

The National Permanent Health Education Policy in Public Health Schools: reflections from practice

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Abstract *This study aimed to analyze aspects of the implementation of the National Permanent Health Education Policy of the Brazilian Ministry of Health, based on the experiences of Public Health Schools. Five workshops were held in schools located in different regions of the country, taking into account an analysis of the conceptual and organizational basis of the policy. The methodological premises hinged on a reflexivist approach based on a dialogue between the research team and school participants, which built on the identification and meaning of the experiences of these institutions in permanent health education (PHE). This study shows that the principles and values of the PHE were adequate in these schools and employed as pedagogical practice, not only in clearly educational situations, as formative processes, but also in the very institutional development management and actions, as well as in their political action. The important role of these schools as co-fosterers of PHE in the country and their capacity of mobilizing different social agents should be emphasized.*

Key words *Permanent health education, School, Public policies*

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Introduction

The expansion of health services and actions networks promoted by the implementation of the Unified Health System (SUS) in 1990 reoriented actions and strategies related to work management and training of health workers, generating several innovative experiences in the fields of management, care and training¹.

The review of the operational conferences and norms in the late 1970s, when the Health Reform movement began, already pointed to the need for a specific public policy for Health Education that reevaluated the traditional proposals misaligned vis-à-vis the needs of services². In this course, the Ministry of Health (MS) established, in 2003, the Labor Management and Health Education Secretariat (SGTES), assuming the institutional responsibility for the construction and implementation of the National Permanent Health Education Policy (PNEPS) as SUS strategy for the training and development of sector workers³.

Two Ordinances were enacted: GM N° 198/2004⁴ and GM N° 1996/2007⁵. Both propose that the processes of qualification of workers build on the references of health needs and local reality, that aim to transform professional practices and the own work organization and that, above all, they be structured from the questioning of health work processes. They recognize the role of the multidisciplinary team and the social character of the educational action carried out in collective work processes, without denying the importance of specific technical training². The main difference between the two Ordinances is in the guidelines and the devices for their implementation in the states.

In this movement, the number of public health education institutions in the three management levels increased at state, municipal and federal levels. The common mission of these institutions of training cadres for the public health system⁶. Their operation is guided mainly by demands imposed by public health policies, incorporating into their agendas courses and projects formulated from agreements or tenders, especially by the MS. In their daily routine, they play functional roles within the structures to which they belong, but because of the nature of their mission, they are open to a dialogical coexistence, favored by the very dynamics of the SUS⁷.

These institutions are environments with own values, experiences, ideas and practices. A laboratory of technological incorporations, the School is a place of apprehension and synthesis, estab-

lishment of relationships, mediations and translation. If, on the one hand, the School appears as a dialectical social institution, on the other, it is a complex institutionalized organization, which shifts between different planes and dimensions⁸.

Keeping in mind the changes under way within the PNEPS configurations, in 2008, researchers from the Sérgio Arouca National School of Public Health, Oswaldo Cruz Foundation (ENSP/Fiocruz), submitted to the MS a proposal to study the challenges facing Schools in their technical-pedagogical, administrative and communication realms. Conducted in 17 states, the result strengthened the organization of networked schools⁹. The Brazilian Network of Public Health Schools (RedEscola) – whose Executive Secretariat is headquartered at ENSP/FIOCRUZ – now consists of 50 public health education institutions distributed throughout the country.

Considering Schools as a privileged locus for the training of SUS workers, RedEscola has focused its reflection on the role of these schools and the position of these institutions within the PNEPS, both in its conceptual bases and in the MS-related organizational devices. Different actions and studies have subsidized this reflection, and, with this intention, the research project to which this paper¹⁰ refers emerged.

Methodology

Between 2014 and 2016, five research workshops were held in Public Health Schools. Besides the regional criteria, participation in the discussion on PHE within RedEscola and work in Permanent Education Hubs or in the Teaching-Service Integration Commissions (CIES) were also decisive for the selection of Schools.

The following schools were chosen: School of Public Health of Paraná, School of Public Health of Minas Gerais, School of Public Health of Goiás, School of the SUS of Tocantins and School of Public Health of Pernambuco. It is noteworthy that the invitations included the participation of local partner institutions, which added to the research the School of Public Health of the Municipality of Aparecida de Goiânia, the School of Public Health of the Municipality of Goiânia, the School of Public Health of the Municipality of Palmas and the Aggeu Magalhães / Fiocruz-PE Research Center. Hence, nine educational institutions participated in the research.

Considering the PNEPS construction context, we opted for an exploratory study, based on

reflexivist epistemology and which shares common assumptions with those expressed in politics. One assumes that knowledge is a creative process directly related to improvisation, whose practice refers to the coordination of perceptions and actions, as Ingold¹¹ explains.

Workshops were conceived as conversational spaces in which “discussion groups are carried out as a dialogical device to produce knowledge about the subject under investigation”¹². This resource derives from the qualitative research, especially from the approaches of the field of social constructionism^{13,14} and from the systemic facilitation of collective processes¹⁵, allowed to promote among the school workers a moment of collaborative reflection of knowledge construction.

We chose this methodology, in which reflection is developed jointly, based on the premise that meanings are built in interaction and that the intentionality of the actions produced in social processes are a central aspect¹³. We based the choice of the discussion group on the appreciation of the interaction between the study participants and the visibility for the relational process of knowledge production¹³.

Since the study did not focus on the particular views of certain social agents, but rather on the understanding of how the group of workers in each School experienced PHE, we decided to use the group as a research resource, considering that specific interactive contexts provide opportunities for collective reflections. Emphasis was thus on the situated character of collectively constructed knowledge¹⁶.

The methodology sought to produce a moment of joint reflection in which Schools’ workers could bring in their conceptions and experiences. Instead of starting from a research hypothesis to be confirmed or refuted, the objective was to stir a reflection on the implementation of PHE from the identified experiences, according to the narrated contexts.

We avoided starting from a norm-defined concept to evaluate the level of implementation of the policy. We also did not wish to reproduce a researchers x researched situation, given a set of aspects: i) the recognition of the expertise of Schools’ workers that participated in the workshops, since they implement the policy and that this is inserted in social processes that are affected by social agents; ii) the belief in the critical capacity of workers and in a possible criticism being part of dialogues; iii) the premise that the presence of the researchers affects the relationships established in the research and that, therefore, re-

searchers act as facilitators of the dialogue; iv) the possible collective construction of knowledge.

Based on a common methodology, each workshop counted on the researchers’ willingness to create a conversational context that generated trust among the participants and to adapt, if necessary, the proposed script, coordinating actions and perceptions. Each meeting lasted 12 hours, was recorded – with the consent of all participants – and provided elements for the final systematization process. We performed data analysis using Logos software¹⁷.

The guiding questions were formulated at the initial stage, when a review of the literature on PHE was carried out. At the time, we realized that there was little academic output on policy implementation and an emphasis on normative and conceptual aspects, which left us puzzled about implementation practices.

The reflection generated by these questions was transposed to drawings, in order to map the relationships for each experiment, according to representations shown in captions of Figure 1. This resource showed great dialogical potential throughout the research and produced diagrams that show the complex social relationships underlying PHE, including human and financial resource flows.

Figure 1 is the reproduction of a diagram developed at the Recife Workshop, which demonstrated the full understanding of the methodological proposal and allowed the participants themselves to perceive, in a reflexive process, the complex relationships in which such experiences are involved. In addition, we were aware that the workshop time would not allow people to “drown in details”¹⁸, but that it would not be possible to ignore them either. For this reason, the use of the diagram was pertinent, as suggested by Becker on examining the use of ““thinking with drawings” in surveys”¹⁸.

Results

Conceptual Basis of Permanent Health Education

Work education is a qualifying matrix for the health care of the population. The expansion of the Brazilian health system, which began in the 1970s, and the consequent need for labor development for the sector led to the emergence of several training programs, which sought to build political-pedagogical models committed to the

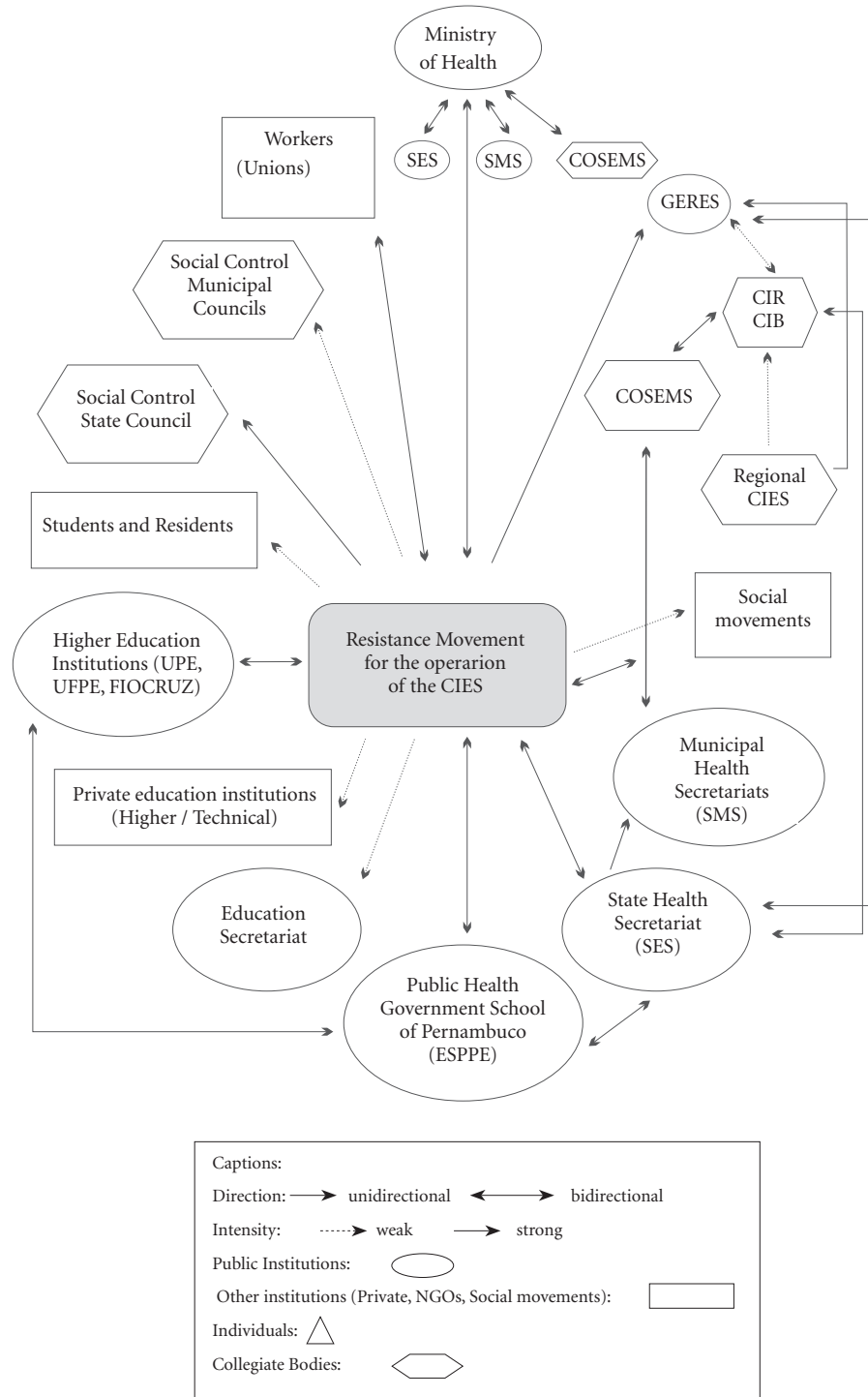


Figure 1. Institutional relationships of PHE experience identified in the School of Public Health of Pernambuco.

Source: Pesquisa A Política Nacional de Educação Permanente em Saúde: análise dos fatores condicionantes à sua implementação, em diálogo com as experiências das Escolas de Saúde Pública, CNPq/ENSP/Fiocruz, 2013-2016.

promotion of dialogue between education and health services².

Despite advances, there remained a critique to the hegemonic education model based on timely courses that aimed at updating, qualifying or even specializing a specific professional category. They occurred outside the work environment and used transmissive methods of knowledge.

In the words of Paulo Freire¹⁹, transmission-based pedagogic methods predominate the lecturing relationships, in which educating becomes an act of depositing, classified by him as “banking education”, since knowledge would be a kind of donation of those who know (educators) to those who do not know (students). In this way of educating, teachers have the last word, leaving students with the role of passive acceptance of the content that is “deposited” in them¹⁹.

Ribeiro and Mota²⁰ explain the impact of this transmission model:

Professionals are elevated to the paradise of ‘how it should be’, translation of the truth of accumulated and updated scientific knowledge applicable in a kind of universal and unique representation of patients and services. When they return to their work, however, they find themselves confronted in their everyday realities with the impossibility of applying the acquired knowledge²⁰.

PHE draws on the use of active methodologies of knowledge, contrary to the transmissive ones. It is, more specifically, a problem-solving pedagogy, based on the dialogic-dialectic relationship between educator and learner, that is, they both learn together²¹. In this conception, to problematize means “to analyze the practice”, which presupposes to break with the individual logic, shifting to team analysis.

Davini²¹ says that problem-solving pedagogy allows greater integration among professionals and between professionals and the community, seeking solutions, acting in both the professional and the affective sphere, strengthening social and professional commitments, as well as developing group awareness and contributing to the strengthening of professional identities.

Another PHE important concept is *meaningful learning*, when knowledge is constructed taking into account the knowledge previously acquired by the learner, so that it makes sense in their daily practices. The concept also suggests that the transformation of professional practices be based on the critical reflection on the reality of the daily routine of real professionals, working in the network of health services³.

Ribeiro and Motta²⁰ reinforce this view: “There is no learning if stakeholders are not aware of the problem and if they do not recognize themselves in their singularity”. Such action would imply to stimulate in these stakeholders/workers transformations in their way of acting and thinking, in order to involve them actively in the dynamics of institutions, in a movement of knowledge and decisions horizontalization.

The PHE concept was already being developed and disseminated in Brazil by the Pan American Health Organization (PAHO) in the 1980s and is now seen as a strategy for the reorganization of practices and policies for training, care and management in line with SUS principles – Universality, Equity and Comprehensiveness – and its guidelines for decentralization and popular participation²². The operational translation taken as guiding reference of this strategy was called the “Four-Square Model of Permanent Health Education”²³, that is, teaching, management, care and social control.

The structuring axis of PHE is the *work* category; this is where practices carried out both individually and collectively are foreseen, presupposing the active participation of workers in their own learning process. This category is the focus of the management and structuring of the services, attuned to the transformations of the work world, either adapting to new labor relationships or to the growing demands of the health system³.

Considering the complexity of the Brazilian health system, Ceccim²⁴ affirms that PHE is necessary for the consolidation of practices aimed at solving the health problems of local populations. The expected result is workspace democratization, development of the learning and teaching capacity, search for creative solutions to problems, teamwork development, improved health care quality and humanization of service.

Different authors assign to the PHE model the ability to cause changes in work processes. Sarreta²⁵ says that the differential is the collective construction of new work strategies committed to the principles and guidelines of the SUS and the needs of each region through the problem-solving of daily practices, aiming to recover actions and develop autonomy and participation.

Rovere²⁶ points out that PHE presupposes a democratic process, since it implies starting to learn to ask, rather than providing ready-made answers. Thus, the implementation of a PHE policy requires, and at the same time establishes, more democratic organizations and spaces that allow reflection. In this perspective, by adopt-

ing such values, the PNEPS seeks to break with health system verticalization, creating arenas for confronting problems.

PHE experiences in Public Health Schools

In the research workshops, we asked participants to select experiences that they identified as PHE. At the end of the five workshops, we collected 25 experiences: 15 of them referred to courses, while four addressed political articulations and six institutional processes of Schools or State Health Secretariats.

PHE in the Courses

The main courses are of several types: improvement, training, pedagogical training, residency, specialization and masters' degree. These courses serve a wide range of audiences: professionals from the state and municipal health secretariats, community health workers, endemic diseases' control agents, municipal and state councilors, social movements, tutors and residency preceptors. As for the format, there are both classroom and distance education courses, regionalized courses (such as the case of some residencies) and even courses in the workshop format. The chart shown in Figure 2 summarizes responses given by workshop participants when asked about the aspects that characterize the courses described as PHE experiences.

Data collected allowed clustering in three large blocks: relationship with the service, pedagogical practices and regionalization.

The relationship with services was highlighted in all the experiences presented. Many courses were designed from the demand for services or from specific groups, such as the Landless Movement, in Minas Gerais. Several initiatives aim to transform work processes or, as final work, the elaboration of intervention projects in the health facilities in which the students work, as well as collective and individual proposals. Work is the structuring axis of PHE and the reflection from the practice is highlighted as a fundamental aspect of these courses. However, on-service training faces three major challenges: managers' lack of knowledge and dismissal of PHE; tutors and teachers lack of understanding about PHE's pedagogical principles – which hampers innovations and often leads to transmissive pedagogical practices with preset content and not suited to the local context; and the precarious work relationships that lead to discontinuous presence of

students-workers and tutors/preceptors at the workplaces, in the case of some courses. As emphasized in one of the workshops, the human resources policy applied in the SUS in recent years, anchored in the Social Health Organizations (OSS) and temporary contracts, is contradictory to the PHE policy.

In the research, it was evident that the pedagogical practices used in the courses constitute the main identification of the PHE. The so-called “active methodologies of knowledge”, based on the problem-solving pedagogy – that seek critical reflection from practical questions, discussed in a team, in dialogue with theory – and in meaningful learning – that considers previous knowledge and experience of participants – are the hallmark of all courses. These methodologies lead to proposals for intervention in practice.

Distance Learning (EaD) was underscored as a teaching modality with a potential for exchange and integration. On the other hand, monitoring and evaluation processes were nonexistent in courses, especially regarding the impact on participants' own practice, as well as on the health indicators of the serviced population, in contradiction to what is provided in the two ordinances that implement the PHE policy. Work with multidisciplinary teams is also a rare aspect in the course experiences analyzed. There are still training for specific categories of workers, especially those that are at the extremes of social valorization, such as Community Health Workers and physicians. It is also common to find management professionals separated from health professionals. Physicians hardly participate in multidisciplinary pedagogical proposals. A striking example is multi-professional residencies where doctors are not included, since the category has a specific residency. There are some efforts to work with multidisciplinary, such as the Caregivers of Long Stay Institutions for the Elderly, in Goiás. This aspect deserves more attention in the evaluation processes of such experiences. On the one hand, it is necessary to understand how to deal with the power relationships inherent to health teams, and, on the other hand, to analyze the extent to which PHE contributes to a more egalitarian appreciation of all workers and their perceptions of health, care and management.

Noteworthy is the fact that many courses are regionalized, or partially regionalized, such as residencies that share time between the capital and other health regions. If, on the one hand, adaptation to the regional reality was strongly emphasized in the experiences, on the other

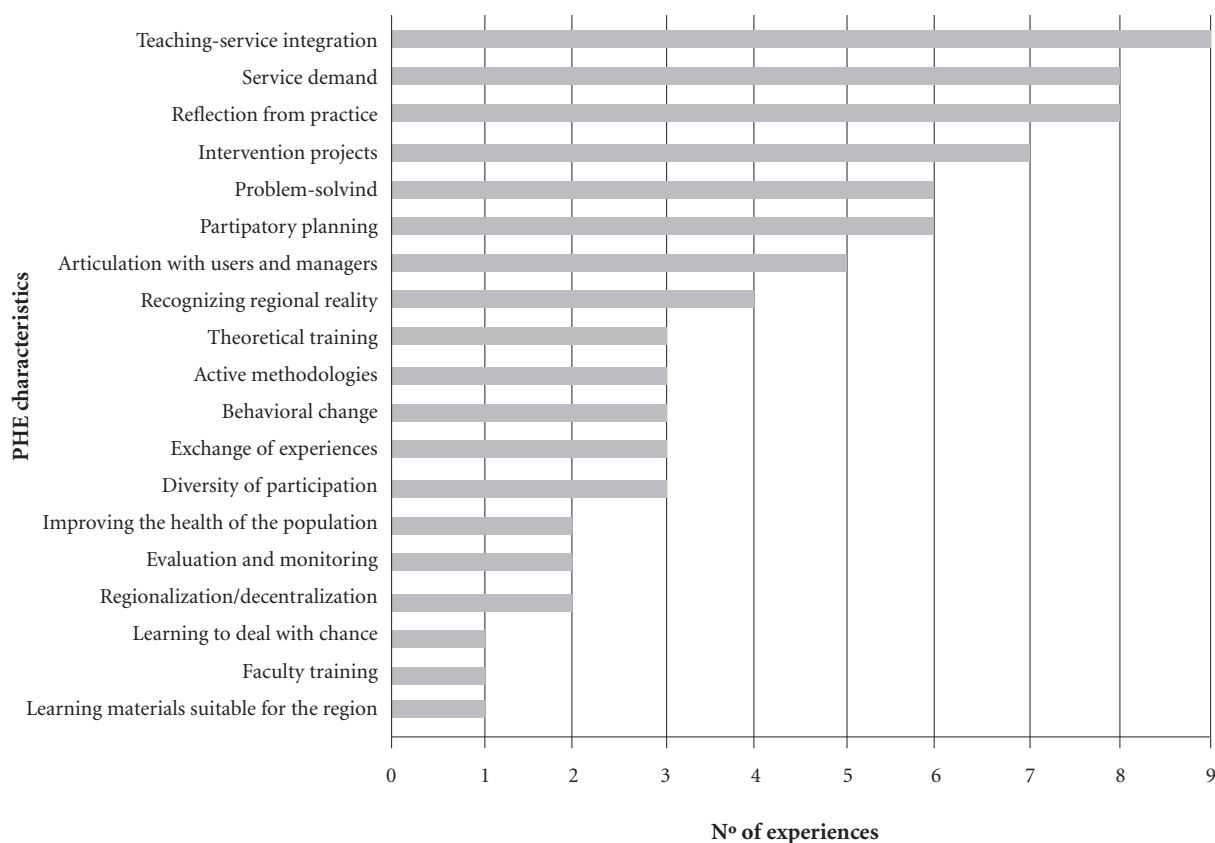


Figure 2. Characteristics of PHE identified in the courses of Public Health Schools.

it was criticized, especially when dealing with “ready-made” courses from the MS, with single didactic material and closed curricula, since they do not allow an adaptation to local and regional realities and needs. The effort to consider local conditions and cultural diversity builds on methodology and teachers, tutors or preceptors who have not always been prepared for this pedagogical conception. The need for the contents of such courses to be constructed more horizontally and negotiated between MS and schools was strongly emphasized.

A deadlock is the issue of certification, since this is necessary for the valorization of the workers’ curriculum, but which, on the other hand, is linked to pedagogical principles that conflict with those of Permanent Education, such as closed curricula, external control, workload, evaluation type, among others.

PHE in Political Articulations and Institutional Development

The political processes experienced by the schools identified as PHE experiences are varied actions. As examples of such experiences, we mention the participation of the Curitiba school in the Conference of Local Development and in the implementation of the SUS Research Program, and the elaboration of the State PHE Plan and the Movement of Resistance for the Operation of CIES in Pernambuco.

These were processes considered as PHE practices by Schools, which justified them by bringing some of their essential characteristics: participatory and collective planning; articulation between different stakeholders, such as health professionals, users and managers, or even different sectors of public power, such as education and health; recognition of regional particularities; and proposals for intervention in reali-

ties. Schools are important political agents in the field of health in their states and municipalities and, as such, carry the PHE principles in their actions, to the extent that they absorb them as pedagogical practices inseparable from their political action.

Initiatives focused on the institutional development of the Schools themselves are also referred to as PHE's practices. The following were mentioned: in Goiânia, management of work processes and updated legislation; in Palmas, pedagogical workshops; in Curitiba, the process of selection of PHE projects; in Recife, the structuring of the School of Pernambuco and the coordination of a research program for the SUS in the state. Participative planning and service demand were the main characteristics, as well as the process of reflection from the practice, problem-solving and exchange of experiences. Appreciating the regional reality was emphasized in the School of Pernambuco's structuring process, for example. With regard to the so-called "Four-Square Model of PHE", it is evident that social control is the most fragile part of this process. Few experiences include articulation between managers and health professionals, and few consider social control bodies.

Policy's Institutionalality

In order to understand, in the light of the results of this study, how Schools experienced in their states and in their educational and management practices the implementation of the National PHE Policy and how they appropriated and processed, in their territories, PHE's principles and concepts, we need to first understand how formulation and national implementation of such a policy occurred – or how it was first attempted.

The conduction and induction of PNEPS, in accordance with Ordinance N° 198/2004, was designed to be implemented in a loco-regional manner through the Permanent Health Education Hubs (PEPS), which should: identify training needs; mobilize the training of managers, actions and services for the integration of the care network; propose policies and establish inter-institutional relationships; formulate training and trainers policies; establish the agreement and negotiation between management, social control, trainers, students and services, in addition to establishing cooperative relations. Managers, students, social control stakeholders, health workers, associations and other service representatives

and educational institutions⁴ could participate in the PEPS. The implementation of the number of hubs in each state of the Federal Government followed a criterion of the state itself, agreed in the Bipartite Interagency Commission (CIB), with subsequent approval in the State Health Council (CES), as shown in Figure 3.

Each state educational institution presented its projects in the Regional Hubs. If approved, they were again submitted to the State Hub for later approval by the CIB and CES. Upon approval, the project was forwarded to the MS, which decentralized funds directly to the institution.

Three years later, in 2007, the Ministry of Health reissued the PNEPS, adapting it to the operational guidelines and the Health Pact regulation implemented the previous year, through Ordinance N° 1996. The Pact reinforces the importance of the planning and management tools of the SUS, advances the construction of specific legal instruments and places great emphasis on regionalization and the articulated and solidary commitment of federated entities⁵.

Such a reorientation has caused more changes in the organization of politics in the states than in its conceptual appropriation. Hubs would continue to be composed of the same stakeholders, but would be reorganized into Teaching-Service Integration Centers (CIES), now coordinated by the of Regional Management Collegiates (CGR) and guided by the Regional Plan of Action for Permanent Health Education (PAREPS), as shown in Figure 4.

The idea would be to break with the logic of buying and paying educational procedures – the so-called "course counter" – a practice that would have been installed in the Hubs. Another fundamental change was the decentralization of the federal resource of the National Fund for the State Health Funds, aiming at the implementation and execution of the Permanent Health Education actions. Thus, the CIES should construct the projects and strategies of intervention in the field of the workers development training to be submitted to the CGR for approval at the CIB. There was an intention to increase the regional capacity for intervention in the area of Health through Permanent Education as a guide to the Health Education practices⁵.

Institutionality experienced in Schools

In the scope of the study, transfer of PNEPS funds to the states was discontinued as of 2011, generating concerns in Schools regarding the

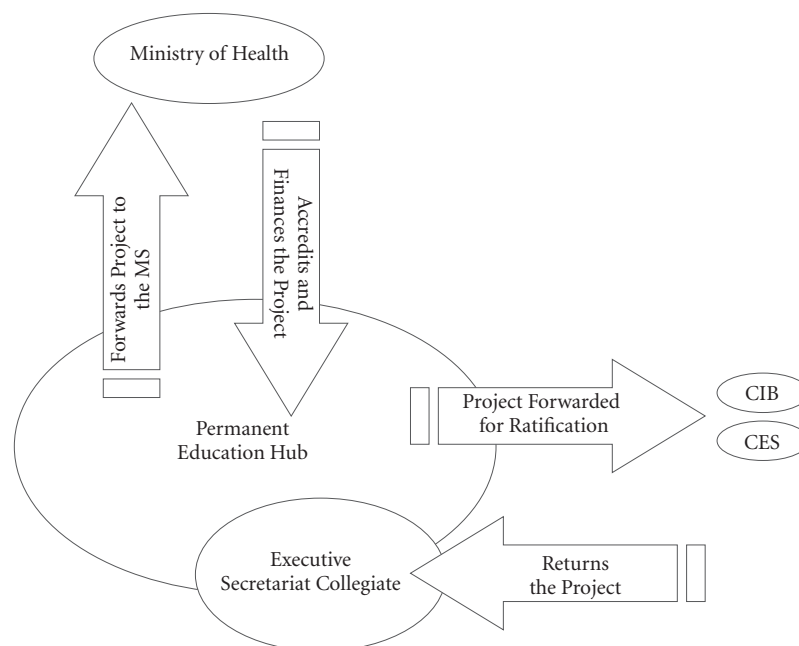


Figure 3. Organization of the National Permanent Health Education Policy established by Ordinance 198/2004.

Source: Pesquisa A Política Nacional de Educação Permanente em Saúde: análise dos fatores condicionantes à sua implementação em diálogo com as experiências das Escolas de Saúde Pública, CNPq/ENSP/Fiocruz, 2013-2016.

further implementation of the policy. When decentralization of funds was assured, these were guided by priority lines of action, provided by Ordinance N° 1996/2007, which, however, did not always correspond to the needs of the states, requiring negotiation power between federal and state management for adaptation to the regional health reality.

Nowadays, in addition to these funds, Schools have counted on the health secretariats, especially state secretariats to collaborate and support their actions, and with the direct negotiations with the CIBs, in detriment of the agreements in the CIES.

Problems related to funding have triggered institutional issues. If Ordinance N° 198/2004 guaranteed financial decentralization between the MS and the institution after direct agreement in the Hubs, generating the aforementioned “counter logic”, the second Ordinance resulted in an exacerbation of devices that ended up hampering access not only to resources, but also to the very experience of the policy in its basic principles.

The research identified the difficulty in the decentralization of the CIES in health regions, even because the state management itself found it hard to adapt to the new proposal for regionalization of the Health Pact. Hence, two findings became evident: the weakening of CIES as a setting for agreements or solidary co-management; and the replacement of this role by the CIB, which turned out to be, for the Schools, an “easier way” to agree on and finance actions.

Another aspect to be highlighted refers to the composition of the CIES, when these exist, because it is impaired in the representation of the stakeholders that compose them, especially in relation to workers and users, who could be represented by the health councils. This gap unbalances the “Four-Square Model of PHE”, which is fundamental in the conception of PNEPS.

Research participants view Schools as fundamental structures for the operation of the PNEPS, as well as, in some cases, an environment that houses the CIES and, in others, those responsible for conducting the policy in the state.

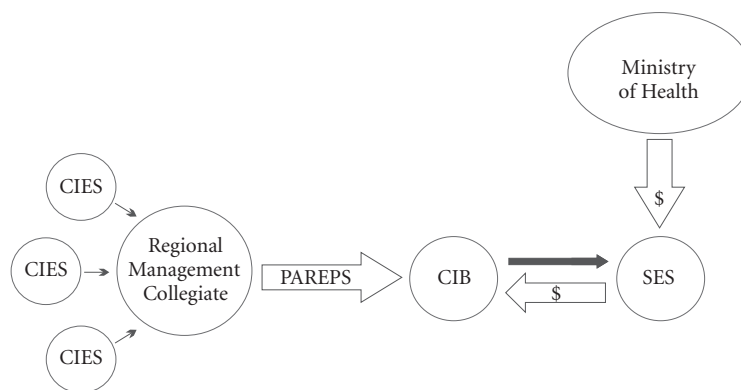


Figure 4. Organization of the National Permanent Health Education Policy established by Ordinance N° 1996/2007.

Source: Pesquisa A Política Nacional de Educação Permanente em Saúde: análise dos fatores condicionantes à sua implementação, em diálogo com as experiências das Escolas de Saúde Pública, CNPq/ENSP/Fiocruz, 2013-2016.

In addition, they are aware of their relevance to society and to the strategic training of staff for the public health system. In turn, they resent that the MS does not recognize them as an inducing and legitimate space for the political discussion of PHE. Some reported the difficult communication between the School and the national coordinators of the Policy, which is restricted only to the financial transfers of large pre-established programs.

In the Workshops, it was unanimous to indicate the lack of monitoring and evaluation of the impact of the actions, although the two Ordinances provide for the construction of a specific Commission for such purpose. Likewise, participants affirm that Health Education actions do not receive from the municipal or state manager the same importance of care actions. On the other hand, while funding was considered an important aspect, scarcity or lack of funds was not characterized as the main problem for the implementation of actions.

In spite of the obstacles and challenges posed for the implementation of PNEPS in their principles and guidelines, we identified that there is a broad domain of the concept and commitment to its political-pedagogical ideology for health training. More than that, there is also great concern regarding the future and directions of politics, as well as regarding the Permanent Health Education itself.

Final considerations

If, in the guise of a spontaneous narrative, we gathered the main elements resulting from this research and resumed some concepts already mentioned in order to simply “tell what we have seen and learned”, we would certainly have two salient viewpoints: one on the very forms of doing, that is, of the relationships and processes occurring from (our) experiences in the workshops in the states; and the other, capable of producing an overview – although quite accurate, as would the eyes of an eagle see from the heights at the same time all the valley and the small prey that is hidden in the vegetation – about the loco-regional uses that Schools make of the devices of the PHE Policy and its concepts.

Initially suspicious and reticent – “yet another workshop about what we already know, yet another research where they will ask us some things and then go to their computers and worksheets to draw the obvious conclusions” -, Schools’ workers soon realized that the cold relation “researcher-informant” was not the one we used. When they saw themselves as interlocutors of a study that also (and especially) interested them, as teachers-researchers, participants gradually began to intervene in (and cause) dialogue.

The spontaneous reports, as well as the final evaluation, showed us that, first, participants saw study workshops as a PHE activity. That is, the methodology and follow-up of the workshops

took place according to the principles of PHE – the opposite would seem to us an undesirable idiosyncrasy, but we were not sure, at first, if we would achieve the expected results, mainly because the workshop days have become a significant learning moment for all. They also said that the dialogic methodology, as well as the “diagrammatic” thinking we suggested for mapping institutional relations, provided the Schools with an accurate reflection on their own practices and the clearer visualization of their problems, strengths, management processes and pedagogical practices. According to many, “they had no idea of the complex relationships and the variety and diversity of experiences” they experienced day by day.

On the other hand, the second story deserves a backdrop. We know that the Ministry of Health formulated, implemented and induced the PHE Policy in the national territory. However, the MS itself ended up opposing to its own Policy, demanding vertical courses, establishing guidelines in disagreement with needs and creating devices that somehow ended up unbalancing power relations. In addition, PHE’s funding has been successively reduced to the detriment of other priorities.

The good news is that PHE’s principles, bases and concepts were “accepted” and were definitely incorporated into the practices and activities of the Schools in their territories, in such a way that even non-PHE actions ended up being executed according to the principles of problem-solving, teaching-service dialogue, shared knowledge and experiences and meaningful learning.

Put simply, Schools seem to have believed more in PHE than the policymakers themselves, at the national level. They did not stop doing PHE just because funding subsided until it was suspended. Instead, they incorporated its precepts into their institutional development actions, assimilated concepts and methods, appropriated them and transformed them into their own unique needs and possibilities.

Hence, what we perceive when confronted with the “life of Schools” in their local contexts is that they have been paving the way to become increasingly democratic institutions, building (and becoming themselves) foci of reflection, providing the necessary arenas for creative coping of problems in work reality. This is what we have informally called the “Permanent Health Education Culture” in the Brazilian Health Schools certainly has a very important role in this recent construction.

Collaborations

MLM Cardoso, PP Costa, DM Costa, C Xavier, RMP Souza contributed equally to the production of this paper.

Acknowledgments

The National Council for Scientific and Technological Development (CNPq) funded this study. Authors thank Safira Reink Silva for the careful transcription work of the research workshops.

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Article submitted 07/07/2016

Approved 12/09/2016

Final version submitted 05/12/2016