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Health in School Program in the view of managers in five towns of the Western Paraná, Brazil

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ABSTRACT

Introduction: In school, education and health should be related to promoting health and turning the Health in School Program (HSP) into an effective cross-sector policy. The managers' view about the implementation of the Program in towns of the 10th Health Regional Office of Paraná, Brazil, and the Regional Education Center from the city of Cascavel was questioned. **Objective:** To analyze the managers' understanding of the implementation and development of the Health in School Program. **Methods:** This is an exploratory study of a qualitative approach, with data from interviews with managers of five towns in the Western Parana region from the 10th Health Region and the Regional Education Center of Cascavel. These towns have implemented the Program by 2012. Fifteen managers (eight from the health area and seven from the education area) participated in the interviews conducted in July, August, and September 2015. The data were systematized and based on thematic content analysis. **Results:** The theme "The managers' perception about the implementation of the HSP" was systematized and unfolded into the subthemes: motivations for participation, planning, evaluation and monitoring, developed actions, the cross-sector policies, and financial resources. **Conclusion:** The HSP was implemented in the studied towns, however, in differentiated stages, although the developing actions aimed at its integration. The cross-sector policy has become an important strategy for the development of health and education. The program needs to improve actions for health promotion and training of the subjects involved.

Keywords: Public Health; intersectoral collaboration; education; health promotion.

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INTRODUCTION

The health-education relationship, when dealt with at school, takes on peculiar contours, delimiting an environment where health and education professionals must meet, and for which specific policies must be proposed and implemented.

From this perspective, the Health in School Program (HSP), of the Ministry of Health and the Ministry of Education, seeks to develop intersectoral policies to improve the

quality of life of the Brazilian population [1]. Thus, the HSP makes room for the implementation of actions to promote, prevent, and care for health, facing the vulnerabilities of children and adolescents that may cause interference in their proper development[2]. Brito et al.[3] add that this program based on integrality can contribute to improving the health of schoolchildren.

For this, the integrality assumed in the professional attitude must provide the integration of services beyond health, to ensure the care of the subject based on intersectoral actions[4]. The intersectionality in health integrates national and international plans and programs to articulate knowledge and experiences in planning, execution, and evaluation, which aim at reaching solutions to health-related problems and equity in health[5].

In this intersectoral scenario, the school space has been pointed out as a favorable environment to carry out health education programs[2].

Thus, the HSP contributes to the comprehensive training of students in the public basic education network through actions of prevention, promotion, and health care[6]. Thus, the following question emerges as a question in this study: what is the view of the HSP managers regarding the implementation of this program in municipalities that first adhered to the proposal in the Tenth Regional Health Department/PR and the Regional Education Center of Cascavel/PR, Brazil? It is assumed that managers have been prepared to develop the program and that the actions developed are based on intersectionality, integrality, and promoting the health of schoolchildren.

Therefore, the objective of the study was to analyze the managers' understanding of the implementation and development of the Health in School Program.

METHODS

A qualitative exploratory study was conducted; this type of approach was chosen for the possibility of reflexivity in discussions around a particular phenomenon chosen by the researcher[7]. A qualitative exploratory study was conducted; this type of approach was chosen for the possibility of reflexivity in discussions around a particular phenomenon chosen by the researcher.

The research was conducted in an intersectoral context, involving municipal health and education managers who worked in the management of the HSP. The inclusion criteria for data collection were that the municipality had joined the HSP by the year 2012. And, as exclusion criteria, municipalities that joined the program after 2012. Fifteen managers participated in the study, of which eight (53.3%) are health managers and seven (46.7%) are education managers.

The interviews were guided by semi-structured scripts, contemplating two correlated thematic axes: identification of the subjects, and the implementation and development of the HSP, composed of open and closed questions, which reproduced the guidelines for the development of the program expressed in the step-by-step booklet of the HSP[8].

Data collection occurred from July to September 2015 and the interviews were recorded and transcribed in full, subjected to content analysis, systematized, and organized into thematic units. The subjects' speeches are identified by the acronyms GS or GE, referring to Health Manager or Education Manager.

The content analysis technique, proposed by Minayo, was chosen for the treatment of the data in its three stages: pre-analysis, exploration of the material, treatment of the results and interpretation based on the theoretical foundations initially built[9].

The study was developed according to the guidelines of the National Health Council Resolution No. 466/201210, approved by Opinion CEP no 1.134.653, on 06/25/2015.

RESULTS

Among the 15 participants, the health managers had degrees in Nursing 3 (37.5%), Psychology 1 (12.5%), Nutrition 2 (25%), Administration 1 (12.5%), and Middle Level 1 (12.5%). Those in education had degrees in Pedagogy 3 (42.85%), Nutrition 2 (28.57%), Mathematics 1 (14.29%), and Languages/English 1 (14.29%). The time of performance of the health managers ranged between one and nine years; for those in education, it was two to ten years.

One can schematically visualize, in Figure 1, the construction of the emerging themes, whose central approach was the managers' perception of the HSP implementation.

The implementation of the HSP was prompted by the regional management of the Unified Health System (SUS). As mentioned by the managers, regarding the *demands for adherence:*

"[...] the Regional that called for this discussion [...]" (GS2).

"[...] the region presented the program [...] they pass to the municipalities all the programs that come from the government [...]" (GS7).

Among the managers' motivations for the implementation of the HSP, acting on the students' health would be a way to establish *early diagnoses and, consequently,* to *positively interfere in the teaching-learning process*.

"[...] at school, the importance of it [HSP] is to be looking for the problems, whether visual, auditory or other problems [...] (GS1)".

"[...] it would also improve the teaching-learning process [...] most of the children where this screening was done went to the Ophthalmol [ophthalmologist] and it improved a lot in the literacy issue" (GE2).

It can be seen that the *resolution of the problems identified* is based on the program's work on biological issues.

The conditions that affect the children's growth and development were attested to in their speeches:

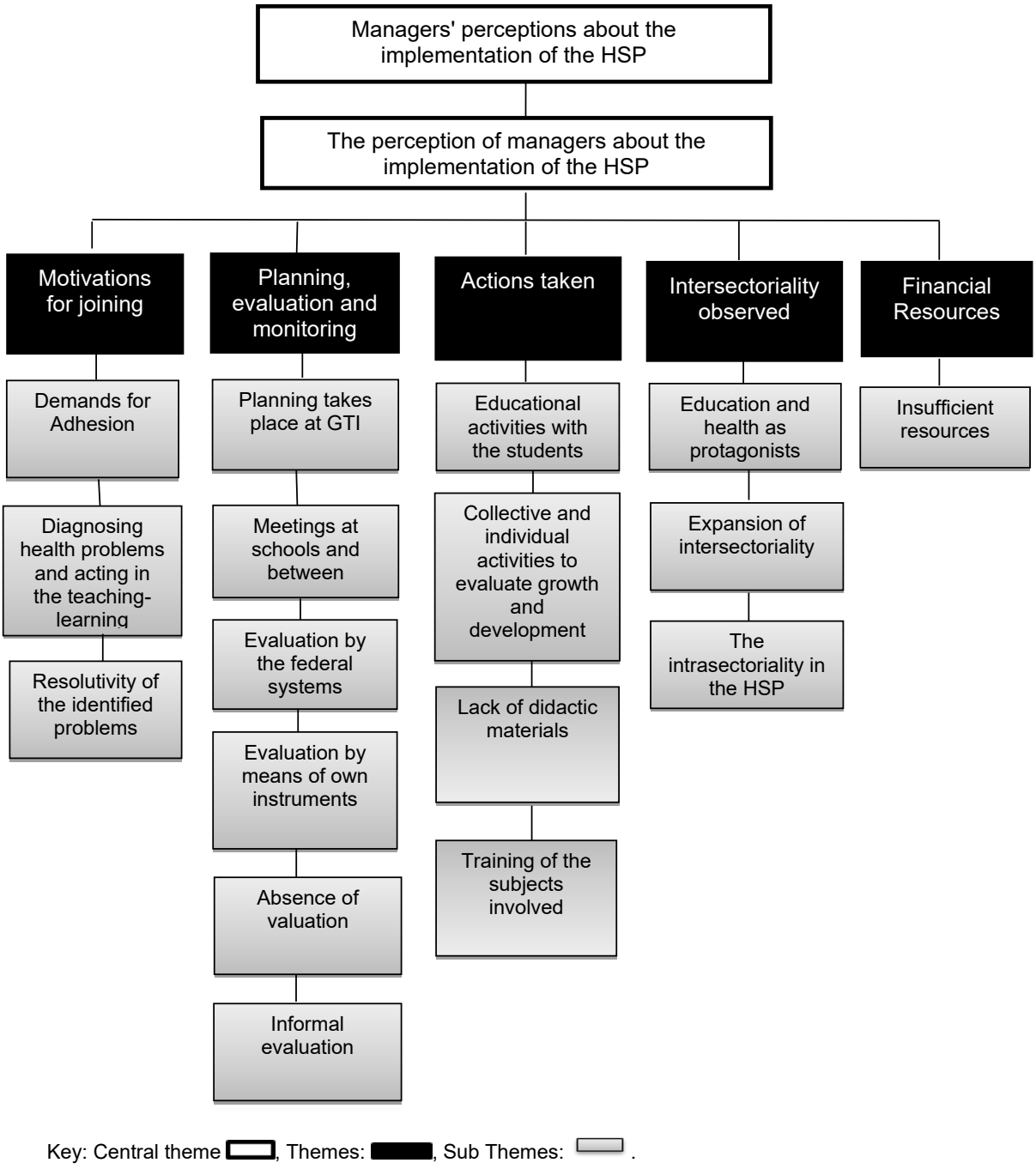

Figure 1: Emerging themes in the study

"[...] encountering barriers in some professionals because we were part of the school and there we detected the problem in the student and couldn't refer [...]" (GS5).

"[...] nothing was invested, we inserted into the SUS network all these people identified in the schools" (GS2).

The planning, evaluation, and monitoring of the HSP should happen in the Intersectoral Working Groups (GTI)[8]. It was identified that the GTI is present in almost all the municipalities studied and the actions to be developed involve *planning in the GTI*.

"Through the intersectoral group, meetings are planned, actions are listed, and strategies are developed to be carried out" (GE5).

"[...] The demand comes out of the GTI [...] do the GTI and see what we are going to work on [...]" (GS7).

The evaluation, planning, and control sometimes take place in collective discussion spaces, such as in *meetings at schools and between secretaries:*

"[...] The health department [...] education department [...] every two months, we do the planning [...]" (GS6).

"[...] it was through a meeting with the representatives of each secretariat for us to determine which themes to work on [...]" (GE4).

As for the evaluation, managers refer to the filling out of the data required by e-SUS and the Ministry of Health's Integrated System of Monitoring Execution and Control (SIMEC), which are *evaluations of federal systems*.

[...] "We have that HSP monitoring that is done through the e-SUS [Online System for Registration of Unified Health System Data]. So there is this external monitoring" (GS2).

"Through the SIMEC program, the e-SUS, and the municipality's program that we have. It records the meetings" (GS4).

Municipalities were identified as having gone beyond the official records and created their *instruments for evaluating* and monitoring the program, from individual evaluation forms to spreadsheets with the data collected.

"The GTI itself developed the instruments because, in the beginning, nobody knew how to give much direction [...]. So we started to build our instruments" (GS6).

In some cases, the *absence of evaluation was* observed, as follows: "[...] No. Not written like this, no official document. It accompanies the actions daily, we accompany the results. It is even an idea to prepare an instrument" (GS7).

Regarding the activities developed, it was identified the realization of *educational activities with the students,* focused on health education, especially the lectures.

"[...] we did a lecture in all the schools about STD, teenage pregnancy, they were collective meetings in the schools" (GS3).

Collective and individual actions to evaluate growth and development were identified as the most remembered:

"In 2013 we hired speech therapist to evaluate all preschool students, hence early childhood education do evaluation, vision exam, acuity [...]" (GE4).

"About our part that would be the nutritional assessment, we started doing data collection, we weighed all the students [...], then we found out what? That 30% of our children are obese, overweight it was scary" (GS8).

The biological aspect of school health is outstanding, perhaps because it is the most objective of the program's actions.

Regarding the sending of *teaching materials* for the development of educational activities in schools, what was identified in the managers' statements was:

"[...] I didn't see it, no. So far no specific material has arrived for this no [...]" (GE1). "[...] no [...]" (GS1).

"[...] no. What was possible was done with the municipality's resources [...]" (GE2). "[...] money from the municipality itself [...]" (GS2).

In addition, the training activities for the subjects involved were the least frequent: "[...] what was very successful was when we trained the teachers and with all the school staff" (GS7).

"[...] we trained all the school staff, we worked with all the parents, with the staff" (GS8).

The managers recognize that the program has contributed to the strengthening of intersectionality, through the necessary dialogue between the different secretariats. *Education and health* were identified *as protagonists*:

"[...] the relationship between the two secretariats regarding the HSP has grown a lot [...] the two teams have become more in tune, have become stronger" (GE5)".

"[...] this union between the secretariats, that was very nice" (GS8).

The intersectionality is more evident between the health and education secretariats, but it was realized that this factor needed to extrapolate, seeking the *expansion of intersectionality*.

"[...] actually it's not just the HSP issue, because there's always a patient there that sometimes goes to look for Social Assistance goes to look for Health, the Secretary of Education, works quite a bit in partnership" (GS5).

"We took into consideration the networking, but Social Assistance helped us a lot in the issues [...]. So we got together so that, based on a certain problem, we could see the best way to help" (GE2).

They express that there are difficulties in the education sector itself when other educational levels are not so close to the issues discussed in municipal education, straining the *intrasectoriality in the* HSP. This condition, of course, brings tensions to the execution of actions carried out by the municipal administration, as is the case of the HSP.

"[...] there is still a school that always has that Director, we have the greatest difficulty with the Directors of state schools in rural areas, we have more difficulty even our contact with them [...]" (GE6).

The development of programs requires the allocation of resources that were foreseen for the HSP, but the managers considered that they could not meet the demands unleashed, which brought up the sub-theme: *resources* are *insufficient*.

"No. Everything we got to do visual acuity was with resources from the municipality" (GE2).

"The Ministry of Health is leaving something to be desired - we need that resource that is in the ordinance" (GS6).

DISCUSSION

The implementation of programs, especially those that involve multiple sectors, requires preparation and articulation so that they have a greater chance of success. It is observed that the adhesion was put in place without dialogue between all interested parties, which may indicate difficulties in articulation between different sectors.

In this sense, the implantation and implementation of public health programs are complex in the three administrative sectors

(municipality, state, and federal government), challenging their development in school settings[11].

Another essential aspect of the effectiveness of the HSP is the union and effective participation of managers, professionals from the Health and Education teams, and the school community is facing the specific deficiencies perceived in each place, considering the individual and collective needs[12].

This difficulty among the different sectors in the adhesion and implementation of the HSP exposes that there is a tendency for the Ministry of Health to centralize everything from financing to the adhesion processes by the municipalities, which can hinder the effectiveness of its main element, which is intersectionality.

Thus, intersectionality is an increment, which allows a broader approach by health and education professionals, adding their work, and knowledge, to extrapolate their abilities to address problems and thematic discussion in health education in a clear way[13,14]. The intersectionality between health and education has been highlighted by researchers from both areas, thus, professionals can develop relevant methodologies and direct a meaningful approach to users of health and educational institutions[15].

When the managers emphasize the services provided by the HSP, it draws attention to the fact that these students are unassisted by Primary Care, and are identified by the program's actions. Thus, the resoluteness, proposed by the National Primary Care Policy, is responsible for solving these problems, even if it requires reference to other points of care in the health system[16].

It was identified different stages of monitoring and evaluation of the program, a condition to advance any welfare proposal. The permanent monitoring done by the manager allows for the delimitation of his territories, and situational diagnosis based on the social determinants in the epidemiological scenario[17].

The coordination of the HSP through the Intersectoral Working Groups (GTIs) is centered on shared management, in a construction in which both the planning and the execution of actions are carried out collectively[1].

In the studied municipalities, the composition of the TSG presented, as participants, eight (53.33%) managers from the health department, seven (46.67%) managers from the education department, eight (53.33%) representatives of the health department, eight (53.33%) representatives of the education department; other professionals were mentioned in the interviews, composing the TSGs as three (20%) social workers, two (13.33%) psychologists, two (13.33%) pedagogues, three (20%) dentists, two (13.33%) speech therapists, two (13.33%) psychopedagogy specialists, 01 (6.66%) nutritionist, four (26.66%) social assistance secretaries, one (6.66%) nurse, two (13.33%) sports secretaries, and one (6.66%) physical educator.

It is evident, in this study, that the composition of the GTI enables the intersectoral articulation of the public Health and Education networks, and other social networks for the planning and development of the actions of the HSP, which favor shared management.

The production and recording of data have been one of the obstacles to HSP's monitoring and control. The available information systems did not "enable the identification of care in schools [...]". Faced with a scenario in which information on school health actions was a challenge for the program's management, either because it was insufficient (the basic health network had not yet adopted the e-SUS/AB, making it difficult to obtain information on Component I actions) or because of the delay in obtaining it (SIMEC data are consolidated only once a year)[18].

Therefore, the study developed by Chiari et al.[6], in which the monitoring and evaluation of the HSP actions were carried out using municipal instruments, developed by the management, based on the activities performed by the health teams.

The health promotion approach, one of the foundations of the program, seems to be a challenge for the construction of the HSP.

The school health actions gained notoriety from the year 1889, with sanitary situations, considering the precarious living conditions of society, associated with the absence of a public health system and the presence of epidemics. Only from the 1950s on, the programs were directed to health at school, with actions focused on the biological issues of the problems related to education[19].

Currently, the theme of health at school receives important attention from several international organizations, especially the World Health Organization (WHO) and the United Nations Educational, Scientific and Cultural Organization (UNESCO), which confirms its relevance worldwide[20].

Still, it is important to consider that, in the last four decades, the theme of health has begun to be incorporated more strongly into the school environment and point to important advances and changes in the understanding of health, from the incorporation of its social determinants, the idea of the right to health, and the incorporation of the collective dimension to the goals of health education[21].

Another action front of the program is the educational actions, present in component II. They may have been hampered by the lack of materials that should be produced and used for the program. There is a constant lack of materials for the execution of the HSP actions; the clinical and teaching materials that should be provided by the Ministry of Education and Culture (MEC) have not been received, and the professionals are not consulted about the need for materials for the development of the program's actions[22].

The need for these resources was also identified in a study on a school health intervention, conducted in the United States of America so that actions could continue to be carried out[23].

Another difficulty was the lack of specialized personnel in the health sector to act in the development of actions. This finding corroborates the study by Moraes et al.[24], which points out the

lack of human resources and the absence of didactic materials with specific language and characteristics for the approach to this public.

Thus, it is fundamental, besides the permanent training for the professionals who work in the school, to hire professionals with diverse backgrounds, with the profile and competence for health promotion actions[25].

In the schoolchildren's health issues, nutritional diagnosis and vision and hearing evaluations, which are part of component I, stood out. Obesity and overweight have become a common problem in the school environment, as opposed to malnutrition. Considered a global epidemic, it requires the adoption of preventive measures that can reduce the rates of overweight and obesity in children and should be intensified, both in the public health system and in school spaces[26]. Thus, identifying it can help establish health promotion and prevention measures.

On the other hand, this finding may reflect the fragility of Primary Care, which should, even outside the school environment, have mapped, care, for the attached population, since, if efficient, it could solve most of the health problems in all stages of the life cycle, hindering the exercise of integrality[27].

Thus, the study, developed in the Northeast region of Brazil, identified that the presence of a nutritionist in Primary Health Care is important to solve problems related to food and nutrition in schools, to ensure food and nutritional security[28].

The school is an environment of reflection and formation of future citizens, being considered as one of the spaces where one can act to promote health, nutrition, and prevention of diseases, contributing to the integral formation of the individual[22].

It was expected that the implementation of the program would be accompanied by the training of the actors that would develop it.

A study identified that health and education professionals involved in the development of the HSP actions expressed that the training to work in the program was minimal and considered that this failure hinders the development of actions and the achievement of satisfactory results[29].

In similar studies by Medeiros and Pinto[30], in Rio Grande do Norte, and by Farias et al.[13], in Pernambuco, the same difficulties in results were evidenced. For the implementation of the actions foreseen in the HSP, the initial and continuing education processes of professionals are essential, and they must be attentive to intersectoral and interdisciplinary actions[11].

Thus, training processes through the continuing education of professionals is a viable option to make the educational actions more adequate to the needs of the population[2].

The process of training managers and teams must be a commitment of the three government sectors, to be worked continuously and permanently, aiming at integrality[1].

Intersectionality is another basic dimension of the HSP, as it must articulate the different sectors involved in the development of the program's actions, and requires inclusion in the daily practice of professionals, enabling the construction of dialogical knowledge, in addition to producing health in school spaces effectively[31].

Intersectionality is a better understanding among members of the health sector. In the education sector, it is understood with some strangeness; they attribute it to the notion of partnership, pointing to the need for networking in face of the complexity of existing social problems[22]. This fact reinforces weaknesses in the implementation of the program, exposing that it was not widely discussed, which would strengthen intersectionality.

For the development of the HSP, intersectionality must be worked in such a way that the program's actions are not configured only as specific health or education actions, but also make it possible to form an integrated, participative space in transformation, under the perspective of Health Promotion[2].

It is important to highlight that intersectionality and strategies for its development require expansion and involvement beyond the education and health sectors. Thus, the establishment of partnerships with other points in the service network constitutes a strengthening of the program[32].

Another aspect to stress intersectionality was the lack of collective evaluation moments, as identified in the practice of some municipalities that have no systematized evaluation of the program.

The resources for the program were remembered as problematic. The managers point out that, in the first version of the program, when the resources were passed on in full when the actions were agreed on upon[33], the program achieved good results; since the 20% passed on when the actions were agreed upon, with the rest after the actions were performed[34], this caused difficulties for the program.

The program implemented actions aimed at evaluating the growth and development of schoolchildren that identified problems, which require the manager to program actions to solve them.

Conclusion

The HSP implementation, in the studied municipalities, followed the guidelines established by the Presidential Decree, and the intersectoral articulation, in the HSP implementation process, is an experienced practice, and other secretariats composed the intersectoral actions, organized by the Municipal Intersectoral Working Group.

Although about the evaluation and monitoring of the program, weaknesses were evident, the municipalities have developed their instruments, considering the inexistence of instruments made available by the Ministry of Health and Education.

It was identified that there was the implementation of collective and individual educational activities, and those related to growth assessment, thus, health promotion actions do not emerge clearly among those that were implemented, constituting a challenge for the program.

Regarding the training process for the managers and teams that work in the development of the program's actions, it was found that it is necessary to think about improvements to reach the program's objectives.

It is concluded that the HSP, although presenting some structural and managerial difficulties, is implemented in the studied municipalities, however, with differentiated stages, but developing actions to ensure the completeness of care, the intersectoral approach has become an important strategy for the development of actions relevant to health and education, capable of providing improvements in the quality of life of students who make up the schools.

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