

The concept of “Intersectoriality”: contributions to the debate from the Leisure and Health Program of the Prefecture of Santo André / SP¹

O conceito “Intersectorialidade”: contribuições ao debate
a partir do Programa Lazer e Saúde da Prefeitura de Santo
André/SP

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Abstract

On the basis of research carried out from the “Leisure and Health” program, planned and implemented by the Health and Sport and Leisure Departments of the Prefecture of Santo André between 2007 and 2009, we discuss the concept of “intersectoriality”. We understand that the setting of this theme is determinant in the discussion and qualification of the initiatives targeting, in this case, bodily practices considering that the literature constantly presents new elements for the debate aiming to guarantee strategies that effectively meet the health needs of the population. Interviews with the managers of Leisure and Health were conducted with the purpose of aiding the discussion. The topics discussed in this article point out the fragility of the intersectorial action in the program and give evidence that the difficulty of intersectorial action is also the subject of discussion and confrontation in the academic literature. From this perspective, the study calls attention to five difficulties of the intersectorial action, which should be considered in the preparation of intersectorial projects and programs: the complement between sectoriality and intersectoriality; the need to regard the context; agreement and alignment in relation to concepts, objectives, guidelines, goals and evaluation of projects, programs and policies; setting up working networks and communication between those involved.

Keywords: Intersectoriality; Public Health Policies; Corporal Practices; Leisure and Health.

Resumo

Com base em pesquisa desenvolvida a partir do Programa *Lazer e Saúde*, planejado e implementado pelas Secretarias de Saúde e Esporte e Lazer da Prefeitura de Santo André entre 2007 e 2009, problematizamos o conceito “intersectorialidade”. Entendemos que o recorte sobre este tema é determinante na discussão e qualificação das iniciativas voltadas, neste caso, para as práticas corporais, haja vista a literatura apresentar, a cada dia, novos elementos para o debate visando garantir estratégias que efetivamente respondam às necessidades de saúde da população. Entrevistas com gestores do Lazer e da Saúde foram realizadas com intuito de subsidiar a discussão. Os temas discutidos neste artigo apontam para a fragilidade da ação intersectorial no Programa e evidenciam que as dificuldades são também objeto de discussão e enfrentamento ressaltados na literatura acadêmica. Nesse sentido, o estudo chama a atenção para cinco dificuldades da ação intersectorial que devem ser levadas em consideração na elaboração de projetos e programas intersectoriais: complementaridade entre setorialidade e intersectorialidade; necessidade de caracterizar o contexto; pactuação e alinhamento em relação a conceitos, objetivos, diretrizes, metas e avaliação dos projetos, programas e políticas; constituição de redes de trabalho e comunicação entre os diversos atores.

Palavras-chave: Intersectorialidade; Políticas públicas de saúde; Práticas corporais; Saúde e lazer.

Introduction

Technological advances and the process of globalization, oriented by a market which is the principle regulator of conflicts, have produced great changes in people's lives and in the ability of the health care systems to meet users' needs. The health-disease process results from the way production, work and society is organized in a specific historical context and biomedical rationality, linked to the capitalist way of thinking, has not managed to change social determinants of health.

In Brazil, the search for other paths to health has meant thinking about community participation in developing coalitions between the public and private sector and in establishing an inclusive health care system (Westphal, 2000; Brasil 2006). A milestone in this process was the 8th National Health Care Conference (CNS) - “Democracy is Health” in 1986, the final report of which presented the bases of the proposal for the Brazilian Unified Health System (SUS): “the broader concept of health, the need to create public policies to promote it, the necessity of social participation in constructing the system and health care policies and the impossibility of the health sector alone responding to the transformation of the determinants and constraints in guaranteeing healthy options for the population” (Brasil, 2006, p.10).

Thenceforth, the health care strategy recovered the perspective of promoting health defined in international conferences (Brasil, 1996) which focused on specific aspects of the health-disease process, such as violence, unemployment, lack of basic sanitation, inappropriate housing, hunger and poor air and water quality, placing the emphasis on the possibilities of the subjects and collectives opting for specific ways of life so as to create new ways of satisfying the interests, desires and health needs of the Brazilian population.

So, a greater coverage of health care interventions are proposed, so that the organization of health care functions beyond the walls of the Primary Health Care Unities (PCUs) and of the health care system, encouraging increased healthy choices on the part of the subjects and collectives. This democratic perspective of health care organization exceeds the institutionalized systems of social

control and commits itself to creating mechanisms of social control and society participation – user, social movements, health care workers, managers from diverse sectors – requiring the participation of political, human and financial resources which goes beyond the area of health care.

Thus, health care faces the challenge of inter-sectoriality as a new form of organization faced with the pyramid shaped majority of municipal structures, arranged in various levels of hierarchy and departments, which makes popular participation in exercising social rights difficult (Westphal and Mendes, 2000; Junqueira, 1997). Intersectoriality is the connection between subjects from diverse sectors, with different knowledge and powers with the view of tackling complex problems. In the field of health, this can be understood as a coordinated way of working which aims to overcome the fragmentation of knowledge and of social structures to produce more significant effects in the health of the population. More than a concept, it is a social practice being constructed based on dissatisfaction with health care sector responses to the complex problems of the modern world (Feuerwerker and Costa, 2000).

From this perspective, intersectorial actions have been shown to be an important strategy in the search for new models of organization and can be understood as a connections between knowledge and experiences in the planning, effecting and evaluation of policies, programs and projects aimed at specific communities and population groups in a specific geographic area, with the aim of meeting needs and expectations in a synergetic and integrated way (Junqueira R., 2000; Junqueira et al., 1997). It is a process of learning and determination for the subjects, also resulting in the integrated management of social policies and aims to respond effectively to the problems of the population in a specific territory. Thus, it is necessary to consider the interests at stake and the processes that favor certain sectorial policies (Nascimento, 2010) and permeate organizations with a new logic which demands the political commitment and will of administrators to change

their practices and offer citizens a better quality life (Junqueira, 1997).

Thus, the health sector commitment is to make it increasingly visible that the health-disease process has many aspects, belonging to diverse governmental, private and non-governmental sectors, which should make up their agendas when they set up their specific actions and policies to guarantee health care as a human right and citizenship issue (Brasil, 2006).

There are many challenges to intersectoriality, and there is no golden rule as to how it should be practiced or of whom the agendas should be composed. However, in the literature, there are experiences which can give clues as to how to resolve certain health care problems. This article aims to contribute to this debate, based on the research-intervention together with the *Leisure and Health* program implemented by the Health, Culture and Sports and Leisure Secretariats in Santo André, prioritizing their limits and possibilities.

The Leisure and Health program

Leisure and Health was a program from the Health, Culture and Sports and Leisure Secretariats in Santo André/SP based on the identification of the population's high demand for bodily practices, for which the private market had organized itself and the public sector had not. Initially, in 1998, the Department of Leisure experimentally introduced Liang Gong in Community Centers and, due to high demand, this was expanded to include Tai Chi Chuan and Yoga in 2001.

At this time, the municipal administration in Santo André placed emphasis on popular participation through Participatory Budgeting (PB) plenary sessions in different areas of the city and bodily practices appeared as a demand chosen by the population in one of the plenary sessions. From then onwards, the activity gained in strength with oriental practices taking place in parks and Education Centers in Santo André (CESAS) and in some health unities (HU²) with the appearance of the “Walking to

² In Santo André, the health unity (HU) was adopted, rather than the primary health care unit (PCU), as other professionals work in HUs, not just a primary care team.

Health” program, initially implemented in ten and, the following year, increased to twenty-two HUs, with the simultaneous creation of three Muscular Strengthening Centers (MSC) located in two parks and one CESA. This set of projects was named *Leisure and Health* and went on to become part of the Health Secretariat agenda, especially the Walking to Health activities which took place in the HUs in the municipality and the MSC, which focused on dealing with adults and the elderly, preferably those dependent on the SUS³.

The following objective appeared in the Leisure Department 2006 program:

To provide the population with better quality of life, encouraging bodily practices aiming at promoting health. The Leisure Department/SCEL and the Health Secretariat developed three activities together: 1) Program of oriental practices - Lian Gong, Tai Chi Chuan, Yoga, Chi Kung, Therapeutic Massage and country dancing - in parks and Educational Centers; 2) Monitored walking program in health unities, consisting of permanent courses, meetings, seminars and events; 3) Muscular Strengthening Centers in: CESA Palmares, CESA Cata Preta and Chácara Pignatari. These centers use resistance training which aim to provide the elderly with better health conditions.

Although the agenda was jointly agreed with the Leisure and Health Care sectors, the actions were clearly fragmented, compartmentalized, i.e. the majority of planning, development, systematic evaluations and selecting the professionals who undertake the activities was all done by the Department of Leisure, while the Department of Health Care (DHC) was responsible for paying the professionals and took part in regular evaluations. Even so, it can be affirmed that there was intersectorial logic in the construction of the common objectives and in the way tasks were divided.

Method

It was decided to use a qualitative methodology in the research-intervention in Santo André together

with the *Leisure and Health* program so as to grow closer to the situation of the managers directly and indirectly responsible for the Program. Systematic observation of the activities took place and semi-structured interviews were carried out with managers from the Department of Leisure and from the Health Secretariat and with HU managers. To facilitate opening and guiding the “conversation” (Minayo, 2006), a script of seven items was drawn up approaching issues such as public policies, bodily practices, problems, possibilities and limitations of the relationship between the leisure and health sectors. Over the course of the interviews, it became necessary to improve the script, correct expressions with possible double meanings and remove inappropriate questions (Oliveira, 1999). The interviews were recorded and later transcribed with the consent of the interviewees, after being informed about the research, its objectives, instruments and guarantees regarding adherence or not.

After identifying that the *Leisure and Health* program serves a large part of the urban region of Santo André, through oriental practices, the “Walking to Health” program and the MSCs, it was necessary to draw up an outline of the field study in order not to lose the context or the peculiarities of the Program, bearing in mind that the activities took place in socially and economically different regions.

Thus, the methodology adapted to identify the individuals to be interviewed began in the two departments which administered the *Leisure and Health* program: the Department of Leisure (subjects 1 and 2) and the Health Secretariat (subjects 3 to 8). In the former, those responsible for decision making and organizing and executing the Program were interviewed. In the DHC, although the guidance was the same, it was more complex, as the organization and execution of the practices were directly linked to the managers of the 32 HU managers in the municipality. Thus, the outline was based on the territorial organization of the health care sector, structured into four administrative areas, in such a way that the interviewees were conducted with one subject from each administrative area. The IV management area

³ The term SUS dependent refers to registered citizens using the HU.

was not included as it concerned the sub-prefecture of Paranapiacaba and Parque Andreense, an area not covered by the *Leisure and Health* program.

The appointments and the interviews with the managers of the two departments took place in a quiet environment, with interest on the part of the interviewees. It was more difficult to arrange the interviews with the HU managers and we adopted “availability” as a criteria for choosing the managers.

After a careful reading of the interview scripts, themes⁴ were identified and organized into the following categories: difficulties, positive aspects and the National Policy for the Promotion of Health (PNPS). The data were organized in a matrix in which the lines were empirical categories and sub-categories, and the columns were the interviewees. When the matrix is read horizontally, the categories stand out from the context and gain relevance across what the interviewee said. When read vertically, the subjects were what stood out, with their statements on the different themes. This methodology provides a broad and relational view of the empirical categories and the interviewees and, at the same time, a detailed analysis of the contributions of specific literature.

Results and discussion

In order to discuss intersectoriality based on the data taken from the matrix, we decided to create sub-categories within each theme so as to organize the sets of statements and to improve understanding, discussion and dialogue with the literature. Thus, the text which follows is presented with the focus on the following subthemes: 1) Joint action; 2) Sector of the sector; 3) People, policies or people’s policies; 4) the *Leisure and Health* program or bodily practices; 5) Owner, partner or collaborator; and 6) Communication as stitching together. It is worth noting that the topic of intersectoriality, the central object of interest in this article, was present in all categories of analysis: it appeared in the difficulties, in the positive aspects, in statements specifically about the

Leisure and Health program and in issues relating to the PNPS, which proves the initial assumption that the *Leisure and Health* program would bring important elements to the discussion of this topic.

Joint action

The first subtheme identified from the interviewees’ statements was problems with joint actions.

... it sometimes happens that, as these projects are being developed, there are different intensities of working together. [...] But the main problem is the joint operation of the project. In some cases, for example, as in the case of walking, all the administrative part of contracting personnel is [done] via the Health Secretariat, but the pedagogic part is developed by the Leisure Department and sometimes the two parts have difficulties talking to each other. In the case of the MSCs, it’s the same thing, in the model which we use here, the Health Secretariat acquired the equipment and we had the Education Secretariat involved, in addition to those of Leisure and Health. We implemented it together, but we also experienced some difficulties in creating better organization of what had been contracted at the beginning of the project (Subject 1)

... I initially thought that we had problems with some professionals as they understood that this was a matter for Leisure... (Subject 8)

The statements above highlight that one of the reasons which affects joint action is the isolated and individual management on the part of each department. The concept is based on a segmented vision of the municipal administrative organization, which encourages linear thinking and makes it co-operation and acting in partnership more difficult, discouraging intuitive reflection.

...there are several people looking on and there is no very clear flow of how the work is going to be carried out. So, I think the problem is this: there is nobody in any of the secretariats or departments or in the prefecture who has this vision, who could organize things so as to optimize them. Resources are

⁴ “Theme” is an idea which consists in discovering the core meanings making up a communication and the presence or frequency of which mean something to the analytical object in view (Minayo, 2006). In other words, themes emerge based on units of meaning which are naturally liberated from a text analysed according to criteria relating to the theory which guides the reading (Bardin, 1976).

limited, for example; so, you try to optimize; when there are several different secretariats involved, sometimes, you end up getting lost and optimization is not so positive, so, this is the problem. (Subject 3).

Leisure and Health mobilizes different individuals in diverse secretariats which, in one way or another, are involved in the proposal, for example, managers, nurses, community health workers, physical education professionals and administrators. However, the statements indicate a lack of individuals with an overall view of actions - a wide view, from conception to evaluation -reaffirming the linearity of thinking and acting and, thus, contributing to segmentation and individualization of the work.

...I think that, what we have today, for these two activities, is our relationship with Leisure and the Education Secretariat, who provide us with the location for the strengthening centers. The Education Secretariat [...] provides the place, it helps with the organization to some extent, as the CESA employees are those who help us in one way or another; so, they also have an important role to play, but I think that, fundamentally, it is the Department of Leisure which guide the thing, which is able to contract professionals, as they know specialists... (Subject 3).

Joint action is understood as carrying out tasks which depend on each other. The Education Secretariat provides the location, the HUs are the reference spaces for the population's bodily practices /physical activity and the Leisure Department contracts the specialized individuals. It is explicit that the intersectorial relationship outlined in this program is perceived as the sum of its parts and not from an intersectorial perspective, as none of the parts involved is able to, in fact, make up the whole. For *Leisure and Health* to make progress in the intersectorial aspect, it is necessary to articulate the parts which are operating alone as "it is through the relationships of the parts, so new potential appears which also feeds back, stimulating them to express their individuality" (Junqueira L. A. P., 2000, p. 36-37).

Despite the segmentation of the health care

sector, intersectoriality is gaining in force as a fundamental strategy for acting in structural problems in society which affect the health-sickness process. International movements such as "Promoting Health" and "Healthy Cities",⁵ the logic of which necessarily incorporate intersectorial actions are becoming increasingly central to the county's health care sector (Monnerat and Souza, 2011).

Sector of the sector

As a result of the lack of joint action between the different departments forming the *Leisure and Health project*, the vision is of a sectorized action, through which each subject recognizes a fragmented and private perspective, losing the essence of the program:

...when I came to this unit I started to question the attitude of the professionals, not just the doctors, but the cleaners, the nurses, the administrative staff. I saw it as very sectorized: I'm a nurse..., I'm a receptionist... and there was not much involvement. I think that this does not work in a unit, you have to be involved, you have to have a professional attitude, be able to go up to the doctor and say: look, doctor, this can't go on. (Subject 7).

In addition to the segmentation between different sectors of municipal administration, highlighted above, the statement above identifies another type of fragmentation: internal division within the sector itself. In other words, in the HU, for example, the receptionist has a well-defined role, as does the nurse, the cleaner, the physical education professional and the doctor, but with little or no coordination between them. There are few joint actions and co-responsibility between these professionals in organizing work processes, which shows the formation of small sectors within the health care sector.

It is also necessary to highlight that coordination between the professionals and subjects involved should occur where the activity takes place, as this is the perfect location for political coordination of urban and social development, as it is there where the target subjects of these policies are found (Spotsati, 2006; Nascimento, 2010).

⁵ The Healthy Cities movement, promoted by the World Health Organization since 1986, aims to establish urban public policies focused on improving quality of life, with emphasis on intersectorality and social participation.

...because what happens is always fragmented, there is no connection between the health care service worker's thinking and the health care service user's thinking, it doesn't exist. Their thinking does not intersect at any time and they are as different as chalk and cheese. It is difficult for those of us who have spent quite a lot of time in the city, when the two groups manage to agree on the same issue... (Subject 4).

Apart from division within a specific sector which underpins fragmentation in the way of thinking of health care professionals working in the HU - main gateway for SUS users - there is also fragmentation, an incoherence between the thinking of the health care worker and the service user, as in the statement above. This disconnection directly affects the implementation of programs and activities thought up by the administration and/or by those involved in the services, as, very often, they do not make sense to the health care professionals and users involved.

This disconnected way of acting does not only concern the sectors or those involved, it is used within the HCC itself, entrenched in posts and professions (as stated by subject seven) governed by specific regulatory bodies (verticalized councils and administration, for example). This division within the sector is in agreement with that presented by Campos and Dimitti (2007) which describes segmentation beyond posts and professionals, in other words, it is in the architectural design of the majority of outpatient clinics, with a succession of small rooms for appointments or procedures which, being totally unconnected, can function as geographically distinct spaces.

However, we must not fall into the trap of thinking that in order to construct programs or projects with strong intersectoriality we need to be against sectoriality, as intersectoriality is not the opposite of, or a substitute for, sectoriality, they are complementary. For projects and programs to be efficient, they need to complement sectorial policies with intersectoriality (Sposati, 2006).

People, policies, or people's policies

Implementing programs or projects focused on specific ideas or desires of those who are, at that

particular moment, at the head of the action, rather than on objectives and directives of the public policies of the sector is one of the causes of the lack of progress or discontinuation of many projects which are developed.

...there is a specific person who, in that department, is open minded, who is more able to listen, to discuss a project, who looks beyond their own belly button; then, a great project ensues, but the people who work in the Prefecture are like that: we are here and tomorrow were there. Management is very focused on us here in Santo André, I think; this is not a policy. So, this issue of intersectoriality ends up not working there, because there is no policy, there is just a person. If the person is not there, it doesn't go ahead, and that's really bad when that happens... (Subject 4).

This focusing on people and not on the political project, highlighted by subject 4, throws light on the difficulty of having continuity and ownership of the project on the part of the professionals engaged at that moment and those who will take over in the future. This difficulty tends to be more accentuated in the public sphere, a location in which the individuals are dislocated from sectors or even distant from the government, irrespective of their competence or involvement in the project, as the municipal organizational structures are still organized in the shape of a pyramid (Westphal and Mendes, 2000) and are centralized, which makes intersectoriality difficult, as the "characteristics and the demands within the territory (dynamic, citizens, nature) is what determines the extent and intensity of the intersectoriality in the face of the objective to be achieved" (Sposati, 2006, p. 135). Although the directives of the policies are drawn up by people, their implementation is still hostage to individual interests (people's policies) or of political groups responsible for the administration during a specific period.

The Leisure and Health Program or bodily practices

Another important issue concerning intersectoriality, identified based on the interviews concerns fragmentation of the Program, in other words, at the same time as it can be viewed as an integrated initiative, it can also be understood as a set of isolated bodily practices:

...I think that what we have today [that is good], for these two activities, [Walking to Health and MSCs] is our relationship with the Leisure Department and the Education Secretariat... (Subject 3).

...so, maybe the potential to create situations of sociability, create leisure situations, group leisure situations, so as to strengthen links, strengthen ties, so the person does regular physical activity, with pleasure, in their groups. I think this goes for both the Walking and for the MSCs... (Subject 1).

This disconnection, together with the lack of unity referred to by Morin (1996), can be understood as a significant difficulty in constructing intersectorial actions in *Health and Leisure*. We can perceive that the managers involved in the Program position themselves so as to segment it; their references, in fact, are bodily practices such as “Walking to Health”, MSC and Lian Gong, rather than *Leisure and Health*.

This way of understanding and intervening is in agreement with the predominant logic in the world of work, a dichotomous logic in which actions are sectorial and many of the so-called intersectorial tasks are, in fact, developed in an integrated fashion, in other words, integration occurred due to specific projects defined by specific sectors (Westphal and Mendes, 2000), as in the case of *Leisure and Health*. The program originated in an experimental action by the Department of Leisure, based on identifying significant demand for bodily practices on the part of the population, and formed part of the health sector agenda after demand was observed in the Participatory Budget, but throughout its implementation, the majority of planning development systemic evaluations and hiring professionals to carry out the activities was done by the Department of Leisure, while the DHC was responsible for paying them and participating in regular evaluations.

According to Westphal and Mendes (2000), management models for intersectorial projects can be divided into three types. The first assumes that the secretariats and other bodies segmented by area of knowledge are substituted by a territorial section, according to the logic of decentralization and inter-

sectoriality. With this new understanding, it falls to regional - and not sectorial - secretariats to identify problems in their geographically defined area and plan integrated actions to improve the quality of life of the population in their jurisdiction.

The second type is based on gradual changes in processes, in such a way that their essence is not based on changes to the structure or the legislation but rather in innovative, permanent gradual changes in the administrative apparatus. As in the case of Curitiba, described by the authors, in which the administration transformed all of the campaign proposals into 24 strategic intersectorial projects which permeated all of the sectors of the organizational structure, while maintaining posts and functions. Each of the bodies kept their specific functions, although their specialty was grouped together in creating the intersectorial projects which were developed through the logic of problems and territory.

Inojosa⁶ (1999), cited in Westphal and Mendes (2000), points out a third type, which would be in coordinating the sectors in networks of partnerships between government, non-governmental and community bodies to resolve the problems of the population living in that specific area.

Owner, partner or collaborator

Another point that stands out is the understanding of what a partnership is and what its implications are in managing intersectorial projects. Intersectoriality can happen at different levels and between different spheres. The rhetoric of collaboration states that all those involved are equal, that is, they all have the same amount of power. However, the partnership issue involves the idea of conflict, considering that those involved have differing degrees of power, due to subject structural inequalities, such as access to money, information or power (Westphal and Mendes, 2000).

Thus, issues concerning partnerships contain constant conflicts which need to be identified, discussed and resolved for improvement in intersectoriality to take place, and cannot be simplified and understood as simply working together or through a relationship of ownership.

6 INOJOSA, R. M. Healthy municipalities movement: legal aspects related to the operationalization and implementation of intersectorial planning. In: NATIONAL SEMINAR ON HEALTHY MOVEMENTS: CONCEPTUAL, LEGAL AND OPERATIONAL ISSUES, 1999, São Paulo. Annals... São Paulo: Faculty of Public Health/USP, 1999.

...partnership is a complicated thing [...] I always thought that those in Health Care were our partners, but I heard the opposite, that it is we who are their partners, although we manage the program and do all of the monitoring. Understanding partnerships is complicated, as a partnership means working equally, but what I see today, what prevails, is the following: he who maintains the program financially is the owner of it, and the rest are partners, even if the partnership is only in the financing. In the case of Health, conversing with those dealing with communication, [...] he used this exact expression "Oh, I thought that it was the opposite, I always heard that it was you who were their partners, because over there in the Department of Health, they say... that the program is theirs and it is you who are the partners". So, I think there is some kind of disconnection concerning partnerships, people's understanding of it [...] We exchange funds, because they can't be contracted to work in this type of activity, working with the elderly and so we are totally free to manage, to define; you know, they don't interfere in anything... (Subject 2).

The statement above shows the operational and conceptual confusion in the joint actions in *Leisure and Health*. The power struggle for ownership of the program is explicit, emphasizing the conflict involving economic power, operationalization and management of the activities. In the first statement, which highlights ownership of the program, the interviewee (subject who works in the Department of Leisure) shows discontent with the unequal partnership as, although they manage the program and do all of the monitoring, there are those with little involvement in running project who understand that they (Health) are the owners. This excerpt also highlights operationalization, so the inequality in the partnership does not seem to matter anymore, quite the opposite, it seems like something positive, liberating them to act without "interference". The use of the term interference by the interviewee is interesting, as it is accompanied by liberty to manage and define, giving the idea that the partnership restricts the progress of the tasks.

...those managers who are responsible for the day-to-day activities have their own interests, they have a very interesting movement, now those who

see themselves as partners do not always position themselves as expected, act or commit themselves as expected [...]. Moreover, as we provide a service in places which are not necessarily under our management [...] and we experience other types of resistance. So, if you're going to bring in a new service, Walking to Health, for example, it takes place in the Health Unities and it is these unities which are responsible; often those responsible think that the arrival of this program is an innovation, they treat it as a benefit to the Unity but other times, they think it will complicate the running of the Unity and it seems to me that the issue is basically understanding of the health policy... (Subject 1).

The interviewee proposed classifying interest/efficiency based on day-to-day involvement (day-to-day x sporadic). The closer the individual is to day-to-day activities, the more efficient their involvement, and the more distant they are, the less effective. Thus, the health care manager or professional who operates in a location where activities take place is more involved with the program than a municipal manager. In the same way, a distinction is made between a HU manager and a partner, suggesting that the partnership is only the relationship established in managing the project and that the subjects involved locally are not part of this partnership.

To conclude, we can infer that, according to the logic of efficiency adopted based on day-to-day involvement, the subjects who define the strategies and resources for the *Leisure and Health* Program have poor interest/efficiency, compared with those linked to its day-to-day activities, which is in agreement with health promotion policies. Health as a social production of multiple and complex determiners requires the active participation of all subjects involved in producing it - users, social movements, health workers and managers and those in other sectors - in analyzing and formulating actions which aim to improve quality of life. The process of producing knowledge and practice needs to be through constructing shared management (Brasil, 2006). Thus, it becomes explicit that the *Leisure and Health* Program faces difficulties in coordinating partnerships, be that in the varying degrees of power, in involvement of those involved, or in the understanding of the basic concepts of intersectorial action.

Communicating as stitching together

Difficulties communicating is another point highlighted in the interviewees' statements and is presented as an important axis in constructing effective intersectorial actions.

...today it is difficult for me to talk with other departments. Leisure, for example, I don't know who is the reference there, I don't know who is the reference in Social Services... here in the Health Department we are closed off. For example, the Leisure Department does activities which could be passed over to us and which we could divulge for this group to take part in too. The School Park has free courses, great activities that we can't promote, because we don't know about them. Communication is not well done. I think that we have a communication problem... (Subject 6).

...as far as I remember, no [other activities by the primary health care network], because that is what we always say, we don't talk much, we don't know much about the other departments... (Subject 5).

It was noted that the lack of communication not only impede knowledge of the activities established by other departments in the prefecture, but also made knowing about the *Leisure and Health* Program itself more difficult. Communication is the stitches joining intersectorial action as it coordinates the different part, exposes conflicts and can enable solutions.

Campos and Dimitti (2007) go even further, pointing out the importance not only of facilitating communication between different actors, but also the need to set up a system which produces synchronic and diachronic sharing of responsibilities according to each project. The role of each person, of each professional, needs to be very clear, somebody needs to be responsible for the longitudinal part and for constructing a logic which aims to integrate the contributions of the various services, departments and professionals. In general, this role falls to members of the reference team.

In fact, subject six's statement indicates this same thing when referring to the lack of a contact in communication between the different departments in the Prefecture. Despite the importance of communication in stitching together intersectorial actions,

it has not been highlighted in many definitions of intersectoriality found in the literature. Rede Unida, for example, defines intersectoriality as

The coordination between subjects in diverse social sectors and, therefore, with diverse knowledge, power and willingness to deal with complex problems. It is a new way of working, of governing and of constructing public policies which aim to overcome the fragmentation of knowledge and social structures to produce more significant effects on the population's health (Feuerwerker and Costa, 2000, p. 26).

Likewise, Rodrigo Junqueira, Luciano Junqueira, Rose Inojosa and Suely Komatsu do not include the aspect of communication in their definitions of intersectoriality.

Final considerations

Analyzing the process of implementing the *Leisure and Health* Program in the municipality of Santo André revealed important issues for reflection on modes of organizing health care, both in the positive dimension as well as dealing with difficulties concerning operationalizing initiatives associated with bodily practices and promoting health in the SUS. Deeper examination of the issue of intersectoriality enables us to understand the complexity and the importance of the individuals and sectors involved. This field - in the dimension of knowledge and practices - is essential in identifying new potential, co-responsible involvement and an integrated perspective of the process of implementing programs, projects and public policies.

The six sub-themes discussed in this article indicate the fragility of intersectorial action in the *Leisure and Health* program and demonstrates that these obstacles are also the object of discussion and tackling issues highlighted in the academic literature. Thus, we highlight some points indicated in this analysis which should be taken into consideration when constructing intersectorial actions.

The first concerns complementarity between intersectoriality and sectoriality, in other words, intersectoriality is not antagonistic to, or a substitute for sectoriality. Quite the opposite in order for projects and programs to be effective, it is im-

perative that sectorial policies are complemented by intersectoriality.

The second concerns the need to look at the thing as a whole, while still preserving the individuality of the parts and permitting each part to create their own organizational and architectural design for the action, as there are specificities in each place and in the teams which will act. It is, therefore, essential that the team managing and carrying out the projects be formed of subjects paying attention to context, which enables the tasks to be identified, adapted and aggregated so as to suit the workers' and users' ways of thinking and acting, thus giving meaning to the action.

Another aspect concerns agreements between those involved with regards the concepts, objectives and directives of the projects, programs and policies, so that their management and execution is not restricted to the understanding of individuals and, therefore, vulnerable to changes in posts and sectors so common in public administration. This agreement should involve not only the workers in the service but also, above all, the community in question, so that the programs and projects become less vulnerable to changes in the administration and to enable sustainable action.

The fourth concerns the need to construct work networks and understanding that this form of joint activity involves the idea of partnership, i.e., of continuous conflict, as the network includes different individuals with extremely varied working conditions and degrees of power. An "active socialization", as Venturini (2010) terms it, an intervention of elevated professionalism both from the technical point of view and from that of costs, which would be based on a temporal criterion of functions and would seek to activate the integration of the social networks and institutions involved. There are, therefore, two important steps in constructing such a network: recognizing not knowing, in other words, the insufficiency of what is already known and the need to create new alternatives which depend on the influence and coordination of other types of knowledge; and the predisposition of the various

segments to relinquish some power in order to make intersectorial actions viable, which, as has already been said, does not assume the absence of conflict or of contradictions, quite the opposite they are constantly present and learning to develop tolerance and the capacity to listen and to negotiate is part of the process (Feuerwerker and Costa, 2000).

The fifth point, communication, is what ties all of these issues together, the key piece of the puzzle in the "jigsaw" of intersectoriality. Effective communication between those involved and the sectors is what stitches together intersectorial action, in other words, it is what establishes the connection between errors and corrections, between problems and solutions, the while with the parts and, at the same time, enables joint action, recognizing not knowing and highlighting conflicts generated by differing degrees of power and working conditions.

Thus we can add new elements to the definitions of intersectoriality based on analysis of the results obtained by this study. Constructing specific language and concepts for each situation is relevant in composing a definition of intersectoriality which were not previously highlighted or even found in the literature on the subject. Thus, we can conceive of intersectoriality as coordination between subjects with different power, knowledge and experience in planning, carrying out and evaluating policies, programs and projects with the objective of constructing new concepts and language, synchronic and diachronic⁷, to meet the needs and expectations of the specific communities and population groups at a certain time and a specific geographic space so as to overcome fragmentation of, on the one hand, knowledge and practice and, on the other, social structures.

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⁷ The term synchronic refers to communication between individuals established through the spoken or written word, occurring at the same time. Diachronic also refers to this communication, but over time.

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