The implementation of intersectoral actions to assist children with congenital Zika virus syndrome in the state of Rio de Janeiro

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Abstract: This paper focuses on the actions and partnerships established between members of the State Secretariats of Health and Social Assistance in Rio de Janeiro and other organizations in the health and assistance areas to respond to the health emergency triggered by the congenital Zika virus syndrome between 2015 and 2018. Some characteristics of the context were: a severe economic crisis, the erosion of the governance capacities of the state political authorities as well and scarce technical-scientific knowledge about the epidemic. The study was grounded on an analysis of documents related to the topic, 17 semi-structured interviews with managers and professionals from the two secretariats. Interview scripts focused on intersectoral actions and processes of cooperation and coordination within and between organizations. The analytical grid included aspects of the interpersonal, informational, and decision-making roles of managers and technicians. The results show that, despite the political and economic crisis, the Secretariat actors managed to create a flow of care for patients. Informal cooperation and coordination mechanisms were crucial for the creation of long-term intersectoral strategies.

➤ **Keywords:** Public Policies. Implementation. Intersectoriality. Cooperation. Coordination. Zika Virus.

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Introduction

The Zika epidemic emerged in the country in 2015, in a context of low knowledge about the disease and serious impact on the lives of many women and children, especially those belonging to the most socially vulnerable groups. The fear about the possibility of the birth of an entire generation of children with serious neurological disorders led to intense mobilization from different social segments and spheres of government.

This situation has brought immense challenges to social protection, such as guaranteeing diagnosis and offering health care to these children, in the sphere of primary and specialized care, as well as other social rights, including access to transportation for treatment and access income, considering that most of these families live in a vulnerable situation.

The response to the crisis posed by the epidemic required governance involving intersectoral federal entities, multilateral organizations and national and international research institutions, which gave rise to the formation of several networks and actions. In the health area, the National Network of Specialists in Zika and Related Diseases (Renezika) was created, formalized with Ordinance No. 1,046, of May 20, 2016, to support the Ministry of Health with research information related to the Zika virus and related diseases in various spheres – surveillance, prevention, control, social mobilization, health care and scientific and technological development (Brasil, 2016a).

In December 2015, the federal government launched the National Plan to Fight Microcephaly and its consequences, which at the time was the main neurological manifestation for the recognition of congenital Zika syndrome (CZS). Only later, with the monitoring of the children, other manifestations were observed, including the syndrome without the presence of microcephaly.

It is important to highlight that the focus of government action on children who had microcephaly at birth caused difficulties in planning actions, in addition to hindering/excluding access to intersectoral policies for those children who only later showed neurological conditions resulting from Zika (Aragão, 2017).

The implementation of the Plan involved 19 bodies and entities in three axes of action: Combating the vector; Technological development, education and research; and Care. This provided for several actions to support children and their families (Brasil, 2015).

As a result of this plan, in March 2016, the Ministries of Health (MH) and Social Development and Fight against Hunger (MSD) presented the design of an intersectoral strategy that gave rise to Ordinance 405, with the aim of establishing the Strategy for Rapid Action to Strengthen Health Care and Social Protection for Children with Microcephaly (RAS). The Ordinance aimed to guide the Unified Health System (SUS) and the Unified Social Assistance System (SUAS) to work together to locate, diagnose and provide health care and social assistance to children in this context. This strategy should be implemented at the state and municipal level (Brasil, 2016b,c). The federal government's purpose was to accelerate the diagnosis of the condition, to guide care and assistance actions, especially the Continuous Payment Benefit (CPB).[1] To this end, it was necessary to locate and confirm the diagnosis of suspected cases, provide a clinical evaluation of the child and issue a detailed medical report with the necessary information, in order to enable care planning and instruction in the CPB granting process, in the case of families within the eligibility criteria provided by law.

The strategy required coordination in planning and management at central levels – the federal government, states and municipalities –, as well as cooperation between service units, at the local level, in the implementation of social and health assistance actions.

Within the scope of the SUS, the ordinance guided the determination and location of suspected cases of microcephaly through an active search – by the State Secretariat of Health (SSH) – and the provision of transportation and accommodation for the child and family, when they lived outside the home, under the responsibility of municipalities. The structuring of the assistance network, as well as the definition of reference services and health care flows, was the responsibility of state, municipal and district SUS managers. In an agreed manner, these actors defined the health establishments that would issue medical reports with diagnosis for the eventual process of granting the CPB.

Within the scope of SUAS, the ordinance guided collaboration with the SUS network in the active search for children suspected of microcephaly and their families, the identification of children eligible for the CPB, as well as the provision of social protection services and benefits to these groups.

Considering the particularities listed, this work aimed to analyze how an intersectoral strategy, in the area of health and social assistance, mobilized actors,

created institutional mechanisms and networks to assist affected children in the state of Rio de Janeiro. With this, the intention was, from the perspective of public policies, to identify in the process of implementing these actions elements that explained, in addition to possible successful actions, difficulties and institutional learning. As we know, the comparison between what is planned and what was actually implemented has repercussions on future approaches to social problems (Schofield, 2004; Sabatier; Jenkins-Smith, 1999).

Work methodology

Intersectoral actions are those implemented based on joint action, focusing on a specific target group; require reasonable levels of coordination to be effective. In the case of policies or programs with interfaces in different sectors, coordination and cooperation are even more crucial to achieving results. The coordination process refers to decisions and actions taken by one or more actors at a similar hierarchical level – ministries, for example – with the aim of reducing gaps or producing redundancies in the provision of public services, which expands horizontal interconnections (horizontal articulation) and allows adjustments to be made to intersectoral policies and programs (Peters, 1998; Solar; Irwin, 2010; Rantala; Bortz; Armada, 2014).

Vertical cooperation or articulation, in turn, refers to the joint action of a group of individuals from different government spheres – states and municipalities, for example – to achieve a common objective, aiming for greater efficiency in their actions and optimization of resources (Gillinson, 2004).

Within the scope of political theory, these issues are seen as a problem of collective action that public policy must face (Olson, 1965; Elster, 1989; Gillinson, 2004), and the answer to which depends on mechanisms of cooperation and coordination, without which it is unlikely that sustainable results will be achieved (Polski; Östrom, 1999; Östrom, 2005; 2009).

The study design included the analysis of technical-normative documents, produced by the MH and SSH/RJ; meeting minutes of the Bipartite Intermanagers Commission (BIC), which establish pacts between state and municipal managers in the formulation and implementation of health policies. Seventeen interviews were carried out with managers involved in the coordination and standardization of actions and higher education professionals responsible for the diagnosis and care of children and their guardians, distributed as follows:

- *Federal level* (4): 1 technical advisor from the Ministry of Health; 3 higher education professionals from Instituto Fernandes Figueira (service).
- *State Level* (9): Superintendent of Specialized Care at SSH (1) (coordination); Superintendent of Primary Care at SSH (1) (coordination); SSH Institutional Supporter (2) (articulation with municipalities and data monitoring); State Brain Institute (2) (service); Superintendent of Social Assistance (1) (coordination); Technical Assistance Advisor (1) (member of the Management Committee); State Public Prosecutor's Office (1) (attorney responsible for meeting demands filed by civil society and mothers).
- *Municipal Level* (4): Municipal Health Secretary (1); Municipal Secretary of Social Assistance (1); Municipal Coordinator of Basic Protection of Social Assistance (1); Direct Service Professional (1).

The interviewees were chosen based on the "snowball" technique, in which the first respondents indicate key people, who were extremely important for consolidating the data.

Different scripts were created for professionals who worked in management positions and for professionals responsible for caring for children and families. The differentiation of the scripts was important so that the professionals could define, in their speeches, the specific aspects of their performance.[2]

Data analysis was carried out based on operational categories, including types and coordination mechanisms; knowledge of the activities of each organization; communication channels between organizations and actors; monitoring of procedures and their levels; sharing information and resources. As end activities for identifying these categories, the following were explored: definition of reference services and access flows; active search for diagnosis or treatment; transport availability; diagnosis/medical report; referral to different services.

Coordination and cooperation in actions developed by SES-RJ

Emergency period

Although the 1988 Federal Constitution defined the role of coordinating and planning policies at the state level for state governments, the historical difficulty of overcoming political issues has brought numerous difficulties to the implementation of decentralization in the state of Rio de Janeiro (ERJ), which resulted, over the years, in the accumulation of the functions of state system manager and service

provider. Furthermore, the implementation of actions to combat the Zika congenital syndrome epidemic occurred in a context in which the state was facing a strong political and financial crisis, further increasing the challenges to be overcome.

Even with the existence of such difficulties, the managers of the state secretariats of Health and Social Assistance presented Joint Technical Note no. 001, of July 1, 2016, establishing the guidelines for the creation of the state *situation room*, aiming to monitor notified cases and those in follow-up. Coordinated by the Primary Care Superintendence of the State of Rio de Janeiro, it was made up of several actors from both policies. To centralize information on the monitoring of these children in their territory and formulate action strategies, each municipality had to indicate a person responsible, known as a *focal point*, for each of these areas, which required this professional to have knowledge of the network and the ability to coordinate with the services (Rio de Janeiro, 2016).

Municipal focal points were responsible for notifying suspected/confirmed cases and requesting the inclusion of these children in services. The data collected was reported to state Health and Care managers, who in turn consolidated the data from the federated unit and sent it to the Ministry of Health.

The sharing of information about cases in which an active search was necessarily followed a flow coordinated by state bodies. After analyzing the information, it was passed on from SSH-RJ to the State Secretariat of Social Assistance. From there, the data was sent to basic care units, within the health sector, and to the Social Assistance Reference Centers (SARC), within the scope of assistance. As a result, searches for cases of children diagnosed with CZS were carried out in the territory.

Based on these data, the situation room, responsible for monitoring actions, established strategies to close cases and ensure children were monitored through health and care policies. During this period, several meetings were held at the secretariats, internally and/or jointly, to exchange information and define support strategies for municipalities.

The suspected cases were sent to the State Brain Institute (SBI), responsible for diagnosing children with microcephaly, carried out in three stages: multidisciplinary consultation with the children and their families; carrying out complementary exams and making reports available; guidance on doubts and regarding the follow-up services that should be provided in the child's municipality of origin, who was responsible for inserting the child into the network and defining care flows.

The situation required qualified personnel and financial resources. It is worth remembering that, as the work was developed, new demands emerged: integration with INSS, which operated the CPB for children identified by social assistance, as well as with the education area, for the provision of daycare centers. In this process, a set of factors were highlighted that influenced the cooperation and/or coordination process within the Rio de Janeiro State Secretariat of Health, systematized in Chart 1, as follows.

Chart 1. Intersectoral Coordination and Cooperation in the state of Rio de Janeiro to fight SVZ

	FACILITATING ELEMENTS	DIFFICULTIES/OBSTACLES
COOPERATION	Commitment and autonomy of health institutions. Significant number of health services and research networks in the state. Ability to expand partnerships and maintain the plan, even after the emergency situation has lifted.	Low level of knowledge about the disease. Dispute for the primacy of knowledge to be constructed by the epidemic. Limited intersectoral articulation; Context of political and economic crisis at the state level.
COORDINATION	Ability to build partnerships over time with institutions and services. Performance of managers at CIB to coordinate and publicize actions.	Shortage of human and financial resources. High turnover of technicians at the central level of municipalities.

Source: own elaboration.

In the case of research institutions, there were disputes over the primacy of analyzing the epidemic phenomenon, which may have also influenced cooperation initiatives. In services, lack of knowledge and controversies about the disease generated uncertainty about procedures, especially the health care protocol, which required changes in the conduct of actions by states and municipalities.

In coordination, the main conflicts highlighted are of an *intra-organizational* nature, mainly within the state health structure, attributed in part to the political and financial crisis experienced by Rio de Janeiro. There was little support from the state government to the problem of the epidemic, with the managers of the

respective secretariats responsible for implementing the necessary measures with the municipalities, in a context of few financial and human resources.

Another difficulty experienced in the state was defining the focal points that would be responsible for assistance and health in monitoring the completion of the diagnosis and monitoring of children. The variety in the population size of the municipalities, and the consequent concentration of cases in larger cities, especially in the metropolitan region, which brings together a large part of health resources, made it difficult to define focal points in smaller municipalities, with a low number of cases and distant specialized services. This factor was aggravated with changes in municipal governments in January 2017. The change of managers led to the dismissal of previously appointed focal points, making it difficult to continue in the process of finding and monitoring children.

As the literature used in this work has demonstrated, coordination is developed by actors at central levels who act within an integrated decision system and delimited by rules, norms and formal procedures that aim to guarantee the rationality of the designed actions. The professionals who carry out field actions interact from their sectors/workplaces, making the script determined by the central levels operational. The interviews showed that, in the case of SSH, formal mechanisms such as communications and memos, in general, were only used for communication with higher levels of the secretariat. Informal contact mechanisms prevailed, such as telephone and apps, used to schedule discussions and schedule meetings.

Despite these organizational difficulties and the absence of intersectoral mechanisms for developing the state coordination role, individual initiatives by managers and health professionals, through the creation of interpersonal networks, were able to generate cooperation between different actors. This "informal" cooperation took place between public organizations, allowing some degree of coordination among public services.

Post-emergency period

Ordinance No. 3,502 of the Ministry of Health, published on December 19, 2017, defined the end of the emergency situation related to the epidemic (Brasil, 2017). At that time, SSH needed to adapt its work to the new reality: even with the decline in incidence rates, new CZS cases were still identified and needed monitoring. Other equally important points were related to the follow-up of

children with late manifestations of the syndrome, in addition to those who were reaching the age to attend elementary school.

The difficulties experienced by municipalities during the CZS epidemic, which required support from state managers to overcome it, served as the basis for developing a work plan that would continue actions in the new reality. In 2018, these initiatives were incorporated into the *Plan of the strategy to strengthen child care actions suspected or confirmed* by CZS and STORCH[3] (Rio de Janeiro, 2018). It is worth noting that the preparation of the plan was in line with the propositions present in Ordinance no. 3,502, of December 2017, and which were aimed at all Brazilian states. In the state of Rio de Janeiro, several professionals and institutions involved in the discussion and care of CZS cases became part of the State Management Committee, with the aim of discussing strategies, continuity of actions and planning agreed in the Plan.

Structuring of the Plan for Actions Linked to Zika-STORCH (2018) organized the interventions based on nine axes of action: Axis I – Epidemiological Surveillance; Axis II – Promotion and Prevention; Axis III – Primary Care; Axis IV – Specialized Care; Axis V – Hospital Care; Axis VI – Rehabilitation; Axis VII – Health Education; Axis VIII – Intersectorality; and Axis IX – Management (Rio de Janeiro, 2018).

The continuity of discussion and monitoring of cases, even after the end of the public health emergency, reinforced the need to give legitimacy to institutional spaces and arrangements. Methodological and planning changes must be considered in the development of intersectoral propositions, in the decision-making plan of the public agenda (Costa; Bronzo, 2012).

The reorganization of activities aimed at producing a consistent and quality record of monitoring information on children suspected or diagnosed with the syndrome; defining and understanding the role of focal points; offering transport to children for treatment outside the municipality; defining a flow that would facilitate the sharing of cases between basic care and primary care; reducing the high number of children with an open diagnosis; and carrying out intersectoral activities that ensure protection for children. Several actions and a set of monitoring indicators were designed to ensure monitoring of their implementation and subsequent evaluation. Despite the difficulties experienced by the state body in carrying out its coordination role, efforts were made to maintain the situation room, aiming at discussing cases; developing strategies and actions to improve the health care

provided to these children; and expanding partnerships with other secretariats and teaching-research institutions dedicated to the CZS issue.

At the federal level, initiatives by technicians were taken to understand the disease, seeking to approach and coordinate studies that would advance knowledge about the development of the syndrome in children. A consortium was created to establish coordination between studies from different *cohorts*. The construction of the network in a timely manner enabled cooperation between different organizations and research institutions.

The reorganization of these activities through the *Plan for implementing the strategy to strengthen care actions for children suspected or confirmed* by CZS and STORCH was fundamental after a turbulent period within the scope of the Federal Government. In this field, the impacts were generated, above all, with the impeachment of President Dilma Rousseff, in 2016, a factor that caused changes in the technical teams of several ministries involved with the Zika virus issue. Furthermore, it is reinforced that the discontinuity was not just on the federal side, as the decree of the end of the emergency coincided with the 2016 municipal elections. As stated, with the inauguration of new mayors in January 2017 and changes in teams, many municipalities had to start over from scratch, interrupting processes already underway.

The aforementioned aspects and the declaration of the end of the emergency meant the reduction of resources and activities, made coordination difficult and interrupted ongoing cooperation processes. However, as universities, research institutes, societies and associations, services from different specialties were mobilized, interest in studies on the dynamics of the epidemic and its consequences remained.

Coordination and cooperation in the implementation of intersectoral actions

It is observed that, despite the difficulties of human and material resources, the cooperation process between the SSH and the Municipal Health Secretariats made it possible to identify demand and reevaluate previously discarded cases. This performance can be attributed to two main factors: the relationship developed by the groups with their work object and the various partnerships with teaching, research and care institutions.

Cooperation between actors, in its various aspects, explains a large part of the success of actions to combat the epidemic. In this aspect, it is possible to identify the establishment of cooperative ties between the members of the management group, and between them and various partners in the health sector, justified in the interviews carried out not only for technical reasons, but also for the defense of public health.

Although the development of intersectoral actions is a guideline widely defended by public policies as a practical necessity, as problems that must be faced by different sectors affect the same population within a territory, the integration of policies, or at least the articulation between sectors such as Health and Social Assistance, is implemented. What also occurred, in the case studied, in the relationship with other social areas, such as Education and Social Security.

There are several factors that explain the difficulty of intersectoral actions, but one can highlight the centralized and sectorized tradition of the Brazilian bureaucratic structure, the forms of transferring resources between levels of government and the low tradition of interorganizational cooperation.

This sectorization also implies heterogeneous budgetary, managerial, fiscal and organizational management for local governments. In Brazil, the decentralization process has been implemented with an exacerbation of municipalization, in a very uneven way and, at first, with a lack of definition of roles at the federal and state levels (Abrucio; Franzese, dateless).

Furthermore, the institutional arrangements of health and social assistance policies place limits on states exercising intersectoral action. Although the policies are decentralized and provide for shared responsibility between levels of government, the coordination and cooperation mechanisms between the bodies involved are fragile, making it difficult to integrate service networks, optimize resources and share financing. In health, for example, management is local and financing is shared between the three spheres of government. In social assistance, management is shared and actions are funded by the municipality. In the specific case of CPB, management and financing are federal responsibility (Vaitsman; Lobato, 2017).[4]

It is identified that weaknesses in the integration of services occur in numerous aspects. Among them, the low technical and financial capacity in the supply of equipment and human resources; the dependence of many municipalities on state bodies; regional disparities and social inequalities; and the capacity to manage and provide services (Lobato; Senna, 2015).

From an implementation point of view, it is observed, with regard to inter-organizational conflicts, that there is reasonable autonomy for some of the entities and services involved in tackling the epidemic. Either because they are research and/or service institutions, with great capacity to attract resources and therefore have power and prestige, or because they belong to different levels of government. Despite the high commitment to confronting the epidemic, the initial disputes over the primacy of analyzing the phenomenon may have initially influenced cooperation initiatives. The situation was overcome with the subsequent establishment of several partnerships between these actors.

The intra-organizational conflicts identified within the state health structure, attributed in part to the political and financial crisis experienced by the state of Rio de Janeiro, limited the adherence of the central level of the state government to the problem of the epidemic and its performance as coordination, making the managers of the respective secretariats responsible for implementing the necessary measures in the municipalities, with few financial and human resources.

The prominent role of professionals and managers occurs in the face of difficulties in coordinating the service network and the absence of intersectoral mechanisms. Many of the actions implemented depended on the individual initiative of managers and professionals, through the creation of interpersonal networks, generating cooperation. This "informal" cooperation took place between public organizations, allowing some degree of coordination between services.

The most recent debate on the issue of public policy implementation seems to converge towards understanding this process not only as a stage subsequent to the decision and design of an intervention and prior to its evaluation. The classic top-down view of implementation has been replaced by the understanding that this is a complex process in which formulation and implementation interpenetrate at various levels and "decision-making layers". In other words, they permanently adjust to technical and political needs, as well as the actors who put them into practice (Lotta, 2019).

Several authors[5] highlight uncertainty as a typical component of implementation processes, since the phenomenon of uncertainty permeates all social relationships. In the field of public policies, its importance has been discussed in different ways for several decades.

According to Raaphorst (2017), the literature points to three paths for analyzing the topic: uncertainty as an information problem; as a problem of interpretation; or even, as a problem related to social interactions.

Although the topic can be seen from all these angles, the third approach to the problem of uncertainty – and the one that is most interesting, in this case – refers to its presence in social relationships. Here, the assumption is that uncertainty is an inseparable part of social relations. Freedom of action, or the manager's discretionary power, is often related to the unpredictability of facts or the tension that may surround some situations that must be faced.

The relational approach is defined by not considering reality in a static way. It recognizes that actors in implementation processes not only follow rules, but that these are mediated by the manager's opinions and values. Furthermore, they need to face situations that had not been foreseen, such as, for example, refusals and resistance to projects, both from the affected public and, eventually, from local managers.

In this research, it was observed that the variable "uncertainty" crossed practically all aspects of the work carried out at SSH-RJ, in a much more acute and complex way than could be assumed.

In the specific case of the state secretariat, the situation became a vicious circle: the delay in paying salaries affected many employees who were unable to pay for transportation to work; there were reassignments and dismissals of people in advisory roles that hampered the continuity of work in the teams; and the lack of transport for visits to municipalities was also a factor that made the processes difficult.

The temporary hiring of professionals and technicians (either through outsourcing of services or because they are politically appointed positions) generated high turnover in service management, with interruption and discontinuity in actions.

It is important to highlight that the Bipartite Inter-Management Commissions have been fundamental spaces for the process of decentralization and democratic management. It is in this space that the state and municipalities agree on the actions and policies to be implemented. Through them, it is possible to evaluate existing scenarios and organize the planning of public policy systems between levels of government. Among those interviewed, it was found that this space also contributed to the cooperation and awareness of municipal managers regarding intersectoral coordination. These instances of agreement demonstrated the initiative at the state level to coordinate actions, with dissemination and guidance for emergency

measures (focal points, protocols, referrals), limited by the restriction and instability of financial and human resources.

It should be noted that the state of Rio de Janeiro, despite the importance of its research and health care institutions, has a major "bottleneck" in the definition and organization of care flows, aspects that are largely related to precariousness of the regulation system.

On the initiative of groups of mothers in association with research and care institutions, networks were created to demand services for children with the syndrome, known as advocacy and support networks. The networks promoted the creation of support structures for families, the discussion of children's problems and demands and the holding of public hearings with the participation of the Public Prosecutor's Office, aiming to create a flow of care that would avoid the "pilgrimage" of mothers through several services and even duplicate service.

The participation of an external entity in a political coalition with multiple actors involved and roles that are not very well defined can lead to changes in the views of opinion makers, influencing their decisions and leading to the possibility of agreement (Sabatier; Weibler, 2007).

In the specific case of caring for children with Zika, as the disease was unknown, there were no pre-established protocols. It was necessary for health and rehabilitation services to incorporate a certain number of places for child care into their agenda. The interference of the Judiciary in that context is ultimately explained by two factors. On the one hand, the serious economic and political crisis that the state of Rio de Janeiro was going through. On the other, due to the presence of several specialized services that have their own characteristics and missions, which were not prepared to respond to the specific issues raised by the epidemic. The Public Ministry of the State of Rio de Janeiro (PM-RJ) was asked to intervene in order to organize health care for those children. Through a Public Hearing with various actors, the inclusion of specialized services was agreed and the flow of care was defined.

The mothers' movement placed the day-to-day activities of associations within the scope of judicializing access to rights for children and their families. This insertion of the Public Ministry and other bodies, such as the National Council of Justice, reflects the importance of mothers' movements and organizations in the face of issues linked to CZS. However, it also reflects the restrictions of managers in

the appropriate delivery of care, compromising access to the rights of children and families, who need to resort to the Judiciary.

Final considerations

Directing strategies to combat the public health emergency caused by the Zika virus epidemic highlighted the role and importance of epidemiological surveillance and social assistance surveillance systems. The identification of the first cases contributed to the creation of strategies, protocols and regulations that reinforced, among other things, the importance of joint action between policies.

When analyzing the implementation of intersectoral actions in assisting children with CZS in the state of Rio de Janeiro, we see the importance of research institutions and the management committee in conducting strategies for the period of confronting the epidemic and in the continuity of priority actions after the end of the public health emergency.

Even in a scenario of political and economic crises, there was an important performance by strategic actors, inserted in public policy management institutions, such as the State Secretariats of Health and the State Secretariat of Social Assistance, in the creation of flows and strategies to assist children and families.

The collected data indicate that the implementation of intersectoral health and social assistance actions, where they occurred, depended more on the initiative of informal cooperation between public agents than on formal policy mechanisms. Care protocols were created for diagnosis and monitoring of confirmed cases, information networks and mechanisms for monitoring actions in municipalities. However, the coordination of the service network was failed, due to the decentralized structure of the health and social assistance systems, the lack and low quality of services in the municipalities and the financial and human resources instability. Care services for children and families remain precarious and of low quality and there is no full control over inconclusive cases.

In the context analyzed, the health sector played an important role in articulating with other public policies, despite areas such as social assistance still struggling to implement the guidelines set out in the policy, as well as guaranteeing adequate financing for the care of families. Social security, as it presents a very hierarchical structure, also challenged the creation of intersectoralized actions that would guarantee access to rights and benefits.

Intersectoral cooperation and coordination mechanisms are identified as strategic in the effectiveness of public policies. In Brazil they are fundamental, especially in social policies. The areas of health and social assistance contain an intersectoral perspective, as they have a broader conception of social problems and recognize the need for integrated policy action to ensure social protection. The 1988 Constitution included the idea/principle of social security, which provided for a single institutional structure among the areas of health, social security and social assistance.

However, the subsequent trajectory was one of separation of resources, functions and closed borders between the different areas. This sectoralization was reproduced in the official apparatuses of states and municipalities, generating vertical structures with overlapping actions and institutional voids. Institutionalized intersectoral mechanisms do not guarantee, by themselves, the adequate provision of services, but they strengthen the state's action and can even protect this action in crisis contexts, as in the case of Rio de Janeiro during the Zika epidemic.

The study demonstrated that informal mechanisms could, even if with limits, inform the creation of longer-term intersectoral strategies, as was the case with the *Plan for implementing the strategy to strengthen care actions for children suspected or confirmed* by CZS and STORCH. The plan, however, comes up against the lack of adherence to intersectorality by the structures of different policies. In this sense, in order to achieve the necessary intersectorality, it is necessary to review the institutional structures that restrict it.

Another factor of great importance, which deserves to be mentioned, is related to the issue of institutional learning, which occurs during the processes of implementing a policy, even if this, in this case, has been defined as relatively short-lived – the time of an epidemic.

If we consider that the execution of a public policy represents the "State in action", and, at the same time, exposes the difficulties and eventualities in carrying out this task, the importance of *learning about policies* is unmistakable. In the case studied, the post-emergency period makes clear the reorganization of tasks by the SES, aiming to diversify and expand the quality of services provided, structuring activities into nine axes that included/expanded themes such as promotion and prevention, intersectorality and management.

As Schofield (2004) highlights, learning is simultaneously limited by bureaucracy and highlighted by the bureaucratic and hierarchical role that implementers play.

Topics such as motivation and length of experience contribute to expanding learning. This reorganization, and the creation of a Management Committee, also suggest *political learning*, aimed at strengthening the SSH as an organization, at a time when the role of the Ministry of Health has redirected its institutional priorities.[6]

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Notes

[1] Income transfer benefit worth one monthly minimum wage for people with disabilities (and the elderly) with a per capita family income of up to a quarter of the current minimum wage.

[2] This study was funded and is part of the research "Social Sciences and Humanities in the face of the Zika Virus Epidemic in Brazil", submitted by Fiocruz/Ensp, approved by the Ethics Committee, in accordance with Resolution No. 466/12 of the National Council of Health of Brazil, through CAAE: 67311617.8.0000.5240. All participants signed the Free and Informed Consent Form.

[3] Syphilis, toxoplasmosis, rubella, cytomegalovirus and herpes viroses.

[4] Even though CPB is a social assistance benefit, which is responsible for registering and referring potential beneficiaries, as well as carrying out social assessment within the scope of the INSS, there are restrictions on this social assessment in relation to the medical expertise carried out by the INSS. (Vaitsman; Lobato, 2017).

[5] Pressman & Wildavsky (1973), Zahariadis (1999), Walker & Marchau (2003), and Raaphorst (2017).

[6] S. A. V. de Siqueira, E. Hollanda, I. K. da N. Beserra, L. Lobato e J. Vaitsman: participation in all phases of the article elaboration.

Resumo

A implementação de ações intersetoriais na assistência a crianças com síndrome congênita do vírus Zika no estado do Rio de Janeiro

Este trabalho analisa as ações e parcerias estabelecidas entre os integrantes das Secretarias Estaduais de Saúde e da Assistência Social do Rio de Janeiro e outras organizações da área da saúde e assistência para atender à emergência sanitária desencadeada pela síndrome congênita do vírus Zika entre os anos de 2015 e 2018. O contexto caracterizava-se por acentuada crise econômica, erosão da capacidade de governança das autoridades políticas no estado, e reduzido conhecimento técnico-científico sobre a epidemia. Além de análise de documentos relativos ao tema, foram feitas 17 entrevistas com gestores e profissionais das duas secretarias. Roteiros semiestruturados focalizaram ações intersetoriais e processos de cooperação e coordenação inter e intraorganizacional. A grade analítica contemplou aspectos dos papéis interpessoais, informacionais e de tomada de decisão dos gestores e técnicos. Os resultados mostram que, apesar da crise política e econômica, os atores das secretarias conseguiram criar um fluxo de atenção aos pacientes. Observou-se que mecanismos informais de cooperação e coordenação foram fundamentais para a criação de estratégias intersetoriais de longo prazo.

➤ **Palavras-chave:** Políticas Públicas. Implementação. Intersetorialidade. Cooperação. Coordenação. Vírus Zika.