teaching methodologies mainly included the problematization strategy, discussion opportunities, group study and presentations with dialogue.

Participation in educational activities is a way to democratize institutional relations and a strategy to recompose relations among the population, health workers and managers. For that, the organizational culture based on the centralization of decisions and verticalization of programs and projects needs to be overcome, as proposed by the professional education policy[6]. Participation of members from groups of health occupations is unequal and unbalanced, with privileges for those who occupy management positions in the bureaucratic structure.

Those who participated in training activities considered them a great opportunity to update their techno-scientific knowledge, both to develop their technical abilities and to understand the SUS operating mechanisms, such as social control and management pact.

Strong dissociation between health workers' practice and SUS principles predominates in the studied region, which contributes to maintain a vertical and unequal relation between those who know and those who supposedly do not know, as the following discourse shows: *[...] the greatest difficulty is to convince the population to follow recommendations on hygiene and adequate treatment* (Q923).

Activities focusing on personal relationship, quality of service, motivation and humanization of care were included in the educational activities of the three groups of occupations. These activities are in agreement with flexible management, which among other characteristics, presupposes workers' relational capacity[1]. Workers are required to have minimum education, like in the case of CHAs[9], but at the same time, they need to have strong relational capacity for teamwork and to attend the population, that is, adaptation capacity, problem-solving abilities and being able to interpret information. Thus, relational attributes like cordiality, good sense of humor and a smile are taken as synonyms of greater humanity and are more important than specific technical knowledge in the health area.

The study participants have incorporated the apparently humanizing discourse: *[...] clients should be well attended* (Q910). *[...] and, when talking to people and orienting, we have to show love* (Q382). *[...] workers should smile more. Be humorous helping each other. Be more human, kind* (Q663).

However, the emphasis given to the relational aspect permeated by kindness, good sense of humor and expressions of joy has not been sufficient to overcome difficulties experienced by CHAs for example. These difficulties include little specific technical knowledge, lack of professional acknowledgement by the health team members and users as well. Other difficulties related to work conditions were also reported, such as the absence of adequate physical structure, reduced number of workers and lack of material and equipment.

Thus, difficulties of many kinds in health work environments are not overcome only through relational measures. These measures are not sufficient to realize changes in professional practice and represent only an elaborated strategy that aims to obtain improved performance at the expense of breaking solidarity among workers[1]. Another characteristic required by flexible management is the multipurpose worker[1], that is, people capable of working in different sectors by performing *[...] several functions within his position, thus avoiding that employees are conditioned to a single task* (Q328).

This report reveals that the incorporation of the multi-functionality and multipurpose discourse is typical of the current process of capital reproduction. The "new" mode of work management has influenced the relationship among the team as reported by interviewees when they list the following difficulties: competitiveness, lack of unity, lack of democracy in the work environment, lack of respect from superiors, co-workers and users, little ethical behavior from the leadership towards the team and patients. These are obstacles in the development of collective work and lead to conflicts in the work environment, especially because they are related to social relationships involving several workers with different intentions, in which people are coherent with their perspective of the world, work and social practices.

The practice, still common in health institutions, to provide people with jobs based on political criteria, e.g. alliance established during elections, leads to problems because oftentimes people without proper training and knowledge occupy leading positions. In addition to frequent interruptions of projects and programs, which make medium and long-term projects infeasible, the health workers' daily routine is marked by constant demands from users and coordination. Thus, government employers expect *[...] to be seen as human beings and not as working machines* (Q758).

Among their suggestions to overcome difficulties, participants indicated the availability of courses focused on education, worker's motivation and improvement of the workplace. These reports show a work environment little consistent with those who should promote health.

Difficulties faced in work justify their demand to reduce current weekly workload to *[...] 30 hours, this work is exhausting, stressful and requires concentration* (Q326). *And provide a professional in the psychological area to attend the staff* (Q651, Q676, Q831, Q391). *[...] aiming to take care of workers' mental health* (Q100).

This discourse shows the weariness experienced by health workers in the work process, which has incorporated the general rationale of the productive sector, demanding productivity and quality of care without equivalent improvement of work conditions.

CONCLUSION

This study evidences that the majority of workers in primary care attended some kind of training/education activity in the studied period. However, acquired knowledge was not always implemented due to organizational and managerial problems. Conflicts between workers and users and among team members were observed as a consequence of anti-ethical attitudes.

The majority (50.2%) of workers were hired as government employees, although unstable work ties were found, which can hinder the development of professional educational projects due to reduced adherence, high mobility and turnover of workers in institutional projects.

The diagnosis, whose main results were presented in this study, should guide the Committee of Management at PREPS/Western from the 10th Paraná Health District in the elaboration of professional health education policies and in the establishment of priorities for its implementation in the short, medium and long terms. In addition, it will show teaching institutions and public management the health sector's real needs in terms of education and professional development of health workers.

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