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Continuous Health Education policy in Brazil: the contribution of the Teaching-Service Integration Standing Committees

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Abstract *The article analyzes the role of Permanent Committees of Teaching-Service Integration (CIES) in the implementation of Permanent Education in Health Policy (EPS). It is a multicenter study with a qualitative-quantitative approach which used a self-applied online questionnaire and a semi-structured interview for data collection. The key respondants were the responsible for EPS Policy of the 27 State Health Secretariats (SES) and 7 coordinators of CIESs of the five regions of Brazil. The findings showed the existence of a specific EPS sector in most SES; high level of schooling, experience and stable employment status of the managers. Regarding CIESs, it was verified: existence in most of the states; creative process diversity; plural composition; regularity of meetings; good relationship with training institutions; difficulties in the use and management of resources destined for EPS. The study indicated progress, showing the importance of these instances as spaces of negotiation, agreement and development of EPS. However, challenges still need to be overcome in order to consolidate projects in the SES, strengthening the PNEPS.*

Key words *Continuous health education, Teaching-service integration committee, Public policies, Brazilian Single Health System*

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Introduction

One of the pillars sustaining Brazil's Single Health System (*Sistema Único de Saúde* – SUS) is the level of training and qualification of its employees[1]. In accordance with this premise, Brazil instituted the National Continuous Health Education Policy (PNEPS), as a strategy for training and development of health workers, put in place by Ministerial Order GM/MS 198 of 2004[2].

Continuous Health Education (*Educação Permanente em Saúde*, or CHE) is understood as a teaching concept that relates learning, service, teaching and health, contributing to professional development, management of the sector and social control[3]. The basis of the CHE is to ensure provision of the most important learning that should orient the actions of professional development and the strategies for change in health practices[3]. Thus, it is presented as a health education strategy that is characterized as a process of participative and transformative management, which includes what is referred to as the 'qualification quadrilateral': teaching institutions, workers, managers and users[2,4,5].

Aiming to make progress in implementation of the policy, Ministerial Order GM/MS 1996/2007 set new strategies for action to adapt it to the operational directives and regulations of 'Health Pacts' and 'Management Pacts'[6-8]. The central change was in the regional scope, through the Regional Management Committees (CGRs) and the creation of Teaching-Service Integration Standing Committees (CIESs), which are permanent inter-sector and inter-institutional instances that participate in the formulation, conduct and development of the PNEPS, as specified in Article 14 of Law 8080/90 and in the NOB/RH-SUS[9,10].

One decade after the implementation of the policy, issues that appear to hinder its development were identified: discontinuities, changes in focus and financing issues[11]. Another limit is that educational actions can turn out to be subsumed in the duties of HR management, since there are managers who do not discuss and/or are not aware of the health education management policies[12].

As to the contribution made by the CIESs, previous surveys[8,13] have indicated lack of coordination and low activity of these instances in the implementation of the Continuous Education policy in the states, suggesting that work is needed on their role of macro-regional articulation, starting with the configuration given to these committees. On this point, there are gaps in the literature about the duties and the role of the CIESs.

From this point of view and in view of the scarcity of studies on the question, this paper analyzes the role of the CIESs in the development of the Continuous Education policies implemented by the State Health Authorities (SESs) of Brazil as a whole. The study is part of the survey "Analysis of the Continuous Education Policy implemented by the State Health Departments", which analyzed the structure, the processes of the PNEPS, the state continuous education plans (PEEPS), and the spaces for dialog and agreement, especially of the state and regional CIESs, in the states. For the purposes of this article, part of the results of the national survey will be presented.

Method

This is a multi-centric study with a qualitative-quantitative approach[14], the research scenario for which comprised the SESs and CIESs of Brazil. The data were collected by a self-applied questionnaire made available online to the managers or parties responsible for the conduct of Continuous Health Education in the SESs, and a semi-structured interview, of the coordinators of the CIESs. The questionnaire investigated aspects of the profile of the managers and of the organizational and operational dimensions of implementation of the policy.

The interviews were recorded and conducted by three researchers, with the help of a script which dealt with: identification of the CIESs; coordination with formative institutions; activities carried out; and financing.

Processing of the data of the questionnaires was recorded in a digital database and carried out in Microsoft Excel spreadsheets. The interviews were transcribed in full, submitted to a subject content analysis[15], and dealt with operationally in three stages: (i) pre-analysis, comprising organization of the material to be analyzed through reading and marking of the passages to be worked; (ii) codification, classification and categorization of the material; and (iii) interpretation of results. In this last interpretation stage the following categories emerged: history; creation; composition; dynamics and functioning; activities carried out; relationship between the CIES and the SES; relationship with the formative institutions; and allocation/use of funding.

The survey was approved by the Research Ethics Committee of the Social Medicine Insti-

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tute of Rio de Janeiro State University. To preserve anonymity, the interviewees were identified by the letter I, numbers 1 to 7.

Results and discussion

Profile of Brazil's National CHE Policy in Brazil's State Health Departments

Comparison of the profile of the state-level managers of CHE revealed a predominance of women (74%), a high level of education, and training in the area of health. Other studies also refer to more women in the health sector[16,17], but the number of women taking over management positions stands out, and is corroborated by the findings of the National Health Departments Council (CONASS)[18]. This study identified, in 2015, females in 70.4% of the health education management structures in the SESs.

On the question of health managers' employment relationships, this study shows important evidence on job status and situation, in that 62% of respondents are on the permanent staff of the SESs, under the specific employment law for direct government employees; have been in their job between three and eight years; and have a prior experience in continuous health education. These findings suggest stability in the processes carried out, greater qualification of the management, and value being given to career professionals in the Departments (Table 1).

The findings also indicate that 20 of the 27 SESs have a specific Continuous Health Education sector in their organizational structure. However, its absence also seems not to make the existence of CHE activities non-viable, since they are carried out by technical areas, in varying scenarios, involving varying players (Figure 1).

As to the status occupied by the area in the Department, it was found that in only three states the Continuous Health Education sector is directly linked to the center of decision ('cabinet') of the Health Department. Also identified were various levels of subordination and nomenclature in the jobs, with emphasis on the terms 'director-level', 'management' and 'coordination'. These results suggest different understandings of the functions, values, perceptions and importance of the continuous education policy.

Table 2 presents the internal structure – the physical, material and human resources – for the principal educational activities of the CHE sector. It was found that these sectors of the SESs have: their own physical structure, internet and IT resources (more frequently cited), and audiovisual resources (less frequently cited), and equipment for video conference calls and a library. In the SESs in which CHE is not in the organization diagram, the managers also say they have a physical structure for carrying out educational actions.

In relation to findings of a previous survey[19], which indicated the precarious infrastructure for adoption of more collective education strategies, such as physical space, equipment, computers and internet, it was found in this study that there was a group of investments mentioned by respondents which show the use of incentives provided by government policies for training and qualification of health workers.

Ninety percent of the SESs said they had specific dedicated structures for training of staff, such as technical schools (59.3%) and schools of public health (22.2%), as well as training centers. The evidence is important and confirms the potential of these spaces for production and dissemination of supplies of education that are relevant to the competencies of the sector and to the field of education and work in health.

However, there are aspects linked to the functional dynamics of the levels of training connected to the SESs which need to be pointed out. The Conass[18] survey revealed that in 81% of the SESs, the execution of the actions of development/training of employees was attributed to other sectors.

This present survey identified the existence of CIESs at state and/or regional level in 88% of the SESs.

The managers stated that the CIESs are mostly coordinated by the representative of the body responsible for continuous education in the SESs, and have their own working dynamic, which is in line with the character that is expected of the CIESs, namely: permanent instances for the formulation and conduct of development of the State Continuous Health Education Policies (PEEPs)[20].

A certain coherence is seen in relation to the activities carried out by the Continuous Health Education sector in the SESs, evidencing an important movement of organization of the state's policies. Among the duties mentioned we notice the following – all areas under responsibility of the Continuous Health Education sector: organizational assistance and coordination of the CIESs (77.8%); articulation and organization of the stages of the curriculum (74.1%); and training and qualification in specialized and technical/professional courses (70.4%) (Table 2).

Table 1. Profile of the manager/person responsible for conduct of the Continuous Education Policy in the State Health Department.

	Brazil	
	N = 27	**%**
Gender		
Female	20	74,1
Male	7	25,9
Level of schooling		
Full graduation	27	100,0
Higher qualification		
Professional Master's degree	2	7.4
Academic Master's degree	7	25.9
Specialization	16	59.3
Doctorate	2	7.4
Area		
Human resources	10	37,0
Collective Health / Public Health	9	33,3
Management	3	11,1
Education	3	11,1
Other	6	22,2
Type of employment relationship		
General Employment Law (CLT)	2	7,4
Higher Management or 'commissioned'-level	8	29,6
Government Employee Law / Higher Management or 'commissioned'-level	7	25,9
Government Employee Law / position with bonus	1	3,7
Government Employee Law	9	33,3
Time with the State Health Department		
Less than 1 year	14	51.9
1 to 5 years	6	22.2
6 to 10 years	5	18.5
Over 10 years	2	7.4
Time in present position		
Over 8 years	2	7.4
4 to 8 years	5	18.5
1 to 3 years	6	22.2
Less than 1 year	14	51.9
Prior experience of work in Continuous Education		
Yes, in Health	16	59,3
No	11	40,7

Source: ObservaRH/IMS-UERJ. Assessment of the Continuous Health Education Policy of the SUS implemented by the State Health Departments (Avaliação da Política de Educação Permanente do SUS Implementada pelas Secretarias Estaduais de Saúde). Brazil, 2015.

Ministerial Order 1996/2007 lays down that the state plans must contain the specified CHE actions that are based on basic requirements that reflect the guidelines of the PNEPS. In this context, 22 of the SESs researched have PEEPs prepared with the participation of the workers.

The positive aspects of the PEEPs as indicated by the respondents are presented in Graphic 1. The ones that stand out are: dialog with the teaching institution; projects that meet local demand; possibility of negotiation; and agreement and approval of projects.

The study also indicated that, for the managers, the areas of competency of the CHE sector in the Department are: identification of the needs for training and development of health workers, and the main health problems faced by management and by the services of the region; and pro-

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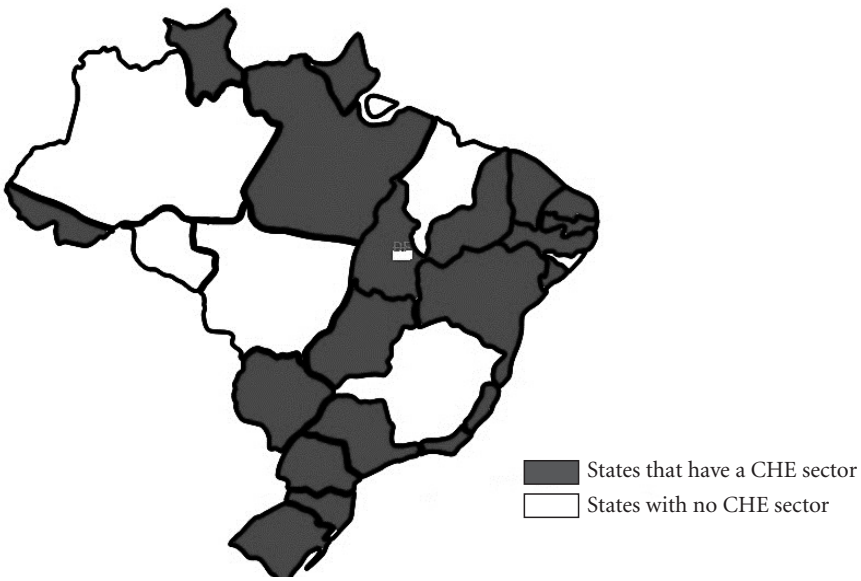

Figure 1. Specific Continuous Health Education sectors in Brazil, by State, 2015.

Source: ObservaRH/IMS-UERJ. Assessment of the Continuous Health Education Policy of the SUS implemented by the State Health Departments (Avaliação da Política de Educação Permanente do SUS Implementada pelas Secretarias Estaduais de Saúde). Brazil, 2015.

motion of integration of health and education in strengthening the institutions that train professionals that operate in the area. The transfer of funds by the Health Ministry was also cited by the majority of the managers as the most important contribution by that body.

The greater part of the funds involved for the execution of the PNEPS arises from the funding originally from the federal government. In the view of the managers of the SESs, issues of an administrative and juridical-legal nature hamper their execution. In prior studies[12,21], release of the funds and doubts about the financial management were the difficulties most referred to by the managers. In line with the evidence, it was found that 30.8% of the managers of the SESs and SMSs stated that the release of funds is one of the principal difficulties faced[13], in view of the impediments for their use.

Decentralization of the financing of the PNEPS, with shared responsibility, has limits. The various instances of the SUS have been able to produce rapid mechanisms for financing and contracting of health actions and services, but this has not happened in the educational actions and services, because "the whole of the public machinery, which operates well in the scope of health actions, "gets blocked" when it is a question of actions for education"[21].

A need is also reported for enhancement of the administrative processes and the legal frameworks of states and municipalities, which should be able to make the contracting and execution of the CHE actions practical[22]. It contains aspects such as criteria for distribution of funds for implementing and monitoring of projects[20,23]. Stroschein and Zocche[20] highlight that there is a need to enhance the administrative processes and legal frameworks of states and municipalities to make possible the contracting and execution of CHE actions.

Another important dimension refers to the participation of the collective instances of management in the decisions on the priorities of Continuous Education. More than 85% of respondents said that they plan their actions and select the clientele that participates in them following criteria decided and agreed in the Bipartite Inter-managers Committee (*Comissão Intergestora Bipartite* – CIB).

The managers state that all the workers may take part in the processes of qualification that are proposed, but they stress that the legislation restricts some actions to members already serving

Table 2. Structuring of Continuous Health Education in the State Health Departments, Brazil, 2015.

	Brazil	
	N = 27	%
Specific Continuous Health Education sector in the structure of the Department		
No	7	25.9
Yes	20	74.1
Whether the Continuous Health Education sector is included in the official organization diagram of the Department		
Don't know	1	3,7
No	10	37,0
Yes	16	59.3
Existence of a specific physical structure for the Continuous Health Education sector		
Yes	18	66.7
No	9	33.3
Physical resources available to the Continuous Health Education sector		
IT resources	22	81.5
Classroom	10	37,0
Meeting room	18	66.7
Internet	22	81.5
Audiovisual resources	18	66.7
Specific structure for training/qualification of personnel		
School of Public Health	6	22,2
Technical school	16	59,3
Training and Qualification Center	2	7,4
Does not have own structure	3	11,1
Main areas/activities under the responsibility of the Continuous Health Education sector		
Specialization Courses	19	70.4
Assist and advise the CIES	21	77.8
Coordinate the CIES	20	74.1
Medical and multi-profession residencies	14	51.9
Articulation/organization of curriculum phases	20	74.1
Technical/professional training/qualification	19	70.4
ProgeSUS	14	51.9
Telessaúde	10	37
Pró-Saúde	9	33.3
PET-Saúde	9	33.3
Ver-SUS	7	25.9
Existence of dialogue between the Continuous Health Education sector and the technical areas of the state Health Department		
Don't know	1	3.7
No	0	0
Yes	26	96.3
Existence of a CIES in the state		
No	2	7.4
Regional and State-level	14	51.9
State-level	8	29.6
Don't know	1	3.7

Source: ObservaRH/IMS-UERJ. Assessment of the Continuous Health Education Policy of the SUS implemented by the State Health Departments (Avaliação da Política de Educação Permanente do SUS Implementada pelas Secretarias Estaduais de Saúde). Brazil, 2015.

on the permanent staff, and occupants of 'commissioned'-level government employment positions (*cargos em comissão*), excluding the simply contracted employees.

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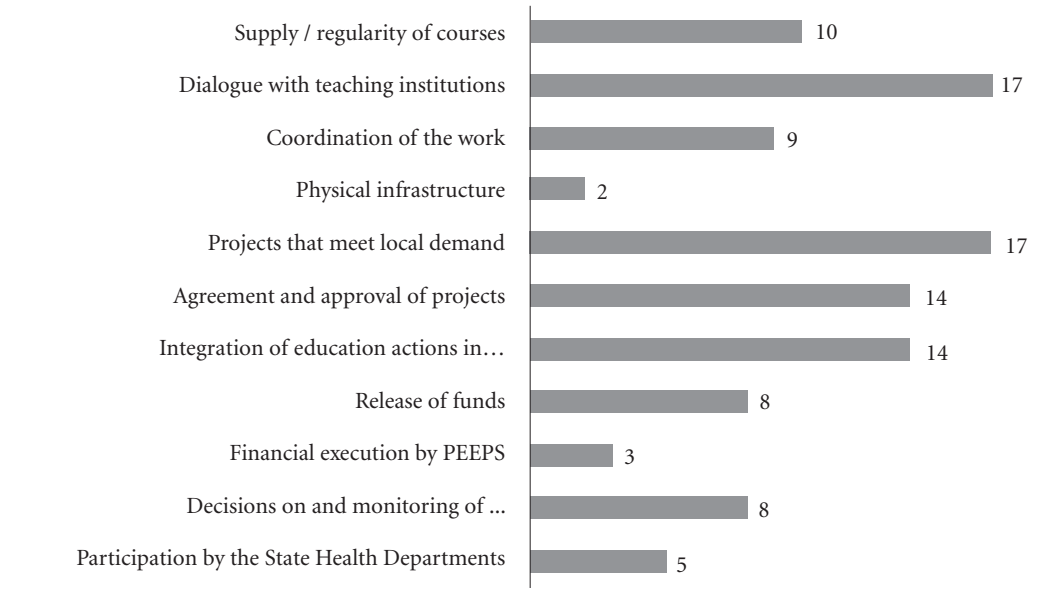

Graphic 1. Positive aspects of the State Continuous Health Education Policies (PEEPS) indicated by state-level Continuous Health Education managers. Brazil, 2015.

Source: ObservaRH/IMS-UERJ. Assessment of the Continuous Health Education Policy of the SUS implemented by the State Health Departments (Avaliação da Política de Educação Permanente do SUS Implementada pelas Secretarias Estaduais de Saúde). Brazil, 2015.

The restrictions indicated inhibit the effective creation of a permanent process for qualification, with consequences for the worker and for the quality of the service provided to the population. Today, the public sector has a considerable volume of workers contracted in outsourced structures, through the so-called Social Organizations (*Organizações Sociais* – OSs), Public-utility-registered NGOs (OSCIPs), or by service providing companies, in which the qualification of professionals is not considered, according to the rules set by the control bodies[24], as being a responsibility of the individual State, in a role as employer.

Continuous Education in the SESs is monitored using various modalities, including: control of the total number of people concluding the educative modules that are offered; use of the funding; reports on courses. It is perceived that, although the evaluations are firmly anchored on quantitative aspects, movements to qualify and institutionalize the evaluation processes have been stimulated within the SESs.

The following were stated to be benefits of CHE: personal growth of the worker; progress in career; payment of bonuses and improvements; and changes in the work process. Prior studies[23,25] underline that CHE promotes reflection and changes in the manners of organizations and working of the service, contributes to teamwork, and induces changes toward better integration between the team and the community.

The CIESs and the development of the CHE policy implemented by the SESs

This section presents results of the interviews carried out with seven coordinators of the state CIESs in line with the categories previously defined.

History, creation and composition

The interviews revealed that the process of institution of the CIESs took place at different moments and stages, such as: in a movement to raise institutions' awareness; seminars for debate and explanation of the policy; meetings with various players; and even the formation of a collective. Also reported was an instance of work in partnership with the inter-manager committees and regional health committees for establishing the regional CIESs.

The composition of the CIESs is pluralistic, that is to say, it has wide representation from

various institutions: both public and private training and qualification institutions; members of state and municipal management; the State Health Council; the Municipal Health Departments Council (Cosems); foundations; healthcare units; and unions of workers of the SUS. One of the interviewees said that, because it is a wider process, the composition of the CIESs in the respondent's native state had not followed the shape laid down by the Ministerial Order:

[...] *we started from the principle* [...] *that what was needed was not to follow only the Ministerial Order. The Order limits a thing, in my view – there's an aspect of very highly defined directives, but the CIES is a wider thing, and continuous education involves a whole process.* (E5)

This plurality of the CIES is noted as positive, making it possible for the committee to be more open, balancing the power of the management and strengthening the social control.

[...] *I think that the conception of composition of the CIESs that they have to be pluralist is one of the strategies that works in favor of there not being something closed – that they don't give the whole of the power to the management, that they don't leave the social control alone and unsupported* [...] (E6)

A study in the city of Campinas indicated low participation of the population in the instances of decision, and agreement of the actions of CHE as a limit for Continuous Education policy[26]. We may recall that the aims of CHE have been stated as a strategy to promote: participative management; appropriation of public health policies by the managers, workers and users; and humanization of the work relationships[25,27].

Functional dynamics, and activities

The question of the Committees' work processes produced some important answers. In the majority of the SESs the committees meet monthly.

On the dynamics of the meetings, an unequal functioning between the regional CIESs, which are at different stages of organization, was reported in one of the states.

Another report highlighted the fact of the meetings being open, with any of those present able to speak, in a strategy to ensure designed to ensure that there were at least the minimum number of participants. In this respondent's opinion, the workflow progressively organized itself and the committee learned from the errors and mistakes committed:

The meetings of the state-level CIES were absolutely open, there was no configuration of who could speak, who could do this, who could do that. [...] *With time, this flow of work organized itself: we began to work on our own mistakes and misunderstandings, to organize the flow*. (E6)

In another state, the fact that the coordinators of the CIESs did were not included in the actual management was considered, by the interviewee, as a positive differential. He indicated the fact of the regional policy being executed by the regions themselves, while the state-level CIESs do not take decisions for the region, and that there are, thus, no hierarchical actions. Thus, the regional bodies showed differentiated functioning: better or worse, attributing this difference to the flexibility and autonomy existing in the regulations.

The participation of the segments of workers and users was indicated as fragile in the CIESs, this being attributed to the fact that these segments are in the process of getting to know what their role is. In a study in Rio Grande do Sul, it was found that the participation of the workers in the decision on educative proposals raised active interest in some, and disinterest in others[19].

The mobilization of many of the teaching institutions in participating in the CIESs resulted from the expectation of raising funds. The interests diminished when they found that the discussion was broader because the intention was to overcome the 'logic of the shop counter', and discuss the policy more broadly:

[...] *some typical examples of a teaching institution is that many came to it looking at* [...] *a logic of wanting to raise the funds that were there. When they perceive that we were in a much broader discussion than that, that we in fact wanted a policy, not this 'shop-counter' logic, we wanted to also overcome that – that was when a lot of people lost interest in this a little*. (E5)

This 'shop-counter logic' gives a picture of the moment of the centers of CHE, prior to the PNEPS, when the limited participation of the municipalities in identifying needs for construction of CHE strategies induced other players to assume protagonist roles, creating problems, because in general the projects were not being structured based on local needs for services, that is to say, they were proposals pre-prepared by the IESs, without the necessary articulation[25].

It was highlighted, as important for the functioning of the CIESs, that the managers should have a dynamic posture and a decentralized vision of the SUS, which could make the teamwork possible. When this occurs, the CIESs work well, and so do other structures. Another study[26] found that low participation of managers in CHE actions was indicated as a limiting factor for implementation of the regional CHE plans.

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The carrying out various types of courses is among the most frequent activities of the CIESs. The interviewees argued that it is necessary to maintain the debate on the need for technical courses that are already planned, and specialization courses in various areas (obstetrics, ICU, mental health), and to reflect on the people coming out of the courses offered, noting where, how and whether they continue operating in the services network.

One interviewee reported that the work of the CIESs is far from ideal, because the greater part of their members are still not yet aware of the meaning and importance of their activity.

The majority of the people still don't really yet have this awareness of what the CIES is [...] – *the people from the regional committees, the state CIES itself have this difficulty of not yet knowing what the role of the CIES is* [...] *the manager, the worker, social control, each of these is still lacking this recognition*. (E3)

In one of the states, for example, it was found that members of the regional CIESs, already participating or about to be included, were being trained.

In one of the interviews it was emphasized that there are difficulties for doing away with the logic that training solves all the problems, because CHE goes beyond training:

[...] *there is a lack of ability to go beyond this logic that 'training alone solves everything'* [...] *continuous education goes well beyond higher education – which is the phrase I suppose you would use for this mechanism of training* [...] *what sustains this, what makes the wheel go round is in fact these almost individual changes and collective changes in the process of work there at the end, one person's knowledge complementing the knowledge of another, the discussions, the point of view of the other person who is not seeing the social control system, of the individual himself that is being affected. This is very complex – that you should imagine that isolated trainings will succeed in solving this wider process*. (E4)

The process of decentralization was not accompanied by a qualification of the managing teams and this can be stated in relation to the CIESs, which need to get to know the process of management, organization and structuring of the PNEPS of the respective territories they cover[21].

Some interviewees indicated that the CIESs are not a priority for the government and as a result courses, training and seminars are relatively one-off and fragmented. A prior study had shown that reiterative and technical-based educational proposals, with the emphasis on training, qualification and courses in specific areas, are indispensable in health practices, but it is necessary to overcome fragmentation and discontinuity[26].

Relationship between the CIESs and SESs, and formative institutions

Three interviewees stated positive situations in relation to CIES/SESs in which all the processes are remitted to the CIES and to the CIB:

[...] *I believe that there was always this tranquil relationship with the members of the CIES, more you might say in a movement of collective construction, than in a contrary movement, you understand? Our relationship is indeed a relationship of collective construction, discussion of the processes of continuous education, we have no serious problem of understanding. Whenever there is a disagreement, we reach a consensus through dialog* (E1).

In two states, the relationship with the SES is considered good, but there is a distancing, and disinterest:

[...] *I think that it's a lack of understanding, really, of what the integration committee is*. [...] *We expect with this new restructuring of the Bipartite Inter-Managers Committee that this distancing will be reduced and that we'll have a more intimate relationship with the secretary, after all he is the state-level coordinator of the Bipartite Inter-Managers Committee*. (E2)

It was also mentioned that there are direct relationships of the SES with the Health Ministry, suppressing the pass-through of information to the coordinator of the CIES. Another interviewee reported problems of understanding about the role of the state in relation to the CIES – autonomy, or the state only as a body to maintain the executive secretary's office.

All the interviewees reported some approximation of the CIES to the formative institutions, of varying juridical nature, scale and intensity. The public and private IESs, of federal and state level, and also the technical schools of the SUS network, are part of this relationship. It was also said that, in spite of the constitution of the CIES, the relationship with the formative institutions is close, but is not yet institutionalized, varying the integration and the participation of the teaching institutions by region.

One of the interviewees indicated that the institutions seek financial counterpart and have a utilitarian vision of the service:

[...] *There is a certain lack of participation by the formative institution, it's not, it's not enough,*

it's not in accordance with what's in the Ministerial Order. We don't have this active participation of the formative institution [...] *at state level; in the interior of the state, it's almost non-existent*. (E3)

The findings of the interviews corroborate the prior survey[21], which recognizes that there is a good articulation between teaching and service, but that it needs to be enhanced, especially in those that allow teachers, students and workers, together, to build educational programs in accordance with the care, and the management.

One of the hindrances highlighted is about the stages of the curriculum. Both federal universities and the private colleges have the public services network as a field for internships, leading to a strong presence of pupils in the network, an aspect that is questioned by the Public Attorneys (MP).

[...] *this question of internship is taking up a lot of our time, the Public Attorneys being very demanding for a response from us in relation to the IESs*. [...] *many students within the units and that these institutions ought to be helping the state in counterpart. Since we don't have a teaching hospital, all the internships are done within the units of the state, so that it's a big program that we are taking to the CIES to help to assemble a plan of action and see how it is that these institutions could be giving something back as counterpart*. (E1)

One of the interviewees understands that the genesis of the relationship with the academic world took place during the beginnings of the policy, with the implementation of Continuous Education and family health centers, spaces where the projects were discussed and negotiated. But at this present moment what is happening is that the academic world arrives with its project ready, only looking for financing, at the same time as there is an incapacity of the management to establish how this relationship will take place, leading to the academic world having a predominance.

It was stated that the relationships with the IESs with CIESs that had been like a 'project shop-counter' were transformed, thanks to the recognition that it is necessary to take part in the meetings with the CIES to debate needs:

The CIES underwent a period of great discredit, because the formative institutions still widely had a position that "if it's not a projects shop-counter, then tell us where the counter is." It's no longer like that, we no longer go to ask for money to sell our courses, but then where is it that we have to go? "Ah, we have to go to the meetings of the CIES for us to converse." (E6)

This same interviewee said there is still a lot of disinformation in relation to the SUS in the universities themselves. He believes that the CIES has contributed to the changes in the process of training/qualification, through the development of proposals from the Health Ministry, such as: PET-Saude, Pro-Saude and multi-professional residencies.

Allocation and use of funds

The interviewees were concerned about the difficulty, and disagreed in relation to the use and handling of the funds allocated to Continuous Education. They also say that there are limitations for the use of these funds, low capacity for spending on the part of the states, some funds that are earmarked, with little flexibility of use, limits imposed by Law 8666, and challenges in the courts, among other problems.

They highlighted the suspension of automatic pass-through of funding, and the possibility of financing by project, starting in 2012, as a backwards step. It was argued that the transfer of funding should be fund-to-fund, giving more autonomy to managers, enabling them to present their priorities.

[...] *that we should start this practice again. I think it's damaging. It will be a race for the funding. And then, if there isn't a good coordination, there will be a fratricidal dispute between us and the academic world to see which of us is able to bite off the most funding. I think this is damaging, this is a competition that finishes up being perverse for the system, it's self-consuming, it will be one swallowing the other to see who gets to the funds first*. (E3)

Two interviewees stated that there is a difficulty in the execution of the funding. The first of them said that one of the reasons is the disinformation about how to use them in accordance with the specifications of the Ministerial Order, and as established in the process of regionalization of the policy. This situation left the funds blocked for certain periods, with accumulation between 2008 and 2011. In another interview, the difficulties for financial execution of the funds were attributed to the Health Ministry Order. The interviewee argues that the idea that the state does not have the formal competency for execution of the funds is mistaken.

A mechanism of fund-to-fund transfer for funding under Ministerial Order 1996/2007 is regarded as an advance, but some difficulties remain. There are doubts about the financial management, especially on the contracting of services

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in the area of education, such as the impediments of remuneration of public-sector workers in the activities of CHE, specified in the Normative Instruction of the Federal Audit Court, which finishes up inducing the presence of an 'intermediator' for passing on the funds[21].

In a survey of members of the CIESs of Greater Florianópolis and the Coal Region[21], a great difficulty was reported in using the funding allocated to CHE actions through collectively prepared projects, and based on social needs evidenced at a local level. The two CIESs both indicated, as difficulties, the bureaucratic procedures associated with the slow movement of the bodies involved in the dynamics of the work process of the CIESs.

Final considerations

Continuous health education ('CHE') has been understood, as to its basic conceptual and methodological assumptions, as a strategy that has transformed health practices, helping to destroy the traditional paradigm that orients the processes of training and education of health workers. It is an instrument that points to personal, social and cultural development and is centered on the processes of teaching-learning, in which the subject who learns is himself an active and autonomous agent and a manager of his/her education.

This ideological and political conception, which is operationalized at the local health region level, invites people to permanently reflect on the reality, seeking creative solutions for overcoming the problems with health and, consequently, qualifying actions aiming to increase the capacity for problem solving, and efficiency, of the health system.

Based on this point of view, the analyses of the Continuous Education Policy (PEP) in the organizational, operational, and control focus reveal that: 88% of the SESs have PEEPS (State policies on Continuous Health Education), a formalized Continuous Education structure, and physical resources for the work of training/qualification. A total of 92.6% of the managers of the SESs said that the CIESs are strategic, with regional scope, the coordination of which has its own, or state-level, dynamics, coordinated by the person responsible for the PEP. The scarcity of funds and limits for their education are the biggest obstacles. The health ministry contributes, as priority, with the transfer of funds. The importance of CHE was highlighted as a factor inducing changes in the work process, while at the same time the CIB was recognized as an important instance of participation and making of agreements.

The study indicated progress, demonstrating the importance of the CIESs as instances and spaces of negotiation, agreement and development of CHE. However, there are challenges that still need to be overcome for the projects in the SESs to be consolidated in such a way as to strengthen the PNEPS.

It is assumed that, in spite of the restrictive economic and political situations, continuation of the technical and financial investment by the federal government is fundamentally essential for maintaining the actions linked to the PNEPS.

Because of the complexity of elements of this field, the results of this paper are not exhaustive on the universe of questions that surround the role of the CIESs in the implementation of the National Policy for Continuous Health Education (PNEPS). In the research on which this article is based, a group of elements was investigated to analyze the capillarity of the CHE policies in the country. In this paper certain dimensions of analysis were chosen. There are other cross-sections and approaches that can deal with the specific aspects of dimensions such as examination of the relationships between the spheres of management for implementation of the PNEPS, or comparison of the status of implementation of the policy in the regions and/or states. Considering the scope of the investigation and the inter-federative nature of the PNEPS, further studies would indeed be important.

Collaborations

T França, KR Medeiros and SA Belisario worked on the conception, collection and interpretation of data, drafting of the paper and final approval; CR Pierantoni worked on the conception, interpretation of data, drafting of the paper and final approval; ICM Pinto worked on the conception, collection and interpretation of data and drafting of the paper; AC Garcia and JL Castro worked on collection and interpretation of data and approval of the final version.

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