# An analysis of the work process of health and education professionals in the PSE

## *Uma análise do processo de trabalho dos profissionais da saúde e educação no PSE*

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**ABSTRACT** Studies contribute to the School Health Program. However, only some investigate the work process of professionals to understand the possible conformation of intersectoral and integrated projects, or technologies as mediators in work practices. The present study sought to analyze the practices of professionals in a Family Health Unit/Primary Health Care unit in Salvador, Bahia, Brazil. This qualitative case study involved a Primary Health Care unit and four schools. The data collection procedures comprised semi-structured interviews, document analysis, and participant observation. The analysis categories were built from the theoretical framework of the health work process by Mendes Gonçalves. The results showed: weak partnership relationships between agents; professionals' perception of the object of work, predominantly identifying diseases and preponderant clinical knowledge vis-à-vis the knowledge of collective health. Health actions gathered the agents, but they presented hegemonic, disjointed, sectoral practices, focused on the disease, and conducted mainly through lectures. No integrated and intersectoral projects or educational technology as an additional resource in the work practices were observed. The products deriving from the participation of all will improve articulation between the professionals working in these spaces.

**KEYWORDS** Health education. Health promotion. Work.

**RESUMO** *Estudos trazem contribuições sobre o Programa Saúde na Escola, mas poucos investigam o processo de trabalho dos profissionais, a fim de compreender se existe a conformação de projetos intersetoriais e integrados ou tecnologias como mediadoras nas práticas de trabalho. O presente estudo buscou analisar as práticas dos profissionais em uma Unidade de Saúde da Família, em Salvador-BA. Este estudo de caso, de abordagem qualitativa, envolveu uma Unidade de Saúde e quatro escolas. Os procedimentos para coleta de dados compreenderam entrevistas semiestruturadas, análise documental e observação participante. A construção das categorias de análise ocorreu a partir do referencial teórico do processo de trabalho em saúde de Mendes Gonçalves. Os resultados demonstraram: fragilidades nas relações de parceria entre os agentes; percepção do objeto de trabalho pelos profissionais, predominantemente, como identificação de doenças e saber clínico preponderante em relação ao saber da saúde coletiva. As ações de saúde aproximaram os agentes, mas apresentaram práticas hegemônicas, desarticuladas, setoriais, focadas na doença e executadas, principalmente, por meio de palestras. Não existem projetos integrados e intersetoriais ou tecnologia educacional como recurso auxiliar nas práticas de trabalho. Os produtos, resultantes da participação de todos, trarão contribuições para melhor articulação entre os profissionais que atuam nesses espaços.*

**PALAVRAS-CHAVE** *Educação em saúde. Promoção da saúde. Trabalho.*

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## Introduction

Over time, the school has shown different meanings concerning its social function, mission, and organization in health education. The School Health Program (called PSE in Portuguese) was established by presidential decree in 2007; the budgetary responsibility of the Ministry of Health with the municipalities that adhere to the PSE was established in 2008. The rules for joining the Program were redefined in 2017, besides providing the respective financial incentive for funding actions[1–3]. An ordinance to transfer financial incentives for COVID-19[4] prevention action was enacted in 2020.

The adherence to the PSE, an agreement signed between the municipal health and education secretaries with the Ministries of Health and Education, occurs every two years. It represents the responsibilities of the health and education sectors with the local development of the PSE. Currently, all 417 municipalities in Bahia participate in the program[5] in the new PSE cycle (2021-2022).

Studies[6] reinforce the importance of multidisciplinary and intersectoral work in promoting the quality of the actions performed, and teamwork is an attribute that allows expanding changes in work and care. Thus, the PSE is an opportunity to expand the principles of health promotion. However, some gaps are observed and must be overcome. Among them is the expressive lack of knowledge about the PSE by the professionals involved[7–9].

Moreover, we observe a paradoxical situation between theory and practice, which involves the training of professionals working in the PSE in pre-established actions and, often unrelated to the local context with its social determinants of health[10,11]. The PSE improves student care, but the expanded health promotion concept is not yet a reality, as it is challenging to conduct multi-strategic actions with social participation and empowerment[12].

The existing regulations in the official documents of the Program point to a partnership between education and health in most of the structuring of the PSE, but there are contradictions and inequalities in the participation of the sectors – we highlight the predominance of health in areas such as financing, adherence, and coordination of the program[13]. While intersectoriality and territorialization are valued at the normative level, isolated and discontinuous actions are frequent[14], besides communication challenges and power distribution between sectors[15]. The difficulty of reconciling the institutional times of the various sectors and the different involvement is highlighted, which can prevent the continuity of actions[16].

There is also a reductionist understanding of the Program, in which the PSE contributes to overcoming health problems through diagnosis and medicalization[17,18]. School projects are expected to be articulated with the PSE, but they are characterized as welfare actions, without integration between professionals and with little involvement of students[19].

We observed that studies contribute to understanding the PSE implementation. However, only some investigate the work process of health and education professionals to understand whether integrated and intersectoral projects or technologies as a supportive resource in work practices are established.

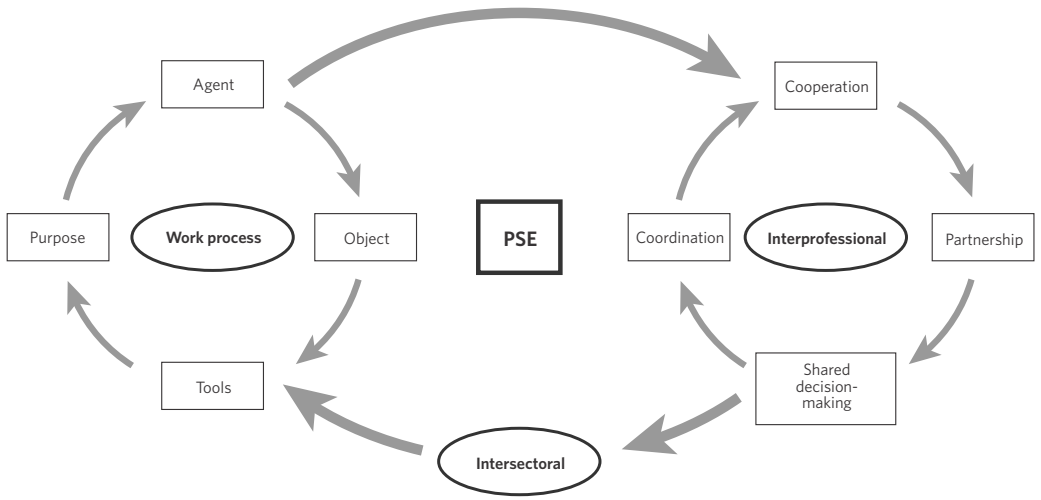
Therefore, this study aims to contribute to understanding the articulation between health and education professionals within the PSE, besides their work processes, and broadening the discussion on the construction of integrated and intersectoral projects in developing actions and technologies to mediate practices that involve professionals, students, and their families.

# Methods

## Conceptual elements

This study adopted a conceptual discussion about the work process, intersectoriality, and interprofessionality in the PSE as theoretical references. The following components can be analyzed in the health work process: the work object, instruments, purpose, product, and agents. These elements were examined in an articulated way with each other and through interface with intersectoriality and interprofessionality since the PSE Work Process theoretical model is configured in these reciprocal relationships (*figure 1*).

Figure 1. Theoretical model of the School Health Program work process




Source: Own elaboration.

Concepts such as those of Junqueira[20] were employed to understand intersectoriality, the author advocate that it transcends a single social sector, which articulates knowledge and experiences in planning, conducting and evaluating actions, targeting social development and overcoming social exclusion, associated with Paim's[21] understanding of intersectoriality as a device to articulate sectors and integrate practices, reorganizing work processes.

Like intersectoriality, interprofessional practice is an alternative approach to knowledge production. Interprofessionality is centered on collaboration, defined as interprofessional interaction through the application of tools that comprise shared identity, common objects, interdependence, interaction, shared responsibility, and team tasks[22]. Some essential elements are necessary for effective collaboration: cooperation, coordination, partnerships, and shared decision-making[23,24].

This research considered work agents, namely, health and education professionals. The management representative and the school council members also participated in the study, considering their relationships with work agents and their influences on the work process.

## Context of the territory under analysis

Salvador is the economic, political, and administrative center of the state of Bahia. Its political-administrative organization comprises 12 Health Districts (DS), characterized as health territories. The Family Health Unit (USF) chosen in this case study will be titled by the fictitious name *Mundo de Alice* and is located in the fictitious name *Gato Risonho*, in Salvador. The selection of this unit is justified because it was the researcher's workplace, besides being a pioneer USF in qualifying in the PSE since its beginning in this DS in 2013.

The PSE was not the first attempts to link health and education in this DS. Intersectoral projects were already in place in daycare centers, schools, and community associations in the territory, often carried out by health professionals who worked in the USF and the Social Assistance Reference Centers (CRAS). However, they occurred at specific times without the idea of continuing actions.

The DS *Gato Risonho* has three USF and three traditional basic units, all conducting PSE actions. Currently, 17 educational units have joined the Program in this DS. Five of these 17 are linked to USF *Mundo de Alice*: two are municipal schools, and three are state schools. Four schools were included in this research, and only schools that implemented the Program since the beginning, 2013, in the DS *Gato Risonho*, were considered.

## Data production strategies

The data production procedures were grounded on documents, and semi-structured interviews were carried out from 2020 to 2021. The documents refer to the presidential decree that addressed the PSE guidelines and strengthened the idea of intersectoriality.

The DS indicated the reference health professionals of the PSE for the interviews. Each school manager appointed an education professional and a council member representing the family. The interviews with the council members were justified to understand better the activities developed and to guarantee different viewpoints. The interview with the management professional was held with the only existing local district technical reference of the PSE.

The semi-structured interviews aimed to identify the perceptions and conceptions regarding the challenges and potentialities in the developing actions in the PSE experienced until the interview in 2021. Moreover, they sought to characterize the agents, instruments objects, and purposes of the work process and analyze the interprofessional and intersectoral relationships of those involved in the Program. Fourteen interviews were held using previously defined questions, one of which occurred online and the others face-to-face (*table 1*).

Table 1. Identification of respondents and assigned acronyms

| Age | Occupation (s) | Position/Title | Sector | Assigned school | Professional Relationship | Acronym |
|---|---|---|---|---|---|---|
| 39 | Historian | Teacher | Education | Casulo | Civil Servant | A1 |
| 50 | Mathematician | Teacher | Education | Lagarta | Civil Servant | A2 |
| 58 | Mathematician and Lawyer | Teacher | Education | Borboleta | Civil Servant | A3 |
| 48 | Pedagogue | Teacher | Education | Metamorfose | Civil Servant | A4 |
| 51 | Pedagogue | Teacher | Education | Metamorfose | Civil Servant | A5 |
| 44 | Nurse | Nurse | Health | Borboleta | Civil Servant | A6 |

Table 1. (cont.)

| Age | Occupation (s) | Position/Title | Sector | Assigned school | Professional Relationship | Acronym |
|---|---|---|---|---|---|---|
| 40 | Nurse | Nurse | Health | Casulo | Civil Servant | A7 |
| 37 | Dental Surgeon | Dental Surgeon | Health | Lagarta | Civil Servant | A8 |
| 43 | Dental Surgeon | Dental Surgeon | Health | Metamorfose | Civil Servant | A9 |
| 44 | Self-employed | School Board Member | Education | Lagarta | Not Applicable | A10 |
| 43 | General Services Assistant | School Board Member | Education | Casulo | Not Applicable | A11 |
| 47 | Child Development Assistant | School Board Member | Education | Metamorfose | Not Applicable | A12 |
| 52 | Administrative Assistant | School Board Member | Education | Borboleta | Not Applicable | A13 |
| 42 | Occupational Therapist | District PSE Reference | Health | Not Applicable | Civil Servant | A14 |

Source: Own elaboration.

## Data analysis

The data obtained were coded and analyzed under the analysis matrix built from the conceptual references underpinning the work process in the PSE and sources of evidence for intersectoriality and interprofessionality (*table 2*).

Table 2. Analysis categories, conceptual elements, and guiding questions for analyzing the work process in the School Health Program

| Analysis categories | Conceptual elements | Guiding questions |
|---|---|---|
| Work process | Agents | Which professionals participate in the actions? |
| | | What are the attributions and responsibilities of each of these agents in the PSE? |
| | | How is the relationship between health professionals and education professionals? |
| | | Is there active participation by schoolchildren and other community members? |
| | Object | What is PSE? |
| | | Opinion about the program. |
| | | What is your perception of the actions developed in the PSE? |
| | | The nature of the activities is focused on what kind of actions? |
| | Purposes | What would a successful PSE look like? |
| | | What are the reasons for carrying out PSE actions? |
| | | What benefits does the program bring? |
| | | What is the potential of PSE in health promotion? |
| | Tools (material and immaterial) | What work tools are used? |
| | | Is there training for health and education professionals to work in the PSE? |
| | | Articulation between the different sets of knowledge. |

Table 2. (cont.)

| Analysis categories | Conceptual elements | Guiding questions |
|---|---|---|
| | Work process organization | How does the planning and scheduling of PSE actions work? |
| | | How are actions monitored? |
| | | How are the actions developed evaluated? |
| | | How are PSE actions planned? |
| | | What challenges do they face in organizing work? |
| | | How is productivity launched? |
| | Product | Is there a channel for disseminating actions? |
| | | How does the PSE contribute to the health of schoolchildren? |
| | | Relationship between what is perceived at the local level and what is established in the Program's guidelines. |
| Intersectoriality | Understanding | What are the concepts of intersectoriality? |
| | Information exchange | Is there a joint monitoring and evaluation process? |
| Interprofessionality | Coordination | Performing joint planning. |
| | How was the participation of schools and health units defined? | Monitoramento e avaliação em conjunto. |
| | Cooperation | Joint monitoring and evaluation. |
| | | Partnerships |
| | Is there knowledge sharing? | Decisões tomadas em conjunto? |
| | Shared decision-making | Is there joint decision-making? |

Source: Own elaboration.

The interviews' analysis considered the subjects' perception of intersectoriality, interprofessionality, PSE, and the planning of the Program's actions and aspects related to the work process developed among professionals conducting the PSE. The analysis also included the perception of the PSE of some of the Program's target stakeholders who live in the actual context of their school and community – in this research, the school council members belonging to the students' families.

The Research Ethics Committee of the State University of Bahia approved the research under Opinion Nº 4.840.495 before working in the research field, observing Resolution Nº 466 of December 12, 2012[25]. Respondents participated in the research after they accepted and signed the Informed Consent Form (ICF).

# Results

## Who works in the Program?

The agents involved in the research were workers from USF *Mundo de Alice* and workers from four schools. The management representative at DS *Gato Risonho* and the school council members who represented the students' families were also part of the study, given their relationships with work agents and their influences on the work process.

Three of the four Board members were also school employees. Three of the five health professionals, including A14, self-declared brown. Three of the five education professionals self-declared black, and two self-declared white. Two of the four Board members self-declared black, and the others, brown. Ten respondents

had Higher Education, and four had High School level – all of the latter belonged to the school council.

## Student health promotion: a utopia?

The respondents' statements revealed that the PSE was necessary for the health promotion of students. However, one of the health respondents reported that he was unaware of the Program's guidelines and never had access to documents that clarified the matter. Little knowledge of the PSE guidelines was observed, mainly on the part of the school community members. Again, regarding the respondents' perception of the object, two health professionals reported that the Program had low effectiveness in some aspects, including the difficulty in referring students to specialized health services when necessary.

One of the teachers stated that the Program was obsolete, worked on specific occasions, and did not include all students. Furthermore, the integration of the PSE into the school system was suggested based on a return to the school health model of the 1940s, when the Unified Health System and the Health Care Network did not exist, in which the health professional health care would work in the school:

> *[...] I lived at a time when this possibility existed. [...] we had [...] a dentist within the unit, with a psychologist and socio-pedagogists [...] the school met much more the needs with this integration of health-related professionals within the schools [...] It was complete.* (A3).

Not far from this logic, in the interviews with the council members, we noticed that their idea of health care was focused mainly on personal hygiene conditions, referring to health assistance assumptions, very present in hygienism:

> *[...] It is a program aimed from the initial phase when the child comes to school [...] showing children what it is like to care, regarding hand hygiene, teeth brushing, because we have tooth decay.* (A12).

The narratives showed that the respondents perceived health promotion actions as necessary for schoolchildren. However, there were different perceptions regarding the themes that most interested and those that were most developed in the Program's actions.

The PSE indicates a diversity of actions with themes already defined by the guiding documents, as confirmed by the professionals. These include most of the topics of great interest and are most frequently reported by the respondents. However, the actions proposed by the PSE are the same for all of the territory without considering the epidemiological profile of each school community. For example, actions aimed at mental health were highlighted as one of the most frequently reported needs by teachers and Board members:

> *[...] we have significant cases here of girls with depression and who cut themselves, [...] it should be treated with the school core [...]. To help each other deal with the situation. Because we don't know what to do [...].* (A1).

However, it is not a topic of discussion in the Program as a proposed theme, nor did it appear in health workers' narratives.

## What is the purpose of the Program?

A14 pointed out that the Program should adopt an intersectoral practice to achieve its goals. He stated that when health professionals see children and adolescents within other contexts, such as school, it is possible to observe several components that interfere with health and development, which are not seen within the office. Furthermore, the school enables the use of creativity through innovation and other technologies, such as educational and transformative tools:

> *[...] for being with the teacher, the territory to listen, sometimes, to other demands [...]. The PSE is powerful for that, too, for the expanded work network. [...] I see this richness of exchanges in professional relationships [...].* (A14).

Although this understanding existed, did education professionals participate in the planning of the Program's actions? In the interviews, the teachers suggested that the PSE be integrated into the school's Political-Pedagogical Projects (PPP) and discussed among the school community members. However, until then, these suggestions only existed in the field of ideas:

> *[...] to insert it in the school's PPP; insert it as integrated. [...] so that we begin to analyze and verify that this disseminates and is projected in other levels [...]. However, I need to learn how to do it.* (A3).

## Knowledge exchange in the PSE

We noted a predominant knowledge by health workers and that education workers were assistants and, sometimes, supporters of the actions. Most of the narratives did not show the participation of education agents in the planning and implementation of actions. Council members were unanimous in answering that they did not participate when asked if they gave their opinion on the actions carried out at the school.

When asked about the methodology adopted to perform the actions, most health professionals responded that they transmitted their knowledge in lectures, often without reflection, exchange, and construction of knowledge among the participants.

Some practical activities were also described, such as supervised brushing and topical application of fluoride. They rarely used games, conversation circles, or debates that involved entertainment in the actions. Despite this, all respondents confirmed when asked whether they would like to use some educational game.

The PSE's actions were highly challenged during the COVID-19 pandemic, as schools remained closed for face-to-face activities. The actions gradually resumed as the students returned to the semi-classroom mixed format. Some health professionals used technologies such as WhatsApp and other platforms, which the school already used, to share educational videos that could assist in the continuity of actions.

The professionals also reported that the management did not promote courses on how to work in the PSE. The courses or training would contribute to taking ownership of knowledge involving the themes worked on in the Program. They also reported that they felt pressured by the management to implement the actions and they often lacked intangible and material subsidies. On the other hand, the management stated that the dismissal or reassignment of qualified professionals to work in the PSE would be hindering elements.

When asked what technological resources and work materials were used to carry out educational activities, there was a consensus that they were limited. It was very often necessary to use own resources to implement actions. One of the respondents asked where the financial resources destined for the Program went since so much was needed and so little was offered.

The organization of the work process

Given the analysis of the interviews, it became evident that the local territory's health characteristics were not used for planning the actions, and the meetings at the central level determined the activities.

The communication was more articulated between the municipal health and education secretariats was observed, which may explain, according to reports, the results obtained in the monitoring of actions in municipal schools as more fluid and positive than in state schools. It is worth noting that the administrations of the state and municipal governments, in this context, are in opposition.

When identifying the existing relationships, we noticed that the approximation initiatives always occurred through the health teams from Primary Health Care. The teams arrived at the schools to present the actions, discussed them with the school board or some teachers, and performed without group planning with the school community later. However, it was suggested that this articulation should be inducted by the management of the health and education sectors, as highlighted by some professionals, to facilitate the process.

Except for management, none of the respondents commented on monitoring actions when asked. According to A14, the result in the district was positive due to the number of actions indicated by the management and those that were implemented, even with adversities, such as the low number of professionals to perform the activities and work overload, since some health workers acted alone in the Program.

The district management produced annually a report analyzing the established goals. When the goals were not reached, the reasons were diagnosed. What needed to be improved sometimes were resources to solve some issues.

Regarding recording the information, the entire entry of productivity in the information system was performed only by health professionals. They highlighted that it was a laborious process, and they were sometimes unable to register, leading to underreported information.

## Does constructing practices dialogue with the school community and its health needs?

When asked about the contribution of the PSE to the health of schoolchildren, education professionals recognized the importance of the Program in this regard, besides its collaboration in the individual's school and social education throughout life. Some health professionals still perceive the Program as based on curative practices, which reflect a biomedical and fragmented view of health:

> *[...] it improves health [...] the doctor examined and requested tests. In the other return, he would look at these test results. We would refer them to visits with ophthalmologists if there were alterations. [...] So, in general, the student's health improved.* (A7).

When it occurred, publicizing the actions was limited to WhatsApp. However, the use of social networks has become more evident in the pandemic, which could help in the dissemination of these activities:

> *[...] It's such important work with such a significant impact. Even in the long term, these actions would deserve more significant publicity because we follow those students yearly.* (A8).

Another aspect analyzed, territoriality, should have been considered for conducting the actions since each school community represents different epidemiological realities. However, in practice, no actions were directed to each territory differently.

The school community did not participate in the articulation of knowledge. The demands of agents directly involved with the PSE were not heard, and the agents were unaware of their role in the face of the PSE's objectives. There was no sharing and co-responsibility of knowledge among those involved in the Program. The aim was that both the planning and the implementation of the PSE were guided by intersectoriality.

## Intersectoriality: how is this understood?

One of the teachers did not know how to answer, the others understood it as an integration and exchange of knowledge between health and education. Again, in the education sector, one of the participants claimed that there were no actions for this to occur in practice and transferred the responsibility

for articulating knowledge and practices to the health sector.

Apparently, the term intersectoriality had more clarity in its understanding among health professionals, who pointed out a fragility in this relationship from the management. Notwithstanding this, all health workers understood that this articulation was what facilitated the PSE. In this setting of articulation between all sectors, one of the health workers revealed his understanding of intersectoriality in the work process using an interprofessional perspective:

> *[...] That's precisely what happens within a family health team. This multidisciplinary involvement of all professionals [...] this articulation with the school. [...] that facilitates the PSE and opens the doors to implement actions.* (A8).

### Interprofessionality: cooperation, coordination, partnerships, and shared decision-making in PSE actions

There were no reports of cooperation in planning actions or shared decision-making among the agents. Moreover, the respondents reported that responsibility for the Program's activities always fell on health professionals or a specific education agent. Apparently, education professionals were not included as co-responsible for the development of actions but only as supporters.

Similarly, as stated by the teachers, the health professionals confirmed the supporting role of the education sector in the PSE actions to those who brought the demands to be implemented and planned by the health sector. The inclusion of families as members of the decision-making processes was not observed at any time.

The narratives of health professionals showed a coordinating weakness of the health and education secretariats. They indicated poor communication between these secretariats and the transfer of total responsibility to health professionals regarding the communication and clarification of the Program.

Regarding the partnership in conducting the actions, we noticed that the respondents generally indicated the partnership as a presupposition for conducting the activities. While being a widely used term, it was also fundamental for building collaborative work. However, practices planned and conducted essentially by health professionals were observed.

## Discussion

Data analysis showed weaknesses in partnership relationships for the planning, implementation, and monitoring of PSE actions among health and education workers, school council members, and management representatives. Studies show that the partnership between professionals is essential so that dialogue, access to information, and the reorganization of practices are the main focus of the program[26]. These weak relationships can adversely interfere with the work process in question.

Mendes Gonçalves[27] emphasizes that the apprehension of the object consists of identifying the characteristics that allow the visualization of the final product, foreseen in the work's purposes. In this study, we observed that a slightly broader perception of the Program's object and purpose, aligned with what was proposed in the PSE guidelines, was very much present in the statements of health professionals.

In this setting, the object of work was understood as the identification of diseases and activities based on lectures, which aimed to provide information to prevent disease, and this was a critical aspect in obtaining an expanded product, as it reinforces the noncompliance with the principle of comprehensive practices based on prevention, promotion

and, health recovery. Despite this, the Program allowed the approximation between those involved and the possible access to several actions and health information, which could be beneficial in preserving the population's health in this territory. Therefore, although comprehensiveness is present in the reports of professionals, it is still a process under construction.

Therefore, clinical knowledge was predominant regarding collective health knowledge, which hindered expanding the means, purposes, and products. From this rationale, the present study showed that PSE health actions adopt hegemonic, disjointed, sectoral practices focused on the disease. They mainly implemented approaches centered on lectures and the unidirectional transmission of information.

We highlight the importance of linking the actions developed in the PSE through a collective construction of knowledge to improve the assistance provided and expand the scope of activities[27]. On the other hand, an integrative review study pointed out that the actions developed in schools are one-off and unsystematic, as responses to specific demands, which limits the scope of the Program's actions[28], requiring the restructuring of educational actions, so that professionals evaluate these actions, observing the reality and the interest of the assisted community[29].

The understanding that everything is about working together and in partnership was a common perception. As these are important factors for obtaining good results, such understanding is a positive indicator for building collaborative work toward intersectoral work[8,30]. Despite this understanding, in practice, the decision-making processes that involve the management, planning, and execution of actions do not occur in a shared way. These findings support some studies concluding that the PSE enabled more significant contact between sectors. However, aspects of intersectoral articulation in the political-management process and practices are weak and limited[31,32].

This fact was also evidenced in the narratives of education professionals who pointed out that the school's PPP did not mention PSE and school health actions. The PPP corresponds to a collectively constructed commitment[33], reinforcing the understanding that the education sector has not given the necessary attention to the PSE, highlighting the fragile practices and relationships between sectors.

At the same time, the respondents showed little conceptual knowledge about intersectoriality and interprofessional work elements that involve the work process, given the importance of training that includes the current discussion of intersectoriality and the participation of students and the community, which guarantees the durability of these actions, already evidenced by other authors[16,34,35]. However, what is still noticeable is the scarcity of training and the lack of protocols that help develop intersectoral actions[36].

However, while health promotion, protection, and care actions are conducted in the PSE, the health promotion proposals do not favor behavioral changes through individual and authoritarian interventions but through a holistic view of health, social determination in the health and disease process, intersectoriality, and social participation[37].

For this reason, spatial relationships with other settings, such as the family, the community, and health services, must be identified with social conditions and different lifestyles through the participation of all[38], even if the active inclusion of the community in the field is one of the challenges of PSE[39].

A study revealed that while being receptive to the PSE actions, the students needed the necessary participation that would allow shared responsibility for producing their health[40]. In this sense, as identified in the present study, other authors[41] point out that linking health actions to the daily lives of schoolchildren is an intense task. Therefore, the need to agree on a common project arises from the recognition that there are different motivations, requiring the search for horizontal relationships,

breaking the supremacy of one knowledge over the other[42].

This study's pandemic setting reflected the need to plan and develop intervention projects adapted to this reality jointly, and using technologies was a possibility of remote health education activity[43].

Thus, considering the pandemic and post-pandemic contexts, the possibility of creating information and communication tools as a teaching resource in learning essential topics such as COVID-19 and other diseases can contribute to the approach to health education in schools and intersectoral articulation. In this sense, it is possible to overcome these issues through knowledge and allow the use of public policies linked to the theme[44].

## Final considerations

The limitations of this qualitative work are the lack of students' perception of PSE activities and the fact that this study was conducted during the pandemic period, which restricted the monitoring and operationalization of actions, requiring future studies that allow the design and implementation of integrated and intersectoral activities.

It was observed the lack of integrated and intersectoral projects or technologies as supportive resources in work practices. To this end, we suggest investments in planning and training for intersectoral practices in the PSE to foster greater articulation between the agents involved. Furthermore, interprofessionality is rarely found in work relationships investigated in the study. As a suggestion to improve the Program, we recommend publicizing successful actions to show those involved the potential for producing health by all of them.

Finally, the fact that the PSE expands the work network and that the school allows the use of creativity can collaborate in building collective projects beyond the school environment. In this sense, the products resulting from the participation of all will contribute to better articulation and practices among professionals who work in these spaces.

## Collaborators

Gonçalves PDS (0000-0001-6680-1538)* contributed substantially to the design, planning, data collection, analysis, and interpretation of data, drafting, critical review, and approval of the final version. Ferreira SC (0000-0002-9884-5540)* contributed substantially to the planning, critical review, and approval of the final version. Rossi TRA (0000-0002-2561-088X)* contributed substantially to the design, planning, interpretation of data, drafting, critical review, and approval of the final version. ■

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## References


1. Brasil. Decreto nº 6.286, de 5 dezembro de 2007. Institui o PSE, e dá outras providências. Brasília, 2007. Diário Oficial da União. 6 Dez 2007.

2. Brasil. Ministério da Saúde. Portaria nº 1.861, de 4 de setembro de 2008. Estabelece recursos financeiros pela adesão ao PSE para Municípios com equipes de Saúde da Família. Diário Oficial da União. 5 Dez 2008.

3. Brasil. Ministério da Educação; Ministério da Saúde. Portaria nº 1.055, de 25 de abril de 2017. Redefine as regras e critérios para adesão ao PSE e dispõe sobre o incentivo financeiro para custeio de ações. Diário Oficial da União. 26 Abr 2017.

4. Brasil. Ministério da Saúde. Portaria nº 1.071, de 18 de novembro de 2020. Altera atributos do procedimento 01.01.01.009-5 prevenção ao covid-19 nas escolas. Diário Oficial da União. 19 Nov 2020.

5. Brasil. Ministério da Saúde. Painel de adesões. Programa Saúde na Escola - Ciclo 2021-2022. Brasília, DF: MS; 2022.

6. Carrapato JFL, Castanheira ERL, Placideli N. Percepções dos profissionais de saúde da atenção primária sobre qualidade no processo de trabalho. Saúde Soc. S. Paulo. 2018 [acesso em 2022 jan 20]; 27(2):518-530. Disponível em: https://www.scielo.br/j/sausoc/a/PmjC6YSs8SYzmWLrd7ccHJH/?format=pdf&lang=pt.

7. Jacóe NB, Aquino NM, Pereira SCL, et al. O olhar dos profissionais de uma Unidade Básica de Saúde sobre a Implantação do Programa Saúde na Escola. Rev Med Minas Gerais. 2014 [acesso em 2022 jan 20]; 24(supl1):43-48. Disponível em: https://pesquisa.bvsalud.org/portal/resource/pt/lil-71873.

8. Sousa MC. Saúde na Escola: analisando os caminhos da intersetorialidade. [dissertação]. Salvador: Universidade Federal da Bahia; 2014.

9. Soares CJ, Santos PHS, Nery AA, et al. Percepção de enfermeiras da estratégia de saúde da família sobre o programa saúde na escola. Rev de enferm UFPE online. 2016 [acesso em 2022 jan 20]; 10(12):4487-93. Disponível em: https://periodicos.ufpe.br/revistas/revistaenfermagem/article/viewFile/11514/13397.

10. Marinho MNA, Vieira NFC, Ferreira HS, et al. Programa saúde na escola: dos processos formativos aos cenários de práticas. J Hum Growth Dev. 2018 [acesso em 2022 jan 20]; 28(2):175-182. Disponível em: https://www.revistas.usp.br/jhgd/article/view/147219/141053.

11. Lopes IE, Nogueira JAD, Rocha DG. Eixos de ação do Programa Saúde na Escola e Promoção da Saúde: revisão integrativa. Saúde debate. 2018 [acesso em 2022 jan 20]; (118):773-789. Disponível em: https://www.scielo.br/j/sdeb/a/SNsdFnbvBdfdhn76GQYGDtM/?format=pdf&lang=pt.

12. Cavalcanti PB, Lucena CMF, Lucena PLC. Programa Saúde na Escola: interpelações sobre ações de educação e saúde no Brasil. Textos Contextos. 2015 [acesso em 2022 jan 20]; 14(2):387-402. Disponível em: https://revistaseletronicas.pucrs.br/ojs/index.php/fass/article/view/21728/13961.

13. Ferreira IRC, Moysés SJ, França BHS, et al. Percepções de gestores locais sobre a intersetorialidade no Programa Saúde na Escola. Rev. Bras. Educ. 2014 [acesso em 2022 jan 20]; 19(56):61-76. Disponível em: https://www.scielo.br/j/rbedu/a/pqb9Bhm3zyYyjJ4VfP55knt/?format=pdf&lang=pt.

14. Magalhães R. Constrangimentos e oportunidades para a implementação de iniciativas intersetoriais de promoção da saúde: um estudo de caso. Cad. Saúde Pública. 2015 [acesso em 2022 jan 20]; 31(7):1427-1436. Disponível em: https://www.scielo.br/j/csp/a/9nJ3qbDGkYYFyM8wk4FmHDx/?format=pdf&lang=pt.

15. Köptcke LS, Caixeta IA, Rocha FG. O olhar de cada um: elementos sobre a construção cotidiana do Programa Saúde na Escola no DF. Tempus. 2015 [acesso em 2022 jan 20]; 9(3):213-232. Disponível em: https://www.tempusactas.unb.br/index.php/tempus/article/view/1798/1664.

16. Farias ICV, Franco de Sá RMP, Figueiredo N, et al. Análise da Intersetorialidade no PSE. Rev. Bras. Educ. Méd. 2016 [acesso em 2022 jan 20]; 40(2):261-267. Disponível em: https://www.scielo.br/j/rbem/a/39ZTRdxxTHwsQx5hCdjWzjB/?format=pdf&lang=pt.

17. Cord D, Gesser M, Nunes ASB, et al. As significações de profissionais que atuam no PSE acerca das dificuldades de aprendizagem: patologização e medicalização do fracasso escolar. Psicol. Ciênc. Prof. 2015 [acesso em 2022 jan 20]; 35(1):40-53. Disponível em: https://www.scielo.br/j/pcp/a/7G9nyym6rhrKYRzFt75Rghb/?format=pdf&lang=pt.

18. Camargo TS. Promover Saúde, produzir responsabilidade: uma análise do funcionamento do programa saúde na escola em Porto Alegre/RS. In: Anais do 6. Sem. Bras. de Est. Cult. e Ed. 2015 [acesso em 2022 jan 20]; (3):1-24. Disponível em: http://www.2015.sbece.com.br/site/anaiscomplementares.

19. Leite CT, Machado MFAS, Vieira RP, et al. The school health program: teachers' perceptions. Invest. Educ. Enferm. 2015 [acesso em 2022 jan 20]; 33(2):280-287. Disponível em: https://revistas.udea.edu.co/index.php/iee/article/view/23008/18954.

20. Junqueira LAP. Intersetorialidade, transetorialidade e redes na saúde. Rev Adm pública. 2000 [acesso em 2022 jan 20]; 34(6):35-45. Disponível em: https://bibliotecadigital.fgv.br/ojs/index.php/rap/article/view/6346/4931.

21. Paim JS. O que é SUS. Rio de Janeiro: Fiocruz; 2009.

22. Reeves S, Pelone F, Harrison R, et al. Interprofessional collaboration to improve professional practice and healthcare outcomes. Cochrane Database of Systematic Reviews. 2017 [acesso em 2022 jan 20]; 6(6):1-15. Disponível em: https://www.cochranelibrary.com/cdsr/doi/10.1002/14651858.CD000072.pub3/epdf/full.

23. Orchard CA, King GA, Khalili H, et al. Assessment of interprofessional team collaboration scale (AITCS): development and testing of the instrument. J Contin Educ Health Prof. 2012 [acesso em 2022 jan 20]; 32:58-67. Disponível em: https://journals.lww.com/jcehp/Abstract/2012/32010/Assessment_of_Interprofessional_Team_Collaboration.8.aspx.

24. Orchard CA, Pederson L, Read L, et al. Assessment of Interprofessional Team Collaboration Scale: Further Testing and Instrument Revision. JCEHP. 2018 [acesso em 2022 jan 20]; 38(1):11-18. Disponível em: https://www.researchgate.net/publication/323590008_Assessment_of_Interprofessional_Team_Collaboration_Scale_AITCS_Further_Testing_and_Instrument_Revision.

25. Brasil. Conselho Nacional de Saúde. Resolução nº 466/2012. 12 de dezembro de 2012. Diário Oficial da União.12 Dez 2012. [acesso em 2022 jan 20]. Disponível em: https://conselho.saude.gov.br/resolucoes/2012/Reso466.pdf.

26. Machado MFA, Gubert FA, Meyer APG, et al. Programa saúde na escola: estratégia promotora de saúde na atenção básica no brasil. J Hum Growth Dev. 2015 [acesso em 2022 jan 20]; 25(3): 307-312. Disponível em: http://pepsic.bvsalud.org/pdf/rbcdh/v25n3/pt_09.pdf.

27. Mendes Gonçalves RB. Práticas de saúde e tecnologia: contribuição para reflexão teórica. Brasília, DF: OPS; 1998.

28. Araújo MJA, Nogueira EAM, Santos VR, et al. PSE: experiências, práticas e desafios na atenção primária à saúde. Research Society and Development. 2021; 10(10).

29. Coutinho BLM, Feitosa AA, Diniz CBC, et al. Álcool e drogas na adolescência: processo de trabalho no programa saúde na escola. J Hum Growth Dev. 2017 [acesso em 2022 jan 20]; 27(1):28-34. Disponível em: http://pepsic.bvsalud.org/scielo.php?script=sci_arttext&pid=S0104-12822017000100004&lng=pt&nrm=iso&tlng=pt.

30. Silveira CC, Estermann ED, Félix JM. A generificação da intersetorialidade no PSE. Rev. bras. Estud. Pedagog. 2019 [acesso em 2022 jan 20]; 100(255):423-44.

Disponível em: https://www.scielo.br/j/rbeped/a/QsFK3V7H56XL7rBKK7RcRsf/?format=pdf&lang=pt.

31. Sousa MC, Esperidião MA, Medina MG. A Intersetorialidade no Programa Saúde na Escola: avaliação do processo político-gerencial e das práticas de trabalho. Ciênc. Saúde Colet. 2017 [acesso em 2022 jan 20]; 22(6):1781-1790. Disponível em: https://www.scielo.br/j/csc/a/nGRj8mdvvwZHvy6G76MrjfJ/?format=pdf&lang=pt.

32. Brambilla KD, Kleb EM, Magro DPL. Cartografia da implantação e execução do PSE: implicações para o processo de desmedicalização. Rev. Belo Horizonte. 2020 [acesso em 2022 jan 20]; 1(36):3-14. Disponível em: https://www.scielo.br/j/edur/a/CGCSFCswjgpYXCV7FYswhDf/?format=pdf&lang=pt.

33. Veiga IAP. Projeto Político Pedagógico da Escola: Uma construção possível. 24. ed. Campinas: Papirus editora; 2009. [acesso em 2022 jan 20]. Disponível em: https://www.sinprodf.org.br/wp-content/uploads/2014/01/PPP-segundo-Ilma-Passos.pdf.

34. Medeiros ER, Pinto GSE, Paiva SCA, et al. Facilidades e dificuldades na implantação do Programa Saúde na Escola em um município do NE do Brasil. Rev Cuid. 2018 [acesso em 2022 jan 20]; 9(2):2127-2134. Disponível em: http://www.scielo.org.co/scielo.php?script=sci_arttext&pid=S2216-09732018000202127.

35. Chiari APG, Ferreira RC, Akerman M, et al. Rede intersetorial do PSE: sujeitos, percepções e práticas. Cad. Saúde Pública. 2018 [acesso em 2022 jan 20]; 34(5):1-15. Disponível em: https://www.scielo.br/j/csp/a/d9GHPC4rRF9WJKQxyqmbZCG/abstract/?lang=pt.

36. Reuter CLO, Santos VCF, Ramos AR. O exercício da interprofissionalidade e da intersetorialidade como arte de cuidar: inovações e desafios. Esc Anna Nery. 2018 [acesso em 2022 jan 20]; 22(4):1-8. Disponível em: https://www.scielo.br/j/ean/a/CBWhDD897ThYB7LYBmQmXFg/?format=pdf&lang=pt.

37. Westphal MF. Promoção da Saúde e Prevenção das Doenças. In: Campos GWS, Minayo MCS, Akermanm M, et al. Tratado de Saúde Coletiva. Rio de Janeiro: Fiocruz; 2006. p. 635-667. [acesso em 2022 jan 20]. Disponível em: https://pesquisa.bvsalud.org/portal/resource/pt/cid-53915.

38. Tavares MFL, Rocha RM. Promoção da Saúde e a Prática de Atividade Física em Escolas de Manguinhos – RJ. In: Brasil. Ministério da Saúde. Escolas promotoras de saúde: experiências do Brasil. Brasília, DF: MS; 2006. p. 157-168. [acesso em 2022 jan 20]. Disponível em: https://bvsms.saude.gov.br/bvs/publicacoes/escolas_promotoras_saude_experiencias_brasil_p1.pdf.

39. Vieira CEN, Dantas AN, Miranda VMS, et al. School Health Nursing Program: prevention and control of overweight/obesity in adolescents: Rev Esc Enferm USP. 2018 [acesso em 2022 jan 20]; 52(5):1-8. Disponível em: https://www.scielo.br/j/reeusp/a/zxNjzJ7ms48mHccxHxWcDby/?lang=en&format=pdf.

40. Oliveira LSP, Vargas DMA, Hartz Z, et al. Percepção de escolares do ensino fundamental sobre o PSE: um estudo de caso em BH, Brasil. Ciênc. Saúde Colet. 2018 [acesso em 2022 jan 20]; 23(9):2891-2898. Disponível em: https://www.scielo.br/j/csc/a/BDk6KBvzRGsrR89t9YJfB7m/?format=pdf&lang=pt.

41. Pereira PLG, Pereira DM, Faria SGR, et al. A implementação do programa saúde na escola em três municípios de MG, Brasil. Rev de Enf do Centro Oeste Mineiro. 2020 [acesso em 2021 jan 20]; 10(10):1-11. Disponível em: http://www.seer.ufsj.edu.br/recom/article/view/3566/2447.

42. Ellery AEL. Interprofissionalidade na Estratégia Saúde da Família: condições de possibilidade para a integração de saberes e a colaboração interprofissional. [tese]. Fortaleza: Universidade Federal do Ceará; 2012.

43. Parcianello L, Santos V, Krug MM. Retomada do Programa Saúde na Escola: Intervenção da Residência Multiprofissional na Atenção Primária. Salão do Conhecimento Inijuí. 2021 [acesso em 2022 jan 20];

7(7). Disponível em: https://publicacoeseventos.unijui.edu.br/index.php/salaoconhecimento/article/view/20679.

44. Souza APB, Souza AH, Manhães FC. Promovendo ferramentas de informação e comunicação sobre Covid-19 na Escola: pensando educação em saúde em tempos de pandemia. In: Anais do 7º Congresso Nacional de Educação; 2021. [acesso em 2022 fev 20]. Disponível em: https://editorarealize.com.br/editora/anais/conedu/2021/TRABALHO_EV150_MD1_SA119_ID9277_05112021194223.pdf.

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