Research & Reviews: Journal of Nursing and Health Sciences

Health Promotion for School Adolescents: The Complexity of Intersectoriality

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Research Article

Received date: 09/05/2020;

Accepted date: 03/06/2020;

Published date: 10/06/2020;

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Keywords: School health, Health promotion, Intersectoriality, Primary care.

ABSTRACT

Objective: The research had the objective of analyzing the integration between the health and education sectors for the health promotion of schoolchildren from the perspective of the School Health Program in a city in the countryside of Ceara.

Method: This is a descriptive study, with a qualitative approach. The study was approved by the Research Ethics Committee of the School of Public Health of Ceara-Brazil, with opinion nº 3.059.629. This study was attended by health professionals (10), education professionals (7) and elementary school students (6) involved in this Program. Data were collected through semi-structured interviews and analyzed based on the theory proposed by Minayo, using the technique of thematic content analysis in its categorical aspect.

Results: The study revealed the development of specific actions in the scope of the School Health Program, superficial knowledge, on the part of health and education professionals about the program, as well as fragile intersectoriality.

Final considerations: We can consider the need for continuing education activities and constant training involving the topic of the intersectoral program, in such a way as to potentiate the mastery and practice of those involved capable of consolidating the Program-related actions in primary care in a consistent and effective way.

INTRODUCTION

Health education in the school environment provides that the individual becomes co-responsible for his/her health and the space in which he/she is inserted, thereby enabling the empowerment of citizens since a young age, so that they can contribute significantly to the achievement of improvements in quality of life [1].

In this sense, the School Health Program (PSE, as per its Portuguese acronym) aims, in an articulated way between the health and education domains, at ensuring a comprehensive training of children and young schoolchildren, in such a way as to enable health actions in the school routine, a place of physical, moral, psychological, emotional and social development of the individual, in addition to facilitating access to health services, as a result of a greater interaction among health professionals, education professionals and the target audience of this program [2].

The establishment of PSE was based on several projects and policies focused primarily on adolescents, with actions aimed at health promotion, identification of risk groups, early detection of diseases, among many others. Over the years, several proposals involving this theme were made available, but then, in the year 2003, the Ministry of Education, in partnership with the Ministry of Health, launched the project Health and Prevention in Schools [3].

Nevertheless, the implementation of PSE only happened in 2009, with the adhesion of municipalities, characterized by an integrated policy initiative that considers the concept of health promotion and has as one of its main guidelines the intersectorality, thereby reinforcing the importance of articulation between the health and education areas, as well as other sectors, always in favor of the good development of the subjects involved in this program [4].

PSE is a tripartite responsibility of the federated entities, which are organized through the Intersectoral Working Group in the Federal Government, States, Federal District and Municipalities that adhered to this program to ensure the implementation of actions, in line with management support, continuing education, follow-up and evaluation [5].

We should emphasize the importance of the active participation of all entities and target audience in the construction of citizenship of young people, with a view to contributing to the strengthening of the activities of the program in question, besides the fact that managers need to be sensitive to the planning of actions and allocation of human, material and financial resources [6].

Health actions developed in the school environment should not only involve students, but also the families to which these students belong and all those who make up and are present in the school routine, from employees to the community in which the school is inserted.

In addition, the fragmentation and disarticulation of public policies with different sectors entails a lot of resistance on the part of those involved, thereby suggesting the need for enhancement in in giving continuity to the program guidelines, in order to have a better appropriation of the intersectoral axis and the real possibilities of action that constitute the program itself [7].

Studies that describe intersectoral actions in Brazilian public health problems clarify that none of the analyzed programs explains the definition of intersectoriality on which they are based and does not present information on their continuity and sustainability, thereby concluding that there is a need to develop a greater number of evaluative researches on intersectorality in health policies [8].

In view of this context, we raised the following question: Is the PSE developed in a municipality in northeastern Brazil in line with the program guidelines with regard to the integration of the health and education sectors?

This proposal had the objective of analyzing the integration between the health and education sectors, in order to provide health promotion for schoolchildren from the perspective of PSE. Since then, we have believed that it is possible to subsidize viable strategies to enhance this program, its qualification and, consequently, to improve the development of children and adolescents, so that they can construct knowledge about their health and their co-responsibility for it, together with the health and school professionals, through continuous actions that contribute to healthy behaviors [9].

MATERIAL AND METHODS

This is a descriptive study, with a qualitative approach, developed from the perception of its participants regarding their responsibilities, actions and commitment in relation to PSE.

We justify the option for the qualitative approach because of its potential to answer very particular questions, thereby encompassing research with a level of reality that cannot be quantified, as it corresponds to a deep field of relationships, processes and phenomena that cannot be quantified or reduced to the operationalization of variables [10].

Data were collected from December 2018 to February 2019 through interviews guided by a semi-structured instrument with questions that sought to obtain information contained in the speech of social actors and understand the reflections of practical reality. We performed 27 interviews with different participants and places of application, namely: 10 (ten) with the

health professionals who are part of PSE (nurse, doctor, dentist and professionals from the Extended Nucleus of Family Health and Primary Care) - at the Primary Health Care Unit; 5 (five) with Managers and Coordinators - at the Municipal Departments of Health and Education; 6 (six) with education professionals - at school and 6 (six) with students in their homes, given that the collection coincided with the school vacation period.

We did not previously determined a number of participants in the study, since the saturation criterion was used, according to which the researcher performs enough interviews to allow a certain recurrence of the information [11].

This study included all health and education professionals who agreed to participate in the survey by signing the Free and Informed Consent Form. As for students, those who expressed interest in participating, who were at home during home visits and whose parents or legal guardians signed the consent forms inherent to the research were included.

The data collected guided the identification of PSE actions performed by health, education and management professionals, as well as the difficulties and strengths found by them for the full implementation of the program-related actions and the impacts of these actions for schoolchildren. Each interview received a code identified by the initials of each participating category, followed by the number in ascending order, according to his/her performance, thereby preserving the identity of the participant and the confidentiality of the research. For this purpose, according to the Portuguese language acronyms, we considered PS for health professional; PE - education professional; G - manager; and E for schoolchildren, followed by the numerical order in each interview held.

The audios of the interviews, with previous authorization from the participants, were recorded on a digital device, so that there was no loss of answers or interruptions of thoughts. These audios were transcribed in full by the researcher and analysed through content analysis of thematic categorical type based on Minayo [10], which gave rise to five categories:

I - PSE, a program distant from the local health context;

II - PSE, specific actions and vertical planning;

III - PSE, a program of disintegrated responsibilities among its actors;

IV - The potentiality and challenges faced for the practice of PSE; and

V - School Children and PSE: “I do not know much”.

The study was approved by the Research Ethics Committee of the School of Public Health of Ceara, with opinion nº 3.059.629, and complied with all the recommendations contained in Resolution 466/12 on research involving human beings of the National Health Council of the Ministry of Health [12]. Participants signed a Free and Informed Consent Form and/or Informed Assent Form.

RESULTS AND DISCUSSION

The study had the participation of four groups, namely: health professionals from a PHCU, education professionals from a school in the same territory as the PHCU, health and education managers, in addition to students. We should underline that the number of participants was not previously determined, since the field stage showed the sufficiency of meanings expressed in the interviews, which made it possible to answer the research objective. From the content analysis, the results were grouped into five categories, as described below:

Category I - PSE, a program distant from the local health context

From the analysis of the speeches, we noticed that all professionals, both those in the health and education teams, such as, for example, teachers and managers, understand about the importance of this program and the virtue of actions that articulate health and education, as can be seen in the statement:

“A program of paramount importance for Primary Care, of a partnership between primary care and other sectors, for example, education, where the question of the intersectoriality of activities is held, when health professionals go to education sectors to provide the service from postural guidance, nutritional assessment and other provisions” (PS3).

Despite the understanding of the importance of the aforementioned program, we found that professionals, both in health and education sectors, for example, managers have little knowledge about the PSE operation, falling short of the information contained in the legislation and texts of this program, which highlights the need for continuing education about the structure, guidelines, objectives, components and actions of PSE, so that these professionals have ownership over the program and can judge, intervene, implement and make the activities actually happen.

In a study conducted with Community Health Workers (CHW) and teachers on the importance of PSE [13], authors stated that this program was important and emphasized the benefits arising from the inclusion of health in the school

environment, such as quality of life for students and improved access for this population to health services, thereby positively affecting education.

A point to be highlighted when inferring shallow or superficial knowledge about PSE refers to the periodicity of the program-related actions. Unfortunately, professionals do not see PSE as a program of continuous and permanent actions, they understand this program as a punctual activity, restricted to a certain time of the year, with vertical planning and targeted actions without any flexibility and without forming a bond or minimal interaction, as depicted in the following speeches:

"Once a year, nutritionists assess the weight and height together with the local team to classify the BMI of our children..." (PS2);

"The periodicity should be more frequent, I only went to school twice, it was supposed to be a monthly thing, you following-up it, being always there at school or every 15 days, something like this ..." (PS6);

"I see it's mainly by campaign, I believe it's more by campaign, in the case of they usually come to give orientation on oral health, but vaccines are by campaign" (PE2).

The low frequency of actions can also be related to the insipient knowledge about their responsibilities regarding the program in question, where PSE is then characterized by specific actions, without forming a bond, as well as participatory planning in the sectors [14].

In the same vein, the studies [8,15] point to an expressive lack of knowledge about the program and the way of operation of other sectors that integrate it, besides the reductionist views about it, whether in the normative, conceptual and/or practical sphere.

The disarticulation of the education and health sectors and also the lack of availability of professionals to work with adolescents in health activities at school, besides actions in a punctual and discontinuous way, only by management guidance, was also found in a survey conducted in a large capital, thereby showing that the existing incompatibility in the PSE context is not restricted to small towns in the countryside [16].

Interministerial Ordinance nº 1.055/2017, which redefined the rules for the PSE adherence, informs that all agreed actions, according to the analysis of the territory, should be carried out during the cycle period (24 months) and should be aligned with the school curriculum and the integral education policy [5].

The PSE Managerial Handbook provides actions, agreed goals and the periodicity of each action, in addition to emphasizing that, for a given period, the activities should include the same students. Based on these determinations and the speeches of the participants, we can observe a non-conformity of the actions and frequency of the municipality that hosted the present research [17].

Category II - PSE, specific actions and vertical planning

With regard to the development of actions in the PSE context, the present study revealed a scenario of repetition in the accomplishment of these actions, regardless of the professional category, in addition to highlighting a program with restricted actions, little disseminated, and that poorly contemplates the actions envisaged in the current legislation:

"And the action to be taken is specifically to measure and weigh students. Moreover, the lectures that are most frequent are on leprosy, which were the ones that were worked on in the two years that I was present, that is, they addressed the prevention and screening of leprosy" (PS1).

"From what I saw, I know that there is one action where they perform fluoride application, a professional comes, she examines, looks at the mouth, looks at the teeth and such, and also offers some lectures ..." (PE1).

"The actions that are developed by the team are a matter of weighing, measuring the children, they also deal with worm infestations, or some issue that has already been indicated by the program: leprosy, vaccination" (PS3).

"So, what we try to perform: supervised brushing, there is also, you go to school, look at the decayed teeth, missing, filled teeth of these children ..." (PS6).

"What has been happening lately is the issue of vaccines ..." (PE6).

The description of these statements shows that the actions developed as belonging to the PSE context are taking place without analyzing the needs of the territory, leaving these activities, sometimes, outside the context experienced by students of that assigned area. The analysis of actions based on territory would have the purpose of bringing health actions closer to the reality experienced by students, thereby making them more involved, which would facilitate the approach, the understanding and, especially, the dynamics of this learning process.

The PSE Managerial Handbook clarifies that the 12 proposed actions are part of the set of minimum actions to be accomplished by the municipalities and that are contracted through the municipal commitment term; therefore, they should be seen as an initial list of essential actions [17]. Despite these actions, there is the possibility of optional actions or more relevant to a given territory. All these actions, whether essential or optional, should be planned and developed according to the needs arising from the reality in which the students are introduced, thereby becoming able to adapt the actions proposed by this program to the local context.

From the analysis of the speeches of this research, we noted that the minimum agreed actions were not held in accordance with the program regulations. Among the actions set out in the Municipal Plan of the School Health Program (PMPSE, as per its Portuguese acronym), there are: PSE 2018 Youth Protagonism Contest; To implement the "Health Promoting School" Project and the "EDUCASAÚDE" Theater Project; "Be Happy, Without Drugs" Project – Prevention and Intervention in Adolescence; Acquisition of Material and Equipment (Inputs) to promote and publicize the PSE actions; Continuing Education for School Pedagogical Coordinators, Teams (FHS) and Community Health Workers (CHW); Establishment of the "Teen Space" for Adolescents in the Primary Health Care Units in Tauá; Workshops for the use of the Adolescent's Handbook on STI-AIDS, Reproductive Sexual Health and similar projects; and PSE Municipal Forum [18].

Category III - PSE, a program of disintegrated responsibilities among its actors

The professionals involved in the PSE actions, whether they are teachers, managers or health professionals "understand" that they have responsibilities towards this program. Nevertheless, minimally, since they believe that their professional category has less responsibilities, thereby exempting themselves, in most cases, from the duty to promote health. This characteristic pervades some health professional categories, but mainly teachers, who, in their speeches, even mention that they abandon the classroom at the time of implementation of the activity, thereby entailing ignorance of the theme of the action, as can be read in the following statements:

"I have no knowledge about that (responsibility); in fact, I just go as a matter of support, because, as for the category I represent, it has not been given me any information about my responsibilities, I just go to watch the team" (PS1).

"My responsibility in relation to PSE is only once a year, when there are these assessments (anthropometry)" (PS2).

"So, my responsibility, if there is one, I don't even know what it is, what is my role when these professionals come to develop these actions here at school" (PE1).

"I have a responsibility, but for the rush and also for trusting my mate, I knew she mastered the subject, I knew the responsibility, but it wasn't because of the schedule" (PS5).

"My responsibility would be basically that, treating patients who are in pain and giving a better quality of life, guiding both children and teenagers and the family ..." (PS6).

"Accordingly, we all have responsibilities; however, as it is a program and there are people responsible, I think they should get know how to deal with it, in order to plan together, that is, the exact day he would come to us, so that we could plan too" (PE3).

Based on the PSE Managerial Handbook, we can understand that the health activities to be developed should be part of the school political-pedagogical project, thereby meeting the expectations of teachers and, especially, students. The themes to be worked on by means of PSE should be discussed in the classroom by teachers, advised/guided by health personnel or directly by health professionals, with actions previously scheduled and with the support of teachers [17].

We highlight the importance of local planning, grounded on the principle that actions take place in the territory and, it is from the critical and analytical perspective on it, that actions and solutions should be prioritized, thereby clarifying the need for prior and joint planning of sectors.

We should also highlight that some professionals understand their functions only as support and when they are called or oriented, which demonstrates the lack of ownership over the program and commitment to health promotion, which is the building block of primary care.

From the research carried out on the School Health Program: in the view of health professionals [19], we understood that health professionals hold the PSE actions by individualizing their responsibilities, thereby limiting them to their professional scope. For this reason, it is important to emphasize that, for a good progress of this program, it is essential that each professional is aware of the relevance of the issues that are being faced and the clarity of their role in the project, thereby avoiding the establishment of poor partnerships, where only one actor assumes all the responsibilities.

Category IV - The potentiality and challenges faced for the practice of PSE

Among the factors that hinder the implementation of the program in question, we noted the lack of materials for activities, schedules overcrowded with other activities that made it impossible for health professionals to participate in the actions of

this program, in terms of mastering the subjects and dealing with young audience, as well as the absence of parents in the activities, which sometimes constitute barriers for the consolidation of successful actions, since they need continuity of care at home, especially when actions were developed for children in kindergartens, where care guidance is necessary for the success of the action or when the actions required permission from those responsible:

"They often throw things on the NASF [Family Health Nucleus], which shouldn't happen, ok! Completely on the NASF. I'll even tell you, there's no material, they want us to go to schools at the time of assessment, we don't have a scale, a tape, a stadiometer, we don't have any material, but he [head] wants us to have done it, check the children's weight and height, so they don't give us the tools to work on, at least the basics, ok! And they want us to work miracles" (PS2);

"And some teachers complain because, during this movie or lecture, people remain idle, which usually implies disorder, fights, discussions, I think that if the lecture were really more informative, it would be more useful ..." (PE1);

"I've been here for a year and I haven't had the opportunity to go yet because of my overcrowded schedule" (PS5).

These excerpts reveal structural problems, indefinite responsibilities, lack of basic material required for the accomplishment of tasks, and it is still possible to observe the lack of commitment and zeal of some professionals with health promotion actions, which encompass both the Primary Health Care (PHC) actions and the PSE actions.

Authors point [20] to the need for greater and better financial investment in PSE, since one of the problems found in their study was also the lack of good materials for the accomplishment of the actions. The incompatibility of schedules, excessive activities and decreased number of professionals for the program-related activities were also found [8], thereby corroborating with the results found in this study.

The lack of partnership with the parents of the schoolchildren is defined as another limiting factor for the development of the PSE actions, since the partnership with the parents for the operation of PSE is crucial, as it comprises a valuable strategy for the continuity of the actions of this program in the family environment. They also complement that the parents act as important collaborators in the identification of risk behaviors and in the mapping of possible solutions. Accordingly, the goal is to bring parents closer to professionals and include them in the planning and actions of activities, with a view to achieving a better use of this program [6].

We noted a discrepancy in the speeches of the research participants regarding the integration between the health and education sectors, where the main mentioned complaint was the lack of communication among teachers, managers and health professionals, thereby denoting imposed activities, without prior and joint planning. Conversely, many respondents stated that there was a good integration between health and education professionals, as shown in the following conversations:

"Planning arrives already prepared by coordination staff, we just run it ..." (PS1).

"The head comes to us and tells us that there'll have an action in a given day, often already said only on the exact day; today there is a visit like this, there is a lecture about it, you should send the students to the video room on this schedule, this certain class" (PE1).

"These actions are all planned by the person responsible for the PSE schedule, and we just develop them" (PE3).

"I still see a weakness in the issue of developing these activities, because I see that it's more the health team that goes to the schools, goes after them, there is no strong dialogue between these two sectors, that's why it needs to be strengthened yet" (PS4).

"In fact, it exists (trouble), but there are not such relevant troubles, sometimes there is resistance from a professional, but these are things that we talk about, in terms of democratic leadership power, in order to convince the professional to participate and engage for real" (G4).

Once again, we can note that there is no strategic planning in partnership with the entities, thereby demonstrating the fragility of the main characteristic of this program, i.e., intersectorality. These statements bring to light the disparity in the concentration of responsibilities, while showing little commitment to the health promotion policy in question.

The lack of planning and interaction between the sectors, the structural and human shortage of resources, the difficulty of acting in health promotion and PSE activities were related to bottlenecks for the implementation of PSE [16].

The overload of work, the excess of bureaucracy, the management problems and the lack of human resources are also pointed out as problems that lead PSE to become just another policy limited to paper sheets, without concretization in practice [6].

As problematic factors for intersectoral action, some authors mentioned [8] communication difficulties between sectors and between the different levels of management and the professionals working at the top of the system, in addition to the

failures in meeting deadlines and goals, decentralized planning, disagreements and disrespect between sectors and difficulty in adopting new attitudes.

For this reason, authors defend [21] the need for greater investment in prevention projects, such as the current changes in the health area in Brazil, in order to overcome the models of education aimed at curativist care, and the consolidation of an expanded concept in health, which involves and integrates different levels of action: promotion, prevention, treatment and rehabilitation.

Financial and collaborative responsibilities should be the same or very similar for the two portfolios, health and education. One of the causes of the disconnection between health and education is due to the transfer of resources, the time dedicated to the program and the involvement of the stakeholders, which are not equivalent. This reality brings to light the non-compliance with the responsibility of the Municipal Intersectoral Working Group (GTI-M, as per its Portuguese acronym) [22], which should jointly manage the resources available for the implementation of PSE.

Despite the non-conformities found with the research, it is possible to accept the assumption that the surveyed professionals have knowledge about the magnitude of the program in question as being a great potentiality, thereby enabling us to glimpse the transformative potential of PSE, that is, although the study participants have reported little knowledge about objectives and/or responsibilities, they are convinced of the possible benefits arising from the actions implemented in this program, even though they do not accomplish them according to legal requirements.

Category V - Schoolchildren and PSE: "I do not know much"

Regarding the perception of schoolchildren, we observed a lack of knowledge about PSE, since none of the interviewees was acquainted with the program, thereby demonstrating ignorance about the name of the program, despite being able to list some individual actions carried out at school:

"I don't know much. I know that one day they went there to talk about health. It's a good program" (E1).

"I don't know anything. They arrived there at school, gave medicines, vaccines, gave a lecture on health, on prevention. It's good!" (E2).

"Not, I never heard about it" (E4).

"I don't know anything, I know that people go there, give lectures, but I didn't even know the name of this program" (E5).

The young participants in the research were able to identify some activities, with an average of eight different themes of actions, but the most present in the speeches were actions to promote healthy eating, oral health and actions to fight the *Aedes aegypti* mosquito.

A study conducted in Belo Horizonte [23], focused on schoolchildren, informs that the most cited PSE activities were assessments of visual acuity, oral health and supervised brushing, vaccination status and application of HPV vaccine, promotion of healthy eating, body practices/physical activities, education for sexual health, reproductive health/prevention of STD/AIDS, fight against the use of alcohol, tobacco, other drugs, and actions to fight dengue, thereby showing greater dynamism in actions.

Actions aimed at change are related to empowerment, with the education process being responsible for choices and decision making focused on the responsibility for the human life itself, and should be integrated with the knowledge and experience of the student, so that there is development of an identity. Depending on how educational actions are conducted, they can only transmit information, without providing any change in behaviors [23].

Accordingly, it is necessary for schoolchildren to participate in the choice and construction of the topics to be addressed, since a substantial learning is related to their needs and experiences, thereby making references to active methodologies [9].

The benefits arising from the actions implemented by PSE are still very incipient. Schoolchildren, despite knowing how to distinguish what is bad for their health, still have a certain immaturity to prefer the healthier or more correct, instead of the easier or even more pleasurable.

By studying the perception of elementary school students about the School Health Program [23], it was possible to evaluate the good results by means of the improvement of their perceptions in areas related to physical well-being, family life, financial resources, friends, school life, social acceptance and leisure, thereby showing positive impacts arising from the PSE actions.

Therefore, in their study [19], authors corroborate the hypothesis that the approximation between school and health unit only tends to contribute to helping adolescents to transform scientific information into healthy behaviors and, consequently, change their habits.

The lack of bonds between health professionals and schoolchildren was clearly expressed in this research, showing once again the way in which activities are carried out, which does not converge with the approach of the health team in their territory, nor with the increase in access to health services on the part of adolescents, unfortunately.

The lack of bonds and the low frequency of actions contribute to the non-approximation of these schoolchildren. The manifestation of this distance gains significance among adolescents in the face of risks and vulnerabilities, such as: the practice of immature and unsafe sex, the spread of sexually transmitted infections, the prevalence of unwanted pregnancies, the use and abuse of alcohol and other drugs, the violence, which are situations that could be avoided or mitigated if there was greater control over these issues that often contribute to interrupting dreams, adding distress, anticipating responsibilities and imposing an early maturation [20-23].

CONCLUSION AND FINAL CONSIDERATIONS

The study enabled us to identify that the majority of health professionals, as well as managers, have a relatively short time in their functions or positions, which could explain or not the fragilities in relation to PSE. On the other hand, teachers seasoned in their activities, with more than 10 years of service, also did not demonstrate greater knowledge or interest in this program, which suggests that the length of service does not have a positive impact on the acquisition of ownership over PSE.

Health promotion actions are often secondary to health care actions, by health professionals, as opposed to the axes of primary health care. Accordingly, we can understand the need to include health promotion actions in the schedule of health professionals, as well as in the routine of education professionals, so that there is a full and constant involvement. The act of recognizing the power of health promotion actions should be the first part of the process for the actual achievement of intersectorality.

As for the responsibilities of those involved, we noticed a considerable distance in the practice of common competencies, where we still perceived that health professionals, including some managers, are closer to the planning and accomplishment of the program, but still carried out individually. Planning does not manage to integrate all the actors, thereby excluding from this process the target audience, i.e., the students themselves, besides hindering participation and commitment in the scope of the health of these schoolchildren, which should be participatory and collaborative, thereby becoming integrated and with co-responsibility. It was not possible to identify program evaluation actions among managers, nor among teachers and health professionals.

We identified other challenges that hamper the progress of the PSE activities, such as the lack of materials for the activities, lack of mastery of health professionals in dealing with the young audience and the absence of parents in the activities; therefore, we should consider the need to know about the program on the part of the school community, thereby legitimizing the importance of continuing education activities concerning health promotion and PSE.

Based on the viewpoint of the surveyed students, it was not possible to determine positive impacts arising from the actions, but it was understood that the actions happen in a still very incipient way¸ as there are no integral and permanent actions capable of forming bonds between professionals and schoolchildren, which is, once again, opposed to the PSE and primary care legislations.

Moreover, it is important to implement more dialogical and reflective initiatives, based on their own experience, so that all actors in this program, managers, health and education professionals, schoolchildren and their parents or legal guardians can, based on the construction of knowledge about this program and its potentialities, envisage the fragilities and develop mechanisms of approximation and integration to construct an authentic intersectoriality from the perspective of participative social construction.

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