Chapter 7
Health in School Program: Practicing Intersectorality on a Territorial Basis for the Future of Health in All Policies

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Introduction

> "… the centrality of Pathos,
> the recovery of Eros and the re-invention
> of the heart's logic are fundamental …" (Boff 1999:119)

Among other successful experiences developed in Brazil, this chapter intends to answer some of the guiding questions proposed in the monograph, inserting the description of the Health in School program, developed in the municipality of Guarulhos in the state of São Paulo in the southeast region of Brazil, as part of a federal program being developed in most of the national territory.

To contribute in a way that meets the proposed standard, justifying this contribution, this chapter was developed following a suggested script and tries to answer the posed questions.

As an introduction, we can start by affirming that many advances have been made in recent decades on theoretical concepts linked to health promotion. It is common to speak of social determinants or, more recently, socio-environmental determinants, under the shadow of the Sustainable Development Objectives with

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their international agenda predicted by 2030, but there is still a great deal of distance between the theoretical construction and the desirable and necessary "praxis," so that we can actually talk about "health promotion" with results that really promote quality of life for all, thus going far beyond medical assistance to only avoid diseases.

To talk about health, it is necessary to speak of territory, and in doing so, one cannot be restricted to only describing a certain geographical space but must refer mainly to the people who occupy that space and the enormous complexity of social relations. Environmental and economic conditions that are established, with stories of struggles, dreams, victories and defeats, ventures and misfortunes, and how this whole universe is necessarily reflected in the health conditions of the communities, must be given due attention.

Thus, when one aims to understand and practice "health promotion," one must know and consider the complexity of the social and environmental determinants that affect each particular community, especially when the goal is the development of public policies that will bring about results on a large scale and of a long-lasting and truly transformative character; that is, it is important to take into account that health can only be promoted within particular localities on a daily basis!

As in other areas of social organization, health has historically been seen and constituted as the structuring of current economic models, generally not emerging from the Latin American reality but reaching it from culturally different and historically dominant countries, arriving at the level of the clear dynamics of "commodification of life," which in fact has been happening also with education.

The SUS—Brazilian Unified Health System (Law 8080 of 9/19/1990), emanated from the political process of retaking democracy in the country in the 1970s and 1980s, with the basic premise of decentralization of power at various levels of government organization, has taken considerable deviations, producing results that often fall short of expectations owing to the different conceptions in the SUS imaginary, such as

> …democratic, idealized by the set of proposals of the health reform movement; the formal, expressed in the constitutional text; the real, hostage of financial constraints, a result of readjustments and macrostructural reforms of the economy…; of poor people, impelled by the conception of the international organisms of focalization, and not of universalization, in social policies. (In PAIM, Jairnilson 2006, apud Cadernos da Regionalização COSEMS-SP 2007:7).

Despite this condition, however, over time significant advances have been made in the quality of national public health, having as its main tool the decentralization of management and a greater allocation of public health budget resources, enabling an "…increase of the organization of local health systems, improving the standard of service provision and actions"(COSEMS-SP 2007:8–9).

Finally, by Ordinance 687 of March 30, 2006, the National Health Promotion Policy was approved considering the principles of SUS, in the context of the Pact for Health with its components Pact for Life, Pact in Defense of SUS, and SUS Management Pact.

Today, in the international context, especially in Latin America, we are talking about the need to consider health in all policies (HiAP), and it is significant and emblematic that already in 2006 Brazil asserted in its National Policy for Health Promotion that

> …the promotion of health narrows its relationship with health surveillance, articulating the need for an integrative movement to build consensus and synergies and the implementation of governmental agendas, so that public policies are increasingly favorable to health and life and stimulate and strengthen the protagonism of citizens in their elaboration and implementation, ratifying the constitutional precepts of social participation. (MS 2006:11)

In the same way, in this same document, one reads: "It is understood, therefore, that health promotion is a cross-cutting strategy in which visibility is given to the factors that put the health of the population at risk…, aiming at the creation of mechanisms that reduce situations of vulnerability, radically defend equity, and incorporate participation and social control in the management of public policies" (MS 2006:11).

It is in this scenario, then, that Brazil has been looking for innovative results in its approach to promoting health, and it is evident that, although much remains to correct, significant advances have been made that can bring answers to key questions to qualify more and more what is understood by a real praxis in health promotion.

Contextualizing (Fig. 7.1)

Guarulhos: 1.221.979 Inhabitants/Surface: 342 km²/30% still with green areas preserved/50% of waste water treated/housing problems (invasion areas), final destination of residues, environmental education, employment, use of drugs, violence, early pregnancy, insufficient water resources

Fig. 7.1 Guarulhos—Metropolitan region of São Paulo

Guarulhos is one of the 39 municipalities that comprise Greater São Paulo, Brazil's most economically important region, which also houses the largest airport in Latin America. With almost 1,300,000 inhabitants, according to the latest census of 2010 by IBGEI Brazilian Institute of Geography and Statistics, it is the 2nd largest city by population in the state of São Paulo, the 12th most populous in the country, and the 8th richest city in Brazil, with output representing more than 1% of gross domestic product (GDP). In recent decades, the city has undergone a significant verticalization and disorderly growth, attracting population groups from diverse regions and states who arrive in search of employment and housing opportunities.

This unplanned in-migration has led to the consolidation of an environment marked by strong imbalances and impacts, making the consideration of socio-environmental determinants a fundamental condition for thinking about health promotion, which necessarily implies public policies that can incorporate health into all policy decisions, as well as the guarantee of democratic instruments and social participation.

The management of this whole complex is governed by 21 secretariats, in addition to different coordination and other instances of the prefecture. Thus, the municipality has secretaries of, among others, the environment, public services, urban development, health, and education (Fig. 7.2).

The Municipal Health Secretariat manages more than 100 health facilities, including hospitals, Basic Health Units, 24-hour emergency services, specialty outpatient clinics, psychosocial care centers, dental specialties centers, Reference in Elderly Health, Health And a Public Health Laboratory, a human milk bank, sanitary transport service, Municipal Emergency Service (SAMU), street doctor's office, and a modern Zoonosis Control Center.

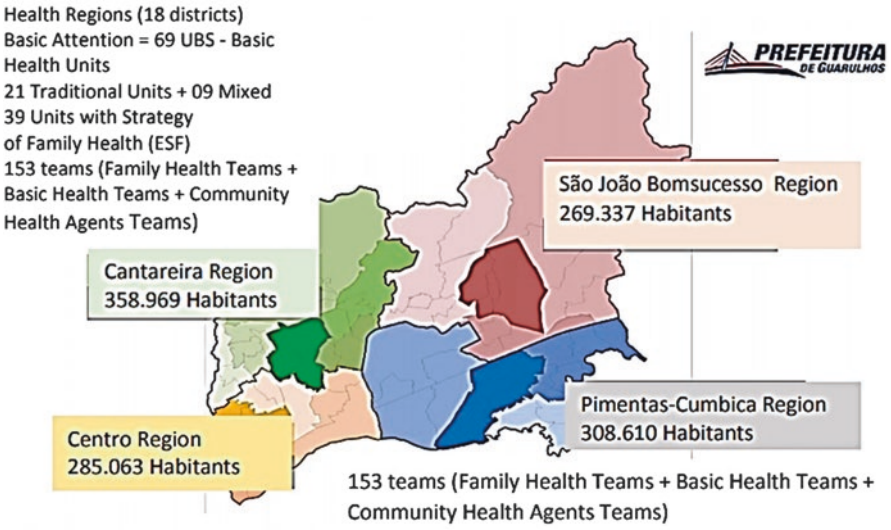

Fig. 7.2 The Municipal Health Department divided the territory of Guarulhos into four health regions

It offers integral assistance for individual and collective health to improve the quality of citizens' life. To this end, it carries out, among other activities, health promotion actions taking into consideration the multiplicity of socio-environmental determinants, as well as the protection and recovery of the population's health, reducing diseases, controlling endemic and parasitic diseases, and improving health surveillance. It counts on popular participation and social control acting as a democratic instrument for the construction of public policies for the sector.

The Municipal Secretary of Education runs 140 schools attended by more than 116,000 students and employs about 5000 teachers. Counting indirect employees, the Secretary of Education has approximately 8000 employees. Also part of the municipal network are the Municipal Centers of Education (CEUs) and Incentive Centers for Reading. It also has 55 schools serving 9400 children aged 0 to 5 years. Its education policy is based on participatory management processes both at the central level and at the teaching units.

The state schools of the municipality, under the management of the Regional Teaching Offices, constitute a universe of 87 schools in Guarulhos North and 88 schools in Guarulhos South serving a total of 174,000 students. It is in this context, very briefly presented, that the PSE—Health Program in the School, forms the center of this contribution to the Monography written and organized by Dr. Ligia Salazar, counting on other collaborators, besides the authors of this article.

PSE: School Health Program

As can be seen on the website of the Ministry of Health, the Health in School Program (PSE) was launched in 2007 by Presidential Decree 6286 as an intersectoral policy between Health and Education, focusing on children, adolescents, young people, and adults in Brazil's public education system that was implemented in an integrated way in an effort to promote health and integral education.

The school is considered a privileged locus where, insofar as one can work on the construction of values and ways of knowing and relating to the world, one can also develop critical and political thinking and thus contribute directly to the social production of health through the defense of the quality of life.

Based on the fact that the PSE's actions should form part of a school's political-pedagogical project, the program takes into account "respect for the political-executive competence of the states and municipalities, the socio-cultural diversity of the different regions of the country and the autonomy of educators and pedagogical teams. " Therefore, both health professionals and educators motivate the adherence of schools to the program and work to strengthen the basic principles of health promotion among students, teachers, and school staff, always counting on the support of area managers in education and health in the establishment of agreements and goals for each school year with the backing of the ministry, in terms of both technical support and the transfer of funds.

Based on the fact that the actions of the PSE must respect the reality of each school, the work of health promotion with students, and with teachers and employees, always has as its main starting point the knowledge and previous potential of the collective school to expose them to practices and attitudes that promote health and improve the quality of life of communities in and out of school.

The program is coordinated through intersectoral working groups (GTIs) based on shared management, in which both planning and execution of actions are carried out collectively to meet local needs and demands. That is, the work in the GTI presupposes an exchange of knowledge and a participative and shared management between health and education professionals, as well as between students, community, and other social networks and partners.

The organizational structure includes the Federal intersectoral Working Group (GTIF) and the State Intersectoral Working Group (GTIE), together with the Intersectoral Commission on Education and Health at the Ciese School. Thus, the municipal GTIs are composed of representatives of the health and education secretariats and, whenever possible, other local partners, and representatives of social policies and movements (youth groups, culture, leisure, sports, transportation, urban planning, civil society, nongovernmental sector, and private sector, among others).

In this way, schools participating in the program include health in the political-pedagogical school project, meeting the expectations of teachers and, especially, students, so that the themes to be explored within the scope of the PSE are debated in the classroom by teachers, guided by health professionals or directly by the health professionals themselves characterizing shared and joint actions respecting the specificity and competencies of the sector.

The program guidelines are as follows:

1. Decentralization and respect for federal autonomy.
2. Integration and articulation of public health and education networks, by linking actions of the Unified Health System (SUS) to the actions of public education networks, in order to broaden the scope and impact of students and their families, optimizing the use of spaces, equipment, and available resources.
3. Territoriality, respecting the realities and the diversity existing in the space under shared responsibility.
4. Interdisciplinarity and intersectorality, allowing the progressive expansion of the exchange of knowledge between different professions and the intersectoral articulation of actions carried out by the health and education systems, with a view to paying integral attention to the health of children and adolescents.
5. Integrality, treating integral health and education as part of comprehensive training for citizenship and full enjoyment of human rights, strengthening the confrontation of vulnerabilities in the field of health that might jeopardize the full development of the school.
6. Care over time, acting effectively on the shared monitoring of student development, carried out by educators in partnership with health professionals, providing for the reorientation of health services beyond their technical aspects in clinical care, which involves promoting health and a culture of peace; promote

the prevention of diseases; evaluate signs and symptoms of change; provide basic and integral attention to learners and the community.
7. Social control: promote the articulation of knowledge, the participation of students, parents, school community and society in general in the construction and social control of public policies of Health and Education.
8. Ongoing monitoring and evaluation: promote communication, interaction, and resolution between schools and health units, ensuring care and attention to the health condition of the students and informing actions taken in the monitoring systems. Evaluate the impact of the actions with the students participating in the PSE.

Program components:

1. Assessment of health conditions: anthropometric and nutritional assessment, evaluation of oral, ocular, and auditory health, verification of vaccination status, identification of possible signs related to neglected diseases and elimination.
2. Health promotion and prevention of injuries: food safety actions and promotion of healthy eating; promotion of physical practices and physical activity; prevention of use of alcohol, tobacco, and other drugs; promotion of culture of peace and human rights; prevention of accidents; sex education, reproductive health, and STD/AIDS prevention; environmental health promotion; promotion of mental health.
3. Training: formation of the Intersectoral Working Group; training of young workers using the methodology of peer education; training of health and education professionals in PSE-related issues at school and distance education (EaD) courses.

Each year, the municipalities participating in the program sign a Term of Commitment with an agreement on goals, with the Ministry of Health of the federal government, for the purpose of combining efforts aimed at the prevention of diseases, promotion of and attention to the health of students by the health program in school, articulated intersectorally between health and education networks. As already pointed out, this is a strategy to integrate public policies as a way to address vulnerabilities that jeopardize the full development of children and young people in Brazil's public education networks.

In turn, at the beginning of each school year, the managers of the participating schools and health units also sign a compromise agreement, agreeing on their goals, as well as the Health Regionals, taking responsibility for the goals that the municipality has agreed to with the Ministry of Health.

All data are fed in a unified information systems based on spreadsheets to be filled virtually on the Ministry website with a specific password for each municipality. Based on these data and the goals achieved, the federal government transfers financial resources to the Health Secretariat of the qualifying participating municipality.

Regarding the financial resources that the federal government transfers to each municipality:

Calculation of financial incentive ceiling:

- Amount of US$960.00 or R$3000.00 (three thousand reais), for up to 599 prospective students;
- From 600 (six hundred) students, each additional 1–199 students add US$320.00 or R $ 1000.00 (one thousand reais) to the maximum annual amount to be received by the municipality.

Criteria for transfer:

- At the moment the Municipality signs the participation term, the municipality receives 20% of the total resources allocated by the Ministry of Health, to the program, according to the number of students who will be benefited each year;
- When 50% of agreed goals is reached, the municipality begins to receive the value proportional to the reach obtained;
- The transfer of resources may occur up to 3 times, occur after an action, and be verified in the information system at 6 months and 12 months.

Information Systems and Monitoring:

At the ministry: monitoring is carried out through the following systems: E-SUS (Virtual Electronic Health Single System) and SIMEC (Integrated System for Monitoring, Execution and Control).

At the local level: The municipality has spreadsheets for each essential action of evaluation carried out by the teams; the data of each health region are later consolidated, and finally the municipality passes on the information to the ministerial level.

Health Program in School in Guarulhos

The municipality has always developed health promotion actions in schools, initially under a program called "Health Promoting Schools Program," carrying out actions with a more restricted focus. In 2010, the municipality adhered to the "Health in School Program" with the Ministry of Health, which had a systematic vision based on socio-environmental determinants and developed in an intersectoral way, aimed at strengthening the territories and developing through the following lines of action:

(a) Integration of public policies when establishing partnerships between the UBS and the schools;
(b) Development of program components;
(c) Regular courses, seminars, and thematic workshops for in-service training of health professionals and educators;
(d) Implementation of projects by teaching units;
(e) Diversification of educational resources suitable for all types of audiences and age groups;
(f) Performing a successful experiences exhibition biennially, with awards for the best experiences;
(g) Search for partners to enhance the development of actions.

Results

Because of the results it obtained since the program's implementation, Guarulhos was considered by the Ministry of Health, under the management of Dr. Alexandre Padilha, as the national reference point for the program.

The process of implementing the program has become more qualitative over time, having gone through several phases of adequacy. One of the most difficult issues to overcome was the practice of integrated and intersectoral work, both internally within each secretariat and between secretariats.

From the outset we faced significant resistance in schools to the entrance of health professionals, and health professionals also had difficulties in adapting to the complexity and specificity of the dynamics of schools.

These impasses were gradually overcome through an exhaustive and regular work of evaluation and monitoring, accompanied by several moments of dialogue in integration workshops with all the professionals involved regionally, always being careful to contextualize the actions according to local realities.

Another change that needed to be made was to get health professionals involved in regularly inputting information to the systems, regularly inputting information to the systems that was added to the new imposed by the Ministry of Health, demanded a concerted effort by everyone involved.

Faced with this scenario of joint growth and gradual correction of deviations, the municipality has presented a performance of increasing quality in several aspects that complement each other, namely:

- Increasing the number of schools in the public school system that are approved by the health teams and joining the program;
- Increasing the numbers of learners involved;
- Increasing the quality of integration achieved among health and education professionals;
- Increasing the number of partners from different segments of the social organization;
- Increasing the quality of the work done by schools, with schools awarded by PAHO in the third Ibero-

American Competition for Good Health Practices 2011, with the Environmental Seal of the Environment Commission of the Guarulhos City Council and in the Health Promotion Forums of the State of São Paulo.

Over time several results have been achieved:

- Early detection of signs of obesity, overweight, and malnutrition;
- Possibility of a better evaluation by the health and education teams on the need to intensify actions to improve results (actions of Component II, for example: evaluation of the quality of the food supply in cooperation with families);
- Better identification of Educandos in need of oral care, with activities of direct and indirect supervised brushing and delivery of toothbrushes and toothpaste, teaching the importance of correct brushing of teeth;

- Identification of students scheduled in a Basic Health Unit of reference for treatment;
- Implementation of new model of Pupil of the Eyes program, aiming at detecting, preventing, and providing visual health to students, contributing to school success, as well as raising awareness among parents and educators about the need to prevent and recognize signs, symptoms of difficulty or visual impairment, and visual changes, as well as the importance of early treatment. This program has guaranteed access to ophthalmological consultation, as well as provision of corrective lenses when prescribed;
- 100% vaccination coverage;
- Higher consumption of vegetables and fruits observed by teachers at meal times at school;
- Reduction in food waste;
- Decreased consumption of foods rich in sugar and fats;
- Adoption of sustainable practices for the consumption of natural resources such as water;
- Awareness of the environment, with respect to plants and green areas, proper waste disposal, and practices of selective collection of waste, combating the Aedes aegypti mosquito and caring for domestic animals;
- Evident multiplication of what has been learned by children with their families.

Immunological evaluation, anthropometric and nutritional assessment, oral evaluation.

Some Results (Fig. 7.3)

Component I (Tables 7.1 and 7.2)

Ocular health—total of students who received an ophthalmological consultation following visual acuity screening. Monitoring prescription glasses only from 2014, when we hire a Mobile Ophthalmology Assistance Unit, which performs the consultations in Polo schools, predetermined by the group conducting the Eyes of a Girl program (Table 7.3).

In the implementation of the program several types of evaluation tools are used, and different segments of the public are involved throughout the year.

The Health Department performs monitoring, but schools do as well by developing their projects mainly within the diversity of axes that are part of Component II of the program.

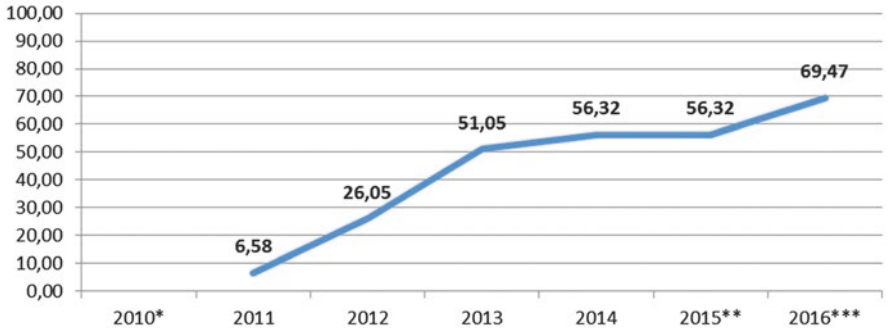

Fig. 7.3 PSE coverage indicator: number of schools approved in relation to total number of schools in public school system. (Source: Nucleus of Information Management—DARAS—Secretary of Health)

Table 7.1 Nutritional assessment—historical series. Source: DARAS—Secretary of Health 2015

YEAR	GOAL PSE COMP. I	Total Nutritional Evaluation	%	Total malnourished	%	Total over weight	%	total obese	%	Total with mal nutrition	% dist. Nutri
2013	113 707	88691	78	5485	6	12026	14	9398	11	26909	30
2014	114929	98711	86	4729	5	12182	12	9423	10	26334	27
2015	121191	92773	89	7515	8	13778	15	10437	11	31730	34
2016	149463	114200	76	5108	4	19451	17	16135	14	40694	36

Source: DARAS -Secretary of Health

Table 7.2 Evaluation of oral health—history. Source: DARAS—Secretary of Health 2015

YEAR	GOAL PSE COMP. I	Total evaluated in oral health -	% evaluated in oral health	Total with oral health needs -	% with oral health needs -
2013	113707	83844	74	30175	36
2014	114929	85530	74	35373	41
2015	121191	91153	75	38108	42
2016	149463	10496	67	40758	41

Source: DARAS - Secretary of Health

Table 7.3 Number of children benefiting from visual acuity program—Pupil of the Eyes. Source: DARAS—Health Secretary 2015

YEAR	Nº OF TESTS CARRIED UOT	Nº OF GLASSES INDICATED
Source: DARAS – Health Secretary 2015 Secretaria da Saúde 2015		
2010	1220	-------
2011	2291	-------
2012	3926	-------
2013	4400	-------
2014	5169	3074
2015	7299	4151

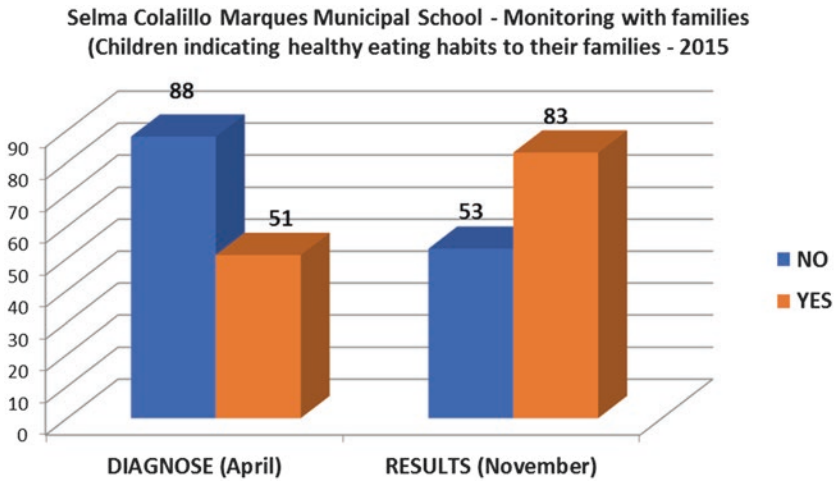

Fig. 7.4 Selma Colalillo Marques School—Monitoring with family members

Component II

For example, one indicator that is considered very important is the "Level of Learning Multiplication" by children, along with their families, since it is understood that health promotion begins with self-care by each family; this is one of the information tools used, in addition to sensitization (Fig. 7.4).

In this chart, blue columns refer to children's negative responses to talking about healthy habits in their families, and the orange columns refer to the child's affirmative responses. In the diagnostic evaluation in April, 88 children did not talk and 51 children did. In the evaluation of results in October, the situation is reversed, with only 53 who do not speak and 83 who do. In other words, the values of the columns are inverted, showing that the work done sensitized them, increased their knowledge, etc., mobilizing to play the role of multipliers with their families.

Component III: Formations, Seminars, Journeys, Successful Experiences, Contests

Historic Serie

2012

June 25: First PSE seminar, "Strengthening Partnerships," whose main objective was to establish a global and interconnected vision of the topics formulated with the Curricular Proposal of the Municipal Department of Education (Municipal Network Schools) and the Curricular Parameters (State Schools)

November 13: First exhibition of successful experiences of PSE, where 20 cases were presented and 8 awarded with cameras.

2013

January 23: Training in accident prevention and first aid

March 4: Opening of program with training in visual acuity screening with awareness of National Mobilization Week whose theme was Infant Obesity and Ocular Health;

April 4: First PSE conference (on adolescent health, child obesity, hypertension in childhood and adolescence, biology and control of dengue, attention deficit and hyperactivity syndrome, drugs in childhood and adolescence: aiming to qualify health promotion actions through intersectorality in the search for quality of life as potential results of the PSE),

May 28: PSE seminar on worker health and disease prevention.

June 26: Seminar on sexuality

August 13: Environmental education seminar on a way to promote health through school

October 29: PSE seminar: Taking care of one's body and healthy eating

2014

April 10: Mobilization Week: Culture of Peace seminar: "Corporal practices, physical activity, and leisure in a perspective of culture of peace and human rights"

August 15: "Meeting the Millennium Goals: Breastfeeding a victory for all life"

October 9: Adding forces in the fight against drugs: raising awareness, welcoming and preventing;

November 14: Second exhibition of successful experiences: "Promoting the exchange and sharing of experiences, strengthening and qualifying the participation

of all in the partnership." Health and education accounted for "18 experiences where 8 were awarded with a multipurpose speaker."

2015

March 9: Opening of the seminar program "Importance of Vaccination—Myths and Truths," focusing on the HPV vaccination campaign;

May 20: "Overcoming Homophobia: Challenges for Health and Education";

August 11: "Healthy Food and Food Safety: Practices to Promote the Quality Of Life";

November 12: Seminar: "Environmental Education—A Look at the City, Quality of Life and Health at School"

2016

February 25: Targets scorecard, with signature of regional compromise terms and Talk Wheel about the aedes mosquito;

April 12: Second PSE day, with the following themes: together in prevention: discussing gender and sexuality; nutrition in schools; restorative justice contributions to the culture of peace; dealing with the abuse of psychoactive substances in childhood and adolescence;

June 23: "Together against the Mosquito" contest. Awards for works in the following categories: drawing or painting, comics, slogans, and parody—12 award-winning schools;

November 18: PSE seminar: "Cultures and Practices of Inclusive Education from an Intersectoral Perspective"

Intersectorality and SETP—Health in All Policies

This is the core of the work that must be done when thinking about health promotion, and if we accept that to promote health we need to consider the diversity of socio-environmental determinants involved, we are necessarily talking about complexity and, therefore, of inter- and transdisciplinarity.

From this point of view it is practically unfeasible to imagine that health can be promoted by a particular secretariat. This statement strengthens the idea of the importance of being strategic by applying intersectorality.

The PSE in Guarulhos is placing increasing emphasis on this format, which is obviously still in process since it represents a relatively new approach. Throughout these almost 6 years of implementation of the program, we have noticed that there is a significant gap between theory and practice when it comes to intersectorality. In other words, the majority of professionals in the program affirm that it is an important and necessary strategy, but when intersectorality is applied in practice, sharp resistance is encountered; this resistance can arise in the form of, for example, definitions of identities and skills, difficulties in engaging in productive dialogue, and conflicts over the roles that the partners in each segment should assume.

In our experience, even though considerable improvements have been made, all these situations have taken place and are still happening, especially when new actors begin to

form part of the intersectoral network. Over time, those who have grown into the role of managers have learned to deal with these deviations, using different tools, namely:

- Promotion of evaluation workshops on a regular basis, providing spaces for discussion, always in the presence of the various actors involved, to promote an analysis of deviations;
- Provide conditions so that they are themselves involved in deviations, which are stimulated to propose solutions that are closer to the ideal of intersectoral work;
- To promote reliable information and communication about the characteristics and specificities of the dynamics of each of the segments involved, for the purpose of facilitating understanding of the different modi operandi and qualifying the entry of one actor into the field of the other, seeking to minimize the natural friction caused by modifications in the routines of work customary to each area;
- Permanently visit UBSs—Basic Health Units and the UEs—and teaching units to "feel" in loco, when intersectorality is actually happening in practice, or when there is are noises of miscommunication or a confusion over roles and elevations, creating obvious friction and tensions in interpersonal relationships;
- The creation of a regulation for the samples of successful experiences, in which a point of high evaluation of the projects is precisely the level of intersectorality achieved.
- To hold PSE seminars in three consecutive years as part of the official program of Education Week, which will necessarily end up strengthening the quality of intersectorality, increasing its scope.

We understand and know in practice that the role of managers is of fundamental importance. There are different levels of management in the program. Two people coordinate it from the municipal Secretary of Health and Education and two others from the two state Departments of North and South Education.

On the other hand, at the central level, an Intersectoral Working Group (IWG) was created, with representation from each sector involved (public sector, civil society, and private initiative) and representatives who have a voice and a vote in the management decisions of the program. Finally, in each territory, other intersectoral collectives are created, involving several actors as each reality or project is being developed, and the management in this case is the responsibility of the managers of the UBS of the surroundings of the schools and the vice-directors of the teaching units.

The role of the GTI has shown to be strategic in contributing to:

(a) The quality of the management of the program, since it is a space of representation of each of the sectors or partners involved, where it is not only possible to carry out joint agreements but also to analyze deviations with a lot of transparency and can trigger shared processes of correction of deviations and
(b) What is expected of the results of the program to achieve its objectives, as well as to qualify the level of intersectorality, since it is known that we can only strengthen the territory if in fact there is intersectorality in practice.

Challenges and anticipation of future advances in the program:

- Maintain the PSE with the guidelines implemented throughout this period (2012–2016);
- Extend coverage to 100% of schools in the public school system;
- Strengthen the action of nutritional evaluation, finalizing and presenting the line of care of nutritional disorders with training in anthropometric and nutritional assessment for the nursing teams of AB—Primary Care Network;
- Initiate hearing screening in schools;
- Maintain the Ophthalmologic Assistance Mobile Unit, expanding the assistance to the state network and providing corrective lenses when prescribed;
- Strengthen the partnership between health and education more and more, so that professionals in the schools and Basic Health Units work in a more integrated way and understand the PSE not as something extra to be worked on but as a transversal opportunity that allows them to optimally fulfill their roles in health promotion;
- Improve the dynamics and deadlines for feeding municipal and ministerial systems with the results of local actions.

Conclusion

Analyzing some of the questions and challenges proposed by Dr. Ligia, we believe that the experience just described may answer some of these questions.

The first finding is that, despite knowing the importance, historically there is still a significant distance between theory and practice regarding intersectoral work. As reported, this was one of the first impasses that had to be overcome in the work being carried out with the program in the municipality of Guarulhos. Therefore, in answering the first question, we understand that in speaking of intersectorality we are necessarily speaking of complexity, and therefore there are several aspects of each alternative of the presented definition that can be applied; however, we believe that to speak of it as "a public health practice to control the influence of the determinants of health inequities, articulating sectors that have traditionally been outside the management of health programs "(SALAZAR 2013:2) is close to what we mean by health promotion.

Therefore, we understand that the definition indicates intersectorality as a strategy that necessarily implies both a managerial and operational/technical action in a process, which in our case is still in progress, already with evident advances but still Intersectoriality significant potential for further development.

Regarding the second question, we believe that the presented case confirms that we are indeed working in an intersectoral way and have made significant progress in overcoming the initial impasses arising from the lack of tradition in working in this way.

This initiative emerged in 2011 in the face of the history of a program that involved public school students as part of a public education system that needed to

be expanded in the face of a very complex social and environmental reality involving various social and environmental determinants.

As already described, the program has already been in existence for 5 years, and we intend to continue on the basis of the results achieved and because we believe that the intersectoral work makes it possible to envision ever bolder goals. In the ongoing processes, information tools, mainly virtual ones (social networks—Health in the School Program: https://www.facebook.com/groups/1608466092737548/?fref=ts) were constructed, both in terms of cooperation and integration between partners, with shared coordination through the establishment of an IWG, which meets monthly to ensure good management of the program.

The partners primarily involve the entire structure of the health and education secretariat, as well as other municipal secretariats, as well as representatives of the third sector and a private initiative, according to the different projects that the schools develop.

Regarding the third and fourth questions: Already since the late 1970s at the Alma Ata conference, the social determinants have been highlighted, which necessarily implies intersectoral work. The Brazilian Ministry of Health has assumed this condition mainly since the consolidation of the SUS (Law 8080/90) and bodies such as the Brazilian Association of Public Health believe and invest in the discussion and training of professionals with this vision.

Thus, the factors that contribute are diverse: a global movement linked to Millenial Development Goals and now to the ODS, the complex reality of a municipality, which necessarily implies considering socio-environmental determinants and therefore demands intersectoral work. On the other hand, as has been pointed out, the main factor that hampers intersectoral work is a lack of culture with respect to this practice, which has necessitated an intense process of training and permanent dialogue between the actors and parties involved.

Faced with this reality, several adjustments were obviously necessary, such as, among others:

- Increasingly qualify the processes of evaluation and shared monitoring of the different lines of action of the program;
- Make greater investment in the training of both health professionals and educators, not only for the themes inherent in Components I and II of the program, but also the practice of intersectoral work in the face of the specificities of each reality;
- Encourage regional agreements to better serve the local reality;
- Provide seminars for the exchange and sharing of successful experiences on an intersectoral basis, so that as a reference, they stimulate the participation of teaching units not yet engaged;
- Define ways of rewarding the best works as a way of stimulating increased competition each year to attract more schools into the program.

Finally, in relation to evaluation processes, several strategies are used that may reflect the inherent complexity of the program itself:

(a) Quantitative evaluations that reflect the number of schools and children affected by the program, according to the targets set for each region and approved by the Ministry of Health;
(b) Each axis of Component I implies individual evaluations of each student reflecting their health status;
(c) In the same way, each axis of Component II implies differentiated assessments according to the specificities of each; the assessment should be both quantitative and qualitative, especially concerning behavioral aspects, such as the adoption of sustainable practices.

Final Words

We affirm that the experience of implementing the Health in School program in the city of Guarulhos has been shown to be an excellent path for health promotion, mainly owing to its absolutely intersectoral character.

Since the program was implemented in 2011, many adjustments have been made gradually, according to the various evaluations that indicated a need to correct deviations. Always the has been not only to comply with numerical goals approved by the Ministry of Health but mainly to be able to verify behavioral changes and, therefore, habits that encourage the self-care of the community, allowing conditions to act with criticality and protagonism or, in short, the development of people's ability to prevent the loss of their health

The main lessons learned from the work through "intersectorality" were as follows:

- Strengthening the identity and potential of the territory's action;
- Empowerment and autonomy of local actors and partners involved;
- Optimization of time, material, and financial resources, with the appreciation of people's efforts;
- Development of concrete actions to prevent and promote health;
- Increase, empower, and qualify the ability to network by establishing networks of strategic partnerships;
- Strengthen the role of schools within the territory as spaces that disseminate good health practices in the community.

In short, we seek to contribute to the guarantee of rights in all its aspects by linking them to an intersectoral design that converges with the empowerment of students and the entire school community, with a sense of autonomy and protagonism of all participants, given the complexity and diversity of the socio-environmental determinants that characterize each community, seeking to build new partnerships and new strategies that guarantee health promotion to its full potential.

There is still much to be learned and built, but there is certainly already a meaningful and consolidated experience that allows us to know the details about where we are and where we want to go.

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