School Health Program: potential and limits of the intersectoral articulation to promote the health of children

Programa Saúde na Escola: potencialidades e limites da articulação intersetorial para promoção da saúde infantil

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ABSTRACT The study aimed to understand the potential and limits of the intersectoral articulation of the School Health Program for the promotion of children's health from the perspective of primary care professionals. This research had a qualitative, descriptive-exploratory approach, carried out with 20 health professionals from different professional categories, in four municipalities in the Greater Florianópolis. Data collection was carried out through interviews from November 2020 to March 2021. The data underwent content analysis and discussed according to the theoretical framework of health promotion. It stood out as potential: monitoring the health conditions of schoolchildren, expanding access to health information, partnership with other sectors, and the creation of links with the school community. The limits highlighted were the partial coverage of the school network, the lack of knowledge about the program, the overload of activities, the lack of human resources and infrastructure, and the impacts caused by the COVID-19 pandemic. It is concluded that there is a need to strengthen the School Health Program as a public policy with the purpose of implementing articulated actions between health and education so that they can actually improve schoolchildren's quality of life and act on their social determinants.

KEYWORDS Health promotion. Intersectoral collaboration. Child health. Primary Health Care. School health services.

RESUMO *O estudo objetivou compreender as potencialidades e os limites da articulação intersetorial do Programa Saúde na Escola para a promoção da saúde infantil, sob a ótica dos profissionais da atenção primária. Pesquisa de abordagem qualitativa, descritiva-exploratória, realizada com 20 profissionais da área da saúde, residentes em quatro municípios da Região da Grande Florianópolis. A coleta de dados foi desenvolvida por meio de entrevistas, no período de novembro de 2020 a março de 2021. Os dados passaram por análise de conteúdo e discutidos à luz do referencial teórico da promoção da saúde. Destacaram-se, como potencialidades, o acompanhamento das condições de saúde dos escolares, a ampliação do acesso à informação, a parceria com outros setores e a criação de vínculos com a comunidade escolar. Os limites evidenciados foram a cobertura parcial da rede escolar, o desconhecimento sobre o programa, a sobrecarga de atividades, os impactos causados pela pandemia da Covid-19, a falta de recursos humanos e de infraestrutura. Conclui-se que há necessidade de fortalecimento do Programa Saúde na Escola enquanto política pública, com vistas à efetivação de ações articuladas entre saúde e educação para o alcance da melhoria da qualidade de vida dos escolares, com atuação sobre os seus determinantes sociais.*

PALAVRAS-CHAVE *Promoção da saúde. Colaboração intersetorial. Saúde da criança. Atenção Primária à Saúde. Serviços de saúde escolar.*

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Introduction

The modern health promotion movement has been developing more vigorously in the last 30 years, from the publication of the Ottawa Charter, which guided the elaboration and implementation of public policies in several countries, including Brazil[1]. The adoption of health promotion as a redirecting element of the policies of the Unified Health System (SUS) culminated in the National Health Promotion Policy (PNPS). The PNPS reaffirms the relevance of the health sector, with the objective of promoting quality of life and reducing vulnerability and health risks related to its determinants and conditionals – ways of living, working conditions, housing, environment, education, leisure, culture, access to essential goods and services[2].

With the PNPS, the need to systematize intersectoral proposals was imposed with the objective of overcoming the fragmentation of knowledge and social structures, in order to produce more significant effects on the health of individuals and communities. It is understood by intersectoriality

> the articulation of knowledge, potentialities and experiences of subjects, groups and sectors in the construction of shared interventions, establishing bonds, co-responsibility and co-management for common objectives[3].

This represents a great challenge in the articulation and planning of the work process, as it requires respecting the vision of the other and their contribution to the construction of decisions in facing the problems and situations raised, being a key action in teamwork for the Family Health Strategy (ESF)[4].

In this way, the search for integrated practices and intersectoral approaches has been the strategy adopted by public policies for the development of actions to promote the health of schoolchildren, considering that habits, attitudes and beliefs formed during childhood have great chances of being perpetuated into adulthood[5,6]. In an attempt to address the vulnerabilities to which children are exposed, initiatives aimed at the school context have gained prominence, especially because education is considered one of the main determinants for health, which contributes to the empowerment of subjects, promoting their personal and social development and consequently as an instrument of social transformation[7].

In this sense, guided by the contemporary theoretical framework of health promotion and in line with the actions proposed in the PNPS, which encourages articulation between the different sectors, the Ministries of Health and Education prepared and approved the regulation of the School Health Program (PSE), representing a milestone in the process of appropriation of the school space as a health field[8]. This intersectoral policy, based on the principles of integrality, territoriality and intersectorality, aims to work with disease prevention, health promotion and recovery actions to collaborate for the integral formation of schoolchildren, materializing in the partnership between public schools and Basic Health Units (UBS)[6].

The PSE is in a permanent expansion movement, with an increasingly expanding panorama in the Brazilian territory, being the main program focused on the health care of students in public schools, given its innovative nature of intersectoral action[8]. About 99.7% of Brazilian students in basic education, aged between 6 and 14 years, attend schools in the country, and the importance and potential reach of the PSE is perceptible, since the approximation and joint action of the health and education, with the participation of students and family members, enables concrete actions to address the vulnerabilities and social constraints of the health-disease process[9-11].

However, due to the innovative character of the proposed intersectoral action, its effective operationalization is still a challenge for managers. Conducting information, articulating the sectors and actors involved, overcoming the medicalization of education, including

in the regulations, linking permanent and comprehensive actions with its monitoring continue as adversities to be overcome in the daily life of the PSE6. In this sense, carrying out studies on the PSE is important, as they allow estimating the direction of the strategies adopted to favor intersectoral action in the territories and the scope of its use to promote the health of children and their families, in favor of the reduction of social inequities.

Given this context, the following research question emerged: 'What are the potential and limits of the intersectoral articulation of the School Health Program for the promotion of child health?'. From then on, the objective of the study was to understand the potential and limits of the intersectoral articulation of the PSE for the promotion of children's health, from the perspective of primary care professionals.

Methodology

This is a qualitative, descriptive-exploratory research, based on the theoretical assumptions of health promotion[3,12]. It was developed in the Greater Florianópolis Region, in Santa Catarina, Brazil, involving four municipalities with the largest population contingent: Florianópolis, São José, Palhoça and Biguaçu, which adhere to the PSE.

Twenty health professionals participated in the study, and the selection occurred by convenience, due to the involvement with the student's health, indicated by the coordinators of each UBS. All invited professionals agreed to participate in the study, with no refusals. The following inclusion criteria were considered: being a health professional and working in care and/or management practice with school children aged 6 to 10 years, in a public institution, regardless of the type of employment relationship, with previous experience working in the PSE. It was decided to include in the study several professional classes involved in the PSE actions of the Greater Florianópolis Region, of medium and higher level, with the objective to give voice to these workers, from different municipalities and realities. As exclusion criteria, the following were adopted: professionals with less than one year at that unit or who were on vacation or leave of any kind during the period of data collection.

Data collection was conducted by one of the authors, a nurse, doctoral student, with experience in this type of approach. It took place from November 2020 to March 2021, through individual interviews. A script was used containing semi-structured questions, which involved themes about the potential and limits of the intersectoral articulation of the PSE and sociodemographic data of the participants. Due to the restrictions imposed by the COVID-19 pandemic, two modalities were offered to carry out the interviews, in person or virtual, chosen at the discretion of the participants.

To record the information, audio recording was used in face-to-face interviews, through an application available on the smartphone; and in virtual meetings, through the audiovisual resource available on the Google Meet® platform. Subsequently, the information was transcribed faithfully to the speech of the participants, organized with the help of a text editor from the Google Drive® program and stored in digital folders with access limited to the researchers.

Subsequently, the content analysis of the interviews was carried out, comprising three steps: 1) Pre-analysis; 2) Exploration of the material; 3) Treatment of the results obtained, inference and interpretation13. After transcribing the interviews, repeated and exhaustive reading was carried out, thus allowing the ordering of the set of data obtained. Thus, a first classification was initiated to apprehend the relevant structures, enabling the unveiling of empirical categories, interpreted based on the framework

of health promotion and current literature related to the topic.

The study followed the norms and guidelines provided for in Resolutions No. 466/2012 and No. 510/2016. The investigation began only after approval by the Ethics Committee for Research with Human Beings of a public university in Santa Catarina, protocol number 39239820.2.0000.0121, on February 9, 2021. Acceptance of participation in the study was formalized by professionals with the signature of the Free and Informed Consent Term, ensuring anonymity by replacing the names with the initials of the words 'Health Professionals' in portuguese, followed by an arabic numeral, for example: PS1, PS2, and so on.

Results

The 20 study participants were health professionals working in primary care in the following municipalities: 4 from Biguaçu, 5 from São José, 5 from Palhoça and 5 from Florianópolis. *Table 1* characterizes the profile of the participants.

Table 1. Characterization of study participants. Florianópolis, SC, Brazil, 2021

Characteristics	Category	N
Gender	Feminine	17
	Masculine	3
Age	30 – 40 years	8
	41 – 50 years	11
	Não informou	1
Profession	Social Worker	4
	Nurse	4
	Speech therapist	1
	Physician	5
	Dentist	1
	Psychologist	4
	Nursing Technician	1
Education	University graduate	5
	Specialization	12
	Master's degree	3
Time working	1 – 5 years	4
	6 – 10 years	4
	11 – 15 years	8
	Over 15 years	4
Employment relationship	State public employee	20
	Contracted employee	0
Occupation area	Assistential	16
	Manager	4

Source: Research data, 2021.

From the content analysis, two thematic categories emerged: 1) Potentialities of the intersectoral articulation of the PSE; 2) Limits of the intersectoral articulation of the PSE, which will be presented below.

As potentials, the professionals highlighted the closer relationship between the health teams and the school community, which benefited the program, improving the communication process between the sectors and favoring the reach of children and families who, many times, were not assisted by the UBS.

> *I think this interaction is a huge power, all the work I did with the teams in the territory with the schools was always very rich. So we even have a PSE WhatsApp group where we are there for support, the idea is not to be there for urgent care, but for us to communicate, so that we can talk in situations that need it. Because the idea is really for us to dialogue and, understanding that situations are complex, we need more people acting and more policies working together, you know, otherwise we can't handle it.* (PS9).

The articulation between these sectors also enhanced the monitoring of the health conditions of the students, with anthropometric and oral health assessments and verification of the vaccination status:

> *So with children up to the 5th grade, more or less once a semester, we carry out this evaluation of screening for weight, height, vaccination record.* (PS11).

> *We checked the vaccination record, the issue of brushing the children's teeth, we measured the children's weight and height. A study was also carried out on the BMI, so the weight and height of these children, whether they were below, or if they were above.* (PS16).

Many of the assessments are carried out by professionals from both areas, through training, such as visual acuity examination, for example, while and others are exclusively technical competence of health, such as dental procedures. Thus, when identifying possible problems, the participants mentioned the continuity of monitoring the student in the health network when necessary, through appointments at the UBS.

> *Last year we had some actions in relation to obesity, children who were evaluated by the PSE. And then, according to the perception, the children who were overweight and such, these children were referred to the health unit for follow-up, tests were requested, then they came for us to evaluate.* (PS17).

Another factor considered as potential was the expansion of access to health information. In this way, they showed that they carry out health promotion and disease prevention actions, with guidelines, aimed at the self-care of schoolchildren:

> *Within each school year, according to age, we began to see what would be more viable, the topic to be worked on. The first year received brushing and oral health guidance, the second year was hygiene and talking about worms, which is an exclusion disease, the third year we talked about healthy eating and physical activity, the fourth year dengue fever, the fifth year was accidents and violence.* (PS19).

In addition, with the aim of transcending the performance of specific actions by the health team at school and the mere focus on the disease, they mentioned that they seek to link PSE themes to the school curriculum so that they can be worked by teachers in their daily lives in pedagogical activities:

> *Education has embraced this a lot, because of the curricula, we have always encouraged health education actions to be included in schools' pedagogical political projects, in transdisciplinary actions. So, some subjects were worked on in the physical education class, in the science class, in other classes as well, because it is not necessarily the health professional who has to go there to*

work with health-related issues. A well-oriented, well-trained teacher, he manages to work this in the day to day of the classroom, which will make much more difference in that child's life than the professional going there, once or another in the year, giving a lecture and going although. (PS5).

They also highlighted the continuing education activities carried out with the teachers, in which they seek to address, as a priority, themes related to the PSE, according to the reality and needs of each institution.

The idea is to train teachers, in order to train them and make them more comfortable to talk about hygiene, dengue, do training on each topic with specific teachers, from physical education to do anthropometry, explain the importance of healthy eating [...] because they already do a lot of this work within the school, and sometimes what they need is support, training. (PS19).

The principal needed me the other day to work with some teachers about caring for children who were raped at home, how they would work with these children, how they would approach these children, so I took a psychologist with me, it was really good. (PS18).

In an incipient way, they addressed that they seek to bring families together in some actions developed, in order to guide them and clarify parents' doubts on topics involving health care and children's education:

I was invited a few times to do it, which was a partnership of health and education by the PSE, which was the 'School in Family'. So the professionals made themselves available and went to schools at night to talk to the parents; we had a schedule. So, for example, I talked about the establishment of limits, we already talked about the issue of violence, so several themes, as they also raised some themes in certain schools. (PS20).

As a great potentiator of this articulation, the professionals mentioned the partnerships established, either with the multiprofessional team of the Expanded Family Health Center (NASF), or with other sectors, especially those linked to Social Assistance, such as the Social Assistance Reference Center (CRAS).

Once a month we had the School Health Program meeting at the health center with the health teams, representatives of each team, in which I participated, along with other NASF professionals, along with CRAS, with representatives of the schools, there was always the presence, either of the coordinator, or of the educational advisor, or some teacher. (PS6).

We tried to make this assessment a little more multi-disciplinary, work together, integrated with schools, social assistance, guardianship council, when necessary, we discussed cases, each team with its situations. (PS8).

In the second category, in which the professionals discussed the limits of the intersectoral articulation of the PSE, it was evidenced that they face daily limits for the implementation and development of the PSE in the municipalities studied. In some places, the agreement processes were recent, and the coverage of public schools is partial, with priority being given to those linked to the municipal network.

We only signed up in 2017, we agreed on around 11 schools, half of which are child education centers [daycare centers] *and half municipal educational centers* [schools], *only municipal. Until today, we have never worked with the state, also because of the huge number they have and because we are starting.* (PS19).

In the last biennium, from 2019 to 2020, we had the most expanded contractualization in the PSE, for all neighborhoods of the municipality, including from elementary schools and in some state high schools. (PS12).

In addition, professionals mention the lack of knowledge about the program or

reductionist views on the part of education professionals, with little participation in the planning, execution and discussion of the activities developed, usually centered on the management of the school.

> *We had difficulty accessing the school in our area. The manager there believed that our entry hindered their organization a little. But later she understood the objective and we managed to do several activities.* (PS13).

However, the biggest obstacle identified was the excessive demand for activities assigned to the Primary Health Care (PHC) health team, which often fails to prioritize actions in the school context.

> *I think we haven't been able to work* [the PSE]*, but not necessarily because of the school, but maybe because of our limitation. In primary care, we have many demands for care and more and more things come to the team to develop. We weren't able to handle all things like that, groups, care, surveillance and territorial actions.* (PS6).

In addition, they linked that the lack of human resources in health contributes to aggravating this situation, especially when related to the multidisciplinary teams of the NASF, which support the basic teams in many actions:

> *Currently, since I joined, I am the only social worker in all health units, so the demand is like this, very large, [...] imagine, one professional for a municipality that we consider to be quite vulnerable.* (PS1).

> *Today we are four psychologists for all primary care, so this is like trying to dry the ice, so, it's a huge demand, even considering that U share my workload [...] we circulate between the units.* (PS20).

Another limiting factor was the COVID-19 pandemic. There was a significant reduction in the number of professionals working in person at the UBS, as some remained in telework because they belonged to the risk group. Added to this, it further overloaded the health teams that turned to attend this demand, which negatively interfered in the execution of PSE activities.

> *Now, in the phase of the pandemic, we are not going, we are no longer carrying out educational activities, everything is stopped by this whole issue that we are experiencing. Our focus now is within the unit, we continue with child care, but this part of education* [in health]*, this part of the school, we had to take a break.* (PS16).

> *We had a plan together with the health and education team, but unfortunately the pandemic came and we were unable to put it into practice. But we intend to continue with this same plan when this situation improves.* (PS1).

In addition, it should be noted that, due to the pandemic emergency, the prevention of the new coronavirus was incorporated as a priority action. In view of this scenario, they pointed out that there was an impact on the offer of face-to-face activities, which required the adoption of new strategies in remote or hybrid modalities to develop actions in this period:

> *We recorded a puppet theater that talked about COVID guidelines, forms of transmission and hygiene care. This video was sent to the school principals so that they could pass it on to the teachers and they would multiply it for the students.* (PS4).

> *We are starting to build educational materials to put on educational portals, so, on the platforms that education departments are using, whether it's Google Classroom, or the Educational Portal of the Municipal Department of Education. They are educational materials for children to make, draw, paint, videos, leaflets, so that they can be included within educational portals or platforms that schools use for children to have access to health content.* (PS5).

In the study, potentially integrating mechanisms between health and education were identified to promote improvement in the living conditions of schoolchildren. However, there are limitations that interfere in the process of implementation and development of PSE actions, which make it difficult to adopt a logic of intersectoral action.

Discussion

The school, as an institution, is defined by its teaching function, with the objective of carrying out human formation, having as a starting point the recognition of people's needs. Space of knowledge where health emerges as a recurring theme of learning, harboring wide possibilities, such as: actions of clinical and/or social diagnosis; screening strategies and/or referral to specialized health services or primary care; education and health promotion activities, which, with the participation of the family and the support of public policies, should be the children's first contact regarding the understanding of health[14,15].

The inclusion of health in school brings benefits to the quality of life of students and, consequently, improves this population's access to health services, which positively interferes with education. This relevance is confirmed in a study that highlights the school as an environment of important social interactions between teachers, students, family members and health professionals. It is a space from which several demands and needs emerge that can be problematized in its broader context[16], revealing itself as an important potential for the effectiveness and intersectoral articulation of the PSE.

The school space should not be used for medical consultations, with the aim of medicalization or clinical-psychic diagnosis of failures in the teaching-learning process, but for the detection of signs and symptoms of health problems, due to its objectivity and scale gain in a collective environment[17]. In this sense, it is necessary to overcome the logic of the hygienist and preventive model that has lasted in the trajectory of health education, with normative components and predefined contents about what should be done and discussed in health in schools, with emphasis on behavior change or of risk factors, from an individual perspective[6,15].

To expand access to health information, through proposals that encourage people's critical capacity and autonomy, health promotion is a counterpoint to this model[18]. This is understood as a set of promising strategies to face the multiple health problems that affect individuals and communities, with the objective of reducing differences in the population's living conditions through a more equitable social development[19]. Starting from a broad conception of the health-disease process and its determinants, this strategy proposes the articulation of technical and popular knowledge, with the mobilization of institutional and community, public and private resources, in favor of quality of life[1].

In this sense, the importance of the PSE is reinforced, which needs to consider the school and social dimension, as well as the student's local health diagnosis. The program should treat comprehensive health and education as part of a comprehensive training for citizenship; allow the progressive expansion of actions carried out by the health and education systems, in search of comprehensive care for children; and to promote the articulation of knowledge, the participation of students, parents, the school community and society in general in the construction and social control of public policy[17].

A study with representativeness throughout Brazil evaluated data from the National School Health Survey (PENSE), in 2012, and the results showed fragility of political actions to promote school health. Significant regional inequalities were identified,

including: the South and Southeast regions tend to have better scores and a higher proportion of students in schools that include the health promotion indicators evaluated[20].

Health promotion, therefore, as a relevant paradigm in health, should guide not only the practice, but also the teaching of professionals, since its teaching is based on a transdisciplinary, integrative approach, which involves several areas of knowledge, providing opportunities for the integration of knowledge that is relevant to their practice. For this, professional training in line with the construction of capacities that facilitate the implementation of its theoretical-methodological principles is required, encompassing the holistic conception of care, intersectoriality, community empowerment and social participation, the search for equity and action over the social determinants of health[21].

It is also highlighted, in the work between the education and health sectors, that professionals can and should seek the formation of partnerships to solve the difficulties experienced daily, in order to make the actions more effective[18]. These are seen as a potential tool for the performance of the PSE, efficient and viable, capable of improving and/or solving various problems through the union of efforts of sectors and partners that, in collaboration with various areas of knowledge, can increase the impact and the sustainability of any action developed[22]. From this perspective, all professionals involved in the PSE share individual and collective knowledge to form critical and informed citizens, with the skills to act in defense of life and its quality[17], which is an important potential in the intersectoral articulation of this program for the promotion of child health.

The design of the PSE proposes the organization and provision of services in a certain geographic area so that the articulation takes place between the Family Health teams and the schools of the attached territory[17]. Although the implementation of the ESF in Brazil has experienced a significant expansion of coverage in the last decade, with different rhythms between regions and the population size of the municipalities, there are important differences in coverage, access and provision of care in the UBS, in part due to management mechanisms and social inequalities in the country, with relevant repercussions on access to and use of health services, such as adherence to and implementation of the PSE[23]. Furthermore, the complexity of the intersectoral and multidisciplinary model to build a health promoting school makes it difficult to develop the program in the context of municipalities6, revealing itself as a limiting factor for the effectiveness and intersectoral articulation of the PSE.

Although the dialogue between the health and education sectors is closer, the relationship between the services has weaknesses related to the involvement in the formulation, implementation, monitoring or joint evaluation of actions in the school setting, confirmed by the professionals' speech. A study that investigated the practices linked to the PSE in a municipality in Bahia found that planning, activities and evaluations, even informal ones, are carried out by the health sector, generating inequality in commitment, responsibilities and decisions making, with the participation of the education sector considered peripheral, which certainly restricts the potential of the program[10].

The lack of knowledge about the PSE, its objectives and the way in which the other sector works, as well as communication problems between professionals and between sectors and different levels of management, are factors that limit intersectoral action. There are other limitations, such as: schedule incompatibilities; excess of activities and reduced number of professionals; meeting deadlines and goals; centralized planning; divergences and

disrespect between sectors and difficulty in adopting new postures[11]. These factors contradict the health promotion paradigm, which exposes the need for the process of producing knowledge and public policies to occur through shared construction and management[16].

It is noteworthy that management is considered by the health teams as a link between the other sectors, however, it deals with scarce resources to perform this work. In this sense, it is imperative to provide adequate means for teams and management to carry out their actions, with a direct influence on the production and quality of health work. Bureaucratic difficulties also occur, such as the absence or lack of knowledge of how to stimulate funding for intersectoral actions to achieve them4, which are other factors that can limit PSE actions.

It is worth remembering that the unexpected event of the COVID-19 pandemic aggravated the overload of professionals, who had to readjust activities to meet this demand and the need to maintain social distance and prevent the risk of contagion. A study carried out to verify the role of the PHC nurse in routine care actions for the health of the child during the pandemic situation showed that certain actions were no longer carried out, with the suspension of routine care for prioritization of cases, reception and consultation only for acute complaints[24], which was also mentioned by the participants as a limiting factor for the intersectoral articulation of the PSE in favor of the promotion of child health. Thus, in order to continue the actions and with the inclusion of the theme related to the coronavirus in the PSE, a study pointed out that the adoption of strategies using remote teaching made it possible, in a certain way, to continue the integration with the activities developed by the program, which was also verified in this study[25].

In view of the above, it appears that practical actions between health and education lack many debates, theoretical approximations and other forms of partnerships so that, together, they can replace linear and unidirectional thinking with circular and multi-referential knowledge[22]. However, although it has some structural and managerial limitations, the PSE is evident as a tool capable of providing improvements in the quality of life of students, with potential that can have a positive impact on families and communities[16].

Thus, there is a need to strengthen this public policy through the incorporation of intersectoral articulation in the routine of managers and professionals so that, gradually, they acquire skills in the development of truly impacting health promotion actions, aiming to improve the health conditions of the population[4]. As a limitation of this study, it is pointed out the difficulty of reconciling time to carry out the interviews with the participating professionals, who, given the demands, especially in the face of the pandemic, were in an intense work routine.

Final considerations

When revealing the professionals' perception about the intersectoral articulation of the PSE as one of the possibilities to promote child health, potentialities were identified, such as: creation of links between the health teams and the school community; monitoring of students' health conditions; expansion of access to health information; greater approximation of families to the actions developed; and partnership with other sectors.

However, for the participants of this study, there are limits that need to be overcome in order for changes to occur in reality, namely: the agreement of the municipalities studied is still recent and with partial coverage; the lack of knowledge of the program by the educators, in a reductionist view and with little participation in the

planning of activities; lack of resources; the intense demand of professionals working in PHC, especially in the pandemic period, which hampered the development of PSE actions in the school environment. Therefore, there is a need to strengthen the PSE as a public policy, for the implementation of articulated actions between the sectors and the achievement of new partnerships, so that it can, in fact, promote the health of schoolchildren and act on its social determinants, with beneficial repercussions to the entire community.

The present study did not intend to exhaust the debate on the subject. Therefore, it becomes relevant and necessary to invest in new research in order to deepen the understanding of intersectoral work. Furthermore, the development of future research covering other actors involved in the context, such as family, students, education teams and other partners, is considered relevant, in order to understand their view of the PSE as a health promotion policy.

Collaborators

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