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Health Surveillance: the need to reorient work and qualification in a municipality

Vigilância Sanitária: a necessidade de reorientar o trabalho e a qualificação em um município

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ABSTRACT

Introduction: The work of Health Surveillance should be expanded to transpose the inspection dimension, through the development of multiprofessional, educational and communicative activities, with social participation, integration with the Family Health Strategy and based on health information systems. To do this, Health Surveillance workers need to be qualified and work difficulties must be overcome. **Objective:** To verify the development of these activities, to relate them to the professional qualification and to identify the difficulties for the work. **Method:** Descriptive and quantitative study, carried out with the application of a questionnaire to 54 VISA employees of a municipality. A simple descriptive statistic was performed with the variables professional qualification, work process activities and difficulties. **Results:** It was verified that the activities were not developed by most workers, except for multiprofessional work (81.5%), and that the reported difficulties, such as the lack of vehicles (36.4%), exist in other services. The professional qualification (46.3%) expressed a relation only to the multiprofessional performance. **Conclusions:** It is necessary to reorient work and professional qualification to enable the development of activities that, in addition to supervision and control, make up the work of Health Surveillance.

KEYWORDS: Sanitary Surveillance; Health Management; Human Resources; Accreditation; Integrality in Health

RESUMO

Introdução: O trabalho da vigilância sanitária deve ser ampliado para transpor a dimensão fiscalizatória, mediante o desenvolvimento de atividades multiprofissionais, educativas e comunicativas, com participação social, integração com a Estratégia Saúde da Família e baseadas nos sistemas de informação em saúde. Para isso, os trabalhadores da Vigilância Sanitária (VISA) precisam ser qualificados e as dificuldades do trabalho devem ser superadas. **Objetivo:** Verificar o desenvolvimento dessas atividades, relacioná-las com a qualificação profissional e identificar as dificuldades para o trabalho. **Método:** Estudo descritivo e quantitativo, realizado com a aplicação de um questionário aos 54 trabalhadores da VISA de um município. Realizou-se uma estatística descritiva simples com as variáveis qualificação profissional, atividades do processo de trabalho e dificuldades. **Resultados:** Constatou-se que as atividades não foram desenvolvidas pela maioria dos trabalhadores, exceto atuação multiprofissional (81,5%), e que as dificuldades relatadas, como a insuficiência de veículos (36,4%), existem em outros serviços. A qualificação profissional (46,3%) exprimiu relação apenas com a atuação multiprofissional. **Conclusões:** É necessária a reorientação do trabalho e da qualificação profissional no sentido de possibilitar o desenvolvimento das atividades que, além da fiscalização e do controle, compõem o trabalho da vigilância sanitária.

PALAVRAS-CHAVE: Vigilância Sanitária; Gestão em Saúde; Recursos Humanos; Credenciamento; Integralidade em Saúde

INTRODUCTION

In Brazil, health surveillance-related activities are done by the National Health Surveillance System (SNVS), coordinated by the National Health Surveillance Agency (Anvisa) and created by Federal Law n. 9.782, of January 26, 1999, which regulates its activities. The purpose of this agency is to protect the health of the population through sanitary control over health-related products and services. Some of its activities that cannot be delegated are the concession, marketing authorization and production ban, distribution and sale of products and supplies. The other institutions - run by states, municipalities, and the Federal District - that make up this system may be delegated activities such as standardization, notification and penalty enforcement[1].

These activities put Health Surveillance in an inspection dimension, its most commonly known form, which is assured by its administrative police power. Later published legal instruments, however, point to the expansion of this dimension with support in the conduction of activities that do not directly involve the control and inspection of products or services, but that promote the rapprochement with the community and with the other entities of the Single Health System (SUS).

The SUS is established in a perspective of full care and citizenship that is not in line with health surveillance, whose work process prioritizes its inspection dimension[2,3]. It should be considered that health surveillance operates in a broad and complex field, where various agents constantly interact with elements that may pose health risks[4].

Health-related knowledge, through education and communication, should include the knowledge of the population and workers who work in other healthcare actions in a way that contributes to the promotion of health[5]. It is also essential that the population participate in health control, since people's interpretations of health problems can lead to the creation of new activities[4]. The integration between health surveillance and the Family Health Strategy (FHS) qualifies and expands the activities conducted in this scope[6], in addition to promoting the identification of the health risks to which the population of each territory is exposed[7].

After six years of creation of the SNVS, a Working Group (WG) was set up by the Ministry of Health (MS) to elaborate the Health Surveillance Master Plan (PDVISA), which proposes a rupture with the inspection-oriented dimension in order to address health problems more comprehensively[8]. This document recommends activities to strengthen and consolidate the SNVS, like encouraging social participation; health education; dissemination of information; integration with the FHS and planning of actions considering the population's health situation and risk factors.

Federal Ordinance n. 1.378, of July 9, 2013, establishes guidelines for the performance of health surveillance activities, including health surveillance among other surveillance bodies. One of its guidelines is the integration with healthcare, with the performance of activities that are consistent with local reality. This standard also reinforces the need to perform education and communication activities that encourage social participation[9].

Anvisa's Resolution (RDC) n. 49, of October 31, 2013, was published with the purpose of regularizing services provided by individual microentrepreneurs and rural or electronic family solidarity projects. Some innovations brought by this RDC also suggest the need for health surveillance to act in a less coercive manner, with the recognition of customs and traditional knowledge for the protection of small-scale production; reasonableness in the application of requirements; automatic regularization of low risk activities; inspections that provide orientation with accessible language and the provision of educational activities[10].

This movement toward the expansion of health surveillance's scope, with the inclusion of activities transposed to inspection and control, also occurs in the literature. Costa[11] defines and differentiates two models: Traditional Health Surveillance and New Surveillance. The first model, identified as Traditional Health Surveillance, is organized as a result of the spontaneous demand for inspections during which workers check compliance with existing health legislation[11] and take measures, generally of a coercive nature, to avoid or reduce health risks. The second model, the New Surveillance, is characterized by expanded work aimed at health promotion and organized based on health risks and needs, seeking to overcome the isolation of health surveillance, while also favoring interaction with workers from other SUS programs and with the population, through activities of risk communication, health education and collaborative planning[11].

In order to plan activities more effectively and in line with local realities, we must also be familiar with the local health situation and its protective factors. Moreover, it is fundamental that the health surveillance work process be based on Epidemiological Surveillance (ES) data found in health information systems[12]. In addition, the diversity of objects (medicines, health services, food, among others) subject to health surveillance's work requires that its work be operated by multiprofessional teams[11,13].

When addressing the work processes of health surveillance, discussing the workers' qualification and their working conditions is inevitable. Because of the complexity of the work processes in this area, its workers must be constantly updated and retrained, associating new technical knowledge with accumulated experience[14]. The qualification can increase their ability to intervene in health risks and promote significant changes in the work process[15]. An overview of the Brazilian situation of training and qualification of SNVS workers is provided by two national censuses.

The 1st National Census of Health Surveillance Workers (Censo VISA), published in 2006, occurred because of the initiative of Anvisa's Human Resources Policy Committee for Health Surveillance (COPRH) and was supported by the Pan American Health Organization (PAHO) and with the collaboration of the Nucleus of Studies in Collective Health of the Federal University of Rio Grande do Norte, Brazil. 32,135 workers from all regions of the country participated in this census, involving federal, state and municipal entities. It found that 32.6% of them had higher education, 60.8% had postgraduate education and 44.4% had completed refresher courses in the last year[14].

Censo VISA pointed to the need to implement multiple training processes that enable these workers to work safely and effectively[14]. The qualification of VISA workers is also a guideline of the PDVISA, which recommends investment and strategies for training and qualification[8].

The National Census of Health Surveillance Laboratories (Censo LAB) was published in 2010 by the Institute of Collective Health of the Federal University of Bahia, Brazil, in partnership with the National Institute of Quality Control in Health and Anvisa. 1,581 workers from 72 public health laboratories participated. They came from all three spheres of government too. It verified that only 39% had postgraduate degrees and that the majority of the professionals had higher education (59.9%)[16].

Regarding working conditions, studies indicate that health surveillance workers work in places with inadequate infrastructure[17,18], are poorly qualified[12], receive low wages[19] and are still subject to cronyism and interference in their work processes[20]. All these difficulties affect these workers' motivation and satisfaction with their work and can hinder the effectiveness of the activities they perform.

In 2015, Anvisa promoted a National Forum to identify and consolidate the main challenges for the SNVS, supported by debates that occurred previously in all regions of the country[21]. The event was attended by representatives of various institutions, such as the Ministry of Health and municipal and state health surveillance bodies, as well as members of civil society and the regulated sector. Among the inventoried challenges, we can highlight the need to monitor the activities and the absence of a policy focused on workers' qualification[21].

In view of the above and considering the need for a reflection about the qualification and the work processes in health surveillance[2,22], this article intends to verify whether health surveillance workers engage in educational activities, perform risk disclosure and use the systems of health information, in a multiprofessional fashion, with the participation of the population and FHS professionals. Furthermore, we investigated the relationship between the performance of these activities and professional qualification, identifying the barriers that may affect work processes in health surveillance.

METHOD

This is a descriptive study with a quantitative approach performed with health surveillance workers in the municipality of Fortaleza, state of Ceará, Brazil, from January to March, 2014. This state, formed by 184 municipalities, is located in Northeastern Brazil, with an estimated population of over 8 million people[23]. The state has 3% (n = 979) of the country's health surveillance workers[14].

Fortaleza is the capital of the state, with an estimated population of 2.5 million inhabitants and a population density of 8,166.5 inhabitants/km^2[2,23]. The administration of this municipality is divided into six regional secretariats, with the aim of improving the living conditions of the population of each region. The workers of the municipal health surveillance body are distributed in the sanitary districts of each regional office and are coordinated by the Health Surveillance Cell. This, together with the Epidemiological Surveillance Cells, Worker Health Surveillance, Information Systems and Health Analysis and Environmental Surveillance and Biological Risks, make up the Health Surveillance Coordination of the Municipal Health Department.

The universe of this study is formed by 126 workers who worked in health surveillance in Fortaleza, from January to December 2013. The criterion of inclusion was to have been working in the aforementioned body for at least one year before the period of data collection, for 30 hours per week during the length of the study. The exclusion criteria were: to have held a managerial position in the last year; not having performed his or her activities for a period longer than that related to vacation, maternity leave, sick leave or other leave. Respondents could not be on vacation during the time of data collection either.

Data collection was performed for one month, in the place of work and in the working hours of each worker. Our strategy was to gather all the workers in a reserved room and, after explaining the objectives of the study, we asked them to fill out a questionnaire. This questionnaire contained 14 closed-ended questions and one open-ended question, divided into four parts: personal characteristics, professional qualification, work process activities and work difficulties, as follows.

The personal characteristics asked were: age (years); gender (male, female); time in service (years); field of work in health surveillance (food, products, health services, veterinary services, other services). These areas were defined according to the understanding of the Municipal Health Department of Fortaleza that classifies the establishments according to the type of service or product they provide. The "food" area includes restaurants, supermarkets and other establishments related to the preparation and provision of food. The area of "health services" is composed of medical clinics, dental clinics, health units and fitness centers. The "products" area includes drugstores and distributors of medicines, as well as manufacturers, distributors and stores that market cosmetics and sanitizing products. The area of "veterinary services" covers veterinary clinics and slaughterhouses. Other establishments included in these areas were classified as "other services".

The "qualification for work" dependent variable (yes; no) was established with support in the higher education variables (yes; no); completion of *stricto sensu* and/or *lato sensu* post-graduation in health surveillance (yes; no) and participation in training courses in health surveillance in the last year (yes; no). Workers with higher education who completed postgraduate studies and courses in health surveillance were considered qualified for the job.

With the support of the PDVISA guidelines[8] and the literature[4,6,7,11,12,13] we established the independent variables related to the activities that are part of the health surveillance extended work process: multiprofessional work, that is, with professionals of various backgrounds to solve common problems that require joint

action (frequent, intermediate, absent); health education for the population (frequent, intermediate, absent); work integrated with the FHS (frequent, intermediate, absent); use of health information systems to plan actions and determine priorities (frequent, intermediate, absent); disclosure data found in inspections (frequent, intermediate, absent) and participation of the population in the planning and/or discussion of actions (frequent, intermediate, absent). In relation to the year prior to data collection, the periodicity of at least four times a month was considered "frequent" and the "intermediate" periodicity was one to three times per month.

The difficulties faced in their work were grouped in material resources, human resources and work management. This categorization was built with support in the workers' self-reported information, provided by an open-ended question of the collection instrument: material resources (insufficient transportation vehicles, insufficient office material, insufficient equipment, inadequate physical structure, no space for seized products, inefficient database; lack of a cold room), human resources (insufficient workers, managers and support staff, managers without training) and work management (lack of penalty enforcement; remuneration; interference from people not related with the work; poor planning; lack of standardized actions; inadequate training; lack of support; outdated legislation; lack of articulation with other bodies; lack of legal support; lack of safety; lack of population awareness about this type of work; lack of publicity for this type of work).

The data collected were inserted in a database using the EpiData program version 3.1. The StataSE version 9 program was used as a tool for analysis. The study consists of statistical analysis with results expressed in proportion; the x2 and Fisher Exact Tests were applied, with a significance level of 5%. Simple descriptive statistical analysis was performed through the measures of central tendency for the numerical variables. The hypothesis test was applied to evaluate the relationship between professional qualification (dependent variable) and the activities that make up the working process of health surveillance (independent variables).

This study was approved by the Ethics Committee of the Department of Health of the State of Ceará, through Opinion Report n. 463.384, issued in 2013. The guidelines for research involving human beings established in National Health Council Resolution n. 466 of December 12, 2012[24] were followed.

RESULTS

Of the 71 health surveillance workers in the municipality of Fortaleza who could be part of this study, 17 (24%) refused to participate. Of the 54 participants, the mean age was 41.5 years and the mean service time was 14.3 years. More than one third (37%) of them reported that they were in the "food" area (Table 1).

Table 1. Personal characteristics and professional qualification of Health Surveillance workers. Fortaleza - CE, 2014.

Characteristics (N = 54)	N	%	Mean	Standard deviation	Minimum value	Maximum value
Gender						
Female	31	42.6				
Male	23	57.4				
Age (years)			41.5	12.9	26	67
Time in service (years)			14.3	15.4	1.8	43.8
Occupation area						
Food	20	37.0				
Products	12	22.2				
Health services	11	20.4				
Other services	9	16.7				
Veterinary services	2	3.7				
Higher education						
Yes	41	75.9				
No	13	24.1				
Postgraduate in Health Surveillance*						
Yes	26	63.4				
No	15	36.6				
Training courses in Health Surveillance						
Yes	36	66.7				
No	18	33.3				
Professional qualification						
Yes	25	46.3				
No	29	53.7				

**Stricto sensu and/or lato sensu among workers with higher education.*

Table 2. Activities of the Health Surveillance work process. Fortaleza - CE, 2014.

Activities (N = 54)	Frequent		Intermediate		Absent	
	N	%	N	%	N	%
Multiprofessional practice	25	46.3	19	35.2	10	18.5
Health education	5	9.3	5	9.3	44	81.4
Use of health information systems	2	3.7	4	7.4	48	88.9
Integration with the Family Health Strategy	-	-	4	7.4	50	92.6
Population participation	1	1.9	8	14.8	45	83.3
Data publicity*	-	-	4	7.4	49	90.7

*One respondent did not provide this information.

Table 3. Professional qualification according to the activities of the work process in Health Surveillance. Fortaleza - CE, 2014.

Activities (N = 54)	Professional qualification						P value
	Yes		No		Total		
	N	%	N	%	N	%	
Multiprofessional practice							0.014*
Yes	24	96.0	20	69.0	44	81.5	
No	1	4.0	9	31.0	10	18.5	
Health education							0.309
Yes	3	12.0	7	24.1	10	18.5	
No	22	88.0	22	75.9	44	81.5	
Use of health information systems							0.200
Yes	1	4.0	5	17.2	6	11.1	
No	24	96.0	24	82.8	48	88.9	
Integration with the Family Health Strategy							0.615
Yes	1	4.0	3	10.3	4	7.4	
No	24	96.0	26	89.7	50	92.6	
Population participation							0.718
Yes	5	20.0	4	13.8	9	16.7	
No	20	80.0	25	86.2	45	83.3	
Data publicity**							0.613
Yes	1	4.0	3	10.7	4	7.6	
No	24	96.0	25	89.3	49	92.4	

*$p < 0.050$.
**One respondent did not provide this information.

We verified that 33.3% of the workers did not receive any training in the previous year, but 75.9% of them had higher education and 63.4% of them completed post-graduation courses in health surveillance. We found that 46.3% of the workers were qualified for the job (Table 1).

In relation to the activities proposed for the expanded health surveillance, integration with the FHS was not informed by the majority (92.6%), nor was health education (81.4%), population participation (83.3%), use of health information systems (88.9%) and data publicity (90.7%). Almost half of the workers (46.3%), however, frequently worked in a multiprofessional team (Table 2).

We found a statistically significant relationship between the multiprofessional performance and the professional qualification ($p = 0.014$). The other activities that make up the expanded work process of health surveillance, integration with the FHS, health education, population participation, use of health information systems and data publicity did not show a statistically significant relationship with professional qualification (Table 3).

With regard to the difficulties in carrying out the work reported by the workers, we found that 36.4% of the responses in the material resources category referred to insufficient vehicles. As to the category of human resources, 72.7% of the respondents reported insufficient workers,

Table 4. Difficulties found at work listed by Health Surveillance workers. Fortaleza - CE, 2014.

Difficulty (N = 53)	N	%
Material resources	88*	100.0
Insufficient transport vehicles	32	36.4
Insufficient office supplies	14	15.9
Insufficient equipment	14	15.9
Inadequate facilities	10	11.4
Lack of space for seized products	8	9.1
Inefficient database	7	7.9
Lack of a cold store	3	3.4
Human resources	22*	100.0
Insufficient workers, managers and support staff	16	72.7
Untrained managers	6	27.3
Work management	107*	100.0
Lack of penalty enforcement	21	19.6
Remuneration	14	13.1
Interference from people outside the actions	9	8.4
Poor planning	9	8.4
Lack of standardization of actions	9	8.4
Insufficient training	9	8.4
Lack of support	9	8.4
Outdated legislation	6	5.6
Lack of articulation with other bodies	5	4.7
Lack of legal support	5	4.7
Lack of security	4	3.7
Ignorance of the population about their work	4	3.7
Little publicity given to their work	3	2.9

*Difficulties that were mentioned more than once.

managers and support staff. In the work management category, the lack of penalty enforcement achieved the highest percentage (19.6%). Only one worker reported no difficulty in performing his work (Table 4).

DISCUSSION

This study found that the workers with professional qualification in the health surveillance body of the municipality of Fortaleza performed activities in multiprofessional teams. This relationship can be warranted by the understanding that qualification in health surveillance is a complex field of action involving objects from diverse areas of knowledge, which encourages workers to engage in multiprofessional teams.

Work in multiprofessional teams happens mainly during inspections in establishments like clinics and health units, where services are offered by professionals of various categories. Considering that multiprofessional work enables the exchange of knowledge about a problem, this type of activity should be continuously fostered by the service management, not only for joint inspections, but also for other actions, like education in health, involving professionals from other areas of the SUS, such as the FHS.

Regarding the integration of the health surveillance body we studied with the FHS, workers in these areas are part of the same secretariat and work in the same building, but these activities are not performed in a shared manner. The lack of integration of health surveillance workers with other areas, like Women's Health and Stork Network, is also due to the fact that health surveillance is often only seen in its inspection dimension, to the detriment of its role in promoting health[25,26]. In order to change this isolation, health surveillance must be seen and set up as an agent that is part of the complex health area, with the potential to transform care practices and, together with other health actions, to solve the problems of the SUS[25].

The literature[4,5,13,17,19] and some legal instruments[8,9,10] point to the need for workers to actually extend the work process in health surveillance beyond inspection and to act in a more guiding and less coercive manner. The work found in this study does not contribute to the awareness of people regarding health risks, since it is perceived as distant from the population. With that, it does not favor the conduction of health

education activities nor the dissemination of data. Furthermore, by not using indexes from health information systems, the service focuses mainly on meeting the spontaneous demand for sanitary licensing and occasional complaints, following the traditional model of health surveillance[11].

Considering that in the field of health professional qualification does not reflect on the practice[27], this training deficiency hinders the incorporation of other activities. This is contrary to the guidelines that say that qualification in health surveillance enables the adoption of a preventive and participatory work process that is integrated with other health actions[13]. Another study also found that the training and qualification promoted by the health surveillance body did not contribute to reflection on the local reality, hindering changes in the work process[15].

At the municipal level, Censo VISA showed that 41.6% of the workers took courses in the previous year, while 32.2% had a higher education level and 63.7% of the graduates completed postgraduate courses[14]. Censo LAB also found 32.2% of graduates among municipal workers and 39% of postgraduates among workers in all spheres[16]. The body covered in this study has considerably higher rates of graduated professionals and training courses in health surveillance. This demonstrates an improvement of the local reality when compared to other Brazilian municipalities in relation to these questions. The frequency of postgraduate workers is consistent with the data of Censo VISA[14] and higher in relation to Censo LAB[16]. It should be emphasized that this study only addressed specific training and postgraduate courses in the health surveillance area, while the census did not include this detail.

Therefore, the encouragement of municipal management and workers' initiatives for professional qualification must happen often, since the health surveillance work processes involve a plethora of objects (drugs, healthcare services, restaurants) and activities (inspections, health education, data dissemination), in addition to continuous changes in health-related legislation.

The food area concentrates the largest portion of the workers we spoke to. In a study also carried out with workers of the sanitary surveillance body of a municipality in Southern Brazil, the healthcare service area prevailed[19]. This difference reflects the particularities of each body and may also be a consequence of the diversity of establishments that exist in each municipality.

The insufficient number of vehicles is an obstacle that directly jeopardizes the performance of the inspections and other activities that make up the work process in health surveillance. It is also reported in another study[12]. It is important to investigate in greater depth the reasons that led workers to talk about lack of penalties, since this part of the administrative processes is essential to avoid or minimize risks to the health of the population. As for remuneration, workers complained about both its insufficiency and the big gaps in wages among those who do the same job, corroborating yet another study[19].

Another difficulty mentioned in this study is the interference in the work by people who are not directly involved with the service. This situation is also reported in the literature[19,28]. According to Luchesse[20], this area is the health-related area that most commonly suffers interventions to favor one party over the other. This occurs because health surveillance operates in a space of conflict between the interests of the market and the health of the population. As a coping strategy for situations that involve the predominance of particular precepts over the health needs of the population, respondents mention seminars for the community[28]. Infrastructure as a difficulty is corroborated by other studies[17,18]. In addition to jeopardizing workers' activities, such an obstacle may lead them to become demotivated about their work[25].

The lack of integration with other bodies, the lack of knowledge about the work done and insufficient publicity of the work were difficulties mentioned by the respondents. These characteristics need to change so that health surveillance can be recognized as a component of the SUS and open to the participation of the population and workers from other health areas. The low frequency of these difficulties may be related to the workers' lack of recognition of the importance of tackling them with the purpose of expanding the work process by incorporating other activities, in addition to the inspection of products and services that is already routinely done.

The limitations of this study are due to the fact that other factors in addition to professional qualification have not been investigated. This may contribute to the low rate of activities that should also be part of the health surveillance work process and the reasons for the lack of penalty enforcement arising from administrative proceedings. Furthermore, we considered that the workforce may be small for the performance of activities beyond supervision and control.

CONCLUSIONS

We verified that the workers of this northeastern capital have training in higher education and specific professional qualification to work in health surveillance. We also verified the link of this qualification with their multiprofessional performance. This multiprofessional activity occurs internally, but activities that demand interaction with the population and with workers from other SUS actions are not yet well developed. This shows the distance between the work that is done and the recommendations expressed in legal instruments and in the literature that seek to reorient this work toward the construction of a more comprehensive health surveillance.

Professional qualification needs to be reoriented in order to develop the skills that are necessary for the expansion of health surveillance. This study reveals the need for investigations that address other aspects that can influence this phenomenon, like management models, interest and availability of workers and financial resources. We suggest analytical and intervention designs.

The difficulties demonstrate the need for changes in the planning and organization of this type of work. It should be noted that some of them do not require heavy financial investment, such as interference from people outside the actions, lack of penalty enforcement and poor planning.

Finally, the work process and professional qualification need to be reviewed and reoriented toward the creation of a service that, acting mainly in an educational manner, can be closer to the population, value their local knowledge and encourage their participation, as well as seek partnerships with workers who work in other SUS actions.

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Conflict of Interest

Authors have no potential conflict of interest to declare, related to this study's political or financial peers and institutions.