



Competencies for acting in health surveillance: methodological approach

Competências para atuação em vigilância sanitária: abordagem metodológica

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ABSTRACT

Introduction: The adoption of the skills model in the world of education is related to the use, control, training and evaluation of the performance of the workforce, which, based on the the Law of Guidelines and Bases of National Education, redirected the pedagogical practice organized in disciplines towards a practice aimed at building skills. In health, the new educational framework has been aligned with the demands of professional practices, the concept of health defined by the Unified Health System and the quality required in health actions provided to individuals and society, which include care under the responsibility of surveillance sanitary. **Objective:** To present the methodological approach used to elaborate the referential of specific professional competences to act in health surveillance and to point out possibilities of application of the produced material. **Method:** The method used consists of six stages: the first four stages performed by means of documentary analysis; fifth stage through five workshops; sixth step, validation. **Results:** A set of seven specific professional competences was pointed out to work in the areas of health surveillance defined for the proposal of the referential. For each competency, the actions and knowledge that should be developed by professionals were identified. **Conclusions:** The methodology allowed for greater visibility of the practices developed by health surveillance professionals, the creation of a competence framework in line with the mission of health surveillance, strategies and macro choices, values and principles raised as transversal to the competencies. The competence reference presented is in line with the competence profile of the health surveillance manager and, after validation, will subsidize the organization of permanent and continuing education programs for professionals.

KEYWORDS: Specific Skills; Health Surveillance; Permanent Education

RESUMO

Introdução: A adoção do modelo de competências no mundo da educação está relacionada ao uso, ao controle, à formação e à avaliação do desempenho da força de trabalho, o que, a partir da Lei de Diretrizes e Bases da Educação Nacional (LDB), reorientou a prática pedagógica organizada em disciplinas para uma prática voltada para a construção de competências. Na saúde, o novo referencial da educação tem sido alinhado às demandas das práticas profissionais, à concepção de saúde definida pelo Sistema Único de Saúde (SUS) e à qualidade requerida nas ações de saúde prestadas aos indivíduos e à sociedade, que incluem os cuidados sob responsabilidade da vigilância sanitária. **Objetivo:** Apresentar a abordagem metodológica utilizada para elaborar o referencial de competências profissionais específicas para atuação em vigilância sanitária e apontar possibilidades de aplicação do material produzido. **Método:** O método utilizado é constituído por seis etapas: as quatro primeiras etapas realizadas por meio de análise documental; a quinta etapa por meio de cinco oficinas de trabalho; e a sexta etapa, validação. **Resultados:** Foi apontado um conjunto de sete competências profissionais específicas para atuação nas áreas da vigilância sanitária definidas para a proposta do referencial. Foram identificados, para

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cada competência, as ações e os saberes que devem ser desenvolvidos pelos profissionais. **Conclusões:** A metodologia possibilitou maior visibilidade das práticas desenvolvidas pelos profissionais da vigilância sanitária, a conformação de um referencial de competências sintonizado com a missão da vigilância sanitária, estratégias e macroescolhas, valores e princípios levantados como transversais às competências. O referencial de competências apresentado alinha-se às do perfil de competência do gestor da vigilância sanitária e, após validado, subsidiará a organização de programas de educação permanente e continuada para os profissionais.

PALAVRAS-CHAVE: Competências Específicas; Vigilância Sanitária; Educação Permanente

INTRODUCTION

The themes related to the competency model have been studied and debated by several authors and in several forums, both from the perspective of education and work.

According to the International Labor Organization¹ (ILO), the concept of professional competence emerged in the 1960s in the United States (USA), it being possible to add that the concept of training and qualification based on competences arose in the USA in the 1960s and in England in the 1980s. ILO¹ also points out that each country, according to its stage of development, has been creating its model of competence and, consequently, adopting concepts pertinent to this model.

In the same document, the ILO stated that the countries that most emphasized the importance of the professional competence model were Germany, Australia, Canada, Spain, USA, Mexico, and the United Kingdom, and in each of them, there were different connotations about the concept of competence and its form of classification. In this sense, in Brazil, as in other countries, there is no single concept of competence.

Deluiz² considered that the discussion about the competence model started in the business world from the 1980s, in a context of a structural crisis of capitalism in central countries, which began to take shape at the beginning of the 1970 decade. Thus, the adoption of the skills model in the world of work is related to the use, control, training, and evaluation of the performance of the workforce in the face of new requirements related to the pattern of capitalist accumulation: competitiveness, productivity, cost rationalization, among others.

On the other hand, according to the same author², the discussion on the focus of competencies reaches the world of education from the questions made to the educational system in view of the demands of the productive system. The author points out, however, that the notion of competence is “strongly polysemic, both in the world of work and in the sphere of education” and that this polysemy stems from “different theoretical views, supported by diverse epistemological matrices”².

Thus, according to Deluiz³, the notion of competence is a social construction, the subject of political disputes around its meaning, which reinforces the perception that competences vary historically according to social contexts, economic and cultural, and depend on the clashes between the worldviews of the various social actors.

In Brazil, in 1996, the process of education reform was legally initiated, with the approval of Law No. 9,394, of December 20, 1996 - National Education Guidelines and Frameworks Law (LDB)⁴. For Ramos⁵, from the LDB, curriculum reforms began to reorient the pedagogical practice organized in disciplines towards a practice aimed at building skills.

For the health sector, this proposition emerged the need to deepen the study on this new structuring framework of education in the face of the needs for expanded training, consistent with the demands of professional practices, with the concept of health defined by the Unified Health System (SUS) and with the quality required for health actions provided to individuals and society⁶, which include health care under the responsibility of health surveillance.

For this reason, the notion of competence as a structuring factor for professional training and permanent education for SUS workers is not restricted to the technical-instrumental dimension; it must contribute to the renewal of the training process itself, valuing and promoting the autonomy and emancipation of workers and labor relations².

Understanding competence as conditioned by economic, social, and political contexts, it is admitted that its development is not restricted to the individual perspective, since it is built throughout professional life, which presupposes the sharing of experiences and collective practices, in contexts that always vary². Competence is, in this sense, evolutionary and interactive.

The Ministry of Health⁶ pointed out that professional competence in health must consider some important assumptions: the concept of health as a quality of life; the context and concept of health, with the principles of health reform as a reference and SUS as a strategy for sectorial and institutional reordering; the health work processes, which retain some specificities (it is collective and the decisions to be taken imply the articulation of several bits of knowledge, which, in turn, come from several instances: scientific and instrumental bases, with emphasis on scientific knowledge, bases technological, with an emphasis on technical knowledge, and work and social experience. All of these instances mediated by the ethical-political dimension); the need to develop formal and ethical-social competencies that ensure the competence necessary for health work processes.

With these assumptions, competence, in the perspective of health work processes, incorporates multiple dimensions of



knowledge that, articulated, allow this competence to be integrated. Thus, the competence for the different health work processes is complex, multidimensional, global, and integrative.

Considering the assumptions and characteristics of the professional competence in health presented, it is evident that the vision of the competence pointed out implies an overcoming of alienated practices, often marked by ignorance, imprecision in decisions, by forms of non-participatory work organization, by professional turnover, due to communication and teamwork difficulties. And that, overcoming alienated practices is effective by building practices in which autonomy, commitment, initiative, and responsibility are important requirements in the search for solutions for the events that professionals face⁷. The development of these values by professionals favors the overcoming of practices that are not committed to reality, referenced only in previously established norms and routines⁷.

For this reason, the development of health practices, including health surveillance, must be based on the skills necessary for effectiveness, according to the logic of the quality of actions, ethics, and respect for the rights of service users.

From these considerations, it was decided to adopt concepts and propositions discussed by Zarifian⁸ and Le Boterf⁹ since these authors bring an expanded view of competence, attuned to the quality required by the Brazilian health system and to the development needs of its workforce, pointing to the importance of the worker being able to mobilize knowledge and experiences, in order to seek solutions to the problems that the reality of the work presents (and solve them!).

Zarifian⁸ and Le Boterf⁹ comprise competence in the following dimensions:

Competence is taking the initiative and taking responsibility for the individual regarding problems and events that they face in professional situations⁸;

Competence is knowing how to act with pertinence, knowing how to mobilize knowledge in a professional context, knowing how to integrate or combine multiple and heterogeneous knowledge, knowing how to transpose, knowing how to learn and learning to learn, knowing how to get involved⁹.

Zarifian⁸ argues that the choice, by the worker, among different possibilities or paths to be followed is based on knowledge acquired and transformed based on the diversity of the work situations experienced. So, for this author, competence is marked by initiative and responsibility, by the ability to mobilize networks of actors, to share challenges, and to assume areas of responsibility. He states that the initiative is a fundamental component for autonomy, considering that, to demonstrate initiative, the subject has to act in the face of a situation in his professional life and start something to modify it, when necessary.

It is noteworthy that the approach of autonomy and responsibility as social attitudes express new options for work organization

and are built, basically, on the learning that generates compromises in social and personal life; it is a matter of “becoming” autonomous and responsible¹⁰.

Finally, it is highlighted that the option for the view of competence expressed by the authors Zarifian⁸ and Le Boterf⁹ is consistent with the principles and assumptions of the national health system and with the characteristics of health surveillance practices in Brazil, which require, among others, initiative and anticipation of problems, interaction and communication between workers, managers, and users and interprofessional and teamwork, corroborating the idea that mere technical qualification no longer responds to the needs of these work processes.

With these considerations, the objectives of this article were to present the methodological approach used to elaborate the referential of specific professional competencies to act in health surveillance in the areas of health services, services of interest to health, inspection (food, medication, cosmetics, sanitizing, and health products), and inspection of pharmacies and drugstores, tobacco, blood, tissues, cells and organs and to point out possibilities for applying the material produced.

METHOD

This is an exploratory study, with a qualitative perspective, which used as theoretical support the methodological approach proposed by Zarifian⁸, as shown in Figure 1.

This method is also described in the chapter entitled “Building skills of primary health care professionals: a conceptual and methodological proposal”, from the book “Education and work: interface with health management”, in press 2020¹¹.

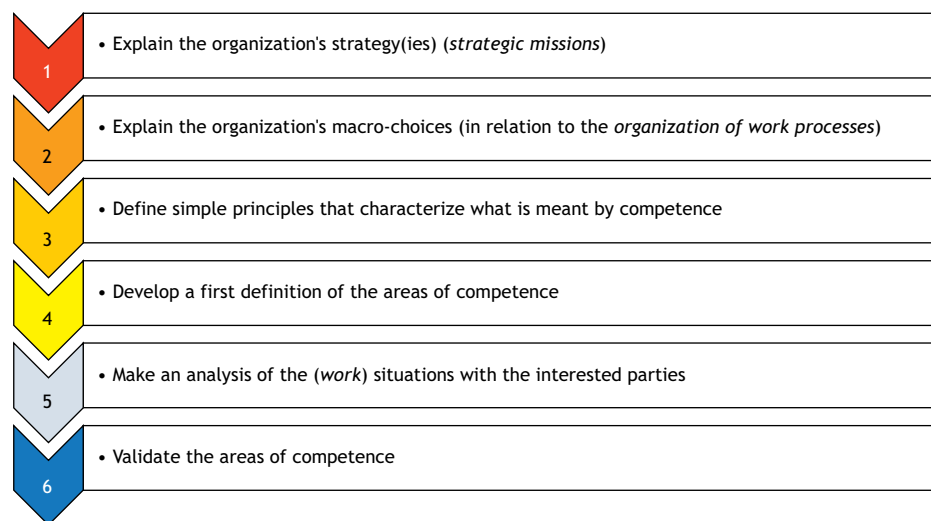
This method allowed, in the first moment, a contextualization of the practices of health surveillance in Brazil, considering the areas of action defined for the study. In the second moment, the methodological path followed enabled the recontextualization of this practice in order to fulfill the objectives of the stages defined by the applied methodology.

The sixth stage could not be performed due to the health context related to the pandemic of the new coronavirus underway in the country.

Source of empirical data

Document analysis

Technical documents, laws, ordinances, and norms regarding the regulation of health surveillance practices originating from the Ministries of Health and the National Health Surveillance Agency (Anvisa), in the period between 1990 and 2019; articles, academic texts, and course notebooks, between 2000 and 2018. The data were analyzed from an exploratory and critical reading of the selected documents in order to highlight specific information, data, and concepts that would allow achieving the objectives of the study.



Source: Zarifian⁸.

Figure 1. Steps in the competence definition model proposed by Zarifian⁸.

Workshops

Conducted with workers from state and municipal health departments with experience in the areas of health surveillance defined for the study, which are: health services, services of interest to health, inspection (food, medicines, cosmetics, sanitizing agents, and health products), and inspection of pharmacies and drugstores, tobacco, blood, tissues, cells, and organs.

The study used the methodology entitled "Mapping the specific professional skills of health surveillance workers who work in the following areas: health services, services of interest to health, inspection (food, medicines, cosmetics, sanitizing products, health products), and inspection of pharmacies and drugstores, tobacco, blood, tissues, cells, and organs". The mapping of these competencies is part of the actions of the Capacita-Visa Program, which aims to support training and continuing education aimed at the professional development of health surveillance workers, depending on the nature, complexity, and mission of health surveillance in Brazil.

The choice for this pedagogical methodology considered its main objectives, which are the collective construction of knowledge, the analysis of reality, confrontation, and the exchange of experiences¹².

This type of approach provides participants with the opportunity to experience concrete and meaningful situations, based on the tripod feel-think-act, serving basically two purposes: (a) articulation of concepts, assumptions, and notions with concrete actions, experienced by the worker; b) experience and execution of team tasks, that is, appropriation or collective construction of knowledge, obtaining with this process the appropriation, construction, and production of theoretical and practical knowledge in an active and reflective way¹³.

The pedagogical strategy experienced in the workshops was to problematize the practices with successive approaches to the central object of the discussions: the analysis of the health surveillance work processes, from the perspective of the workers themselves. It means that the activities of the workshop were organized in a sequenced manner, seeking a reflection on the practices that would allow, within the limits proposed by the objectives of the workshop, to collectively deepen, add, and systematize the content of the discussions. With this, we sought to problematize reality (of practices) and to facilitate the abstraction process linked to the totality, following the methodology, with adaptations, of the original document "Pedagogical training for instructors/supervisors: health area"¹⁴. Discussions about practices were carried out through socialization activities, in which each reported their effective actions, sharing them with colleagues, interrogating them and, from there, reflecting on the means - procedural and technical - of placing them in practice (that is, the know-how; the actions they perform in their daily - or not - work).

The workshops were attended by professionals from 26 states, only participants from the Federal District did not participate in the workshop process, and from 25 municipalities, with population ranges between 10,000 to 500,000 inhabitants.

For the participation of municipal representatives, a selection of municipalities was carried out based on five population ranges, as described below:

- Municipalities \leq 10,000 inhabitants (ha)
- Municipalities from 10,001 to \leq 20,000 inhabitants (ha)
- Municipalities from 20,001 to \leq 50,000 inhabitants (ha)
- Municipalities from 50,001 to \leq 500,000 inhabitants (ha)
- Municipalities over 500,000 inhabitants (ha)



Each selected municipality appointed a professional working in the field of health surveillance to participate, which was distributed in one of the workshops, according to the region of the country where the municipality is located.

To characterize the profile of the workshop participants, the method of individual narrative elaboration on the professional trajectory in health surveillance was used. This elaboration was guided by a guiding script organized in two parts: the first comprised the gathering of information on the date of birth, sex, academic formation, time of work in health surveillance, state, and city where it operates, and area(s) of activity health surveillance. The second part asked the professionals for their opinion on important social knowledge to act in health surveillance; conditions that facilitate work; conditions that make work difficult; teamwork conditions; autonomy to perform the work; and social repercussion of work.

The detailed report of all stages of the study carried out between 2019 and 2020, is described in the format of technical reports made available to Anvisa, which maintains the files in its internal electronic system.

RESULTS AND DISCUSSION

The documentary analysis carried out identified health surveillance as a unique field of public health, involving articulations of an economic, legal-political, and medical-sanitary nature. It is a social and historical practice structured by the State for the defense and protection of health. Its work focuses on the specifics of its objects of control, which must be addressed based on the required quality attributes of these objects, present on the market as merchandise and, at the same time, as social goods of public health interest¹⁵.

The selected documents made it possible to understand the nature, dimensions, and social reach of health surveillance, the complexity of its action, the characteristics of the

workforce that works in the area, and the organized set of practices that characterize the work of health surveillance, considering their technological, systemic, intersectoral, ethical, and social dimensions.

Chart 1 shows the list of documents analyzed, their origin and year of publication.

The contents organized from these documents were systematized in order to fulfill the stages of the competence model developed by Zarifian. Below, each step of the methodology is presented considering its main aspects, results, and discussion.

An important reflection when it comes to presenting knowledge that supports the development of competences concerns the acceptance that the conditions for their training are presented in a multiplicity of places of socialization, among which are: academic training, permanent education, and continuing education⁹.

Considering this observation by Zarifian, another important highlight is that the Ministry of Health has defined a policy of permanent health education (EPS) that is configured as learning at work, in which learning and teaching are incorporated into the daily life of organizations and work, in the actual context in which they occur²⁷. EPS considers the practice as a source of knowledge and problems, problematizing the doing itself; it places workers as reflective actors of the practice and builders of knowledge and alternatives for action.

These two highlights demonstrate that the way of conceiving and practicing permanent education, according to the policy defined by the Ministry of Health, has a great affinity with Zarifian's perspective⁸, when he affirms that the formation of competences it takes place in multiple ways and in multiple places, thus rescuing, among others, the formative role of work and the importance of exchanging and analyzing experiences in professional training.

Chart 1. Documents analyzed, institution of origin/authors, and year of publication. Brazil, 1990-2019.

Document	Institution of origin/authors	Year of publication
Federal Law No. 8,080 of September 19	Brazil ¹⁶	1990
Federal Law No. 9,782 of January 26	Brazil ¹⁷	1999
Article: Constitution of health surveillance in Brazil	Costa and Rozenfeld ¹⁸	2000
GM/MS Ordinance No. 1,052	Ministry of Health ¹⁹	2007
Article: Health surveillance work: theoretical concepts for reflection on practices	Souza and Costa ²⁰	2009
Article: Concepts and area of coverage, on the basis of health surveillance	Costa ²¹	2009
Article: Theoretical and conceptual considerations about health surveillance work, a specific field of health work	Souza and Costa ¹⁵	2010
Profile of Brazilian states and municipalities: 2014/IBGE	Brazil ²²	2015
Health Surveillance Debate Cycle: challenges and trends. What health surveillance does society need?	Anvisa ²³	2015
Project to Support the Unified Health System: Health Surveillance Management Course: Specialization in Health Surveillance Management. Course notebook 2017	Ramos et al. ²⁴	2017
Article: SUS 30 years: Health Surveillance	Silva, Costa, and Lucchese ²⁵	2018
Compiled from National Health Surveillance System procedures	Anvisa ²⁶	2019 - Last update

Source: Elaborated by the authors, 2020.



First stage: explaining health surveillance strategies in Brazil

According to Zarifian⁸, explaining the institution's strategies is the starting point for building the skills framework needed by its workers, as they are the ones that determine the orientation to be given to the skills. The author stresses that it is not a question of explaining all the details of these strategies, but of expressing them, synthetically, in what they have essential. From the analyzes carried out, it was possible to express three strategies, formalized as "strategic missions", presented in Chart 2.

An important characteristic of these strategic missions is that they are relatively durable, do not vary according to the circumstances, and are not dependent on one or another measuring instrument⁸.

It should be noted that the identification of areas of competence is focused on these strategic missions in order to maintain the coherence of the methodological approach.

Therefore, the question asked throughout the process is: what strategic mission should be linked to this or that competence?¹.

Second stage: explaining the macro-choices of health surveillance in Brazil

After defining the strategies, the choices of health surveillance in relation to the form of work organization were expressed. However, due to the logic proposed by Zarifian⁸, it was not necessary to specify these choices in detail (for this reason, the expression macro-choices was used). Nor are they considered definitive, as the experience and evolution of policies and processes to which they refer may show other alternatives.

It is important to make these choices explicit "because they configure the spaces and timing of the exercise of competences in advance"¹.

In relation to this stage, three possible macro-choices were identified for the organization of work in the area of health surveillance, shown in Chart 3.

Third stage: defining simple principles that characterize the vision of professional competence for health surveillance in Brazil

This stage establishes, in a way, a "philosophy" of competence. Such principles were found, in a very explicit and current way, in the document "Compiled of procedures of the National Health Surveillance System - 08/30/2019 (Revision 014 - GGFIS)"²⁶. There, a broad set of attributes was considered fundamental to the health surveillance professional. The following stand out:

- Ethics;
- Teamwork and collaborative practice;
- The ability to adapt to different situations;
- Communication;
- The ability to observe and analyze the reality of different social contexts.

Fourth stage: developing a first definition of the areas of competence

This step is the direct expression of the first three. The question answered at this point is: depending on the strategic missions, the institution's macro-choices, and the principles that characterize the vision of professional competence, how, in a first approach, to design the major areas of competence?⁸.

It is important to note that the areas of competence proposed at this stage are not yet defined as specific areas of professional activity in health surveillance. They are generic, they come from an overview. In this sense, it was decided to adopt the division of competence areas, as proposed by Deluiz²:

- **Technical:** mastery of the contents of the actions, rules, and procedures of the work area; understanding of processes and equipment handling; understanding of systems and networks of relationships and ways of obtaining and using information.

Chart 2. Health surveillance strategies defined based on the document analysis performed on the documents mentioned in Chart 1.

Strategic health surveillance missions
Defend the public interest of health through a set of practices aimed at individual and collective health protection
Adopt the principles of intercomplementarity and interdependence of processes and means of work
Based on teamwork and multiprofessionality

Source: Elaborated by the authors, 2020.

Chart 3. Macro-choices for the organization of work in the area of health surveillance explained from the study.

Collective work organization model, which requires different intervention technologies, specialized knowledge and well-defined ethical-political values.
Health regulation model for activities related to the production/consumption cycle.
Definition of instruments or means of work used to carry out sanitary control.

Source: Elaborated by the authors, 2020.



- **Organizational:** self-planning and self-organization; establishing own methods, managing time and workspace; development of flexibility and creativity in the work process; use of knowledge - obtained through different sources, means, and resources - in the different situations found in the world of work; transfer of knowledge from everyday life to work situations and vice versa.
- **Communicative:** expression and communication with your group, superiors or subordinates and with users; cooperation; teamwork; the practice of dialogue; the exercise of negotiation; interpersonal communication.
- **Sociopolitical:** a reflection on the sphere of the world of work; awareness of the quality and ethical implications of their work; autonomy of action; social commitment; development of the exercise of citizenship; openness to change; development of self-esteem and self-worth.

Fifth stage: analyzing the situations with the stakeholders - the workers themselves

Held through workshops. Mixed groups were organized, composed of workers with different trajectories in terms of training, experience, and work ties, from areas that make up health surveillance, as defined for the study. The objective of this group

composition was to reach the specificities and possible transversalities of the work, also considering its diversities in relation to the places of production of the services to meet the institutional and social demands.

All workshop participants were linked to the health surveillance departments of state or municipal health departments, operating in at least one of the areas mentioned, for a minimum of one year.

Five workshops were held, as systematized in Chart 4, with the aim of discussing the work processes experienced by workers and elaborating, based on their experiences and practices, a framework of specific actions, in order to support the identification of the competencies they need be developed and mobilized as a condition for achieving the strategic objectives of health surveillance.

Chart 5 shows the distribution of participants by region, states, and municipalities, sex, age group, and sphere of attachment to the health surveillance department (state or municipal).

The workshops enabled the collective elaboration of a picture of the actions taken in the daily (or not) work.

Figures 2 and 3 illustrate the survey and classification of actions carried out by professionals participating in one of the workshops.

Chart 4. Distribution of workshop participants by region, number of workshops, dates, and number of participants.

Region	Number of workshops	Dates	Number of participants
Northeast	2	10/15/2019 and 10/17/2019	16
North	1	10/22/2019	13
Midwest	1	10/24/2019	8
South and Southeast	1	11/05/2019	15
Grand total	5	-	52

Source: Elaborated by the authors, 2020.

Chart 5. Distribution of participants by region, states and municipalities, sex, age group, and sphere of attachment to the health surveillance department (state or municipal).

Region	States/municipalities	Total participants	Sexo	Age group	State Visa	Municipal Visa
Midwest	GO, MS, MT Goiânia, Campo Verde, Aquidauana, Terenos, Corumbá	8	Fem > 5 Masc > 3	Fem: 31 to 50 years > all Masc: 31 to 50 > 2 Over 50 > 1	3	5
Northeast	AL, BA, CE, MA, PB, PE, PI, RN, SE São Luís do Curu, Campo Grande, Arapiraca, Natal, Água Branca, Recife, Feira de Santana, and Caruaru	16	Fem > 11 Masc > 5	Fem: 31 to 50 years > 6 Over 50 years > 5 Masc: 31 to 50 > 1 Over 50 > 4	8	8
North	AC, AM, AP, PA, RO, RR, TO Rio Branco, Macapá, Castanhal, Mucajaí, Porto Nacional	13	Fem > 6 Masc > 7	Fem: 31 to 50 years > 4 Over 50 years > 2 Masc: 31 to 50 > 3 Over 50 > 4	6	7
Southeast and South	ES, MG, RJ, SP, PR, RS, SC Diadema, Betim, Tijuca, Rio Acima, Vila Velha, Gramado, Pinhais	15	Fem > 12 Masc > 3	Fem: 31 to 50 years > 9 Over 50 years > 3 Masc: 31 to 50 > 3 Over 50 > 0	8	7
Total	States > 26 Municipalities > 25	52	Fem > 34 Mas > 18	Fem: 31 to 50 > 24 Fem: over 50 > 10 Masc: 31 to 50 > 9 Masc: over 50 > 9	25	27

GO: Goiás; MS: Mato Grosso do Sul; MT: Mato Grosso; AL: Alagoas; BA: Bahia; CE: Ceará; MA: Maranhão; PB: Paraíba; PE: Pernambuco; PI: Piauí; RN: Rio Grande do Norte; SE: Sergipe; AC: Acre; AM: Amazonas; AP: Amapá; PA: Pará; RO: Rondônia; RR: Roraima; TO: Tocantins; ES: Espírito Santo; MG: Minas Gerais; RJ: Rio de Janeiro; SP: São Paulo; PR: Paraná; RS: Rio Grande do Sul; SC: Santa Catarina; Fem: feminine; Masc: masculine; Visa: Health Surveillance. Source: Elaborated by the authors, 2020.



Source: Elaborated by the authors, 2020.

Figure 2. Photo of the survey of the actions taken by the professionals participating in one of the workshops.



Source: Elaborated by the authors, 2020.

Figure 3. Photo of the classification of the actions, carried out by the professionals participating in one of the workshops.

The groups classified the actions raised according to criteria that returned to the definition of health surveillance contained in Law No. 8,080/1990¹⁶ as a

set of actions capable of eliminating, reducing, or preventing health risks and intervening in health problems arising from the environment, the production and circulation of goods and the provision of services of interest to health, covering (i) the control of consumer goods that, directly or indirectly, relate to health, including all stages and processes, from production to consumption; and (ii) control over the provision of services that are directly or indirectly related to health.

Relevant to this definition, the following classification of actions was proposed by the participants:

- Health promotion, prevention of health risks;
- Permanent and continuing education;
- Planning and management;
- Monitoring the quality of products and services;
- Acting as administrative police.

Based on the results obtained in the workshops, a new systematization was carried out, in order to conform a referential of competences that also incorporated the results obtained in the previous stages of the methodology: the strategic missions of health surveillance, their macro-choices, areas of competences and values, and principles raised as transversal to the competences.

As a final result of the entire methodological process, seven specific competencies were developed to act in the areas of health surveillance defined for the study (health services, services of interest to health, inspection (food, medicines, cosmetics, sanitizers, and health products), and inspection of pharmacies and drugstores, tobacco, blood, tissues, cells, and organs), which make up the competency framework presented in Figure 4.

For each competency, the set of actions that compose it was explained and that must be developed by professionals to reach it. Also as part of this framework, the knowledge that needs to be articulated and mobilized to carry out the various actions related to competencies is pointed out.

In the framework of competencies developed, we opted for the joint presentation of knowledge, that is, not discriminated against in relation to each of the competencies. They are considered in their multiple dimensions, as described by Deluiz²: cognitive knowledge: bits of knowledge, know-how and knowing how to do; operational knowledge: technical, know-how, practices, processes; reflective knowledge: understood as behaviors and attitudes of reflection, of questioning; psychoactive knowledge: self-knowledge, stress management, personal investment capacity; and psychosocial knowledge: relational knowledge, ability to communicate.

Sixth step: organizing the validation process

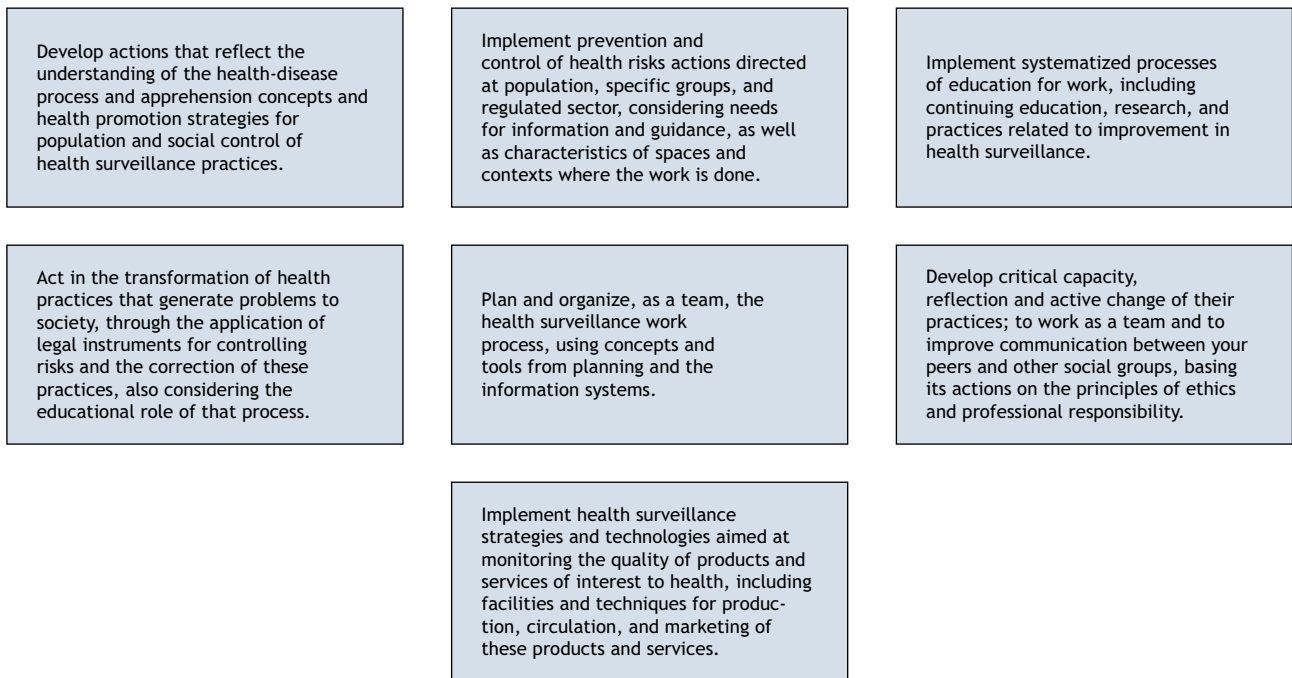
The validation of the competency reference proposal aims to disseminate the material produced, enable the participation of actors interested in the subject, seek consensus around professional skills, and seek subsidies for the improvement of the proposal. This step will be carried out at an opportune moment, when the validation process can be carried out online, through the elaboration of electronic forms that allow a statistical treatment to the suggestions received. The reports generated will be used for final analysis by the team organized for this purpose.

Figure 5 illustrates a possible electronic form format that can be used to collect information in the validation stage.

It is estimated that there will be a period of 30 calendar days for the validation to take effect and the target audience of the suggested process should consist of professionals from the services that work directly in the health surveillance actions; management bodies (Anvisa, Ministry of Health and Education, state and municipal health departments, state health surveillance coordination, city halls, and others); the National Health Council (CNS); the National Council of Health Secretaries (CONASS); the CONASS Technical Human Resources Chamber; the National Municipal Health Secretariats Council (CONASEMS); municipal health councils; foundations; and individuals.



REFERENTIAL FOR SPECIFIC COMPETENCES FOR PERFORMANCE IN HEALTH SURVEILLANCE



Source: Elaborated by the authors, 2020.

Figure 4. Specific competences to act in the areas of health surveillance defined for this study, which make up the competency framework.

Referencial de competências específicas para atuação em vigilância sanitária

O presente formulário tem o propósito de validar a proposta do referencial de competências das competências profissionais e buscar subsídios para o aperfeiçoamento da proposta.

Olá Claudia, quando enviar este formulário, o seu nome e endereço de email serão exibidos para o proprietário do formulário.

1. Considerando a competência abaixo, selecione para cada ação, uma das opções apresentadas:

(1) Atuar na transformação de práticas sanitárias geradoras de prejuízos à sociedade, por meio da aplicação de ferramentas legais de controle dos riscos e de correção dessas práticas, considerando o papel educativo desse processo.

AÇÃO 1: Realizar inspeções sanitárias sistemáticas e investigativas.

Faço

Não faço

Faço, mas não deveria fazer

Não faço, mas deveria fazer

Source: Elaborated by the authors, 2020.

Figure 5. Possible electronic form format that can be used to collect information in the validation step to complete step 6.

It is still necessary to highlight that the last stage of the methodology applied in this study could not be carried out, as explained previously. However, validation is considered an indispensable requirement for obtaining information on the feasibility and

political, technical, and pedagogical coherence of the proposal, considering the mission, objectives, strategies, and nature of health surveillance practices in Brazil. In addition, the validation will point to trends in the transformation of the scope of the



practice of workers working in the areas analyzed by the study, as well as its potential as a tool for managing education and health surveillance work.

It is important to highlight that the proposals made at each stage, based on the analyzes carried out, were discussed and agreed upon with the Anvisa team that coordinated the study.

CONCLUSIONS

The methodological path followed, with emphasis on the processes experienced in the workshops, enabled greater visibility of the practices developed by health surveillance professionals. The discussions carried out corroborated the ideas and proposals developed in all previous stages of the methodology, as the testimonies and analyses carried out among the participants gave voice to what had been analyzed about the nature, dimensions, and social reach of health surveillance, the complexity of its action, the characteristics of the workforce working in the area and its scope of practice.

On the other hand, the analyzes that made possible the application of the first four stages of the methodology guided the work in the workshops, in order to conform a referential of competencies in line with the mission of health surveillance, its strategies and macro-choices and the values and principles raised as across competencies. It is important to highlight that the

processes of discussion and analysis showed a broad competence profile, which covered all the studied areas of activity.

It was possible to visualize the scope of the practice in a perspective linked to the principles of public health. The final systematization of actions and knowledge considered the results obtained in each workshop, generating consolidated results representative of all the discussions held with the group of 52 participating professionals.

Finally, two aspects are highlighted: (i) the results achieved with this study and which allowed elaborating the proposal of the competency framework presented, point out that the competencies described are in line with those found in action developed within the Support Project for the Unified Health System (PROADI-SUS)²⁴ to define the competence profile of the health surveillance manager and organize the specialization course in health surveillance management in 2017; (ii) the proposal for the competency framework developed, after validation, will subsidize the organization of permanent education and continuing education programs for health surveillance workers and the construction of methodologies and instruments for assessing competencies, contributing to education management and work organization processes in this area.

These two aspects highlight the need to invest in training that allows reflection and seeks the development of skills for the various areas of health surveillance in Brazil.

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Acknowledgment

Anvisa management and technical team: Claudia Passos Guimarães Rabelo, Fernanda Horne da Cruz, Janaína Lopes Domingos, Lílian Fernandes da Cunha, Mariângela Torchia do Nascimento, and Rosaura Maria da Costa Hexsel.

Author's Contributions

Marques CMS - Conception, planning (study design), acquisition, analysis, data interpretation, and writing of the work. Rabelo CPG - Writing of the work. All authors approved the final version of the work.

Conflict of Interest

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



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