

Sanitarist acting in multidisciplinary teams in primary health care: activities, challenges and potentialities**Atuação do sanitário em equipes multiprofissionais na atenção primária a saúde: atividades, desafios e potencialidades****Actuación del sanitario en equipos multiprofesionales de atención primaria a la salud: actividades, retos y potencialidades****Received: 28/09/2020****Approved: 05/05/2021****Published: 14/10/2021****Leandra França da Silva¹****Fabiana de Oliveira Silva Sousa²**

This is an exploratory and qualitative study, carried out in the state of Pernambuco, Brazil, from August to November 2019. It aimed to analyze the performance of sanitarians in multidisciplinary teams in primary care, identifying their practices, challenges and potential. Data were collected through semi-structured and audio-recorded interviews with nine professionals graduated in collective health and linked to four multidisciplinary residency programs in family health. The interviews were subjected to thematic content analysis. Three thematic categories emerged: *Practices of Sanitarians at NASF-AB*; *Difficulties in the work process of the sanitarian at NASF-AB*; and *Potentialities of the performance of the sanitarian at NASF-AB*. Health workers have developed a list of activities that cover all dimensions of matrix support, with a predominance of technical-pedagogical and institutional support dimensions. One of the main challenges is the lack of knowledge about the performance of sanitarians by other professionals, managers and users, who are limiting their autonomy in implementing their actions. Their presence in the teams has contributed to the organization of the work process and to strengthening the monitoring, evaluation and articulation of networks.

Descriptors: Family Health; Public Health; Patient care team; Health personnel.

Trata-se de um estudo exploratório e qualitativo, realizado no estado de Pernambuco, no período de agosto a novembro de 2019, com objetivo de analisar a atuação do sanitário em equipes multiprofissionais na atenção primária, identificando suas práticas, desafios e potencialidades. Os dados foram coletados através de entrevistas semiestruturadas e audiogravadas, com nove profissionais graduados em saúde coletiva e vinculados a quatro programas de residências multiprofissionais em saúde da família. As entrevistas foram submetidas à análise de conteúdo do tipo temática. Emergiram três categorias temáticas: *Práticas dos Sanitaristas no NASF-AB*; *Dificuldades no processo de trabalho do sanitário no NASF-AB*; e *Potencialidades da atuação do sanitário no NASF-AB*. Os sanitários têm desenvolvido um elenco de atividades que contemplam todas as dimensões do apoio matricial, com predomínio das dimensões técnico-pedagógica e apoio institucional. Um dos principais desafios é a falta de conhecimento sobre a atuação do sanitário por parte dos demais profissionais, gestores e usuários, que são limitantes da autonomia na implementação de suas ações. Sua presença nas equipes tem contribuído para a organização do processo de trabalho e no fortalecimento do monitoramento, avaliação e articulação de redes.

Descritores: Saúde da família; Saúde pública; Equipe de assistência ao paciente; Pessoal de saúde.

Se trata de un estudio exploratorio y cualitativo, realizado en el estado de Pernambuco, Brasil, en el período de agosto a noviembre de 2019, con el objetivo de analizar el papel del sanitario en los equipos multiprofesionales de atención primaria, identificando sus prácticas, desafíos y potencialidades. Los datos fueron recogidos a través de entrevistas semiestructuradas y grabadas en audio con nueve profesionales licenciados en salud colectiva y vinculados a cuatro programas de residencias multiprofesionales en salud de la familia. Las entrevistas se sometieron a un análisis de contenido temático. Surgieron tres categorías temáticas: *Prácticas de los Sanitaristas en NASF-AB*; *Dificultades en el proceso de trabajo del sanitario en NASF-AB*; y *Potencialidades del trabajo del sanitario en NASF-AB*. Los sanitarios han desarrollado una lista de actividades que cubren todas las dimensiones del apoyo de matriz con un predominio de las dimensiones técnico-pedagógicas y del apoyo institucional. Uno de los principales retos es el desconocimiento de las actividades del sanitario por parte de otros profesionales, gestores y usuarios, lo que limita la autonomía en la ejecución de sus acciones. Su presencia en los equipos ha contribuido a la organización del proceso de trabajo y al fortalecimiento del seguimiento, la evaluación y articulación de redes.

Descriptorios: Salud de la Familia; Salud Pública; Grupo de Atención al Paciente; Personal del Saúde.

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INTRODUCTION

A sanitarian is a professional graduated in the field of public health or collective health, or even a postgraduate in one of these areas. Sanitarian training covers a field of knowledge and practices of a transdisciplinary nature, enabling them to intervene in various dimensions of management and care, with a view to promoting, protecting and recovering health¹.

Its area of knowledge includes health policies, planning, biostatistics, epidemiology, environmental health, assessment of health systems and services, assessment of health technologies, women's health, worker's health, mental health, family health and others^{1,2}.

Despite the possibilities and strategies that a sanitarian has, there are still many difficulties in understanding the attributions and performances of this professional, making it difficult for them to be effective and recognized in the world of health work. Corporate disputes, few studies on their role in health services, are some of the obstacles faced².

Among the wide field of action of this professional is the possibility of composing the multidisciplinary teams of the Expanded Center for Family Health and Primary Care (*Núcleo Ampliado de Saúde da Família e Atenção Básica - NASF-AB*), which was created with a view to expanding the scope of actions and the resolution of primary healthcare (PHC)^{3,4}.

Several studies have been carried out on the NASF-AB focusing on its implementation, form of action and its results, building evidence that it is a powerful proposal to strengthen PHC, while facing challenges to consolidate a model of work process based on matrix support, contrary to the curative and fragmented care, which still predominates in health services⁵⁻⁹.

There are few published records about the inclusion of sanitarians in the NASF-AB teams. The city of Recife was one of the first municipalities that included this professional in the composition of these multidisciplinary teams, in 2010, and defined an action profile with an emphasis on strengthening health surveillance in PHC¹⁰. However, the changes in management in this municipality interrupted the consolidation of this pioneering experience, relocating the sanitarians who worked in the PHC to other sectors of management.

For some years, several multidisciplinary residency programs in the area of primary care have included sanitarians (bachelors in public health) in the composition of their classes, thus exercising their leading role in the qualified training of health professionals, always guided by needs social and consistent with the principles of the Unified Health System (SUS). In the state of Pernambuco, there are five residency programs that offer 11 places per year for training health specialists in family health^{11,12}. However, there is still a lack of investigations on the work process of these professionals at NASF-AB and the impacts of their performance.

This study aimed to analyze the performance of the sanitarian in multidisciplinary teams in primary care, identifying their practices, challenges and potential.

METHODS

This is an exploratory, descriptive and qualitative study. The choice of the qualitative approach was based on the possibility of obtaining information from the context of the practices carried out by the respondents and deepening the analysis based on the expression of their feelings, thoughts, motivations and perspectives¹³.

It was carried out in Pernambuco, from August to November 2019. This research had the collaboration of professionals, bachelors in public health who were, at the time of data collection, linked to multidisciplinary residency programs in family health and developed their practices in NASF-AB teams from four municipalities located in the metropolitan region of Recife and in the rural region of the state.

Residents with more than 6 months of experience at the NASF-AB were included, being informed about the proposal and methodology of the study, its risks and benefits, and signed

the Informed Consent Form (ICF). Respondents were identified with the letter R and a sequential number.

Data were collected through semi-structured and audio-recorded interviews, with an average of 45 minutes, whose script included questions about insertion, activities developed, difficulties faced and perception of collaboration developed in the field of action of the NASF-AB.

Data were transcribed and interpreted through content analysis, which consists of a set of communication techniques for the description of messages that allow the inference of knowledge related to their production/reception conditions¹⁴.

Content analysis is suitable for studies that aim at the apprehension of revealed or hidden messages, in an effort of “*critical surveillance regarding the communication of documents, literary texts, biographies, interviews or observation*”¹⁴. All discursive data were analyzed following a chronological sequence of pre-analysis, material exploration, treatment and interpretation.

Matrix support was used as a theoretical-methodological framework in the analysis of the results of this research. This is based as part of an organizational arrangement, which is characterized as an instrument of care management, aiming to break with the doctor-centered model, not only qualifying but also bringing new meanings to the interventions carried out in the population, working in particular in the realization of comprehensive care to users^{7,15,16}.

This research had the consent of all participating multidisciplinary residency programs and was approved by the Ethics Committee through No. 3,561,978, following the resolution of the National Health Council (CNS) No. 466, of December 12, 2012.

RESULTS

Nine graduates in collective health participated, linked to four multidisciplinary residency programs in family health, of which six (66.7%) were female and the age ranged from 21 to 39 years.

In the data analysis, three thematic categories emerged: *Practices of Sanitarians at NASF-AB*; *Difficulties in the work process of the sanitarian at NASF-AB*; and *Potentialities of the performance of the sanitarian at NASF-AB*.

Practices of Sanitarians at NASF-AB

Here three subcategories are highlighted, namely: *Technical-pedagogical activities*, *Clinical care activities*, and *Institutional support activities*.

- *Technical-pedagogical activities*

Despite the diversity of actions carried out by health workers, the predominance of permanent education actions with the EqSF was evident, especially in team meetings in case discussions, construction of a Unique Therapeutic Plan (UTP) and planning of activities, as well as strong participation in educational groups developed by the NASF-AB team with the population for health and citizenship guidelines, encouragement of self-care and the practice of physical activity, and others:

I focus exclusively on the pedagogical technique. So, it's more in these collective activities, groups, permanent education, discussion of the right to health, social participation, citizenship... I try to bring up topics that we have more autonomy to talk about, such as the expanded concept of health. (R3)

(...) Activity planning; meeting; planning for the organization of the work process. I also work both in participation and in conducting groups (...). And when the sanitarians go, they take interdisciplinary themes, whether the right to health, or the expanded concept of health, matrix support meetings and a lot of continuing education. (R2)

Planning itself is a field activity (common to everyone). But the sanitarian, by studying planning more, has a differentiation in these activities, so, for example, equipping my team (NASF-AB) and the family health strategy, on how they can perform a more effective planning of their actions, this is matrix support, because I'm expanding their knowledge. (R4)

- **Clinical care activities**

Even working within this dimension less frequently than other professionals, it was possible to identify the participation of residents in activities such as: shared or not shared home visits with other professionals in order to analyze the health situation of the family/individual, therapeutic groups and use of integrative practices with users:

I've already made a home visit and I believe that we, as Sanitarists, can make a visit aimed at diagnosing the health situation of that family in general, you know? To understand the context it is going through. (R1)

Integrative practices (...) for example, from auriculotherapy I started to do qualified listening, I started to give a more individual orientation. And then, from the residency classes, I realized that many people say that we don't have a clinic, but then I realized that in public health there is also a clinic. It is a clinic where we can provide individual care and home care, and it was from there that I also started to broaden my vision. (R7)

- **Institutional support activities**

The dimension of institutional or management support was identified through the activities of epidemiological profile analysis focusing on the diagnosis of the territory, strengthening of planning, monitoring and evaluation, as well as on actions for network articulation with a focus on continuity of care.

At some point, I will go to the health department to articulate some activity, get some material or find out how to forward... How to articulate to the network. (R5)

I collaborate in the planning, in this work process, monitoring and evaluation... So which professional is being asked the most? Why are you being asked more? See which unit is asking for more, calculating absenteeism rate... Helping in this organization process. (R3)

We are going to survey data, transform it into information, and based on this information, we will bring matrix support. This is also done through planning... The issue of evaluation, monitoring, everything that has been implemented in the unit has to have a certain evaluation. (R6)

Difficulties in the work process of the sanitariat at NASF-AB

One of the most reported problems was the lack of knowledge about the health care profession and its role in primary care by other professionals, management and users.

When I entered the NASF, I entered with a lot of anguish due to the non-recognition process, I think the professionals didn't really know the role of the sanitariat and I didn't feel that I belonged there. I was very upset and now I'm more like a challenge, because I also don't know about the work process of other professionals. (R3)

Many people say: You have a degree in public health, right? I didn't even know. So the difficulty is like recognition from the professionals themselves. (R8)

Another difficulty is the users, there are people who are ashamed to ask. Because I say my name and say that I am a sanitariat and they are too embarrassed to ask, what is a sanitariat? (...) Because things in Health are still centered on the doctor, nurse and dentist. (R7)

I don't know if the management can also value the potential of the sanitary professional, thus, it's still lost in this sense of knowing what the sanitary professional is. (R2)

Also, the emphasis on individual and care actions in the training of most health professionals was identified as one of the difficulties that health professionals face in their daily lives to implement and implement their proposals:

(...) a limitation that we have, for example, is that professionals are not trained for the NASF-AB are trained for care itself, right? And then, as we work with various professional categories, they want to develop assistance/consultation, but this is not always the position that NASF-AB should be taking, it is one of the dimensions, but it should not overlap with the pedagogical dimension, for example, the institutional dimension of the NASF-AB. (R4)

(...) the other health professions are very focused on assistance and sanitariats are not so focused on assistance, on making consultations with the patient, (...) We were not trained for this. (R8)

Despite being able to develop a wide range of activities within the NASF-AB teams, health workers reported difficulties related to the 'lack of formal definition' of their attributions in primary care.

Because we don't have consolidated material, for example, like other professionals. (R5)

As we come from a new course, whether we like it or not the sanitariat in primary care is new, so they have no defined attributions. (R6)

Residents suggested the "recording of experiences in the service" as one of the strategies for disseminating and strengthening the role of the sanitariat in PHC multidisciplinary teams:

If we don't register, we will keep getting lost, other residents will enter and will also be lost like this "what are we going to do here?" so that's the importance of registering. (R3)

Potentialities of the performance of the sanitariat at NASF-AB

It was identified that these professionals can contribute to the improvement and strengthening of PHC in the territories, as the interdisciplinary nature of their training makes it easier for them to work on broad and complex issues:

People say that we mediated some conflicts, as we are trained in public health, we end up seeing a little bit of everything, we are already very multiprofessional and manage to talk to all areas. (R1)

I think primary care works a lot with the concept of territory, right, and I think we work a lot on this, different from other degrees, from other professionals who are inserted there. They see a lot of the individual and we, in graduation, study a lot the epidemiology, which is the study of populations (...). So, not making the NASF-AB an outpatient clinic, maybe we have this potential and this can contribute to the strengthening of primary care, this look, this expanded vision that we have. (R3)

The sanitariat in the territory has a broader look in relation to the determinants and conditions of health, in terms of what this can impact on the individual's health, I think this is a good thing about our training. (R8)

Another facility mentioned for the work of the sanitariat in PHC is related to their ability to analyze the situation and work processes:

Primary care has a deficit in the analysis of what is happening there, if we can visualize, if that service is really having results, if the epidemiological indicators are really good, you know? We can create strategies to improve those activities. (R1)

I conduct the matrix meeting very well, I articulate the team in conflict resolution as well, encouraging teamwork (...). (R4)

DISCUSSION

The emphasis on the work of health professionals in the technical-pedagogical dimension is a differential when compared to the types of activities most demanded by most health professionals who work at the NASF-AB. Several studies point to a trend of overloading care actions to the detriment of those related to permanent education^{6,7,9}.

The participation of sanitariats in technical-pedagogical activities supports the expansion of the NASF-AB's performance beyond a predominantly clinical perspective, since the insertion of this professional expands the possibility of debate and reflection on issues related to the organization of the process of work, planning, comprehensive care, health surveillance and network articulation. These themes are uncommon in the training and experience of most health professionals, and the inclusion of sanitariats in this context corroborates the expansion of the team's view of the health-disease process and the construction of care.

Participation in the organization and facilitation of team meetings are expertise mentioned by residents that help the NASF-AB to strengthen the work planning and the bond with the supported teams. Team meetings are considered devices for planning and organizing actions, with the participation of several professionals who manage to resolve doubts and work together in a multidisciplinary way, seeking integrality of actions and more assertive decisions for the care of users¹⁷.

The care dimension is pointed out in the argument that sanitariats do not work with a focus on the demands of clinical care, but rather focuses on collective rather than individual actions. However, when provoked to expand this conception from the concept of extended clinic, it is possible to include a broader spectrum of actions in this dimension and suppose that this can still be a field of discoveries for this professional¹⁸.

The services and visits reported take place as a way of knowing and analyzing the needs of a particular user or family, resulting, in most cases, in educational-preventive guidance and a direction of a flow of care.

The clinical care actions carried out by sanitariats can also be based on health promotion practices, bringing these professionals closer and closer to the population. Considering the expansion in the fields of work of the sanitariat, some Public Health courses already discuss and prepare their students to also address activities that make them have an analytical vision, through listening resources that operate the needs of individuals/groups according to its

singularities and subjectivities for greater effectiveness of comprehensive care for users within the services, using non-pharmacological techniques, but related to an expanded clinic through the analyzed context¹⁹.

In addition to expanding the field of work of the bachelor's degree in public health, their tools and knowledge have also been expanding within their performance, always seeking to work in accordance with the real needs of individuals in a shared and expanded way within their possibilities and attributions.

The dimension of institutional support includes activities of analysis of the work process and results, encouragement of co-management, articulation and integration of teams and services. A study carried out on the implementation of this institutional support in the NASF in the state of Rio de Janeiro, points out the execution through collective spaces with matrix supporters and institutional supporters, discussing issues of work process with reference teams on: elaboration of monitoring and evaluation reports; support tools; among others. As a result of changes in the management model, through a more horizontal and shared management that enabled the expansion of autonomy and accountability of the team workers²⁰.

A sanitariat is a professional who has great power to act within this dimension from their specific core of knowledge, in which they are already able to work with issues related to articulation, monitoring, evaluation and among other tools that are worked within of their own training. Thus, it is an important contributor to the quality and resoluteness of primary health care.

Sanitarists have encountered difficulties in their work process with the multidisciplinary family health teams and the NASF-AB. One of these obstacles is the lack of knowledge about the performance of this professional in PHC. This is one of the most reported problems in teamwork in the health area and this constitutes an obstacle to interprofessional collaboration²¹.

As this is a new graduation, graduates of the collective health course still face several difficulties related to recognition and insertion in the labor market²². There is little flexibility of health services in covering this new professional due to the existence of some conflicts of interest in the territories²³.

There are few records on the performance of sanitariatists in teams that work in PHC¹⁰. In this aspect, the multidisciplinary residency programs have played an important role in inserting vacancies for sanitariatists in their pedagogical projects. This training and work experience experienced by the subjects who make up the referred residency programs has a strong potential to expand knowledge about the work of sanitariatists in multidisciplinary teams in PC, revealing contributions that this professional adds to primary care. In addition, preceptors, tutors and professors who are able to follow this experience may be stimulated to new training needs for health professionals still in their undergraduate course.

The need to make themselves known, demonstrating their values, attributions and possibilities of action, are issues raised by collective health graduates that suggest carrying out more dissemination activities as a strategy to achieve greater visibility within the world of work²⁴.

Another problem reported was the fact that most professionals had their training focused on care and individual actions. Transforming this reality implies overcoming various difficulties faced in defragmenting this biomedical model within the health area, a hegemonic model that has been influenced for years by macro and microsocial factors. From issues of society to the accumulated knowledge of science itself and the search for the construction of a care model that works in coherence with the principles of the SUS are challenges for health services, managers and especially their professionals²⁵.

The NASF-AB faces challenges with regard to overcoming the fragmented model of individual care, considering that this is not the main destination, being an issue that generates controversy in the performance issues of these teams²⁶. And, the perspective of action of

sanitarists causes tension within the team and in the tendency of the supported teams to give more value to the assistance's back-up actions to the detriment of others.

The formation of bachelors in collective health has a strong interdisciplinary characteristic, and this expanded view of social and political issues is part of its essence, seeking transformations in territories and collaborating in the articulation of the network²⁷. This professional profile can contribute to the strengthening of collective and intersectoral actions in the context of primary care.

Health professionals are trained to work in different scenarios within the health system¹, and are prepared to perform activities based on health situation analysis, intervention and evaluation of health promotion actions, health planning, among others.

With this potential to provoke a shared analysis of the contextual and organizational aspects of the work process, sanitarians can help to strengthen and expand the continuing education of the NASF-AB and the integration between the different teams that work in the same territory.

CONCLUSION

The sanitarians who work in the NASF-AB teams, in the region this study was performed, have developed a list of activities that include the dimensions of matrix support, with a predominance of technical-pedagogical and institutional support.

The broadened and interdisciplinary vision characteristic of the training of the sanitarian helps in the tensioning of the fragmented and biomedical model that prevent further advances towards the realization of integrality in the scope of primary care.

Among the challenges faced by these professionals to carry out their duties at the NASF-AB, there is: lack of knowledge of their performance by other professionals, managers and users. This aspect is also limiting the autonomy of sanitarians in implementing their actions.

Health workers have contributed to the organization of teams, resulting in an improvement in the planning of actions. They also collaborate in strengthening the monitoring and evaluation of actions, in strengthening collective practices for disease prevention and health promotion, in implementing matrix support in the organization of the work processes of the teams working in PHC and in the articulation of networks in the territory.

The small number of participants and the fact that these professionals work in the same federative unit limit generalization. Therefore, it is suggested to carry out further studies on the insertion and performance of these professionals in primary care.

Studies like this are important for greater dissemination and knowledge of the work of this professional in the NASF-AB team, in which their skills are still being built and their contribution to the strengthening of a broader and more effective PHC is seen.

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Leandra França da Silva contributed to the design, collection and analysis of data and writing. **Fabiana de Oliveira Silva Sousa** collaborated in the design, writing and review.

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