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Intersectorality in the 'Health in Schools' Program: an evaluation of the political-management process and working practices

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Abstract *This study analyzed inter-sectoral activities between the health and education sectors in implementing the Health in Schools program in a city within a metropolitan region in northeast Brazil. Analysis of the political-management process looked at the following dimensions: professional practices and subject understanding of intersectorality. The results show that subjects define intersectorality as partnership and joint efforts. Regarding decision making and resource mobilization, during program implementation we noticed that healthcare leads, and education tends to play a more peripheral role. Health activities in the schools use a biomedical approach and primarily consist of lectures. We believe that the program strengthened the relationship between these two sectors. However, intersectoral coordination in the political-management process and practices show weaknesses and limitations.*

Key words *Intersectorality, Health in schools, Program implementation*

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Introduction

Intersectorality has been defended as an initiative in opposition to the fragmentation of social policies, and essential for overcoming the iniquities in health and to improve the quality of life of the population, especially in countries with low to medium per capita income[1].

Discussions around its meanings and scope are vast and simultaneously generic. Among the various concepts of intersectorality, there is a degree of convergence that may be understood as the coordination of different sectors and players, and shared power and knowledge in order to take integrated action on problems and demands, aiming to improve quality of life[2,3].

The international debate on intersectorality in the field of healthcare has stressed interventions on the social determinants of health[4-6], and creating partnerships and alliances for implementation[7,8]. They also point out that local interventions are more likely to produce sustainable and satisfactory results[9,10].

In Brazil, intersectorality is valued in numerous public policies, such as those regarding Education, Healthcare and Social Services. In Education, intersectorality is associated with the concept of partnerships and collaboration between government institutions, NGOs and society as an alternative to improve education[11]. In Healthcare, it is a considered a fundamental element for changing the care model and reorganizing the system[12], and is mentioned in numerous works in Health Promotion as a strategy for action that impacts the social determinants of health[3,12]. The partnership between the health and education sectors has existed since the beginning of the 20th Century, particularly in relation to the implementation of healthcare programs for school pupils[13,14]. Studies show that these policies and actions have revealed numerous weaknesses and challenges when it comes to implementing intersectoral actions, such as uneven sector commitment, fragmented actions and a predominance of sector and biomedical approaches[15-17]. Promising experiences such as the Health Promotion Schools[18] have introduced new approaches, prioritizing health promotion and intersectorality. However, in practice progress was timid and fraught by the inability to create integrating actions[14].

In 2007, the HSP (Health in Schools Program) was created[19] as a strategy for permanent integration and coordination between healthcare and education policies. The goal is to expand healthcare actions focused on public school students, articulating the public primary care and education networks, and contributing to comprehensive student education, with health prevention, promotion and care activities. In addition to education and health, the HSP calls for the involvement of other sectors and players, depending on the organization in each territory. Comprehensiveness, territoriality and intersectorality are the underlying principles for this Program.

Few cities in Brazil subscribed to the program in its initial phases. At the time, city eligibility criteria were 100% coverage by the Family Health Strategy (FHS), and low IDEB (Basic Education Development Index) (2.69), or include schools that participate in the *Mais Educação* (More Education) program.

In Bahia, 65 (63%) of the cities meeting the criteria subscribed to the program. In 2011, the program was expanded and the criteria changed; FHS coverage was lowered to 70%, and the IDEB increased to 3.1. Consequently, the number of cities in the program increased from 65 to 282. Later, in 2013, all eligibility criteria were eliminated and all cities became eligible[20]. Furthermore, day-care and pre-school were included, and tracking indicators and performance targets were set. Currently 297 (05%) of the cities in the program are enrolled in the HSP[21].

It is worth mentioning the HSP is the main program focused on healthcare for students enrolled in public schools. Given that in 2015 85% of all primary students in Brazil were enrolled in public schools[22], its importance and potential reach are evident.

Studies about the HSP are still scant, with only a handful published[14,23-25], three of them discussing intersectoral management[23-25]. Results show possible difficulties to implement the Program, and diverse concepts of intersectorality among local managers making up the working groups[23,24], and the predominance of Healthcare in the decisions[23, 24] and definition of rules and standards[25]. It is also worth pointing out that none of the studies looked at coordination between healthcare and education practices.

In order to look into how intersectorality operates in fact, this study analyzed the political-management processes and the practices associated with the HSP, as well as the concepts held by the professionals involved with the program. The location was a city in Bahia that subscribed to the Program in the early days.

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Methodological strategy

This an evaluation study conducted in a city in a metropolitan region in Brazil's northeast, which successfully (according to key references in state management) adopted the HSP in 2008.

To understand the political-management, this study is anchored on the contributions of Teixeira[26] and Junqueira[2] regarding decision-making and resource mobilization. Decision-making here is understood as the process consisting of making a shared choice based on different looks, knowledge and experience[2,26]. Resource mobilization involves a set of planned activities and financial, material, institutional and people resources[2,26].

To understand the practices we used, as the theoretical basis, the contributions of Mendes-Gonçalves[27] on the working process for healthcare and the elements it consists of: a) the subject - the agent performing interventions on the object and interacting with other subjects; b) the object, or the target of a given activity; c) the instrument: material and non-material technology used for the intervention on the object; d) the activity, or the work itself; c) technical and social relationships, the relationships between agents and their activity on the object.

In this study, we adopted the concept of intersectorality as the coordination of different sectors, players and knowledge regarding planning, performance and assessment of measures to act on problems and demands in an integrated manner, searching for improved quality of life[2,3].

We designed a logical program for the Health in Schools Program, listing the goals, actions and results expected (Figure 1), based on its policy framework[19,28] .

We considered two components for the logical model. The first is related to the political-management process, where intersectoral coordination is a program innovation, strengthening local healthcare and education networks. The Intersectoral Working Group (ISWG) is an essential component of the healthcare-education coordination process. Integrated measures, training and the inclusion of HSP in the political pedagogical projects of the schools are the expected outcome, with a view to network coordination and interaction.

The second component is related to practices, and here we find coordinated healthcare activity and addressing vulnerabilities. Among the activities included, we point to clinical assessments, updating the vaccine calendar and defining integrated measures as per the needs found in each area to provide comprehensive care and improve the indicators related to health and education.

Study data was produced from document analysis, systematic observations and semi-structured interviews with city education and health secretaries, members of the municipal ISWG, professionals from three public schools (two city and one state), and professionals from two Primary Family Care Units. In all, 23 subjects participated in this study, five of them managers from the two city departments, and 18 employees of the schools and healthcare units.

For the analysis of the political-management we considered indicative criteria, such as:

a) Decision making processes: which decisions are made, how they are made and by whom; how planning, monitoring and assessment are carried out; sector representation on the ISWG and its responsibilities.

b) Resource mobilization: how financial and material resources are appropriated and allocated to the program, and how other sectors are mobilized and involved.

The following criteria were used to analyze the practices:

a) Subjects: FHU and school professionals, students, parents and the community.

b) Objects: the diseases, risks and social determinants of health.

c) Activities: activities to promote health, prevention and care.

d) Instruments: coordination between the different areas of technical, scientific and methodological knowledge; development of strategies and materials used to perform the activities.

a) Technical and social relationships: coordination between FHU professionals and the schools in planning, scheduling and performing activities; relationships of power and conflicts revealed.

The information obtained from data analysis, interviews and observations was triangulated and analyzed. This study was approved by the ethics committee of the Institute for Collective Health, Universidade Federal da Bahia, Opinion Number 391,683.

Results and discussion

Concepts of intersectorality

Chart 1 shows the profile of the 23 subjects interviewed for this study. Most are young adults

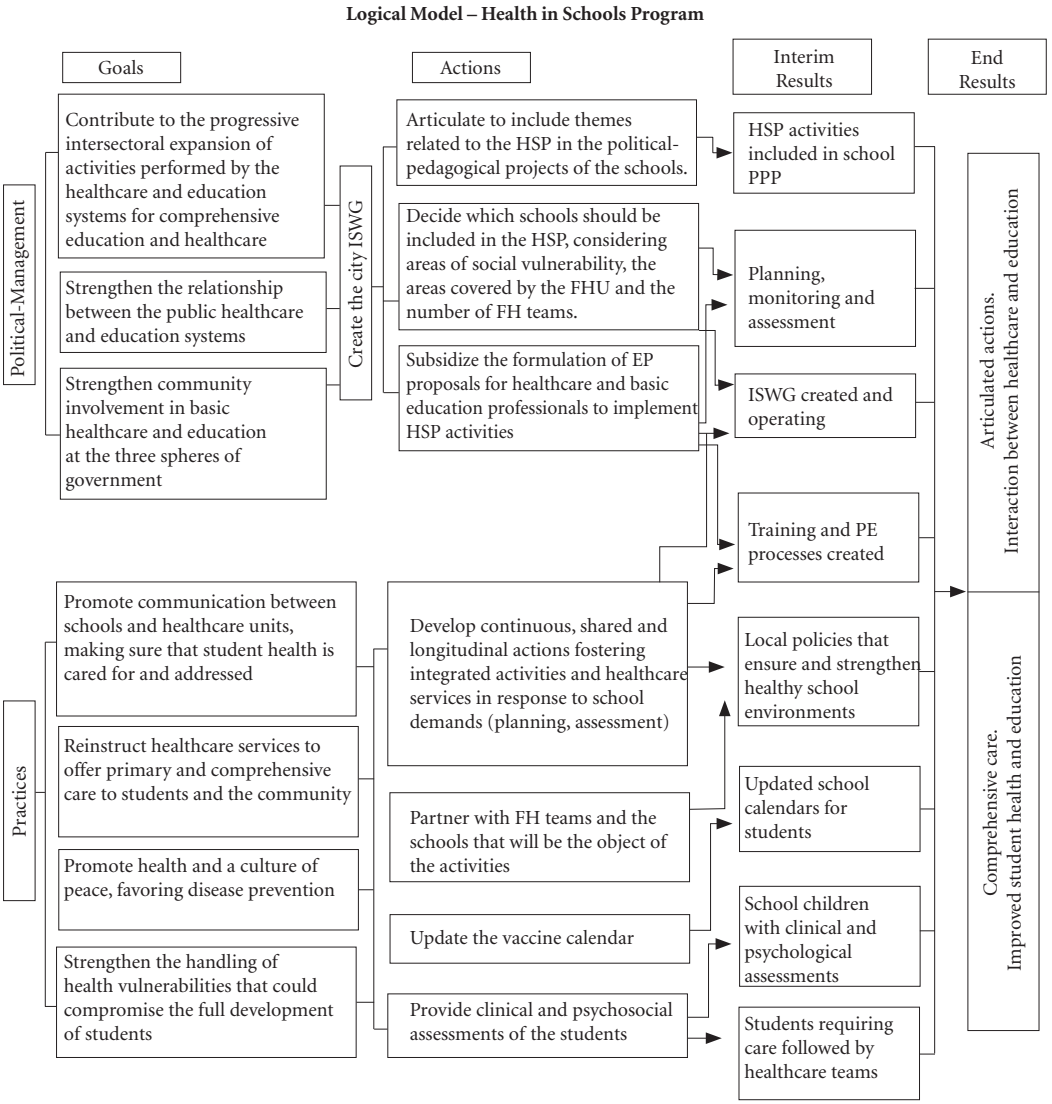

Figure 1. Logical Model – Health in Schools Program.

Source: Study data. Prepared by the authors from the Decree[19] and the instruction 2013[28].

(all under the age of 50) and predominantly female. Almost all had university degrees.

When asked about their understanding of intersectorality, the interviewees did not have a structured or accurate definition, but all shared the concept that it involves joint effort. The term intersectorality is clearly more widely understood among those in healthcare. Among those in education the term is considered to be slightly strange, but is associated with the concept of partnership.

Among the documents analyzed, such as the City Healthcare Plan, the Political-Pedagogical Projects of the Schools, and the Management Reports, we find that the concept of intersectorality is also not clear. Documents from the education sector make no mention to the expression, however they do stress partnerships. We believe that these documents state the importance of joint action and the need for collaborative efforts, although without any conceptual definition of intersectorality and how it should be made operational.

Chart 1. Profile of the interviewees working in the Health in Schools Program.

	Identification	Age	Gender	Years of schooling	Sector	Position	Time in position (years)	Employment bond
Interviewees: Political-management Proces and Processes	E1	41	F	UG	Education	Secretary	< 1	CP
	E2	33	F	UG	Health	Secretary	02	CP
	E3	34	F	UG	Education	HSP Coordinator (ISWG)	02	CP
	E4	31	M	UG	Health	HSP Coordinator (ISWG)	03	CP
	E5	23	F	UG	Health	AB Coordinator (ISWG)	<1	CP
	E6	35	M	UG	Education	Teacher (ISWG)	01	Statutory
	E7	30	F	UG	Health	Dentist	04	TSA
	E8	30	F	UG	Health	Physician	05	TSA
	E9	47	F	UG	Health	Nurse	08	TSA
	E10	39	F	SC	Health	ACS	03	Statutory
	E11	27	F	UG	Health	Dentist	02	TSA
	E12	38	F	UG	Health	Nurse	03	TSA
	E13	29	M	UG	Health	Physician	04	TSA
	E14	34	F	SC	Health	Nursing Technician	10	TSA
	E15	31	M	UG	Education	Vice-Principal	02	CP
	E16	49	F	UG	Education	Pedagogical Coordinator	01	Statutory
	E17	32	F	UG	Education	Teacher	02	Statutory
	E18	32	F	UG	Education	Principal	03	CP
	E19	44	M	UG	Education	Teacher	10	Statutory
	E20	40	F	UG	Education	Teacher	12	Statutory
	E21	28	F	UG	Education	Principal	01	CP
	E22	47	F	UG	Education	Pedagogical Coordinator	03	Statutory
	E23	48	F	SC	Education	Teacher	04	TSA

Legend: M = Male; F = Female; UG = University Graduate; SS = Secondary School; ISWG = Intersectoral Working Group; HSP = Health in Schools Program; PC = Primary Care; CP = Commissioned position; TSA = Temporary Service Agreement.

Source: Study data.

An understanding that intersectorality means joint effort was uniform across all managers and workers, with no significant differences based on years of schooling. The interviewees point to a need for more/closer partnerships among institutions, given the complexity of the social problems and also as a means to optimize the outcome.

In today's context, especially in education, it is impossible to work without partnerships as we fully need one another. We cannot work without information about health, and health cannot work without information about education and public safety. [...] *In these turbulent and violent times, without this support and orientation, this approximation, there can be no prevention, thus joint action is important*. (Education Manager)

Among the various reports one finds an understanding, especially among the education professionals, that it is important to involve the family and community in these partnerships. "Partnerships with the family and community" are considered important to improve the intersectoral activities of the HSP program. These partnerships may overcome numerous challenges, such as bringing schools closer to the communities they are part of[29]. When considering family and community involvement as important dimensions of intersectoral policies, one should give more visibility to the factors that place health at risk, while at the same time developing joint strategies to overcome the problems and adversities identified and experienced by the community within and outside the schools.

Interviewee concepts approximate the concept of intersectorality adopted in this study when they mention "joint efforts", "collaborative" and "partnerships" among the institutions and the different subjects. However, shared power, dialog, horizontal decisions and integrated actions

do not emerge as the dimensions of intersectoral practices. The absence of these issues in how they view intersectorality may factor sector and hierarchical practices, compromising collective decisions and the effectiveness of actions. Silva[30] assumes that one of the challenges in making intersectorality operational is precisely the separation of institutional hierarchies and the relationships of power among different sectors and professional segments.

According to Akerman et al.[31], intersectorality is a polysemic theme, which creates problems for electing it as a research and assessment category. This polysemic nature makes the definition unclear, both from a theoretical point of view and for those players responsible for the management of intersectoral actions.

Intersectoral political-management processes

In this study we found that, although there was an ISWG, its activities were informal as there was no directive to create it or appoint its members. The WG had no formal planning processes, nor any formal monitoring or assessment procedures. Monitoring consisted merely of completing the information systems: the Ministry of Health e-SUS and the Ministry of Education SIMEC (Integrated Monitoring and Control System); systematic information was not used for making program decisions.

Vilasbôas and Paim[32] point out that planning may be understood as one way to instruct human activities, focused on achieving a certain purpose, constituting a social action. According to these same authors, planning practices are considered structured when they use formal procedures and situation analyses based on the consistency, sufficiency and feasibility of the proposals, while informal planning is considered non-structured as it lacks any defined methodological structure. Given these prerogatives, ISWG planning is informal, and thus not structured.

Analysis of the ISWG revealed that it was not responsible for managing HSP financial resources. Funding for the Program was limited to the funds provided by the MoH minimum amount provided for variable basic care, which the managers consider insufficient. According to those we spoke to, the city did not receive any of the clinical or educational materials provided by the MoEd. The lack of financial and material resources makes it hard to undertake some of the program activities.

Regarding participation in the ISWG, only the Departments of Health and Education participate, each one with three representatives. There is no evidence of any strategy to involve other management representatives in the HSP program. The vision of the interviewees differed regarding the importance of organized involvement of civil society, but converged around the need for involvement of representatives of the Department of Social Services.

Social mobilization, integration across institutions and community involvement in decisions are all elements that strengthen intersectoral activiteis[5,8,10,33]. However, even though these concepts permeate the opinions of some members, we found no action that contemplated these elements. It is worth pointing out that the program's logical model includes community involvement in the ISWG.

In decision processes, immediate program actions such as creating a calendar of activities, defining the themes to address and feeding the information systems are the responsibility of the HSP coordinators in the different city departments. More complex and political decisions, such as managing the allocation of financial resources, appointments to participate in external events, the make-up of the ISWG, selection of the healthcare and school units that will participate in the Program are the responsibility of city secretaries of education and health. According to the interviewees, other decisions are made collectively by the ISWG, as per the following report.

There is an ISWG, made up of representatives from both departments. HSP activities are addressed by the group. We decide what to work on based on needs [...] *we decide what to do with the teachers and unit professionals. The decision is always joint, we talk about what is needed and set the priorities*. (Healthcare Manager)

There are indications that decisions are centralized by the health sector. For example, one of the managers said that "financial resources are entered into the healthcare account, so this area as more of a focus on what needs to be done", and "mobilization is greater in health".

We find that planning, activities and assessments, even if informal, are led by the healthcare sector, leading to unequal commitment, responsibilities and decision-making power. Other studies[15,16,34,35] also reveal that healthcare leads intersectoral activities, the same happening in work focused on HIS[17,23,24]. This protagonism may be associated with the understanding that health means more than the absence of disease, thus re-

quiring actions that extrapolate this sector. The greater involvement of a given sector in an intersectoral program may lead to that program acquiring sector character. Furthermore, increased responsibility of the health area for leading HSP activities may be an indication that there is already a biased and fragmented view of healthcare practices in schools.

Program operation

In terms the Program's practical activities, results show that by and large, these were formulated and performed by healthcare subjects, with the target public (subjects) being the students, sometimes involving parents or guardians.

School professionals were only occasionally involved in these activities, and even then, their role was limited to helping with the activities performed by the health teams. We find that, even though unstructured, FHU professionals organized themselves to deliver the activities proposed by the Program, as revealed in the interviews.

Every year we schedule our dates so as not to interfere in the student's school year. We always visit the school as it's quite close, and instruct them about oral health and brushing. There is a date for every school. We go there, hand out tooth brushes, apply fluoride and now we are doing even more. I go to every classroom and evaluate the children's oral health, encouraging them to keep it healthy. (Dentist)

There was no formal mention of the HSP program in the school political-pedagogical projects. Thus, we understand that the Program was not part of the pedagogical actions of the different school units. Most of the Program activities followed a theme calendar prepared by the ISWG. Analysis of the themes in the calendar and activity reports provided by the FHU show that most of these focused on disease intervention, with lectures on "scabies", "pediculosis", "STDs", "obesity" and "violence". We also found themes such as "oral health", "healthy nutrition" and "exercise".

Mendes-Gonçalves[27], looking at the object of one of the elements of the working process, states that achieving this object consists of identifying the characteristics that enable visualizing the end product. The object is a "biased look that discriminates the potential of the product". In the analysis, the activities performed by the different school units focused on disease prevention and identification, organized in the form of clinical evaluations and lectures. The following transcript shows the focus:

The focus of the HSP program is disease prevention, we talk to the students and implement numerous health assessment and education measures [...]. *The HSP is a ready-to-go program, but even so, if we have to focus on a given activity that is part of our reality we do that. The student here present with numerous diseases, from the common cold to serious diseases*. (Nurse)

In adopting disease rather than health as the main object of the activities, the HSP is unable to overcome the challenges of innovating healthcare practices focused on school-age children.

Even though the healthcare and school units in this study were located in different territories, with differing epidemiological and social conditions as stated by the managers and shown in the observations, we found no differentiation of activities to fight problems and inequalities according to the local demands of each territory.

These findings suggest that the professionals were not using epidemiological knowledge as a tool to identify risk and propose interventions. Paim[36] points out that by reducing healthcare needs to health problems, epidemiological knowledge rather than clinical knowledge would be the more consistent way to act on the object.

In short, instruments such as health and education indicators were not used to plan activities, and educational resources were limited to leaflets and posters on disease prevention. Lectures were the methodology of choice.

HSP actions were prioritized by the city schools. At the state schools, measures were sporadic and what caught our attention was the limited involvement of school teams, at the teacher or management level. There was no evidence of active involvement in any coordination and/or mobilization measure. We also found that, at times, school management suggested that the healthcare team "take" some sort of action, when we would have expected this to be taken jointly, showing that the education professionals have distanced themselves from co-responsibility for the Program. We see that "healthcare goes to the school", rather than "the schools promote health".

Effective involvement of school teams could bring to light themes that would lead to more critical and participative student awareness, as we would expect education professionals to have the expertise to provide emancipating education. The discussions of themes considered suitable for the field of Education, such as citizenship, participation, autonomy and empowerment were not found among the activities performed by the HSP program.

Thus, an analysis of the knowledge involved in HSP activities showed a predominance of knowledge from the healthcare sector. This is concentrated on learnings transferred to the students, and the means chosen to mediate this knowledge. When activities are carried out in the schools, knowledge is not built, problematized or reflexive. Teachers have limited involvement and often merely reproduce the teachings and instructions received from the healthcare system. This section illustrates this:

The (healthcare) team talks to the students bout healthy nutrition, lice and other diseases, they update vaccination cards, they are always around here doing something, providing support and information [...] *however, in my view, this support could be more constant. Perhaps the issue is the size of the community and the small number and limited availability of physicians* [...] *when they come the children welcome them*. (Teacher)

I spoke to the principal about what we really needed to talk to students and teachers about. She asked us to prepare a plan, to address sexuality and based on that we organized the activity [...] *we took some gifts to encourage student engagement. If we don't do that, nothing happens*. (Nurse)

Given the reports and observations we find that healthcare practices in the schools still have a strong preventive, fragmented and biomedical bias. They focus on clinical assessments and lectures on disease prevention. However, based on our observations, we infer that students have multiple healthcare needs, and that HSP measures, even if not very transforming, contributed to better health and consequently education. This is confirmed in the following statement by a school manager:

Here at the school we have a high prevalence of STD. Pregnancies and abortions are a constant, and sometimes school is the only place these students are free to talk about these topics [...] *for one reason or another they don't even discuss them with their parents, so activities in the school like lectures and tests help a lot*. (Principal)

The HSP program is important for health promotion activities, according to the directive that created it and the reference documents, it was conceived as a health public policy[19,28,29]. However, this study revealed few health promotion activities. According to the program's logical model, comprehensive care is one of the outcomes expected, and even though (healthcare) professionals claim it is of the utmost importance, it is still incipient and under construction.

The HSP proposal as an intersectoral program remains strongly rooted in sector activities. Dialog, the exchange of knowledge and experience, joint efforts and coordination with other social structures in the territory are important strategies to connect different initiatives, enabling synergy across actions taken to address any problems identified. It is understood that developing local actions involving the subjects that are directly impacted have a greater chance of delivering positive and long-lasting results[7,9,10].

Regarding the factors that make the development of the HSP program difficult in the city selected, the interviewees pointed to the large number of families the FHS must follow, compromising the frequency and quality of school visits. Furthermore, many students live in other territories, making it harder to follow them as if any healthcare problem is found, another team is responsible for care, with no efficient communication between the different teams.

Another difficulty mentioned was the shortage of financial and material resources, and the limited time of the professionals involved to plan activates jointly. In light of these findings, the absence of structured and shared planning in the ISWG could be a factor limiting HSP implementation and intersectorality.

Everyone involved in the HSP program mentioned that, since the Program was implemented, the teams in both sectors are closer and there is more dialog. This greater integration is mentioned as a facilitating factor that enabled the development of several activities. They also consider physical proximity between the healthcare and school units to be a facilitator, as well as schools that offer all-day programs.

The absence of procedures to train all of the professionals for intersectoral activities and to work in the HSP program are factors we found that are hurdles for making intersectorality operational. On the other hand, the willingness of many professionals to consolidate HSP is a factor that could enhance the Program's effectiveness.

Final considerations

This study attempted to discuss intersectorality in management and its operation in healthcare practices focused on school children. In general, the results show that there is limited appropriation of the concept of intersectorality, however the idea of joint efforts and partnerships is

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recognized as a means to achieve a better outcome from public policies. These findings allow us to consider that although the HSP program innovates the proposal of intersectorality, the measures actually developed remained strongly within the healthcare sector only. Involvement of the education sector is peripheral, which certainly limits the Program's potential, especially regarding the outlook for health promotion and citizenship development among school children.

As a limitation of this study we mention the limited number of HSP related activities in the period, thus limiting our on-site observation, and the failure to include students as interview subjects.

As a suggestion for improving the Program at the city level, we recommend creating an ISWG, greater involvement of the education sector in the political-management processes and practices, and training for intersectoral work for all of the players involved. Finally, we suggest new assessment studies to complement the current study, focusing on aspects related to the outcome of the HSP program and its impact on the school children, their families and the community.

Collaborators

MC Sousa helped conceive and implement all of the steps in the study, and also helped draft and review the final paper. MA Esperidião helped design the study, and also helped draft and review the final paper. MG Medina helped draft and review the article.

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