DOI: https//doi.org/10.13037/ras.vol19n67.6718

Original Article

Recebido em: 21/03/2020 | Aceito em: 25/01/2021

Dentist profile in the oral health teams and participation in permanent education actions in the Brazilian Northern region

Perfil do cirurgião dentista das equipes de saúde bucal e inserção em ações de educação permanente na Região Norte do Brasil

Danielle Tupinamba Emmi[1]
Orcid: https://orcid.org/0000-0002-6046-0717

Zaryff Said de Lima[2]
Orcid: https://orcid.org/0000-0002-3394-3561

Mayara Sabrina Luz Miranda[3]
Orcid: https://orcid.org/0000-0003-4749-1698

Resumo

Introdução: A Educação Permanente em Saúde (EPS) pode transformar e qualificar a atenção à saúde, devendo acontecer cotidianamente, a partir dos problemas apresentados nas instituições. **Objetivo:** Conhecer o perfil profissional do cirurgião dentista (CD) que atua nas Equipes de Saúde Bucal (ESB) na região Norte do Brasil, e analisar em quais ações de EPS esse profissional se insere. **Metodologia:** Trata-se de um estudo descritivo com análise documental, com dados coletados do 2º ciclo do Programa de Melhoria do Acesso e da Qualidade da Atenção Básica (PMAQ-AB), módulo VI, de 2014, com 1.189 CD atuantes nas ESB na região Norte do Brasil. **Resultados:** A maioria dos CD não apresentava pós-graduação e tinha até 3 anos de atuação na ESB (74,3%). A maioria ingressava no serviço por concurso público (42,4%), apesar de a "indicação" (30,6%) ser a forma predominante nos estados do Amapá (55,9%), Amazonas (35,6%) e Pará (38,9%). Predominantemente tinham vínculo temporário (48,1%), em que o estado do Amapá se destacou pela presença de 83,1% de seus CD nesse vínculo. A maioria participava de ações de EPS (69,6%), com destaque para os Estados do Amazonas (79,8%) e Tocantins (74,7%). Dentre as ações de EPS que o CD se inseria, destacaram-se as atividades presenciais (85,2%) e as trocas de experiências (33,3%). **Conclusão:** Constatou-se que o tipo de vínculo do CD pode gerar instabilidade profissional e pouca interação com o sistema de saúde. As novas estratégias e tecnologias da informação ainda são pouco exploradas como métodos para EPS na Região Norte.

Palavras-chave: educação permanente; estratégia saúde da família; saúde pública; políticas públicas

Abstract

Introduction: Permanent Health Education (PHE) can transform and qualify health care, and should take place on a daily basis, based on the problems found in the institutions. **Objective:** To know the professional profile of dentists working in Oral Health Teams (OHT) in the North region of Brazil, and to analyze the PHE actions with participation of this professional. **Methods:** This was a descriptive documentary study, with data collected from the 2nd cycle

[1] Faculdade de Odontologia - Universidade Federal do Pará. E-mail: dtemmi@yahoo.com.br
[2] Faculdade de Odontologia - Universidade Federal do Pará. E-mail: zaryffsaid87@gmail.com
[3] Faculdade de Odontologia da Universidade Federal do Pará. E-mail: zaryffsaid87@gmail.com

of the Program for Improving Access and Quality of Primary Care (PMAQ-AB), module VI, of 2014, with 1,189 dentists working in the OHT in the North region of Brazil. **Results:** Most dentists did not have a graduate degree and had worked for up to 3 years in OHT (74.3%). Most entered the service by public tender (42.4%), although the "recommendation" (30.6%) is the predominant form in the states of Amapá (55.9%), Amazonas (35.6%) and Pará (38.9%). Predominantly they had temporary employment contract (48.1%), where the state of Amapá stood out for the presence of 83.1% dentists with this employment contract. The majority participated in PHE actions (69.6%), mainly the states of Amazonas (79.8%) and Tocantins (74.7%). Among the PHE actions with participation of the dentist, there were presential activities (85.2%) and exchanges of experiences (33.3%). **Conclusion:** The type of employment contract of the dentist can generate professional instability and little interaction with the health system. New strategies and information technologies are still poorly explored as methods for PHE in the Northern Region.

Keywords: permanent education; family health strategy; public health; public policy

Introduction

The Family Health Strategy (FHS) is a proposal for reorienting Primary Health Care in Brazil, which aims to promote the health of the population and guarantee the right of everyone to equal access to health services. according to the Federal Constitution of 1988[1]. For this, it is necessary that FHS professionals have a profile and adequate knowledge for their attributions, acquire new skills and competencies to act in the diversity of demands and realities of the territory registered[2].

For oral health, this context is no different, as with the implementation of the National Oral Health Policy (PNSB), Brasil Sorridente, the dental surgeon has been assigned to improve the health status of the population, by building a model of care based on health promotion, protection, early diagnosis, treatment and recovery, in accordance with the principles and guidelines of the Unified Health System (SUS), aimed at the individual, family and community[3], in addition to requiring professional interaction with the health team in an integrated way, something quite different from the individual, curative and disease-centered practice that had permeated dentistry until then.

For this, the Ministry of Health (MS) proposed that the scenario of daily health practices be seen as a teaching-learning place by workers, instituting in 2004, through Ordinance GM/MS 198, the National Policy for Permanent Health Education (PNEPS)[4], which in 2007 was complemented by Ordinance GM/MS 1996 establishing new guidelines and strategies for PNEPS[5].

Permanent Health Education (PHE) aims to produce knowledge from the reality experienced in health institutions by the actors involved, having the problems faced in the day-to-day work and the experiences of these actors as the basis for education and trigger for transformation[6]. PHE requires tools that seek critical reflection on service practices, being, in itself, an educational practice that enables changes in relationships, work processes, conducts, attitudes, professionals and even the team[7].

This context makes its workers protagonists in the daily routine of health services, requiring greater capacity for analysis, intervention and autonomy for the establishment of transformative practices, as well as the management of changes and the strengthening of links between conception and execution of work to improve the quality of health care.

Nevertheless, the existence of conservative educational models and work processes of the dentist that are not in accordance with the model changes brought by SUS, make it difficult to understand EPS as a health policy and the adoption of practices as an effective tool for reorienting

the process of work in Primary Health Care (PHC) in view of the quality of service[8].

In this regard, the Program for Improving Access and Quality of Primary Care (PMAQ-AB) instituted by Ordinance GM/MS 1654, of July 19, 2011[9], aims to induce the expansion of access and the improvement of the quality of primary care, promoting innovation in management, strengthening self-assessment, monitoring and evaluation processes; institutional support and permanent education in the three spheres of government[10]. It is observed, therefore, that the PMAQ-AB is closely linked to the EPS, when these actions aim to transform the practices of doing, working and serving to better face the challenges and solve problems of the community and the territory[11].

PMAQ-AB is a continuous process and aims to deconstruct the negative bias of the evaluation, stimulating a permanent awareness of analysis and decision making to overcome problems and reach goals agreed by the teams, therefore, it can be considered a trigger for the practice agreement of EPS in the teams participating in the Program[11].

In this context, the Family Health Strategy constitutes an important space for the consolidation of PHE and knowing the profile of professionals working in health teams is of considerable importance, given the reformulation of traditional health practices that should be practiced by professionals in the teams. Furthermore, much of this information is incomplete[12] and does not cover all Brazilian states.

Thus, considering the importance of PMAQ as a program to induce changes and that, after 10 years of the institution of PNEPS, the 2nd cycle of PMAQ-AB (2014) took place, the objective of this study was to analyze the profile of Dentists working in Oral Health Teams in the Northern Region of Brazil, based on data from the 2nd cycle of the PMAQ-AB, comparatively analyzing the states in the region the permanent education actions with participation of this professional.

Methodology

This investigation is a descriptive documentary study, based on secondary data from the 2nd cycle of the PMAQ-AB, from a public database, made available by the Ministry of Health, on the Portal of the Secretariat of Primary Health Care (https://aps.saude.gov.br/ape/pmaq/ciclo2/) , without the need for approval by the Research Ethics Committee.

For the study, information was collected regarding module VI, of the Collection Instrument of the External Assessment of the 2nd Cycle of the PMAQ-AB, carried out in 2014.

Module VI comprised an interview with the professional of the Oral Health Team (OHT), with the objective of obtaining information about the team work process and the organization of the service and care to users[13].

During the interview, any OHT professional (Dentist, Oral health assistant or Oral health technician) could answer the questionnaire, depending on the person who added the most knowledge about the team work process[14]. Although 26 Oral Health Technicians (TSB) and 80 Oral Health Assistants (ASB) belonging to the OHT responded to this module during the External Assessment of the 2nd cycle of the PMAQ-AB, data collection in this research considered only the modules answered by dentists to meet the objective of this investigation, totaling 1,189 dentists working in the OHT, in the seven states of the Northern Region of Brazil (Chart 1).

Chart 1: Number of Dentists working in OHT in the states of the Northern Region of Brazil, 2014.

State	Number of dentists
Acre (AC)	60
Amapá (AP)	59
Amazonas (AM)	267
Pará (PA)	391
Rondônia (RO)	135
Roraima (RR)	20
Tocantins (TO)	257
Total DS (Northern region)	1,189

Source: PMAQ-AB (2014)

The axes of module VI, which had the research variables analyzed were: 1) General information about the interviewee (VI.2); 2) Formation and qualification of the dentist (VI.3) 3) Bond (VI.4); 4) Career plan (VI.5); and 5) Permanent education in the qualification process of the actions developed (VI.6)[14].

For data analysis, the absolute and relative frequency of each variable in each of the seven states of the Northern Region was calculated, using a Microsoft Excel spreadsheet version 2010. Results were presented in tables and figures.

Results

The states of Pará (391), Amazonas (267) and Tocantins (257) presented the largest number of dentists participating in the external assessment phase of the 2nd cycle of the PMAQ-AB (Box 1).

In the North Region, most dentists (74.3%) worked in OHT for a period of up to 03 years of service (Table 1). In the states of Roraima (65.0%) and Tocantins (37.4%), the majority of dentists worked in OHT for up to 01 year, while in the other states of the region, the predominance is dentist working in OHT for a period between 01 to 03 years. On the other hand, when analyzing the number of dentists working in OHT for more than 10 years, only 35 dentists (2.94%) were in this condition, with emphasis on the states of Amapá and Roraima, which did not have any dentist working for more than 10 years in OHT.

As for the employment contract, 573 (48.1%) dentists in the North Region were in the service temporarily (public administration or service provision), where the state of Amapá stood out for the presence of 83.1% dentists in this type of employment contract, however, this state had the lowest percentage (3.4%) of statutory public servants, when compared to the other states in the region. The state of Tocantins, when analyzed separately, was the one with the highest percentage of dentists (5.1%) with a CLT Contract (Table 1).

When analyzing the way of entering in the OHT, in the North Region the public tender predominated (42.4%), this being the way of entering of most dentists in the states of Rondônia (85.9 %), Acre (65.0%) and Tocantins (51.4%). In the states of Amapá, Amazonas and Pará, this admission in the OHT occurred mostly by recommendation (Table 1).

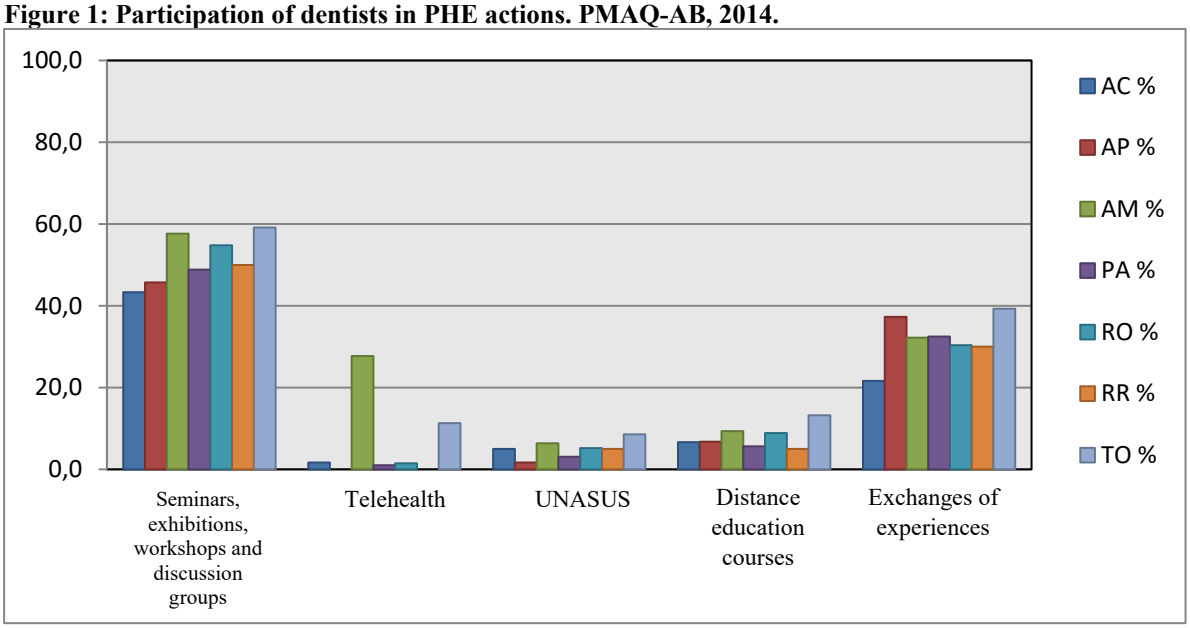
With regard to academic background, most of the dentists working in OHT in the North Region do not have any training at the lato or stricto sensu level. Of those who had, 12.0% had training at the level of specialization/residency in public health/collective health and 10.1% in family

health. The state of Pará had the lowest percentage of dentists with training in Public Health or Family Health when compared to the other states in the North Region (Table 1).

Table 2 lists that in the 07 states in the North Region, the dentist participates in actions of Permanent Health Education (PHE), with emphasis on the states of Amazonas (79.8%) and Tocantins (74.7%).

Among the actions, it was observed that seminars, exhibitions, workshops and discussion groups were the most frequent in all states of the region. However, distance education courses and telehealth still appear in a timid way among PHE actions (Figure 1).]

Figure 1: Participation of dentists in PHE actions. PMAQ-AB, 2014.



Source: PMAQ-AB, 2014.

Dentists, from most of the states in the region, consider that the PHE actions address the needs of the OHT. However, in the state of Amapá, the lack of PHE actions offered to OHT makes the dentists to consider that the actions do not meet the team needs (Table 2).

Table 1: Profile of the dentist working in the Oral Health Teams (OHT) in the state of Pará. PMAQ-AB, 2014.

	AC		AP		AM		PA		RO		RR		TO		TOTAL	
	n	%	n	%	n	%	n	%	n	%	n	%	n	%	n	%
Time working in OHT																
Less than 1 year	10	16.7	15	25.4	89	33.3	135	34.5	24	17.8	13	65.0	96	37.4	382	32.1
From 1 to 3 years	31	51.7	23	39.0	130	48.7	158	40.4	61	45.2	7	35.0	92	35.8	502	42.2
From 4 to 6 years	7	11.7	17	28.8	32	12.0	59	15.1	31	23.0	0	0	27	10.5	173	14.5
From 7 to 9 years	8	13.3	4	6.8	13	4.9	29	7.4	12	8.9	0	0	31	12.1	97	8.1
More than 10 years	4	6.7	0	0	3	1.1	10	2.6	7	5.2	0	0	11	4.3	35	2.94
Type of employment																
Statutory public servant	25	41.7	2	3.4	88	33.0	120	30.7	111	82.2	8	40.0	127	49.4	481	40.4
Commissioned position	0	0	2	3.4	4	1.5	1	0.3	5	3.7	2	10.0	4	1.6	18	1.5
Temporary - public administration	8	13.3	32	54.3	88	33.0	71	18.2	5	3.7	5	25.0	53	20.6	262	22.0
Temporary - service provision	11	18.3	17	28.8	65	24.3	167	42.7	1	0.7	0	0	50	19.5	311	26.1
CLT public employee	13	21.7	0	0	2	0.8	2	0.5	8	5.9	0	0	4	1.6	29	2.43
CLT Contract	1	1.7	1	1.7	11	4.1	15	3.8	5	3.7	1	5.0	13	5.1	47	3.95
Others	0	0	4	6.8	5	1.9	13	3.3	0	0	1	5.0	6	2.3	29	2.43
Did not know/did not answer	2	3.3	1	1.7	4	1.5	2	0.5	0	0	3	15.0	0	0	12	1.0
Type of entry into the service																
Public tender	39	65.0	1	1.7	86	32.2	123	31.5	116	85.9	8	40.0	132	51.4	505	42.4
Public selection	5	8.3	15	25.4	58	21.7	41	10.5	14	10.4	2	10.0	9	3.5	144	12.1
Recommendation	8	13.3	33	55.9	95	35.6	152	38.9	4	3.0	8	40.0	65	25.3	365	30.6
Other way	8	13.3	10	16.9	28	10.5	75	19.1	1	0.7	2	10.0	51	19.9	175	14.7
Academic background																
Specialization / Residence																
Family Health	9	15.0	9	15.3	24	8.9	23	5.9	17	12.6	6	30.0	33	12.8	121	10.1
Collective Health/Public Health	5	8.4	7	11.9	38	14.2	26	6.6	25	18.5	3	15.0	39	15.2	143	12.0
Other	8	13.3	4	6.7	31	11.8	29	7.4	14	10.4	4	20.0	29	11.3	119	10.0
Does not have	38	63.3	39	66.1	174	65.1	313	80.1	79	58.5	7	35.0	156	60.7	806	67.7
Master's degree																
Family Health	3	5.0	0	0	2	0.8	1	0.3	0	0	1	5	0	0	7	0.5
Collective Health/Public Health	2	3.3	0	0	2	0.8	3	0.8	3	2.2	1	5	2	0.8	13	1.09

Table 1. (cont.)

Other	2	3.3	10	17	10	3.7	15	3.8	12	8.9	2	10	12	4.7	63	5.29
Does not have	53	88.4	49	83	253	94.7	372	95.1	120	88.9	16	80	243	94.5	1106	93.0
Doctorate degree																
Family Health	1	1.7	0	0	1	0.4	2	0.5	1	0.7	1	5	0	0	6	0.5
Collective Health/Public Health	1	1.7	0	0	0	0	1	0.3	0	0	1	5	0	0	3	0.2
Other	3	5.0	2	3.4	3	1.1	2	0.5	2	1.5	0	0	2	0.8	14	1.17
Does not have	55	91.6	57	96.6	263	98.5	386	98.7	132	97.8	18	90	255	99.2	1166	98
Total	**60**	**100**	**59**	**100**	**267**	**100**	**391**	**100**	**135**	**100**	**20**	**100**	**257**	**100**	**1189**	**100**

Source: PMAQ-AB, 2014.

Table 2: Permanent Education actions of which the dentist is part in the Family Health Strategy. PMAQ-AB, 2014.

	AC		**AP**		**AM**		**PA**		**RO**		**RR**		**TO**		**TOTAL**	
	n	**%**	**n**	**%**	**n**	**%**	**n**	**%**	**n**	**%**	**n**	**%**	**n**	**%**	**n**	**%**
Participates in permanent education actions																
Yes	33	55.0	40	67.8	213	79.8	243	62.1	94	69.6	13	65.0	192	74.7	828	69.6
No	27	45.0	19	32.2	54	20.2	148	37.9	41	30.4	7	35.0	65	25.3	361	30.3
Do the actions meet the needs of OHT?																
Yes	16	26.7	17	28.8	125	46.8	155	39.6	51	37.8	10	50.0	149	58.0	523	43.9
No	17	28.3	23	39.0	88	33.0	88	22.5	43	31.9	3	15.0	43	16.7	305	25.6
Did not know/did not answer	27	45.0	19	32.2	54	20.2	148	37.8	41	30.4	7	35.0	65	25.3	361	30.3
Total	**60**	**100**	**59**	**100**	**267**	**100**	**391**	**100**	**135**	**100**	**20**	**100**	**257**	**100**	**1189**	**100**

Source: PMAQ-AB, 2014.

DOI: https//doi.org/10.13037/ras.vol19n67.6718

Original Article

Recebido em: 21/03/2020 | Aceito em: 25/01/2021

Discussion

The greater field of action of the dentist in the public service was strongly influenced by the insertion of the professional in Oral Health Teams of the Family Health Strategies. For this, it is necessary, the adequacy of the training of these professionals, leaving an individual, technical and office practices field, to work in multiprofessional teams, integrated with the assisted community, conducting health promotion actions and producing knowledge from their own workplace and community needs.

In this approach, it is important to know the profile of OHT professionals, which is linked to personal characteristics, to their training and qualification processes, and to their experiences and practices. This profile can be improved with the implementation of PHE strategies, among other actions that value the professional[15].

Through the External Assessment Instrument for Oral Health Teams, which makes up the third phase of the PMAQ-AB, OHT professionals were interviewed, with the objective of gathering information about the team work process and the organization of the service and care for patients[13].

Some policies of the MS, such as the Program for the Valuation of Primary Care Professionals (PROVAB), which had the intention of attracting professionals to work in Primary Care, encouraged the presence of recently graduated workers with little experience[16]. However, studies show that PROVAB was criticized for mobilizing professionals to work in Primary Care in municipalities with a deficit of professionals and with great difficulty in settlement[17]. In this study, according to Table 1, it was observed that the majority of dentists in the North Region worked in OHT for a period between 01 and 03 years (42.2%), which may have been favored by the offer of vacancies to the incorporation of dentists by PROVAB in 2013.

A survey carried out by MS[18] showed that the deficient employment contracts established with the professionals of health teams contribute to high professional turnover and dissatisfaction. In addition, it pointed out that the short time spent by professionals in the teams can be a limiting factor for work, as it makes it difficult for professionals to qualify and perform actions, as they lose the opportunity to adhere to and incorporate new values and exercise new health practices. In this context, the difficulty of establishing bonds with the assisted community is also highlighted.

As for the type of link of the dentist in the OHT, the MS recommends that the hiring of professionals for the FHS, in addition to the option of internal selection (in which individuals who already work in the city hall are selected), also requires health professionals who do not belong to municipal staff, by hiring under the Consolidation of Labor Laws (CLT) regime, because through this route there will be expansion and replacement of the staff of public administration at the three levels of government, subject to expenditure limits established by Law of Fiscal Responsibility[19]. However, when analyzing the results of the present study (Table 1), it was observed that of 1,189 interviewed dentists, only 47 (3.95%) are linked by the CLT employment contract modality, implying that, in some way, the other types of professional relationship may have increased the pre-established expenditure limits, especially in the states of Acre, Amapá and Roraima, which had less dentists with this type of bond.

During a study carried out by the Center for Research in Collective Health (NESCON/UFMG) together with the General Coordination of Human Resources Policy of the Ministry of Health, it was

found that in the Southeast region, the dentists were hired by temporary contracts or service provision in 56.4% cases[20]. The reality found in the results analyzed in the North of the country showed that the OHT in the state of Pará most presented the type of bond 'temporary service provision' (Table 1). This demonstrates that the municipalities, in addition to not protecting the labor rights of professionals, place them at the mercy of political changes[21].

Palú[22] reported that dentists temporarily hired end up undergoing political changes, seeking other employment links or sources of income, failing to dedicate themselves to changing the health care model to achieve better results in the service and in health indicators of the population. A study carried out with dentists of FHS in the state of Ceará showed that the wage standards that are quite outdated and the lack of employment relationship bothered professionals to the point of intervening in their practices[23].

Most contracts with Family Health Teams in the state of Pará were temporary, and the most frequent form of selection of workers was through recommendation. This generates implications for the work of these teams, since contracts that can be terminated at any time do not offer stability, strengthening the rotation of the teams, as well as causing their members to be replaced constantly, compromising the process of bonding with the community.

The way of entering in the FHS is important, as it is one of the elements that characterize the knowledge and involvement of the professional with this new proposal for health action. Dentists that are inserted without the proper preparation for this new health care model, end up starting the work inappropriately, which may compromise the positive results with the strategy[22]. The selection of professionals to work in the Family Health Strategy should be governed by the current legislation, and based on the guidelines of the MS[24].

Koster and Machado[25] showed that the Ministry of Health presented in its Labor Management policies in SUS the position that the only legal way of not strengthening the precariousness of work in SUS is to enter through a public tender and a public selection process. Analyzing the results obtained in the North of the country, it was possible to notice that the public tender was the main form of admission of the dentist (42.4%) in the service, although this form is not the predominant in the states of Amapá, Amazonas and Pará (Table 1).

In contrast, the recommendations are routine methods of contract in some municipalities for work in the FHS[26]. This can contribute to the insertion of professionals with no experience of acting in Primary Care and in the FHS care proposal, as well as that the constant change of management during the mandates influences the insecurity of employment contracts and the commitment in the longitudinality of care necessary to the FHS. Our results showed that 30.6% dentists in the region joined the OHT by recommendation, 55.9% in the state of Amapá, 35.6% in Amazonas and 38.9% in Pará, where this is the main form of admission (Table 1).

With regard to the formation of the dentist, the results showed that the majority did not have or were attending any graduate program at the *latu* or *stricto sensu* level (Table 1). Costa et al.[27] commented on the need for training health professionals with higher levels of education and qualification, as this way, they may be more qualified to work in collective and community health.

In this context, it is emphasized that many research professionals worked in the interior of the state, being at a disadvantage compared to professionals who worked in or near the capital, given the greater difficulty in accessing professional update and training courses, mainly due to the territorial extension and the extensive hydrographic basin of some states of the North Region. Martins[28] showed that dentists who worked in the interior of the

state of Amazonas reported difficulties in attending graduate programs, due to expenses with travel and resistance from local management. On the subject, Cutolo[29] highlights the importance of training and raising the awareness of managers, since it would not do any good to invest in human resources, if administrators, managers and politicians are not committed to the pillars of SUS.

In this approach, learning through technological resources to update professionals should be valued as a strategy, especially for professionals who live and work more distant from urban centers. Nevertheless, it was observed that 90% dentists in the region did not participate in distance education courses (Figure 1). This type of instruction allows greater flexibility and opens a window of access to knowledge and information, in a timely, personalized and dynamic way, in comparison with classroom teaching activities[15]. However, the difficulties in accessing the internet in more distant municipalities, and the little dissemination of virtual Information and Communication Technologies (ICT) in the most remote areas of the region's capitals, may have influenced the result found in this study. Thus, it is necessary to strengthen educational models at a distance, prioritizing problematization and incorporating them into the development of PHE projects[15].

The results obtained in this study showed that most of the dentists who operate in the states of the Northern region of Brazil, participated in PHE actions in the OHT they belonged to, and in most of the states in the region, these met the needs of the OHT (Table 2). Recognizing the importance of PHE is the responsibility of the municipalities and health units, and should strengthen actions that can reconcile unique needs and possibilities of demand. It is important to find the balance between pre-formatted PHE offers, with the time and context of the teams, so that they can be used effectively, and in a productive and continuous way by professionals[30].

Among the PHE strategies most used by dentists in the North Region are seminars, exhibitions, workshops and discussion groups, followed by the exchange of experiences. Telehealth and the activities promoted by the SUS Open University System (UNASUS) still appeared in a timid manner in the states of the region (Figure 1). This identifies that conservative education strategies still exist in health services, with traditional transmission methodologies[31]. A similar fact was also registered in a study with workers in the state of Goiás, demonstrating difficulties in understanding the PHE by the actors involved, emphasizing the need for new PHE actions to promote reflection and expansion of health work, as well as subsidizing strategic planning, the construction of plans and support to the bodies responsible for the promotion and management of PHE in the municipalities, to strengthen health services[32].

Ceccim and Feuerwerker[33] stated that training for the health area should focus on the transformation of professional practices and the organization of work itself. The perspective of training, especially of PHE, is that it strengthens itself, awakening its capacity to welcome and care for the health of the populations of its territory. However, the fragmented work process, in which each professional works in their area, with knowledge isolated from each other, promotes difficulties in interaction between members of the health teams[31].

Ferla et al.[34] reported the management of learning in daily work, as the one that generates the development of work and not just the qualification of the worker. In this approach, the encouragement and support of managers is of great importance for the development of PHE proposals, since it is an instrument that requires critical reflection, because if there is no manager sensitized to the proposal, conflicts can occur that hinder solid action with satisfactory results[35]. In this sense, the PMAQ-AB as a change-inducing program,

through its cyclical assessments, allows reflections in the health team on the importance of PHE for health work[36].

Conclusion

Most dentists inserted in the OHT in the Northern Region of Brazil were temporary public servants and who participated in the permanent education actions in the ESF that they integrated.

The states of Amapá, Amazonas and Pará showed a higher percentage of dentists with temporary employment, resulting in a lack of stability in the service, greater staff turnover and weak health system bonds.

Participation in PHE actions was detected in all states in the northern region of the country. Actions that stood out were the traditional and face-to-face strategies, with emphasis on seminars, exhibitions, workshops and discussion groups.

Thus, it is important that the actors involved in the health system understand that PHE is not only aimed at professional qualification, but also provides for the transformation of practices in the daily lives of health services. In addition, aspects such as the form of admission and the type of bond of the dentist generate weaknesses in their performance and compromise the bonds both with the multidisciplinary team and with the community in which the professionals work.

Referências

1. Bomfim ES, Oliveira BG, Rosa RS, Almeida MVG, Silva SS, Araújo IB. Educação permanente no cotidiano das equipes de saúde da família: utopia, intenção ou realidade? Rev Fund Care Online. 2017; 9(2):526-35.
2. Brasil. Ministério da Saúde. Secretaria de Atenção à Saúde. Departamento de Atenção Básica. Autoavaliação para Melhoria do Acesso e da Qualidade da Atenção Básica (AMAQ): 2ª ed. Brasília: Ministério da Saúde, 2016. 180p.
3. Brasil. Ministério da Saúde. Secretaria de Atenção à Saúde. Departamento de Atenção Básica. Diretrizes da Política Nacional de Saúde Bucal. Brasília: Ministério da Saúde, 2004. 16p.
4. Brasil. Ministério da Saúde. Portaria GM/MS nº 198, de 13 de fevereiro de 2004. Institui a Política Nacional de Educação Permanente em Saúde como estratégia do Sistema Único de Saúde para a formação e o desenvolvimento de trabalhadores para o setor e dá outras providências. Brasília: Ministério da Saúde, 2004.
5. Brasil. Ministério da Saúde. Portaria GM/MS nº 1.996, de 20 de agosto de 2007. Dispõe sobre as diretrizes para a implementação da Política Nacional de Educação Permanente em Saúde e dá outras providências. Brasília: Ministério da Saúde, 2007.
6. Ceccim RB, Ferla AA. Educação e saúde: ensino e cidadania como travessia de fronteiras. Trab Educ Saúde 2009; 6(3):443-56.
7. Ferreira L, Barbosa JSA, Esposti CDD, Cruz MM. Educação Permanente em Saúde na atenção primária: uma revisão integrativa da literatura. Saúde Debate 2019; 43(120): 223-239.
8. Maciel JAC, Vasconcelos MIO, Castro-Silva II, Eloia SMC, Farias MR. Educação permanente em saúde para o cirurgião-dentista da Estratégia Saúde da Família: Uma revisão integrativa. Rev APS 2017; 20(3): 414-22.
9. Brasil. Ministério da Saúde. Portaria nº 1654, de 19 de julho de 2011. Institui, no âmbito do Sistema Único de Saúde, o Programa Nacional de Melhoria do Acesso e da Qualidade da Atenção Básica (PMAQ-AB) e o Incentivo Financeiro do PMAQ-AB, denominado Componente de Qualidade do Piso da Atenção Básica Variável-PAB variável. Brasília: Ministério da Saúde, 2011.

10. Brasil. Ministério da Saúde. Saúde Mais Perto de Você - Acesso e Qualidade - Programa de Melhoria do Acesso e da Qualidade: Documento Síntese para Avaliação Externa. Brasília: Ministério da Saúde, 2012. 55p.
11. Ribeiro DT, Nascimento DT, Cunha FM, Ozorio JC, Ferreira AV, Santos TC, et al. O PMAQ-AB como umas das estratégias de estímulo à prática da Educação Permanente em Saúde. In: Gomes LB, Barbosa MG, Ferla AA (Org.). A educação permanente em saúde e as redes colaborativas: conexões para a produção de saberes e práticas, 2016. p. 129-41.
12. Morita MC, Haddad AE, Araújo ME. Perfil atual e tendências do cirurgião-dentista brasileiro. Maringá: Dental Press, 2010. 96p.
13. Brasil. Ministério da Saúde. Secretaria de Atenção à Saúde. Departamento de Atenção Básica. Manual instrutivo para as equipes de atenção básica (Saúde da Família, Saúde Bucal e Equipes Parametrizadas) E NASF. Brasilia, 2013. 38p.
14. Brasil. Ministério da Saúde. Secretaria de Atenção à Saúde. Departamento de Atenção Básica. Instrumento de avaliação externa de saúde mais perto de você – acesso e qualidade. Brasilia-DF, 2013. 50p.
15. Brasil. Ministério da Saúde. Secretaria de Atenção à Saúde. Departamento de Gestão da Educação em Saúde. Política Nacional de Educação Permanente em Saúde. Brasília: Ministério da Saúde, 2009. 64p.
16. Fontenelle LF. Mudanças recentes na Política Nacional de Atenção Básica: uma análise crítica. Rev Bras Med Fam Comunidade 2012; 7(22):5-9.
17. Brasil. Ministério da Saúde. Gabinete do Ministro. Portaria Interministerial nº 2.087, de 01 de setembro de 2011. Institui o Programa de Valorização do Profissional da Atenção Básica. Diário Oficial da República Federativa do Brasil. Brasília: Ministério da Saúde, 2011.
18. Brasil. Ministério da Saúde. Secretaria de Atenção à Saúde. Departamento de Atenção Básica. Avaliação normativa do Programa Saúde da Família no Brasil: monitoramento da implantação e funcionamento das equipes de saúde da família: 2001-2002. Brasília: Ministério da Saúde, 2004. 140p.
19. Brasil. Ministério da Saúde. Guia prático do Programa Saúde da Família. Brasília: Ministério da Saúde; 2001. 67p.
20. Girardi SN, Carvalho CL, Girardi JB, Araújo JF. Configurações do mercado e trabalho dos assalariados em saúde no Brasil. In: Observatório de Recursos Humanos em Saúde no Brasil: estudos e análises. Brasília: Ministério da Saúde, 2004. p.121-37.
21. Lourenço EC, Silva ACB, Meneghin MC, Pereira AC. A inserção de equipes de saúde bucal no Programa Saúde da Família no Estado de Minas Gerais. Ciênc Saúde Colet 2009; 14(Supl. 1):1367-77.
22. Palú APN. A inserção da saúde bucal no PSF, perspectivas e desafios: a visão de odontólogos do Paraná. [Dissertação] Mestrado em Saúde Coletiva. Universidade Estadual de Londrina-PR. 2004. 103p.
23. Facó EF, Viana LMO, Bastos VA, Nuto SAS. O Cirurgião-Dentista e o programa saúde da família na microrregião II, Ceará, Brasil. Rev Bras Promoç Saúde 2005; 18(2):70-7.
24. Mafra LAS, Vilela EM. Estratégia Saúde da Família: Contratação Temporária e Precarização nas Relações de Trabalho. Cad Estudos Interdiscipl 2015; (Gestão Pública e Sociedade): 38-52.
25. Koster I, Machado MHA. Gestão do trabalho e o contexto da flexibilização no Sistema Único de Saúde. Divulg Saúde Debate 2012: 33-44.
26. Alvarenga EC, Oliveira PTR, Pinheiro HHC, Carneiro VCCB. Condições de trabalho de equipes de saúde da família do Pará. Rev Nufen: Phenom Interd 2018; 10(1):58-72.
27. Costa RM, Medeiros-Junior A, Costa ICC, Pinheiro IVA. O trabalho em equipe desenvolvido pelo cirurgião-dentista na Estratégia Saúde da Família: expectativas, desafios e precariedades. Rev Bras Med Fam Comunidade 2012; 7(24):147-63.

28. Martins FM. Educação Permanente em Saúde no interior do Estado do Amazonas: Estudo de Caso na Região de Saúde Rio Madeira/AM. [Dissertação] Universidade Federal do Amazonas. Amazonas. 2015.
29. Cutolo LRA. O SUS e a Formação de Recursos Humanos. ACM: Arq Catarin Med 2003; 32(2):49-59.
30. Brasil. Ministério da Saúde. Secretaria de Atenção à Saúde. Departamento de Atenção Básica. Política Nacional de Atenção Básica. Brasília: Ministério da Saúde, 2012. 110p.
31. Franco TB. Produção do cuidado e produção pedagógica: integração de cenários do sistema de saúde no Brasil. Interface (Botucatu) 2007; 11(23):427-38.
32. Barcellos RMS, Melo LM, carneiro LA, Souza AC, Lima DM, Rassi LT. Educação permanente em saúde: práticas desenvolvidas nos municípios do estado de Goiás. Trab Educ Saúde 2020; 18(2): e0026092.
33. Ceccim RB, Feuerwerker LCM. O quadrilátero da formação para a área da saúde: ensino, gestão, atenção e controle social. Physis 2004; 14(1):41-65.
34. Ferla AA, Rocha CMF, Dias MTG, Santos LM. Redes vivas de Educação e Saúde e a Integração Universidade e Sistema Local de Saúde: saberes locais e múltiplas saúdes como capacidade profissional e como atributo das Redes de Atenção. In: Ferla AA, Rocha CMF, Dias MTG, Santos LM (Org.). Redes Vivas de Educação e Saúde: Relatos e vivências da universidade e sistemas de saúde. Porto Alegre: Rede UNIDA, 2015. p. 9-21.
35. Amorim ACM. Educação Permanente na Estratégia de Saúde da Família: oportunidades de aprendizagem e inovação da prática profissional. [Dissertação] Mestrado Profissional. Universidade Federal de São Paulo. Programa de Pós-Graduação Ensino em Ciências da Saúde. São Paulo. 2013.
36. Almeida TMC, Santos RMM, Sampaio DMN, Vilela ABA. Planejamento e desenvolvimento de ações de Educação Permanente em Saúde na perspectiva do PMAQ-AB. Saúde Debate 2019; 43(Spec 1): 77-85.

Como citar este artigo:

Emmi DT, Lima ZS, Miranda MSL. Dentist profile in the oral health teams and participation in permanent education actions in the brazilian northern region. Rev. Aten. Saúde. 2021; 19(67): 79-91.