CIÊNCIAS DA VIDA E DA SAÚDE
LIFE AND HEALTH SCIENCES
CIENCIAS DE LA VIDA Y LA SALUD

millenium 101

Millenium, 2(9), ??-??.

CONDIÇÕES SANITÁRIAS DOS SERVIÇOS DE ATENÇÃO PRIMÁRIA À SAÚDE NA PERSPECTIVA DA VIGILÂNCIA SANITÁRIA

SANITARY CONDITIONS OF PRIMARY HEALTH CARE SERVICES FROM THE PERSPECTIVE OF SANITARY SURVEILLANCE

CONDICIONES SANITARIAS DE LOS SERVICIOS DE ATENCIÓN PRIMARIA A LA SALUD EN LA PERSPECTIVA DE LA VIGILANCIA SANITARIA

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RECEIVED: 29th May, 2019
ACCEPTED: 21th March, 2019

RESUMO

Introdução: A vigilância sanitária (Visa) tem por objeto o risco associado a produtos e serviços e se insere nas atividades relacionadas a Atenção Primária à Saúde (APS) em sua estrutura e processos.
Objetivos: Analisar a percepção dos profissionais da Visa sobre as condições sanitárias (CS) nos serviços da APS.
Métodos: Participaram do Grupo Focal (GF) profissionais das equipes de Visa de quatro Distritos Sanitários de Salvador. Procedeu-se a análise dos relatos com base em documentos e normativas do MS.
Resultados: Os participantes do GF associaram CS aos riscos à saúde, ressaltando problemas referentes a estrutura dos serviços e disposição de equipamentos/materiais para ações no âmbito da APS. Expuseram estratégias para minimização dos riscos como manutenção preventiva de equipamentos, disposição dos materiais para a prestação do cuidado, monitoramento e organização do processo de trabalho de forma adequada. Constataram a “persistência" como importante na atuação dos profissionais da Visa para alcance da minimização dos riscos à saúde de trabalhadores e usuários na APS.
Conclusões: A técnica de coleta de dados GF possibilitou a discussão do tema e a reflexão dos profissionais sobre suas práticas. Entretanto, constatou-se que para a execução de GF o foco na temática se constitui como um desafio. Considera-se que, houve dificuldade dos profissionais da Visa abordarem as possiveis implicações das CS sobre serviços de APS e no que tange a saúde da população.

Palavras-chave: Atenção Primária à Saúde; Vigilância Sanitária; Grupo Focal; Condições Sanitárias; Risco Sanitário.

ABSTRACT

Introduction: Sanitary surveillance (SS) is aimed at the risk associated with products and services and is part of the activities related to Primary Health Care (PHC) in its structure and processes.
Objectives: To analyze the perception of SS professionals on the sanitary conditions (SC) of PHC services.
Methods: Professionals of Sanitary surveillance teams Participated of a Focus Group (FG) of four Sanitary Districts of Salvador. The reports were analyzed based on documents and regulations of the Ministry of Health (MOH).
Results: The participants of the FG associated SC to health risks, highlighting problems regarding the structure of services and provision of equipment/materials for actions under the PHC. They presented strategies to minimize risks such as preventive maintenance of equipment, supply of materials for the provision of care, and monitoring and organization of the work process in an appropriate manner. They considered "persistence" as an important trait for the work of SS professionals to achieve the minimization of health risks of workers and users in the PHC.
Conclusions: The data collection technique of FG enabled the discussion of the topic and the reflection of professionals on their practices. However, it was found that for the implementation of FG, the focus on the theme is challenging. It is considered that it was difficult for SS professionals to address the possible implications of SC on PHC services and on the health of the population.

Keywords: Primary Health Care; Sanitary surveillance; Focus Group; Health Conditions; Health Risk.

RESUMEN

Introducción: La vigilancia sanitaria (Visa) tiene por objeto el riesgo asociado a productos y servicios y se inserta en las actividades relacionadas a Atención Primaria a la Salud (APS) en su estructura y procesos.
Objetivos: Analizar la percepción de los profesionales de Visa sobre las condiciones sanitarias (CS) en los servicios de APS.
Métodos: Participaron del Grupo Focal (GF) profesionales de los equipos de Visa de cuatro Distritos Sanitarios de Salvador. Se procedió al análisis de los relatos basados en documentos y normativas del MS.
Resultados: Los participantes del GF asociaron CS a los riesgos a la salud, resaltando problemas referentes a la estructura de los servicios y disposición de equipos / materiales para acciones en el ámbito de la APS. Se expusieron estrategias para minimizar los riesgos como mantenimiento preventivo de equipos, disposición de los materiales para la prestación del cuidado, monitoreo y organización del proceso de trabajo de forma adecuada. Constataron la "persistencia" como importante en la actuación de los profesionales de Visa para alcanzar la minimización de los riesgos a la salud de trabajadores y usuarios en la APS.
Conclusiones: La técnica de recolección de datos GF posibilitó la discusión del tema y la reflexión de los profesionales sobre sus prácticas. Sin embargo, se constató que para la ejecución de GF el foco en la temática se constituye como un desafío. Se considera que ha habido dificultad para que los profesionales de Visa aborden las posibles implicaciones de las CS sobre servicios de APS y en lo que se refiere a la salud de la población.

Palabras clave: Atención Primaria a la Salud; Vigilancia sanitaria; Grupo Focal; Condiciones sanitarias; Riesgo Sanitario.

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DOI: https://doi.org/10.29352/mill0209.09.00235

INTRODUCTION

The Unified Health System (SUS) is a policy of the State that is based on an expanded conception of health and a universalist perspective of the right to health. It is operationalized by a set of actions for the protection, prevention, promotion, care and recovery of health that serves millions of Brazilians benefited by the Brazilian public system, on a daily basis, through sanitary surveillance actions, risk control, damage control, among others (Teixeira, Souza, Paim, 2014).

The SUS is composed of a set of public health actions and services which must be organized regionally and hierarchically according to the guidelines of decentralization, comprehensiveness, and participation of the community. The health services are spaces for the provision of actions that promote and protect health, as well as preventive, curative and/or rehabilitative actions aimed at improving the health and life conditions of the population. The diversity of actions and services that constitute the SUS reveals its complexity. In this sense, it is possible to identify three distinct levels of health care, which also differ in technological density (but not in complexity of the activity): primary health care, secondary (or outpatient) care, and hospital care (Solla, Paim, 2014).

Since the beginning of the twentieth century, there have been experiences of creating and expanding care services for primary health care (PHC). In the 1980s, "prior to the implementation of SUS, there was no national primary care policy with segmentation of coverage and fragmentation of care". In the mid-1980s, “sparse municipal experiences and actions of university-service integration based on primary care started to be developed, and inspired the later creation of the Community Health Agents Program (CHAP) and then of the Family Health Program (FHP), as embryos of a national primary care policy". After 30 years of implementation of the SUS, three versions of the National Primary Health Care Policy (NPHCP) were published in the years 2006, 2011 and the most recent in 2017, still in force, the Decree nº. 2.436 (Pinto, Giovanella, 2018, p.1904).

Considering, therefore, the relevance of the discussion about the risks involved in the sanitary conditions, as an object of sanitary surveillance that are present in the structural, environmental and working conditions of the PHC, the present study sought to analyze how professionals of the sanitary surveillance have perceived the relationship between health conditions and risks related to primary health care services.

1. CONCEPTUAL MODEL

According to the National Primary Health Care Policy, one of the responsibilities common to all spheres of government is: "to guarantee the adequate infrastructure and good conditions for the operation of basic health units (BHU), guaranteeing space, furniture and equipment, as well as the accessibility of persons with disabilities, in accordance with current norms" (Brasil, 2017). In this context, the Health Units as care spaces must be in conditions that guarantee the safety and quality of care, and they are therefore subject to sanitary norms and are included in the scope of Sanitary Surveillance, given their function as the responsible institution for the protection, control and reduction of health risks (Silva, Costa, Lucchese, 2018).

Sanitary Surveillance as it is institutionally organized in Brazil has no equivalent systems in other parts of the world, although the regulatory activities are universal practices (Costa, Souto, 2014; Silva, Costa, Lucchese, 2018). In what concerns the performance in health services, sanitary surveillance can be considered a specific component of this system, since its action requires a set of knowledge and practices of a diverse, multiprofessional and interinstitutional nature without which the health services could not fulfill their main role of providing comprehensive health care to users (Costa, Souto, 2014; Teixeira, Souza, Paim, 2014).

Sanitary surveillance is educational (preventive), normative (regulatory) and/or supervisory (Costa, Souto, 2014). Currently, the Municipal Sanitary Vigilance units are inserted as a subsystem of the SUS, the National Sanitary Surveillance System (NSSS), which is coordinated by the National Sanitary Surveillance Agency (ANVISA), created in 1999. As part of SUS, the NSSS operates in an integrated, decentralized manner and with shared responsibilities in the three spheres of government. This agency, therefore, represented an advance in the organization of sanitary surveillance actions; "it can be said that since its creation, the performance of NSSS entities has been greatly improved, with personnel qualification, better physical structure and other resources of control and sanitary surveillance" (Silva, Costa, Lucchese, 2018, p.1956). However, the NSSS faces challenges, as for example the present contradictions between the economic interests and the health interests that are established by the characteristics of the objects under its competence (Teixeira, Souza, Paim, 2014).

The National Sanitary Surveillance Agency, for its regulatory action, publishes Resolutions of the Collegiate Board (RCD) as RCD nº. 50 of 2002 to guide and regulate the construction, functionality and operation of health services required to achieve principles such as regionalization, ranking and accessibility, and to qualify the assistance provided to the collectivity through a physical structure capable of meeting the needs of users with quality (Brasil, 2002).

2. METHODS

A qualitative, exploratory study was carried out using the technique of Focus Group (FG) (Merton, Fiske, Kendall, 2009), whose object was the perception of professionals of the Sanitary Surveillance system about sanitary conditions in PHC services.

2.1 Sample

The choice of the FG technique for collection of information was justified by the possibility offered by this technique of listening to professionals who work on the same objects, representing the same institution, but in different realities of the Sanitary Districts, in the territorial organization for health action of the studied municipality. The use of this technique required planning and organization of strategies to stimulate the debate, as well as creativity, ability and flexibility in the realization of the meeting. The prior structure and the acceptance of the participants who met the inclusion criteria were considered before starting the study (Prates, Ceccon, Alves, Wilhelm, Demori, Silva, Resse, 2015).

The duration of the meeting met what some authors propose in the technique, that the event should last something around two hours, in order to avoid the exhaustion of the participants and to maintain the quality of the discussion and permanence of the participants (Trad, 2009). The meeting took place on 06/10/2014, and lasted 1:11:42h. The team of researchers who conducted the FG was formed by observers and moderators with experience of applying the FG technique. The first ones received the participants, recorded impressions in field journals, and recorded the meeting in audio and video. The moderators were responsible for conducting the work, including the opening, the presentation of the team, the purpose of the meeting and the ethical information, which led to the reading of the Informed Consent Form (ICF) and elucidation of doubts about the ICF. All participants freely agreed to sign the ICF. At the moment of analysis, to maintain anonymity, privacy, and confidentiality, the participants were coded using a letter (P) followed by a control number.

2.2 Data collection instruments

The *corpus* that guided the formulation of the script to be used in the FG technique was based on themes from the manuals and directives of the Ministry of Health (MOH) and on research identified in the literature review, with a narrative structure and organized based on the descriptors: "Primary Health Care", "Sanitary surveillance", "Focus Group", "Sanitary Conditions", "Sanitary Risk". The time period searched was of ten years (Cordeiro, Oliveira, Rentería, Guimarães, 2007).

For the preparation of the script and realization of the FG, the limitation of time and a smaller number of questions was considered so as to give opportunity to hear the expressions of all, as recommended by Trad (2009). The script had 6 questions about the perception of professionals about the sanitary conditions in the FHU, and of possible implications of the sanitary conditions of the FHU on the work process of the teams and on the health of the population and the actions of managers to improve the sanitary conditions of the FHU.

2.3 Inclusion Criteria

In the composition of the FG, the inclusion criteria were the being working in the function of sanitary control inspector in the Sanitary Districts of the studied municipality, that is, workers with authority of police officers (Lima, 2008) who are responsible for sanitary control of public and private health services. It is noteworthy that the participants were from the same municipality, which can be reported as positive for the evolution of the application of the FG technique.

Authors have little agreement on the ideal number of participants in FGs (Ressel, Beck, Gualda, Hoffmann, Marion da Silva, Sehnem, 2008). However, there is convergence in the sense that all participants feel free to express their opinions on the topics addressed. Carrying out a FG with less than four people is not recommended, because this would lead to individual interviews (Thofehrn, Montesinos, Porto, Amestoy, Arrieira, Mikla, 2013). The experience reported in this study had four participants, valuable as a space for reflection on the sanitary conditions of PHC and its implications in the work of professionals and in the care provided to users (Ramos, Aruana, Lima, Santana, Tanaka, 2018; Francesca, Cordero, 2018).

2.4 Data analysis

In order to analyze the findings, we sought to identify the nuclei of meanings in the text transcribed from the recordings and also in the records of the field journals that included the different impressions and observations of the researchers that supported the implementation of the FG technique. With this, it was possible to produce a discussion based on the theoretical reference of content analysis (Campos, 2004) and on the norms and documents used by Sanitary Surveillance. No software was used to organize and support the analysis of the findings.

The findings of this study are part of that entitled "Sanitary Conditions of Family Health Units (FHU) and their implications on the work process, management, and risks to the population", which included several participants from different spaces and representatives from all twelve HD of Salvador/Bahia, in the Northeast Region of Brazil. This research met the ethical aspects established in the Resolution 466/2012 of the National Health Council (Brasil, 2012). The project was submitted to the Research Ethics Committee and approved under number 364.713 and CAAE: 17842013.0.0000.5030. It was also approved in Public Notice nº. 19/2013 of the Research Program for SUS (PPSUS) with funding from the Foundation for Research Support of the State of Bahia (FAPESB).

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3. RESULTS

The following categories were found:

(1) Relation of the sanitary conditions of the FHU with the risks.

Professionals of the sanitary surveillance linked sanitary conditions to risks, relating them to the structure and processes, as well as the results for end-user care:

> "I think they are conditions necessary for you to work well, minimizing risks, and it involves this: procedures, structure (...)" (P1).
>
> In my understanding, when you speak of sanitary conditions, you immediately think of the sanitary risk (...)" "(...) and then you have all the flow of procedures. I think it implies in risk, the part of structure also, the part of equipment and human resources (...) (P2)
>
> I think that within this delay that should not exist, Sanitary surveillance is very important, because somehow speeds up the process. So, I think it's very important that this will cause a difference there at the end. Is it too little? Yeah, but it's important! (P2)

(2) Strategies to minimize risks related to sanitary conditions.

These strategies were classified in:

a) preventive maintenance of equipment in order to ensure quality:

> Another thing that calls my attention is the little care taken with the preventive maintenance of equipment. For example, the tensiometer, the fluoroscope... How can you give a diagnosis of an X-ray if your fluoroscope is not in proper state? (P1)

b) provision of the necessary and continuous materials to provide care:

> The professionals mentioned the structure of the PHC units that has been adapted, which creates difficulties in the provision of health care. "(...) There we also observe something like this: they were not designed for a Health Unit, right? For the care ... You do not know "I'll put here"... It seems an adaptation. "(P3); "They rent a house and they adapt, and the problems go on forever. They are eternal ..." (P1); "(...) sometimes basic materials are absent. Towel paper, liquid soap" (P1).

c) control and monitoring:

> "(...) in the sterilization and the residues ... in the collection of residues, signs of bottles of alcohol for aseptic use, problems with infiltration, air conditioning, lack of control and monitoring of pharmacy, of medicines" (P4).

d) Maintenance of an adequate workflow beyond the structure. The need to organize the work process: it was mentioned that adjustments/corrections are organized more effectively and quickly:

> (...) You have a structure, but you do not have adequate flow, that is, adequate professional actions. It seems that they do not understand, like I said, of the critical areas, how it has to be, the needed caution. (...) So, the issue of procedures, when it is possible to improve them, they really improve (P1).

(1) Actions of SS in PHC services.

About this, some reports said: "resistant action", "persistent work ":

> I summarize it as a persistent work. At times, you go several times ... (...) Then you start changing, sometimes, into something that has no end. That is something that sometimes causes me anguish, because you never finish that action. (...) Until today in ... uses asbestos-insulated tank and was not able to change until today, even with the instrument of Sanitary Surveillance (P3).
>
> A frustration, right? You go, you see, right? The problem. You ask, you start to close rooms, seize products, but... this does not solve the problem, do you understand? (...) But procedural issues, when it can improve, they really improve (P1).

4. DISCUSSION

Objects under sanitary surveillance carry intrinsic risks that are not always perceived by society, and are also sometimes not identified even by professionals who work in health services. The perception of the different actors about risk occurs in a different way depending on the relation established with the object. It is the responsibility of sanitary surveillance to evaluate and manage risks and uncertainties related to the objects of health interest, in the sense of maintaining an acceptable limit of risk or even eliminate it when possible (Costa, Souto, 2014).

Lack of or little experience and low or almost no technical understanding of subjects that require specific knowledge may limit the identification of health risks by people who are not familiar with the subject, such as the relationship between health conditions of PHC services and risks that expose the health of users and workers of public and private health services. The technical knowledge

and practice of professionals of the sanitary surveillance is something to consider when these risks to human health are to be identified (Tang, Sidhu, Fong, 2015).

A study in Canada found that about 43% of health authorities always rely on evidence-based experiences as their foundation for their decisions, and 46% do so often (Tang, Sidhu, Fong, 2015). In the present study, the professionals found that the risks are present both in the structure and in the *"flow of procedures"* developed in health services.

According to the National Primary Health Care Policy, "besides the guarantee of adequate infrastructure and environment, to carry out the professional practice, it is necessary to provide adequate equipment, adequate human resources, and sufficient materials and supplies to the health care provided" (Brasil, 2017). Noncompliance with such prerogatives potentially exposes users and workers to sanitary risks inherent in health services.

It is noticed that in order to minimize the risks related to sanitary conditions, the Sanitary surveillance officials mentioned the use of instruments such as analysis of the physical space (pre-analysis), sanitary inspection, and monitoring to improve the sanitary conditions in health establishments, promoting the quality of care provided to users. They also provide educational actions. All these activities, as actions of the normative, authoritative, inspection field and of sanctioning of actions, give a regulatory character to sanitary surveillance and generate intervention capacity (Seta, Oliveira, Pepe, 2017), exercise of authority by the police that makes it possible to restrict rights in function of the interests of the community - the supremacy of the public interest over the private interest. Therefore, the professionals use a set of intervention technologies that are part of the control system and must be "backed by up-to-date technical and scientific knowledge", in view of the principles established in the Constitution to protect the health of the general population (Lima, 2008; Costa, Souto, 2014).

The participants of the FG reinforced the perception that process-related risks are easier to resolve because they do not depend on financial resources and direct actions of the Secretariat, only on adjustments in the work processes developed in the FHU. The RDC nº. 63/2011 establishes, as requirements for Good Practices, that health services be able to offer services within the standards of quality and safety, in addition to providing the necessary resources for a smooth operation (Brasil, 2011).

The frustration mentioned about the difficulty to solve problems of health services in PHC and the actions carried out with "resistance" and "persistence" evidenced in this study definitively indicates that the practice of sanitary surveillance occurs in the middle of social relations of production and consumption that traverse the State, the market and the society, have as objects the goods and services of health and interest to health, so that they act in actions of prevention and control of risks and of promotion and protection to health (Brasil, 2013, Costa, 2009) based on principles and guidelines of the SUS.

The National Sanitary Surveillance System needs to stand with collective bodies in defense of health interests, fulfilling its "function in the SUS to ensure the quality of goods and services offered to contribute to the improvement of the quality of life of the Brazilian population and ensure the right to health as a fundamental right". In addition, "the argument of the financial crisis of the Brazilian State cannot prevail over the right of the population and the constitutional duty of health protection, under the prevailing public underfunding of the health sector" (Seta, Oliveira, Pepe, p. 2017, 3230, 3232).

As a public and universal health system, and a counter-hegemonic proposal that faces the crises related to capitalism (Teixeira, Souza, Paim, 2014), the SUS is responsible for the provision and regulation of health services, so that the development of their functions is influenced by the "political and economic relations" that are manifested by the interests of the actors involved (Lobato, Giovanella, 2012, p.108).

Sanitary Surveillance, as a "specific component of the system of health services" (Costa, Souto, 2014) or "subsystem of health services" (Teixeira, Souza; Paim, 2014) has suffered a strong influence and pressure of economic interests. Sanitary Surveillance has to face conflicts and fulfill/ensure its duty "of protecting health through state intervention, aiming at prevention of possible damages or risks to health and provision of greater safety to the population" (Seta, Oliveira, Pepe, 2017, pp. 3229).

Health protection implies the right to citizenship, necessitating the State's action to guarantee access, and regulating what interferes with the health of the population (Lobato, Giovanella, 2012).

CONCLUSIONS

In the development of the activities of the FG with Sanitary Surveillance professionals some challenges were identified in the organization and realization of the meetings of the focus group, and during the development of the group. The challenges in the management of the group concern the difficulty of being able to gather the professionals, mainly because they were from the same organ, in view of the possibility of causing an emptying of certain services in that specific moment. Another challenge was to keep the focus on the topic addressed, which requires a moderator who has mastery of the theme and technique, in order to maintain a climate that allows the dialogue, but do not divert the focus from the proposed theme. In contrast to Maldonado and collaborators (2013), who values interpersonal ties in the FG as a positive aspect for the exchange of information during the use of this technique, due to the affinity of the participants and the fact that they belonged to the same group or community, this fact may imply a speech that was sometimes ratified by the participants without criticism on the subject addressed.

Furthermore, other challenges were faced, such as choosing the date for the two focus groups, the difficulties in making contact with the participants, technical problems with electronic recording devices, although they had been tested in advance. However,

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the planning of certain strategies, such as the participation of more than one moderator, the availability of extensive registry and recording material, and technical support were fundamental to overcoming the problems that emerged in the process. Poor communication with professionals was an obstacle to the optimization of the procedures necessary to make contacts and to the meeting of the participants, as well as the care with punctuality and establishment of time limits for the entry of participants in the space of the activity.

The FG gives the participants the opportunity to dialogue that can result in a critical re-elaboration on the theme. In the case of this study, it is possible to think that this new perception may occur directly in the actions carried out in the work environment of the participants, be it in the scope of surveillance or assistance. Each FG has its own dynamics, but the activities that are apparently considered simple can hide difficulties and obstacles, which were exposed in this article. It is worth emphasizing the interaction between the participants and the possibility developed in the group to revisit the reality, discussed through the vision of others.

Despite some limitations to its use, the technique of FG stands out for its potentialities, especially when it is considered that the experiences lived by professionals with authority of police in the field of health are unique and very particular, not of easy general access. Thus, this the technique applied to this group of professionals is a very rich and important tool for research involving the subject.

Regarding the issues related to the perception of sanitary surveillance professionals about the sanitary conditions in PHC services, it was difficult for them to express their understanding of sanitary conditions, as well as to correlate the possible implications of sanitary conditions in health service units for the team work process and the health of the population.

However, the FG contributed to the identification of problems related to the work process of sanitary surveillance professionals in relation to the strategies for risk minimization in the health services studied that presented a difficult articulation of municipal management with sanitary surveillance. This points to the need to make efforts to broaden and discuss the importance of communication about risks in the formation of health conscience that reaches the users of health services, but also sensitize the professionals of the PHC and of sanitary surveillance with consistent scientific arguments to support the technical performance of sanitary surveillance professionals so that they can confront the interests that often weaken health relationships in different contexts of health systems (Silva, Costa, Lucchese, 2018). It is also necessary to take care not to accept actions of sanitary surveillance that disregard the complexity of the actions that occur in PHC services, based on the perspective that the actions have a lower technological density.

CONFLICT OF INTERESTS

The authors declare that there is no conflict of interest

ACKNOWLEDGEMENT

We thank all those who contributed with the collection of news to OAPS/ISC/UFBA

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