Organization and practice of the health surveillance in small municipalities

A organização e a prática da Vigilância em Saúde em municípios de pequeno porte

Micheli Recktenwaldt
Universidade do Vale do Rio dos Sinos. Programa de Pós-Graduação em Saúde Coletiva. São Leopoldo, RS, Brazil.
E-mail: michelireck@gmail.com

José Roque Junges
Universidade do Vale do Rio dos Sinos. Programa de Pós-Graduação em Saúde Coletiva. São Leopoldo, RS, Brazil.
E-mail: roquejunges@hotmail.com

Abstract

The decentralization process of the Health System entrusted the municipalities with responsibilities that used to be at federal level. One of these decentralized duties is the Health Surveillance for which the municipalities receive federal budget. Small municipalities struggle to meet this duty because of the lack of capacitation and the shortage of human and financial resources, producing the overlapping of duties. The aim of this research is to discuss the consequences of these duties overlapping the performance of the health surveillance role in four small municipalities in the region of Vale do Rio Caí (RS). It is both a case and a qualitative study, with data gathering through focus groups with surveillance professionals, interviews with municipal health secretaries, and consultation of municipal management documents. Data were interpreted in the content analysis perspective. Two analytical categories that explain the health surveillance functioning in these small municipalities emerged as outcomes: surveillance devaluation and lack of planning in surveillance. These outcomes enabled the critical discussion of the surveillance role in order to achieve practice comprehensiveness; the health care and management models that define health services' priorities, and the relevance of the process of decentralization and entrusting surveillance duties to small municipalities' responsibility.
Keywords: Health Surveillance; Primary Health Care; Health Personnel; Health Manager; Duties Analysis and Performance.

Correspondence
José Roque Junges
Av. Unisinos, 950. São Leopoldo, RS, Brazil. CEP 93022-630.

Resumo

O processo de descentralização do Sistema de Saúde delegou responsabilidades para os municípios que antes eram de nível federal. Uma dessas tarefas descentralizadas é a Vigilância em Saúde para a qual os municípios recebem verba federal. Municípios de pequeno porte têm dificuldade de responder a essa tarefa pela falta de capacitação e pela escassez de recursos financeiros e humanos, acarretando a sobreposição de funções. O objetivo desta pesquisa é discutir as consequências dessa sobreposição de responsabilidades sobre o desempenho do papel da vigilância em saúde em quatro pequenos municípios da região do Vale do Rio Caí (RS). Trata-se de pesquisa qualitativa do tipo estudo de caso, com coleta de dados por meio de grupos focais com os profissionais da vigilância, entrevistas com os secretários municipais de saúde e consulta a documentos de gestão municipal. Os dados foram interpretados na perspectiva de análise de conteúdo. Como resultados emergiram duas categorias analíticas explicativas do funcionamento da vigilância em saúde nesses pequenos municípios: desvalorização da vigilância e falta de planejamento na vigilância. Esses resultados permitiram discutir criticamente o papel da vigilância para alcançar a integralidade das práticas; os modelos de gestão e de atenção à saúde definidores das prioridades dos serviços de saúde; e a pertinência do processo de descentralização e delegação de tarefas da vigilância para a responsabilidade de municípios de pequeno porte.

Palavras-chave: Vigilância em Saúde; Atenção Primária à Saúde; Pessoal de Saúde; Gestor de Saúde; Análise e Desempenho de Tarefas.

Introduction

The health services decentralization is one of the Brazilian National Health System's guidelines, initiated in 1991 with the Basic Operational Norms (NOB) (Brasil, 1991, 1992, 1993, 1996) that established the political process of interagency agreements (Andrade; Pontes; Martins Junior, 2000) and supported in 2001 by the Health Assistance Operational Norms (NOAS) that defined the broaden municipalities' responsibilities (Brasil, 2001, 2002).

Such broadening meant an increase of responsibilities and resources, former of Federal scope and that, now, are entrusted to states and, mainly, municipalities (Brasil, 2001). Among these responsibilities are all those that concern Health Surveillance (VS) actions.

Health Surveillance comprises

> a continuous and systematic process of data gathering, analysis, and dissemination of health related events, aiming the planning and implementation of public health policies for the protection of population's health, risks, harms and illness' prevention and control, as well as for the promotion of health (Brasil, 2013).

Thus, surveillance acts through specific actions organized by the Sanitary Surveillance (Visa), Epidemiologic Surveillance (VE), Environmental Surveillance in Health (VAS), and the Worker Health Surveillance (VST). These actions aim the comprehensiveness of individual and collective health problems (Brasil, 2011).

A study conducted by Leite, Assis and Cerqueira (2003) from 1997 to 2001 among Epidemiologic Surveillance professionals in the Feira de Santana municipality (BA) showed that the transference of responsibilities to the municipality happened abruptly, that is, professional did not go through any kind of training for the performance of entrusted duties, besides that, the structure revealed itself to be quite deficient having little actions planning, that were unsystematic and discontinuous, and based on solving specific problems without communication between data gathering and

processing and the produced actions, hindering the achievement of comprehensiveness.

As one of the Brazilian National Health System (SUS) guiding principles, comprehensiveness is understood as a "coordinated and continuous set of preventive and healing, individual and collective, actions and services, demanded for each case in all complexity levels of the system" (Brasil, 1990).

For comprehensiveness to be possible, the Surveillance role of constantly observation and analysis of the health situation of a certain territory's population in order to suggest and coordinate a set of actions that aim at the comprehensiveness of care. To face these challenges, surveillance teams need to be coordinated among themselves and the primary care, and to overcome organizational fragmentation and sectorization in order to handle these actions.

To analyze this problem, it is necessary to consider that, in this context, two surveillance concepts, that are different and opposite, are at stake. One is the Brazilian Ministry of Health's suggestion of more integration and coordination among the various surveillances of what is commonly called "Surveillance in Health," without, however, questioning its fragmentation in specific actions (Brasil, 2013). The other is supported by researchers, connected to the Instituto de Saúde Coletiva from the Universidade Federal da Bahia (ISC/UFBA), who propose surveillance as a care model, build and moved by the comprehensiveness principle, named as "Health Surveillance," in which there is no dichotomy between preventive and healing actions, between primary care and surveillance practices (Teixeira; Paim; Vilasbôas, 1998).

To consider comprehensiveness as an organizational principle in institutional level means, for this second notion, a paradigm chance in assistance practice, which is still oriented towards an individual care and focused on illness, to the inclusion of a planning thinking of prevention and health promotion actions (Vilasbôas; Teixeira, 2007).

This means a broadening in the operational surveillance notion in order to integrate in assistance individual just as collective practices, aiming to meet the health needs (Arreaza; Moraes, 2010). This integration demands coordination with primary care, enabling a work processes' realignment that includes the territory as a attention focus, adding prevention and promotion actions to the healing and rehabbing assistance ones. To achieve this goal, it is necessary to have an interdisciplinary view on health problems and an intersectoral confrontation of health needs (Oliveira; Casanova, 2009).

Considering the importance of surveillance for the comprehensive health care and considering the demands for its implementation, the surveillance organization at municipal level becomes a challenge (Oliveira; Cruz, 2015). On the other hand, knowing that the population's social representations of health services are centered around the care of individual health problems, looking for healing actions, in the biomedical model view (Gomes et al., 2011), the prevention and promotion are not concerns for the majority of people and, consequently, are not priority for most of municipal managers.

Despite the vast majority of Brazilian municipalities having less than 20,000 inhabitants (IBGE, 2016), with few human and financial resources for surveillance functioning, when consulting databases, there are almost none studies on the organization in small municipalities. The existing studies deal with the use of information systems and the management of basic health units, having as results the overlapping of duties, deriving from the excess of bureaucratic demand and lack of human resources, which results in overload feeling, stress, and dissatisfaction with work (Romagnolli; Carvalho; Nunes, 2014; Vidor; Fisher; Bordin, 2011).

Surveillance decentralization transferred for the municipalities duties that are demanded by the Brazilian Ministry for the funds transferring. The authorities are concerned with responding to this demands with the available funds, a context that is on the duty overload problem origin, mainly in small municipalities. This view does not discuss the basis issue, the care model change, that would reshape the funds issue and its consequent overlapping.

Considering that this concern and view are common among municipal health authorities, what are the consequences of the administrative

duties overlapping practice on the performance of the surveillance functions in small municipalities? This article has the objective of discussing this issue, considering the health surveillance functioning in four small municipalities of Vale do Rio Caí (RS).

Methodology

This is a qualitative case study research (Yin, 2010). For the research field definition, the selection criterion was being small municipalities, having less than 10,000 inhabitants and belonging to Vale do Rio Caí. Among the various municipalities, four were chosen, having a population smaller than 5,000 inhabitants. The convenience criterion helped in the definition of this municipalities, according to the proximity and easy access for the researcher. Having the municipalities defined, it was made the previous contact with the health secretaries to introduce the research proposal, to perform field and involved actors' recognition, besides the authorization for the research performance by signing the Approval Letter.

Chart 1 – Description of surveillance teams with its professionals' respective duties

Position	Duties
Surveillance Team Municipality 1	
Nurse	Assistance Nurse in Primary Care (AB), Sanitary Surveillance (Visa), Epidemiologic Surveillance (VE) and Worker's Health Surveillance (VST).
ESF Nurse	Technical responsible, nurse coordination and VS and duties related to nursing in Family Health.
Nursing Assistant	Nursing procedures, Visa (sanitary inspection), VE, VST e Environmental Surveillance in Health (VAS) (water sample gathering, field agent activities of dengue prevention and control).
Surveillance Team Municipality 2	
Nursing Technician	Nursing procedures in AB and VE (vaccine room, mandatory notifications, feeding and Information Systems updating).
Nursing Technician	Nursing procedures in AB and VE (vaccine room and occasional monitoring and notification in case of absence of responsible professional).
Nurse	VS coordinator, VE acting: immunization, help in Mandatory Notifications (NC), material gathering for tests in Laboratório Central do Estado (LACEN), registry in the Laboratory Environment Managing System (GAL), quick tests, rabies control program.
Field Agent	VAS (control of dengue, Chagas disease, among others) educational activities related to the former diseases.
Sanitary and Environmental Inspector	VAS: Surveillance of water quality for human consumption/VIGIÁGUA, actions to combat rabies, *Aedes aegypti*, Chagas disease control, zoonosis, guidance about venomous animals and toxic plants, environmental impact/harm inspection, Information Systems (SI) dengue disease and SISAGUA Visa (Sanitary inspection and release of sanitary licenses). Educational lectures on VISA and VA
Surveillance Team Municipality 3	
Zoonosis control Agent	VAS (monitoring and control of dengue and water quality, and information systems typing).
Nursing technician	Nursing procedures and VE (immunization).
ESF Nurse	Assistant nurse in AB, ESF and VE nurse.
Nurse	Assistant nurse in AB, specialties center nurse, VS coordinator with Visa action (sanitary inspection for release of licenses).

continues...

Chart 1 – Continuation

Position	Duties
Surveillance Team Municipality 3	
Municipal Inspector	Inspection of construction sites and compliance, taxes, environment, release of environmental license, and Sanitary Surveillance.
Surveillance Team Municipality 4	
Nurse	VE, Immunization, Information System, State's Medicine Assistance, ambulatory nursing procedures in AB.
Municipal Inspector	Visa (Sanitary Inspection, release of sanitary licenses, receive complaints) and VAS (Water quality surveillance, dengue).
Nursing Technician	Triage and VE: vaccine room, typing and inspection of the Notification Harms Information System(SINAN).
ESF Nurse	Technical responsible, ESF coordination, assistant nurse and VE (responsible for immunization, SINAN notifications, quick tests).

The four chosen municipalities do not have any municipal hospital, having each only a health center. In these centers are located the secretaries and are performed the Secretary of Health services. In the same place are working the Primary Health Care (APS), Family Health Strategy (ESF), and Health Surveillance (VS) teams, besides the care of some medical specialties and urgent and emergency basic services.

The study participants were professionals from different surveillances – epidemiologic, environmental, sanitary, and worker's health – (Chart 1) and the health secretaries from the four municipalities. Data gathering was made by focal groups with the VS professionals, individual interviews with the Health Secretaries, and document analysis of the Municipal Health Plans 2014/2017 and Management Reports referring to 2015.

For the focal groups discussion the topics used were: the functioning and surveillance actions in the municipality and its interaction with the primary care in the territory, a distribution of duties and tasks for each of the surveillances, the consequences for the performance of surveillance actions when the professional has other duties, usage of the data created by surveillance for the organization of health actions in the territory and the participation of surveillance professionals in the planning of these actions by the management tools.

The same guide was used for the individual interviews with municipal health secretaries. All speeches, from the focal groups and individual interviews, were fully recorded and transcribed for further analysis.

The document research had as a goal to analyze the management tools as an addition to the information obtained from the focal groups and interviews, since these documents comprise data related to the surveillance organization and acting, such as actions scheduling, annual goal agreements, guidelines and targets, besides financial resources received from the union.

The data organization complied to the case study perspective, through a database construction, in which evidence showed up. The research data were split into documents, one comprising the focal group transcriptions, another with the individual interviews, and the last comprising the researcher's notes during document analysis. These data were organized and analyzed using the Nvivo software, specific for qualitative data. Data analysis followed the content analysis that works on textual and informational material, having as the main characteristic the categories use (Flick, 2009).

The starting point for the analysis was the main research question: the consequences of surveillance professionals' duties and attributions overlapping in other municipal services on the

organization and acting of health surveillance in small municipalities from Vale do Caí.

For data presentation, taking into account the respect for the participants' anonymity, the VS professionals' speeches were identified by the position and the abbreviation GF1, GF2, GF3 or GF4, that correspond to the focal groups. In the same way, the health secretaries were represented by the abbreviations SS1, SS2, SS3, SS4. The numbers correspond to the numeric denomination of the four municipalities.

The research was approved by the Committee of Ethics in Research (CEP) from Unisinos by the Statement no. 182/2015. The research participants signed two copies the Informed Consent Form approved by CEP, one copy being kept by the participant and the other by the researcher.

Outcomes

Data analysis made clear two analytical categories to understand the surveillance reality in the studied municipalities: surveillance devaluation; lack of planning in surveillance.

Surveillance devaluation

A constant speech by the managers in the studied municipalities is that the financial resources passed on to the surveillance are insufficient to afford specific professionals for the different attributions in surveillance. According to financial data of the Information System about the Public Health Budget (SIOPS), present in the Annual Management Reports (RAG) (SARGSUS, 2015), only one of the four studied municipalities received, in 2015, enough resources from the Union (R$ 60,801.87) for the payment of the employees in the minimum VS team (nurse, one or two nursing technicians, field agent, and sanitary inspector), the rest received about R$ 30,000 referring to the VS budget, coming from the Union.

Since the municipalities have to use their own resources in order to keep the surveillance teams, the managers are obliged to argue that these professionals cannot be exclusive for the surveillance, but should also act on primary care or in other areas of the municipal public service: *The costs of these team is not only from the surveillance budget, so these professionals need to act in other areas also* (SS2); *How can a two thousand inhabitant municipality have a 40h professional to act only in surveillance?* (SS1).

For the managers, this process of gradual responsibility transference for the municipalities demands investment on professional educational, but, according to them, these investments should come from the State, since the resources the municipality receives are insufficient: "*The State passed on too many things for the municipalities,* [...] *but the money is only 30% of what I need"* (SS4).

In the focal discussions with the surveillance professionals, the overlapping duties is a common discourse. A consequence of this duty's overlapping is the lack of available time: *"I am like a workhorse four hours a week carrying chlorine,* [...] *instead of producing a work, a project, a lecture"* (Sanitary and Environmental Inspector GF2).

The involvement in other duties that, in some cases, would not even be the professional's responsibility, restricts the preventive and planning actions:

> *We have little time to research* [...] *to set indicators* [...] *in the sanitary surveillance part I can't do many things, because the work ends up being flawed in preventive activities, the ideal would be to guide, to do groups with the institutions* (Nurse GF3).

Educational actions do happen, but in a specific manner and usually as a response to a harm: *"It is that urgency view* [...] *the planning is about what already happened"* (Nurse GF2).

The overlapping duties, that result on the lack of time, puts the surveillance work in the background: *Many things are left half done, making it a poor job* (Nurse GF1); *So, I couldn't achieve the goal* (Sanitary and Environmental Inspector GF2).

When the professional cannot fully exercise their duties, not reaching goals or performing the work in an adequate manner, they report negative overload feelings: *You overlap functions, that interferes a lot,* [...] *it stresses because it is a lot of things* (Nurse GF4); [and of dissatisfaction for being] *responsible for so many thing and doing so few of each thing* (Nurse GF2).

It is not only about overload, but also about the feeling that the professional is performing duties without being skilled for that, creating a duty deviation:

> *I studied nursing to assist people, but we only have paperwork and reports, reports, and more reports, managing reports* (GF4).

> *I am a sanitary inspector, but who does all this inspection part is the nurse* (GF3).

The nurse notes: *"I moved to the surveillance a nursing technician that has the work hours for primary care"* (GF1). The sanitary and environmental inspector mentions that: *"Besides my duties as an inspector, I deal with the municipality's water, put chlorine in the water, while I should be inspecting"* (GF1).

This scenario rises up a series of questions about what the surveillance represents on the health organization in the small municipalities. The nurse has the feeling that it is *"as if the surveillance didn't exist"* (GF2). For this, the inspector points out as a cause the fact that *"the same professional does lots of things, not having a good inspection nor a good surveillance"* (GF2).

Perhaps due to this weakening, it is not required, in the hiring requirements, professionals capacitated for surveillance positions, except for epidemiologic surveillance. Since the majority of positions is high school level, the managers and the professionals themselves affirm that there is not enough training to perform the required duties. For that reason, the managers defend that *"the State should contribute much more than what it is doing and not simply leave it to the municipalities"* (SS4), and the nurse considers that *"the 1st CRS could call the municipalities and do a meeting to capacitate, like a workshop"* (GF4). These formative spaces already exist for the State Surveillance professionals, since the nurse stated that: *"they helped me a lot because I didn't have a lot of notion and we went after it and asked for help"* (GF3).

The duties overlapping and the lack of capacitation for it are connected to the care and management model applied in the municipalities. The management profile and the investment priorities in the municipalities are important factors that affect the performance of surveillance attributions.

For the managers, health seems to be restricted to clinical procedures, and this notion defined the management profile, reaffirming the lower position that the surveillance takes in the priorities list: *"for the mayors, health focused on doctor, medicines and transport* [...] *for that to have a good number of employees* [...] *and to make them produce more"* (SS4).

The professionals report that surveillance actions are not priority: *"What we have to do is to meet the demand"* (Nursing Technician GF2). A sanitary and environmental inspector considers that the funds transference could include the surveillance more: *"we have the surveillance budget, but we don't have a car for inspection"* (GF2); besides that, another professional reports that *"the surveillance doesn't have an endemic agent, but there is a federal government resource that could pay for it and the municipality would disburse little"* (Nurse GF1).

There is a difference among the position of the professionals and managers on the surveillance acting. Professionals point out difficulties in the realization, for example, of sanitary inspection, since the inspectors acts at the same time as environmental inspector, taxes inspector, construction inspector, compliance inspector, having little time left for the sanitary part: *"the sanitary inspections are done when there is time left* [...] *because the demand of the environmental part demands a lot"* (GF3). On the other hand, the manager of the same municipality says that the inspector is always available, despite working in another department in the municipality: *"he is always available,* [...] *giving priority to the surveillance"* (SS3).

Thus, to perform the surveillance actions in these municipalities represents a challenge, because there is a lack of professionals to guarantee the minimum team, *"there is no endemic combat agent* [...] *the surveillance inspector (Visa) left,"* or because they are improvised and temporary: *"the municipality nominated the nursing technician, for a while, to take over the inspector's duties"* (Nurse GF1).

In this particularities and challenges context, surveillance needs to develop acting strategies to manage difficulties and to be able to perform theirs actions, even with restrictions. It is observed, thus, that the different surveillances show specificities in their organization and acting.

The Epidemiologic Surveillance (VE) in the four municipalities is the nurse's responsibility, who also acts inside the APS. For VE professionals, the main difficulty are the notifications: *"we are not always there to do the notification* [...] *this depends on the doctors who diagnose"* (Nursing Technician GF4). Despite the teams being small and acting inside the same physical space, *"the notifications end up not coming and we only find out after it already passed"* (Nurse GF3).

The Sanitary Surveillance is the responsibility of a high school level professional. Generally, in the studied municipality, Visa showed itself to be quite weakened in its organization, first by the absence of a sanitary inspector in some municipalities, since *"the licenses are simply being issued without inspection and the Secretary of Health is signing it"* (Nurse GF1), and by the overload of inspectors with simultaneous duties in sanitary, environmental, taxes, construction, and compliance inspections, having to share their workload: *"I work 20 hours in the municipality in other inspection areas"* (Municipal Inspector GF4) and also having to pass on duties to other colleagues so that the minimum demand can be done: *"I am a sanitary inspector, but who does all this inspection ends up being the nurse"* (Municipal Inspector GF3).

In environmental surveillance, the professional who usually acts are the endemic agent or the field agent, which is a high school level position. Only two municipalities have a professional for this position, although it is part of the minimum team prescribed, and in the other two it is the same Visa professional that performs the duties for that position. In the municipalities where the field agent acts *"the work is being valued, I see that he really fights for what needs to be done"* (Nurse GF3). The lack of such professional makes the performing of actions and, especially, the achieving of goals difficult: *"I could not achieve the goal, that was not mine, because the field agent was not here anymore and I had to embrace it"* (Sanitary and Environmental Inspector GF2).

The Worker's Health Surveillance seems to be the most precarious one, despite most Municipal Health Plans (PMS) considering the importance of strengthening this area, there is not a professional with a defined position to act on the worker's health. What is possible to see in the studied municipalities is that it is the nursing team who acts on the surveillance and who ends up taking on some few duties: *"what is being done are just the occupational accidents notifications"* (Nurse GF3), *"The only thing done is the SINAN and RINA forms when there are basic accidents* [...] *no educational actions aiming on the worker's health"* (Nurse GF1).

The process of decentralization of surveillance responsibilities and resources seem to not have provided to municipalities the necessary preparation so that they could meet the demands that became their responsibility. As a complicating factor, we it is possible to see in the area are professionals taking on each time more responsibilities and managers that keep themselves bound to care models focused on illness and on medical assistance care, affecting the position surveillance occupies in investments priority and resulting on the weakening of this system.

Therefore, if the municipal administration profile exerts such influence on the way surveillance is organized and knowing that there are management documents that act as specific tools to base the manager on planning, monitoring, and assessment of health actions, it is important to understand how the information created by surveillance are used in the building of these tools, since they should also comprise this important health care area.

Lack of planning in surveillance

Considering that the management documents used in the municipalities also include planning, monitoring, and assessment of surveillance area's actions, it was considered important to identify, among the professionals from the studied

municipalities, if they know the documents and if, anyhow, they participate in their designing.

Among the four municipalities only one designed a Health Surveillance Action Plan, however, it was outdated, since it referred to 2014, which can mean a lack of time dedicated towards VS actions planning.

According to the 2015 Sispacto, which concerns annual goals, guidelines and targets agreement, available at the RAG (SARGSUS, 2015), only one of the four municipalities achieved 100% of the goals concerning the objective 7.1 that is to strengthen health promotion and surveillance. In the goals that were not achieved are the mandatory notification and the cases' closing in up to 60 days; the proportion of vaccine coverage of the basic children vaccination schedule, and the percentage of sanitary surveillance actions considered necessary for the municipalities.

Generally, what is common to small teams is that *"three or four answer for the whole team"* (Nurse GF2), and the surveillance information used are discussed individually: *"There is no such thing of markers follow-up and assessment.* [...] *I would give it to the responsible ones to fill in and then I would assemble everything latter*" (Nurse GF4). In some cases, the manager does not even participate on this process: *"The management documents' designing is done in the cheating style* [...] *We discuss individually. The nurse is the one that answers* [...] *But the manager is the one that signs"* (Nurses GF3).

The more individual participation of the professionals in theses documents' designing can be explained by the lack of team meeting spaces that occurs in some of these municipalities: *"we don't have a space to gather the team, we don't close the unit to sit down and discuss"* Nurse GF3); besides that, *"the team meeting are for talking about the care itself"* (Nursing Technician GF4) and not for the discussion, designing and/or monitoring of these tools.

Just as the management documents are not discussed in team meetings, according to the opinion of most professionals *"the markers are not used and are there more as an obligatory tool"* (Nurse GF3); besides that, *"they are made only to achieve goals, to do the plan and get rid of it"* (Nurse GF4).

Confirming that, the managers themselves say that the data created by surveillance, by markers, should be better used by them: *"we could do better use of these information"* (SS4); *"but, because of the time, work and demand we cannot have more meetings*" (SS2); *"we are still doing a lot of damage control"* (SS1).

If the information resulting from the surveillance work should be part of the health actions planning, equally, in order to have these actions respecting the specificities of the territory's population, they should be organized together with the Primary Health Care (APS), point to the need of a reorganization of the care model.

Thus, what was identified in the studied surveillance teams is that many professionals also perform duties in APS, with the support of ESF teams, especially of community health agents (ACS) who help in the propagation of surveillance information: *"with the agents the demand for quick tests increased*" (Nurse GF3), in the delivery of surveillance educational folders: *"each month we have a schedule in which the health agents go from house to house to do this educational activity*" (Nurse GF1) and in some educational events: *"We just had a mobilization* [...] *we got a students' group and the health agents"* (Municipal Inspector GF4).

The teams that reported the partnership with ESF, especially with the ACS, has the presence strategy nurses in the surveillance teams. In the team that this does not happen, collaboration is harder: *"the surveillance cannot convince the ESF of some actions, because it is the surveillance saying, not the management*" (Sanitary and Environmental Inspector GF2). This datum shows how such collaboration depends on a care model that integrates preventive and healing actions.

If for most of the managers the surveillance ends up in the background and the professionals cannot fully perform their actions, this observation reflects the lack of use of surveillance information in the planning that points out to a deeper issue, which is the discussion about the care model that will determine the management model and consequent resource distribution for

health. Unfortunately, what is observed are the management tools, designed by obligation and, consequently, markers created by surveillance are not used in the health actions planning, because the problem is in the care level that is on the foundation of this planning. Facing this scenario, what can be perceived is a devaluing and weakening of surveillance, created by the kind of management implemented in small municipalities that, in their turn, depend on the notions of what is population health care.

Discussion

The surveillance devaluing, pointed out as cause for the duties overlapping, creating the weakening of surveillance actions and the consequent building of bureaucratic planning that do not meet the real needs of population health, deserves a deeper discussion on the surveillance role and its relationship with the comprehensiveness principle. To understand this relationship, the management and health care models, active in small municipalities, are determinant to the kind of surveillance organization an acting, making the performance of its role difficult and, consequently, inhibiting comprehensiveness to be incorporated in its actions.

The municipal managers are guided and demanded by the Ministry's guidelines that demand professionals with specific duties and actions for each health surveillance team. On the other hand, health demands that ask managers for answers and investment are determined by a model focused on healing clinic actions. This tensioning takes the managers to define their priorities, leaving the surveillance actions in the background, as the research results show. For this reason, it is necessary to discuss a care and management model that comes from a broaden health concept, having as its basis comprehensiveness, that understands the surveillance role in this context. The suggestion of Health Surveillance from the Instituto de Saúde Coletiva from UFBA can be a path.

The comprehensiveness principle must be considered as a way of guaranteeing the conditions for the promotion, prevention, recovery of health and rehabilitation of individuals and all that should also be the aim of surveillance actions. A comprehensive care depends on important changes in practices, in the institutional scope in organization and coordination of health services just as in the scope of professional practices that tend to be fragmented and oriented towards specialization (Campos, 2003).

To change institutional and/or professional practices is not an easy job and demands investment priorities by the managers and the development of professional attitudes that go beyond nature of healing procedures and that are enriched by health preventive and promotion actions. For that, it is essential that all the actors in the local health teams recognized themselves as surveillance agents to identify in their territory's population potential health risks, searching inside that population means of combating those risks (Oliveira; Casanova, 2009). From this perspective, the duties' overlapping would not be put as a problem, as the results point out, because every professional connected to health would a surveillance agent.

This recognition of every professional as a surveillance one depends on the health care model that prevails in these small municipalities. This is another aspect that the results bring to discussion. The models that usually persist emphasize the medic-hospital assistance, being connected to diagnosis and treatment, making surveillance restricted to punctual epidemiologic actions through campaigns and special programs oriented towards specific groups and with some sanitary surveillance actions. Thus, the planning thinking of health preventive and promotion actions, aiming comprehensiveness as an organizational institutional principle, does not occurs (Teixeira; Paim; Vilasbôas, 1998; Vilasbôas; Teixeira, 2007).

Coming from a broaden health concept, different from the current hegemonic care models, reduced to medical and/or sanitary professionals, the Surveillance in Health aims the incorporation of new actors beyond the health professionals, as it was revealed in the research field and with the

population. Besides that, this broaden concept takes into account, more the clinic-epidemiologic determining factors, the social and living conditions of populational groups (Teixeira; Paim; Vilasbôas, 1998).

Thus, the transformation of a care model requires the definition of new purposes, overcoming the care focused on spontaneous demand and on patient care, as it is shown by the results in this study. What becomes important is the search for new work objects and means, besides changes in the professionals' acting way, especially in the relationship with population. Therefore, the suggestion of overcoming traditional models aims to achieve risks and harm preventive actions and actions of health promotion in the territory where these populations live and work (Teixeira, 2006).

Considering this broaden concept of surveillance, unlike what is identified in this study, it cannot be restricted to actions of notification and control of punctual events and/or emergency. Teixeira, Paim and Vilasbôas (1998) point out that surveillance has as its role to organize the work processes in health through intersectoral actions of intervention, promotion and care. According to the authors, these actions need to be based on what they call strategic pillars, that is, the health problems, the territory and the intersectoral practice. For that end, it is necessary a strategic planning guided by the information gathered by surveillance, which does not happen in the studied areas, where the planning is a bureaucratic formality.

Therefore, for Oliveira and Cruz (2015), this role aims mainly to handle health problems in a more effective manner, for that, they suggest an approach of integrated and coordinated work through actions that are based on health situation of the population in the territory, beyond the health institutions' space.

In the same way, if the aim of surveillance cannot be simply resumed to data gathering and analysis, it also need to be a technical basis that, based on scientific knowledge, helps the health services to design and apply constantly enhanced programs and also to support the timely identification and intervention in disease control (Waldman, 1998).

In order to have the information created by surveillance effectively applied in health care, the markers cannot be restricted to notification, for example, they need to be properly analyzed aiming to serve as basis for the planning of strategic actions that enable health promotion and harm prevention and control, integrating primary care with surveillance in health (Pereira; Tomasi, 2016).

At the small municipalities studied, the surveillance potential is not developed, as a tool for practice changes, that is, this surveillance is dependent to control and notification measures, not being able to perform its role integrally in terms of disease prevention and health promotion.

Such change in health practices depends on the management kind used. The management exercise usually complies to decision making models in which the criteria used in the priority definition are various and influenced by party-political issues; by opportunities of resource reaching, that not always match the needs; and even by individual issues of the manager himself (Coelho; Paim, 2005).

In the presented results, it is perceived that the biomedical model of health care seems to be constantly reaffirmed by the managers by the expression of what they consider a priority in health and, consequently, by the professionals who tend to fit themselves into what is demanded by the management. Thus, it is likely that this position focused on the valuing of the healing scope justifies the resource allocation priorities and the lack of planning in Health Surveillance observed in the study.

When it is not exercised a management practice based on a previous process of participative analysis and prioritization suited to the health need, a breach is opened for making empirical and subjective decisions that are more related to interests than needs (Battesini; Fischmann; Weise, 2013).

In order to discuss this, it cannot be forgotten the significant factor that SUS was established not only as a new health care model aiming universal access and comprehensiveness of health actions, but also as a State management model. As such,

in this management model the action, including surveillance ones, besides being decentralized in single command in each government sphere, comprise a system of policies' agreement with tripartite funding, with the community participation and social control (Rezende, 2008).

Therefore, facing the complexity of the current SUS organizational system, it is imperative to ponder on the fragilities of the municipal management of sanitary practices and to go beyond this management's impossibilities discourse that, as identified in the results, tend to report the decentralization of health actions as the responsible for the demand overload in the municipalities and for the transference of financial resources, insufficient to keep the surveillance teams and, consequently, for the difficulties in the performance of actions.

It is clear that the establishment of an intense decentralization process, having as goal the convergence of health actions in the territory, where people live, changed the direction of health actions. Thus, as shown in the results, there was indeed a demand increase, because what used to be a competence of the federal and state scope is now the municipality's responsibility.

However, this process did not happen suddenly, that is, it has been progressively unfolding itself through more than twenty years, since the implementation of the NOB and NOAS (Brasil, 1991, 1992, 1993, 1996, 2001, 2002) through policies agreement by the three government spheres.

Thus, what can be understood is that the municipalities, by agreeing to the surveillance actions with the State and Union, assumed the joint responsibility as a commitment, and, as part of that commitment, need to be also responsible with the funding that is regulated according to the Decree no. 1,378, of July 9th, 2013 (Brasil, 2013).

Therefore, it is not justified the managers discourse on the lack of resources as the exclusive responsibility of the State and/or Union, considering that according to the Complementary Law no. 141, of January 13th, 2012 (Brasil, 2012), the municipality should allocate for the health area 15% of the tax collection. This resource invested in health should also include Health Surveillance actions, which are included in the group of health actions for the achievement of care comprehensiveness.

For the health services to be adequately performed there should be a proper coordination between human and financial resources. For this to happen, the manager needs to be close to his team and to use properly the planning tools available at SUS as the best method for actions follow-up in all health areas in the municipality. It is important to highlight that a proper and planned use of resources in surveillance area demands from the manager technical knowledge, good communication, management skills, and a dynamic and caring attitude (Pinho, 2016).

However, if the managers, due to lack of knowledge and based on a health concept oriented towards disease treatment, elect priorities that put surveillance in the background, the overlapping duties are seen as negative, affecting on a surveillance system that is weakened, devalued and with little planning, as it arose in the results.

If the surveillance is not valued, there is little investment in professional education and capacitation with teams that perceive themselves as unprepared to handle such complex challenges, considering surveillance as an addition to other duties, not perceiving themselves as surveillance agents. When they manage to reorganize the work processes of the ones involved in health practices, so that surveillance can be a part of these diary practices and not only a mere addition, the surveillance actions will be qualified and consequently will have trustful health markers to be used for the planning of health actions (Linhares et al., 2013).

Therefore, it is necessary for the capacitation and education activities to include also the municipal health secretaries and even the mayors, so that they can also be part of the human resources formative process, especially due to the turnover of these professionals with commission based and elective positions. If this continuous and permanent formation is widened to management level, the improvement of surveillance actions will have its highest potential, since what is observed is that surveillance is not a priority focus, affecting the organization manner of actions and professionals' practices.

Final remarks

Surveillance organization and practice in the small municipalities studied presented very similar characteristics. The overlapping duties were the predominant result, pointed out by the professionals and justified by managers through the lack of financial resources to meet the new surveillance responsibilities resulting from the decentralization process. This overlapping is considered by the professionals as a devaluation of surveillance, which does not have the proper conditions to the performance of its duties and tasks in the territory.

When surveillance is not guided by care comprehensiveness, as a SUS principle, it cannot perform its potential of team's practices transformation. The difficulties found are related to the management and health care models that are inseparable, directly affecting the resource distribution, the priority determination in health actions, and consequently the surveillance teams' practices.

References

ANDRADE, L. O. M.; PONTES, R. J. S.; MARTINS JUNIOR, T. A descentralização no marco da Reforma Sanitária no Brasil. *Revista Panamericana de Salud Pública*, Washington, DC, v. 8, n. 1-2, p. 85-91, 2000.

ARREAZA, A. L. V.; MORAES, J. C. Vigilância da saúde: fundamentos, interfaces e tendências. *Ciência & Saúde Coletiva*, Rio de Janeiro, v. 15, n. 4, p. 2215-2228, 2010.

BATTESINI, M.; FISCHMANN, A.; WEISE, A. D. Identificação de prioridades em saúde: uma alternativa técnica de apoio à tomada de decisão. *Ciência & Saúde Coletiva*, Rio de Janeiro, v. 18, n. 12, p. 3673-3682, 2013.

BRASIL. Lei nº 8.080, de 19 de setembro de 1990. Dispõe sobre as condições para a promoção, proteção e recuperação da saúde, a organização e o funcionamento dos serviços correspondentes e dá outras providências. *Diário Oficial da União,* Brasília, DF, 20 set. 1990. Disponível em: <https://goo.gl/j3ChsQ>. Acesso em: 5 maio 2015.

BRASIL. Instituto Nacional de Assistência Médica da Previdência Social. *Resolução nº 258, de 7 de janeiro de 1991*. Aprova a Norma Operacional Básica/SUS nº 01/91, constante do Anexo I da presente Resolução, que trata da nova política de financiamento do Sistema Único de Saúde - SUS para 1991. Brasília, DF, 1991. Disponível em: <https://goo.gl/VfdMwr>. Acesso em: 9 jul. 2016.

BRASIL. Instituto Nacional de Assistência Médica da Previdência Social. *Portaria nº 234, de 7 de fevereiro de 1992*. Edita a Norma Operacional Básica do Sistema Único de Saúde para 1992 (NOB - SUS/92), conforme texto constante no Anexo I da presente Portaria. Brasília, DF, 1992. Disponível em: <https://goo.gl/NqsQ3g>. Acesso em: 9 jul. 2016.

BRASIL. Ministério da Saúde. Portaria nº 545, de 20 de maio de 1993. Estabelece normas e procedimentos reguladores do processo de descentralização da gestão das ações e serviços de saúde, através da Norma Operacional Básica - SUS 01/93. *Diário Oficial da União*, Brasília, DF, n. 96, 24 maio 1993. Seção 1, p. 6961.

BRASIL. Ministério da Saúde. Portaria nº 2.203, de 5 de novembro de 1996. Dispõe sobre a Norma Operacional Básica do Sistema Único de Saúde NOB-SUS 01/96. *Diário Oficial da União*, Brasília, DF, 6 nov. 1996. p. 22932.

BRASIL. Ministério da Saúde. Portaria nº 95/GM, de 26 de janeiro de 2001. Aprova a Norma Operacional da Assistência à Saúde - NOAS-SUS 01/2001. *Diário Oficial da União*, Brasília, DF, 29 jan. 2001.

BRASIL. Ministério da Saúde. Portaria nº 373, de 27 de fevereiro de 2002. Aprova a Norma Operacional da Assistência à Saúde - NOAS-SUS 01/2002. *Diário Oficial da União*, Brasília, DF, 28 fev. 2002.

BRASIL. Conselho Nacional de Secretários de Saúde. *Vigilância em Saúde*: Parte1. Brasília, DF, 2011. (Coleção Para Entender a Gestão do SUS, 5)

BRASIL. Lei complementar nº 141, de 13 de janeiro de 2012. Regulamenta o § 30 do art. 198 da Constituição Federal para dispor sobre os valores mínimos a serem aplicados anualmente pela União, Estados, Distrito Federal e

Municípios em ações e serviços públicos de saúde e dá outras providências. *Diário Oficial da União*. Brasília, DF, 16 jan. 2012. Disponível em: <https://goo.gl/EEpzHy>. Acesso em: 2 ago. 2016.

BRASIL. Ministério da Saúde. Portaria nº 1.378, de 9 de julho de 2013. Regulamenta as responsabilidades e define diretrizes para execução e financiamento das ações de Vigilância em Saúde pela União, Estados, Distrito Federal e Municípios, relativos ao Sistema Nacional de Vigilância em Saúde e Sistema Nacional de Vigilância Sanitária. *Diário Oficial da União*, Brasília, DF, 9 jul. 2013.

CAMPOS, C. E. A. O desafio da integralidade segundo as perspectivas da vigilância da saúde e da saúde da família. *Ciência & Saúde Coletiva*, Rio de Janeiro, v. 8, n. 2, p. 569-584, 2003.

COELHO, T. C. B.; PAIM, J. S. Processo decisório e práticas de gestão: dirigindo a Secretaria da Saúde do Estado da Bahia, Brasil. *Cadernos de Saúde Pública,* Rio de Janeiro, v. 21, n. 5, p. 1373-1382, 2005.

FLICK, U. *Introdução à pesquisa qualitativa*. 3. ed. Porto Alegre: Artmed, 2009. p. 180-193.

GOMES, K. O. et al. Atenção primária à saúde: a "menina dos olhos" do SUS: sobre as representações sociais dos protagonistas do Sistema Único de Saúde. *Ciência & Saúde Coletiva*, Rio de Janeiro, v. 16, p. 881-892, 2011. Suplemento 1.

IBGE – INSTITUTO BRASILEIRO DE GEOGRAFIA E ESTATÍSTICA. *Censo 2010*. Brasília, DF, 2016. Disponível em: <https://goo.gl/mgJQck>. Acesso em: 10 maio 2015.

LEITE, J. A.; ASSIS, M. M. A.; CERQUEIRA, E. M. Vigilância epidemiológica no sistema local de saúde. *Revista Brasileira de Enfermagem*, Brasília, DF, v. 56, n. 2, p. 178-183, 2003.

LINHARES, M. S. C. et al. Programa de educação para o trabalho e vigilância em saúde. *Trabalho, Educação e Saúde*, Rio de Janeiro, v. 11, n. 3, p. 679-692, 2013.

OLIVEIRA, C. M.; CASANOVA, A. O. Vigilância da saúde no espaço de práticas da atenção básica. *Ciência & Saúde Coletiva*, Rio de Janeiro, v. 14, n. 3, p. 929-936, 2009.

OLIVEIRA, C. M.; CRUZ, M. M. Sistema de Vigilância em Saúde no Brasil: avanços e desafios. *Saúde em Debate,* Rio de Janeiro, v. 39, n. 104, p. 255-267, 2015.

PEREIRA, B. S.; TOMASI, E. Instrumento de apoio à gestão regional de saúde para monitoramento de indicadores de saúde. *Epidemiologia e Serviços de Saúde*, Brasília, DF, v. 25, n. 2, p. 411-418, 2016.

PINHO, J. R. O. Atos normativos do financiamento das ações de Vigilância em Saúde. In: UNIVERSIDADE FEDERAL DO MARANHÃO. *Curso de extensão Vigilância em Saúde*: gestão e financiamento das ações da Vigilância em Saúde. São Luís: Edufma, 2016. p. 47-73.

REZENDE, C. A. P. O modelo de gestão do SUS e as ameaças do projeto neoliberal. In: BRAVO, M. I. S. et al. (Org.). *Política de Saúde na atual conjuntura*: modelos de gestão e agenda para a Saúde. 2. ed. Rio de Janeiro: Rede Sirius/Adufrj-SSind, 2008. p. 25-35.

ROMAGNOLLI, A. P. B.; CARVALHO, B. G.; NUNES, E. F. P. A. Gestão de unidade básica de saúde em municípios de pequeno porte: instrumentos utilizados, facilidades e dificuldades relacionadas. *Revista Gerencia y Políticas de Salud*, Bogotá, DC, v. 13, n. 27, p. 168-180, 2014.

SARGSUS – SISTEMA DE APOIO AO RELATÓRIO DE GESTÃO. Secretaria de Gestão Estratégica e Participativa. *Situação do Relatório Anual de Gestão*. Brasília, DF: Datasus, 2015. Disponível em: <http://bit.ly/2s1mAOB>. Acesso em: 20 maio 2016.

TEIXEIRA, C. F. A mudança do modelo de atenção à saúde no SUS: desatando nós, criando laços. In: TEIXEIRA, C. F.; SOLLA, J. P. (Org.). *Modelo de atenção à saúde*: promoção, vigilância e saúde da família. Salvador: Edufba, 2006. p. 19-58.

TEIXEIRA, C. F.; PAIM, J. S.; VILASBÔAS, A. L. SUS, modelos assistenciais e vigilância da saúde. *Informe Epidemiológico do SUS*, Brasília, DF, v. 7, n. 2, p. 7-28, 1998.

VIDOR, A. C.; FISHER, P. D.; BORDIN, R. Utilização dos sistemas de informação em saúde em municípios gaúchos de pequeno porte. *Revista de Saúde Pública*, São Paulo, v. 45, n. 1, p. 24-30, 2011.

VILASBÔAS, A. L. Q.; TEIXEIRA, C. F. Saúde da Família e Vigilância em Saúde: em busca da integração das práticas. *Revista Brasileira Saúde da Família*, Brasília, DF, v. 8, n. 16, p. 63-67, 2007.

WALDMAN, E. A. Usos da vigilância e da monitorização em saúde pública. *Informe Epidemiológico do SUS*, Brasília, DF, v. 7, n. 3, p. 7-26, 1998.

YIN, R. K. *Estudo de caso*: planejamento e métodos. 4. ed. Porto Alegre: Bookman, 2010. p. 23-43.

Authors' contribution

Recktenwaldt and Junges had the same share of contribution in the development of this article.

Received: 12/11/2016
Resubmitted: 02/04/2017
Approved: 04/04/2017