

When Daily Life Teaches: Permanent Health Education in a Local Context

Quando o Cotidiano Ensina: Educação Permanente em Saúde em Âmbito Local

Cuando lo Cotidiano Enseña: Educación Permanente en Salud en Ámbito Local

RESUMO

Objetivo: Compreender as percepções e necessidades formativas de trabalhadores de Unidades Básicas de Saúde em relação à Educação Permanente em Saúde (EPS), identificando desafios e potencialidades para o fortalecimento da formação no território. **Método:** Pesquisa-intervenção de abordagem mista desenvolvida em Sorocaba-SP (2025-2026). Realizou-se levantamento quantitativo (n=145) e qualitativo por meio de seis rodas de conversa (n=58), analisadas via análise de conteúdo temática de Bardin. **Resultados:** O principal obstáculo foi a falta de tempo decorrente da sobrecarga assistencial (73%). Revelou-se um "protagonismo impedido" pelo gap entre o desejo de participar do planejamento da EPS (60%) e a percepção de ser ouvido pela gestão (43%). O teste qui-quadrado de Pearson revelou associação estatisticamente significativa entre sentir-se ouvido e o desejo de participação ativa. Emergiram propostas como reuniões garantidas em escala (tempo protegido) e construção participativa de protocolos (ex: Código Laranja). **Conclusão:** O fortalecimento da EPS requer a institucionalização do tempo protegido e escuta ativa.

DESCRIPTORES: Educação Permanente em Saúde; Atenção Primária à Saúde; Pessoal de Saúde; Planejamento em Saúde; Relações Interprofissionais.

ABSTRACT

Objective: To understand the perceptions and training needs of healthcare workers in Primary Health Units regarding Continuing Health Education (EPS), identifying challenges and potentials to strengthen training in the territory. **Method:** An intervention research with a mixed-methods approach conducted in Sorocaba-SP (2025-2026). A quantitative survey (n=145) and a qualitative stage with six conversation circles (n=58) were conducted, analyzed through Bardin's thematic content analysis. **Results:** The main obstacle was the lack of time due to healthcare overload (73%). A "prevented protagonism" was shown by the gap between the desire to participate in EPS planning (60%) and being heard by management (43%), with a significant statistical association. Proposals like scale-guaranteed meetings (protected time) and participatory protocols (e.g., Orange Code) emerged. **Conclusion:** Strengthening EPS requires the institutionalization of protected time and active listening.

DESCRIPTORS: Education, Continuing; Primary Health Care; Health Personnel; Health Planning; Interprofessional Relations.

RESUMEN

Objetivo: Comprender las percepciones y necesidades formativas de los trabajadores de Unidades Básicas de Salud en relación con la Educación Permanente en Salud (EPS), identificando desafíos y potencialidades para el fortalecimiento de la formación en el territorio. **Método:** Investigación-intervención con enfoque mixto realizada en Sorocaba-SP (2025-2026). Se realizó un relevamiento cuantitativo (n=145) y cualitativo mediante seis rondas de conversación (n=58), analizadas mediante el análisis de contenido temático de Bardin. **Resultados:** El principal obstáculo fue la falta de tiempo debido a la sobrecarga asistencial (73%). Se reveló un "protagonismo impedido" por la brecha entre el deseo de participar en la planificación de la EPS (60%) y la percepción de ser escuchado por la gestión (43%). La prueba de chi-cuadrado de Pearson reveló una asociación estadísticamente significativa entre sentirse escuchado y el deseo de participación activa. Surgieron propuestas como reuniones garantizadas en escala (tiempo protegido) y construcción participativa de protocolos (ej: Código Naranja). **Conclusión:** El fortalecimiento de la EPS requiere la institucionalización del tiempo protegido y la escucha activa.

DESCRIPTORES: Educación Continua; Atención Primaria de Salud; Personal de Salud; Planificación en Salud; Relaciones Interprofesionales.

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INTRODUCTION

Continuing Health Education (EPS) is a strategic guideline of the Unified Health System (SUS) for transforming practices by addressing everyday challenges⁽¹⁾. Unlike continuing education, which focuses on the top-down transmission of technical content, EPS proposes that learning occur on the job, valuing the local context and the autonomy of individuals⁽²⁾.

Despite the regulatory progress of the National Policy on Continuing Health Education (PNEPS), its implementation in Primary Health Care (PHC) faces structural challenges⁽³⁾. The literature indicates that educational initiatives are often reduced to one-off training sessions disconnected from local realities^(4,5). Additionally, the heavy caseload, high staff turnover, and precarious employment conditions—through Social Health Organizations (OSS) and medical contracts with legal entities (PJ)—create barriers to planning and participating in critical training processes^(6,7).

Given this scenario, actively listening to PHC workers regarding their perceptions and training needs is essential for reorienting in-service training strategies⁽⁸⁾.

The objective of this study is to understand, based on the perceptions of workers at Basic Health Units (UBS) in Sorocaba, how training needs align with the principles of the EPS, identifying challenges, barriers, and opportunities for strengthening critical training in the region.

METHOD

A mixed-methods (quantitative and qualitative) intervention study, grounded in the principles of participatory methodologies⁽⁹⁾. The study was conducted in the Primary Care network of Sorocaba, São Paulo (33 UBS, ~1,400 workers) between 2025 and 2026.

In Phase 1 (quantitative), a structured digital questionnaire (Google Forms) was administered, consisting of 20 closed-ended questions and five problem-based scenarios related to the daily routine of primary health care. A total of 145 health workers from different categories, selected by convenience, participated. The data were analyzed using descriptive statistics and Pearson's chi-square test (χ^2) in SPSS software ($p < 0.05$).

In Stage 2 (qualitative), six focus groups were held at strategically selected primary care units (UBS) to represent different models of care (Family Health Strategy—ESF and traditional UBS) ($n = 58$ participants). The 90-minute sessions were facilitated by the researcher using active methodologies (feedback, problem-posing, and proposal-making). The audio recordings were transcribed and analyzed using Bardin's Content Analysis⁽¹⁰⁾ and field notes.

The study was approved by the Institutional Review Board (IRB) of the Botucatu School of Medicine—UNESP (Opinion No. 3,853,093; CAAE No.

28237120.9.0000.5411). All participants signed the informed consent form. To preserve anonymity, the statements were coded by professional category and number (e.g., Nurse 1).

RESULTS

The profile of the respondents ($n=145$) was characterized by a female majority (84%), an age range of 30–49 years (68%), more than 5 years of experience in primary health care (72%), and civil service status (78%). The sample included nurses (42%), community health agents (ACS) (21%), physicians (15%), administrative staff (12%), and dental health professionals (10%). The analysis yielded five categories.

Organizational Obstacles and the Search for “Protected Time”

Lack of time due to an excessive workload was the main obstacle to participating in EPS for 73% of respondents in the quantitative phase and was unanimously cited in the focus groups. The pressure to conduct individual consultations reinforces a reactive work approach, focused on “putting out fires,” which undermines longitudinal care⁽¹¹⁾. The professionals suggested resuming “planning workshops” with periodic closures of the units:

We don't have time for anything. It's patients all day long... How are we supposed to stop and study, or discuss a case? . Nursing Technician 1

We used to have these workshops... We'd

close the unit once every two or three months, and everyone participated. It was the only time we could plan together. That's been lost. . Community Health Agent 1

There was discussion about incorporating guaranteed team meetings into the schedule at traditional UBS clinics, following the model of the ESF⁽¹²⁾. The lack of structured interprofessional spaces for case discussions places an excessive burden on nurses, who alone assume the role of a communication link between the different professions:

The pregnant woman who had syphilis... because often the pediatrician isn't informed. Today, this management is entirely in the hands of the nurses. If we had this space to share cases, everyone would feel empowered. . Nurse 2

Institutional Communication and the “Chinese Whispers” Effect

Institutional communication was assessed as top-down and fragmented, leading to miscommunication. The excessive number of emails received makes it difficult to identify priority updates, perpetuating the use of outdated practices:

We're still using an outdated protocol, which we didn't even receive via email. We also get a huge volume of emails. The protocol changes a lot. . Nurse 5

Although dentistry uses agile channels such as messaging apps to receive updates, this communication—segmented by professional category—ends up isolating professionals in “bubbles,” undermining the comprehensiveness of care⁽¹³⁾.

Impeded Participation and Occupational Illness

A gap was evident between the desire to actively participate in EPS planning (60%) and the perception of actually being heard by municipal management (43%). Pearson's chi- t test revealed a statistically significant association between “feeling heard” and the “desire for active participation” (Table 1).

Table 1 presents the distribution of participants according to their perception of being heard and their desire for active participation in EPS planning.

Table 1: Association Between Feeling Heard and the Desire to Participate in EPS Planning, Sorocaba, São Paulo, Brazil, 2026. Source: Prepared by the authors (2026).

Feeling Heard	Wishes to Participate Actively (Yes)	Does Not Wish to Participate / Indifferent	Total
Always / Often	52 (83.9%)	10 (16.1%)	62 (100%)
Rarely / Never	35 (42.2%)	48 (57.8%)	83 (100%)
Total	87 (60.0%)	58 (40.0%)	145 (100%)

The highly significant association ($p < 0.01$) demonstrates that professionals who feel heard by management desire an active role. Conversely, institutional invisibility demobilizes workers, leading to demotivation and weakening solidarity:

Back in the day, we used to help each other more; the team was more united. Today, everyone just does their own thing and that's it. The team is very demotivated. . Nursing Technician 2

Methodologies, Protocols, and the Science of Implementation

Workers reject one-way lectures, valuing participatory methodologies instead. When faced with complex issues such as mental health, 56.6% chose discussion groups for case studies, compared to 22.1% for external courses and 15.2% for lectures. The top-down imposition of protocols taken out of context was criticized:

A ready-made protocol comes down from above that has nothing to do with our reality. Then it doesn't work, and the blame falls on us for not implementing it properly. . Doctor 2

In contrast, the implementation of the preeclampsia protocol (Code Orange) at the Vila Barão Basic Health Unit was successful due to a collective sense of unpostponable clinical urgency, which mobilized the team to overcome time constraints through shift rotations:

Whether we had time or not, whether we were overloaded or not, we had to get through it. So, we had that need; we had that sense of urgency to act. . Nursing Technician 3

We had a shift change. Everyone who was in the unit participated in the briefing on preeclampsia, and we were able to discuss the topic. . Nurse 6

Transformation Through Listening and

Support for Workers

The conversation circles served as interventions, becoming spaces for engagement and acceptance. In the end, the professionals expressed gratitude for the opportunity to speak and be heard, revealing the lack of spaces for listening within the services:

As they left the conversation circle, many professionals came up to hug me, thank me, and tell me how important this was for bringing about meaningful change in their practice. . Researcher's Field Notebook, December 2025

The initial refusal of the “snack” offered during the circles revealed the widespread use of appetite-suppressing medications (such as tirzepatide) for weight management. This finding highlighted that acknowledging the biosocial dimension and the vulnerabilities of workers is an indispensable prerequisite for educational processes to occur authentically.

DISCUSSION

The results show that Health Education (EPS) in Primary Health Care (PHC) in Sorocaba, São Paulo, faces structural barriers but possesses latent potential. The lack of time due to an overload of care reflects a model focused on productivity-oriented goals, exacerbated by precarious employment relationships^(6,7). This scenario compromises the transformative potential of EPS by reducing it to rapid, top-down training sessions, which function merely as the transmission of disposable information.

According to Jorge Larrosa Bondiá's framework, the excess of information and the fast pace of contemporary daily life generate a crisis of experience, in which rapid information acts as “anti-experience”⁽¹⁴⁾. Authentic EPS requires slowing down, pausing,

and active listening so that learning can be experienced as an experience—that which moves us and transforms us—enabling the emergence of “knowledge from experience” collectively constructed through reflection on practice⁽¹⁴⁾.

An analysis of the success of the Orange Code from the perspective of the Consolidated Framework for Implementation Research (CFIR) highlights the importance of the construct “Tension for Change”⁽¹⁵⁾. The perception of clinical urgency in the face of the risk of maternal death generated the tension necessary for the team to overcome time constraints. In “ ” top-down protocols, the absence of this tension and the failure to adapt to local characteristics (another central construct of the CFIR) generate resistance and render implementation unfeasible⁽¹⁵⁾.

The proposal to institutionalize guaranteed team meetings on a large scale in traditional Basic Health Units (UBS), extending methodological tools from the Family

Health Program (ESF), emerges as a viable strategy to overcome the fragmentation of care and nursing overload⁽¹²⁾. Experiences in municipalities in São Paulo, such as Nova Independência-SP, which established by municipal decree a biweekly “protected time slot” for meetings and training of all health teams with community support, demonstrate the feasibility and effectiveness of institutionally guaranteeing time for Primary Health Care (EPS) within municipal management⁽¹⁶⁾.

CONCLUSION

The adaptation and consolidation of Continuing Health Education in Primary Health Care (PHC) in Sorocaba, São Paulo, require moving beyond the traditional model of top-down technical training. Health workers express a desire for a leading role and value participatory methodologies, but are limited by structural barriers such as a

lack of time resulting from care overload and the fragmentation of institutional communication.

The significant association between feeling heard and the desire for active participation reinforces that the democratization of work relationships and bottom-up listening are indispensable premises within the SUS. The conversation circles proved to be a powerful tool for intervention and care, demonstrating that acknowledging the holistic dimension of the worker is the starting point for transforming practices.

It is recommended that municipal management institutionalize “protected time” through scaled-up team meetings for all health units, periodically resume planning workshops with scheduled closures of the units, adopt integrated communication strategies, and utilize Implementation Science for the participatory development of clinical protocols based on the actual needs of frontline teams.

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