

Introduction of the School Health Program in the city of Cascavel, Paraná State: report of nurses

Implantação do Programa Saúde na Escola em Cascavel, Paraná: relato de enfermeiros
Implantación del Programa Salud en la Escuela en Cascavel, Paraná: relato de enfermeros

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ABSTRACT

Objective: to understand the introduction of the School Health Program in the city of Cascavel, Paraná State, as opposed to the report of nurses. **Method:** a qualitative study with fifteen participants. The data were collected from April to August 2015, through semi-structured interviews, analyzed by content analysis and thematic modality. **Results:** the category "Introduction process" of the School Health Program integrates the subcategories "Identified health problems" and the "Challenges of intersectoriality". The program was implemented quickly, with a fragile training of professionals to perform in the phases that compose it. Structural conditions of schools, human and material resources, and emerging intersectoral interaction were identified obstacles. The integration of the health, school, and family constitutes the program's potentiality. **Final considerations:** it is understood that the actions of the program were based on health assessments of students, and it is necessary for professionals and managers to discuss and analyze the obstacles identified to achieve all the proposed objectives.

Descriptors: Nursing; School Health; Government Programs; Health Promotion; Prevention of Diseases.

RESUMO

Objetivo: compreender a implantação do Programa Saúde na Escola no município de Cascavel, Paraná, frente ao relato de enfermeiros. **Método:** estudo qualitativo com quinze participantes. Os dados foram coletados no período de abril a agosto de 2015, por meio de entrevistas semiestruturadas, analisadas pela análise de conteúdo, modalidade temática. **Resultados:** a categoria "Processo de implantação do Programa Saúde na Escola" integra as subcategorias "Problemas de saúde identificados" e o "Desafio da intersectorialidade". O programa foi implantado com celeridade, com frágil formação dos profissionais para atuação nas fases que o compõe. Condições estruturais das escolas, recursos humanos e materiais, e incipiente interação intersectorial foram obstáculos identificados. A integração da tríade saúde, escola, família configura potencialidade do programa. **Considerações finais:** compreende-se que as ações do programa fundaram-se nas avaliações em saúde dos escolares, sendo necessário que profissionais e gestores discutam e analisem os obstáculos identificados para concretização da totalidade dos objetivos propostos.

Descritores: Enfermagem; Saúde Escolar; Programas Governamentais; Promoção da Saúde; Prevenção de Doenças.

RESUMEN

Objetivo: comprender la implantación del Programa Salud en la Escuela en el municipio de Cascavel, Paraná, frente al relato de enfermeros. **Método:** estudio cualitativo con quince participantes. Los datos fueron recolectados en el período de abril a agosto de 2015, por medio de entrevistas semiestruturadas, analizadas por el análisis de contenido, modalidad temática. **Resultados:** la categoría "Proceso de implantación del Programa Salud en la Escuela" integra las subcategorías "Problemas de salud identificados" y el "Desafío de la intersectorialidad". El programa fue implantado con celeridad, con frágil formación de los profesionales para actuación en las fases que lo componen. Las condiciones estructurales de las escuelas, recursos humanos y materiales, e incipiente interacción intersectorial, fueron obstáculos identificados. La integración de la tríada salud, escuela, familia configura la potencialidad del programa. **Consideraciones**

finales: se comprende que las acciones del programa se fundaron en las evaluaciones en salud de los escolares, siendo necesario que profesionales y gestores discutan y analicen los obstáculos identificados para concreción de la totalidad de los objetivos propuestos.
Descriptores: Enfermería; Salud Escolar; Programas Gubernamentales; Promoción de la Salud; Prevención de Enfermedades.

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INTRODUCTION

Intersectoriality is developed through a set of policies that establish partnerships and alliances among diverse sectors, such as health, education and community participation, with coordinated actions that focus on social determinants, aiming at the quality of life of the population, as opposed to fragmentation of social policies⁽¹⁻²⁾.

The intersectoral articulation between health and school is a practice adopted in international settings⁽²⁻⁸⁾, as in Cuba⁽²⁾, the United States^(3,6), Canada⁽⁴⁾, California⁽⁷⁾, Argentina⁽⁸⁾, with evidence of an increase in the number of nurses in the school environment to attend this model of Health Care^(3,6-7), and in the United States there is a specialization in School Nursing⁽⁶⁾. Schools are understood as a key channel for health interventions because of their capacity to achieve results in an extended way⁽⁵⁾, since it covers the family; an economic intervention for the prevention of diseases and diseases throughout the life, with reduction of the overload of the public health^(4,6).

In Brazil, the introduction process of the healthcare model that integrates health and school has been taking place gradually since 2007 through the School Health Program (SHP). Preference is given to prevention, promotion and health care actions, with the objective of promoting health and the culture of peace, encouraging the prevention of health problems; articulate actions of the health and education sector, optimizing the use of available spaces and resources; contribute to the integral formation and social attention of the students, awakening citizenship and respect for human rights; strengthen the coping with health vulnerabilities that compromise school development, and strengthen community participation in education and health policies⁽⁹⁻¹¹⁾. In order to reach the proposed objectives, the program has a minimum organization to carry out actions, which is composed of component one (clinical and psychosocial assessment); component two (health promotion and prevention) and component three (training)⁽⁹⁾.

In the city of Cascavel, State of Paraná (PR), SHP was implemented in 2013, and because it represents an innovative intersectorial policy, although there are important challenges for professionals and health managers, it is relevant to investigate how the introduction of the program in the experience of professionals participating in its introduction.

OBJECTIVE

To understand the introduction of the School Health Program in the city of Cascavel, Paraná State, in front of the report of nurses.

METHOD

Ethical aspects

It should be noted that the research obtained a favorable opinion for its execution by the Human Research Ethics Committee of

the *Universidade Estadual do Oeste do Paraná*. All stages of the research respected ethical aspects as provided for in NHC (National Health Council)/MH (Ministry of Health) Resolutions 466/2012⁽¹²⁾ and 510/2016⁽¹³⁾. Thus, to ensure confidentiality, the participants' statements were identified through the initial letter representing the nurse, followed by the order of participation in the interview. For example: E1, E2... E15.

Theoretical and methodological framework

Thematic content analysis model proposed by Minayo⁽¹⁴⁾.

Type of study

This is an exploratory, descriptive and qualitative research.

Methodological procedures

Inclusion criteria for participation in the study were: to be a Primary Health Care (PHC) nurse and to have participated in the introduction and development of SHP in the city of Cascavel, Paraná. Exclusion criteria were: that nurses were removed from their activities during the study period and that their information was impaired or not recorded due to problems arising from the digital recording medium. A professional was excluded from the study due to problems with recording. Fifteen nurses from five PHC units participated in the study, which performed an average health assessment in three schools, one of kindergarten, one elementary school and one high school.

Study setting

Initially, the nurses were contacted for appointment scheduling, which was performed in a day and hour according to the availability of the professional, in a reserved place, in the Basic Health Unit.

Collection and data organization

To collect the data, the individual interview was used, guided by a semi-structured script. How was your experience in the process of implementing the School Health Program in the city of Cascavel, PR? It was the guiding question of the interviews. The data collection period was from April to August 2015.

The interviews were carried out through recording and were later transcribed and organized according to the thematic content analysis model.

Data analysis

The pre-analysis was carried out, with organization of the content of the participants' statements, taking up the initial objectives of the research; reading and rereading the data to deepen the information and consequent search of the meanings of the subjects' statements; the exploitation of the material to encode the data. At this time, the units of record or units of meaning were classified and aggregated, defining a category

and two thematic subcategories that make up the results of the study. When the data presented redundancy or repetition, information saturation was verified and the data collection was terminated⁽¹⁵⁾.

RESULTS

The results of the research allowed the identification of a category: "Implantation process in the school health", with respective subcategories: "Identified health problems" and "Challenges of intersectoriality". As for the description of the participants, the age range is between 25 and 51 years; are all female; the time of action in Primary Health Care is between 01 and 25 years of operation. Nine participants are specialists in Family Health/Public Health, three in clinical areas (Gynecology and Obstetrics, Surgical Center and Nursing in Intensive Care) and three have no specialization.

Introduction process of the School Health Program

For the beginning of SHP activities and actions in the municipality, they were provided by the *Grupo de Trabalho Intersetorial Municipal (GTI-M)*, moments of meetings called by some participants as 'empowerment', by others as 'training', 'meetings' or 'reports'. Regardless of the term used, these meetings were considered as insufficient for the transfer of information or guidelines about the activities to be developed in SHP. They were considered fast, with information that did not provide an adequate understanding of the activities and actions of the program. The presence of health professionals was not significant and there was no openness to discuss particularities and/or exchange of experiences inherent in the program introduction process. There was no presence of education professionals. The statements confirm the above:

One afternoon of meeting where everyone attending SHP went to. The CHA [community health agents], coordinator, dentist, nurse [...] they gave a general opinion ... we didn't have much information [...]. (E1)

[...] we had a day of training [...] kind of quick, so we could see what we would be considering in this visual acuity [...] Snellen scale [...]. (E9)

The activities and actions of the program started quickly, with short delivery times of the students' health assessments. This conditioned the accomplishment of joint efforts to carry out health assessments, in a specific period, without continuity. However, the participants understand that the program proposal is their stay in school, with continuity of activities and actions in health. It is noted in the statements:

[...] the introduction process was also [...] "at the drop of a hat". It starts one day, with a deadline [...] it could have had a longer training period, so that everyone could participate [...]. (E6)

[...] last year [...] we had to do it like this, in about a week in schools [...]. (E10)

Regarding the selection of the schools, nurses report that not all schools and municipal centers for early childhood education in the area covered by the Basic Health Units were selected. They can mention the schools covered by the program's actions, but they do not know the selection criteria.

Regarding the material resources to carry out the activities and actions in the schools, they point out that some of these materials were available in the Basic Health Units, some were requested from the municipality and others, even if requested, were not delivered for the beginning of the health assessment activities. They also point out a limited amount of these resources, as observed in this statement:

[...] We didn't receive a scale [...] all the weighing of last year was done with my private scale. This year we didn't even start because we don't have the scales to do it [...]. (E14)

Nurses, nursing technicians, community health agents, social workers, dentists, auxiliaries and/or oral health technicians constituted the human resources of the program. From the testimonies, it was noticed that the nurse was the one who, mainly, organized and carried out the health assessments with the students, followed by the dentist and community health agents. No testimony indicates the presence of doctors in schools.

The lack of material resources and human resources, with a consequent overload of work for Primary Care professionals, as well as inadequate physical environments to perform health assessments in schools, was fragilities that may have interfered in the quality of health assessments of students, such as the testimonies point out:

[...] space in schools also made it difficult [...] there is no specific room to make a visual test, which counts a lot of clarity, noise [...]. (E6)

[...] only increased the service ... it only came overloading [...]. The problem is after you have to stop, to analyze the table, to conduct all the assessment and referrals [...] you don't have professionals and don't have time to do this [...]. (E13)

It was verified that there is no uniformity of nurses' understanding of SHP. Some consider that it is basically constituted by the assessment intervention of the students; others reveal a broader understanding. However, it is noteworthy that nurses who also carry out health education with students, such as lectures and gymnastics about health education, have already performed it since before the introduction of SHP in the city, with the participation of school professionals.

[...] we were able to conduct the assessment and educational activity because it was something that we had since the opening of the unit, not because it came from SHP [...]. (E6)

Some study participants responded that the activities and actions developed in SHP are in line with what the program foresees. Others understand that in order to achieve the proposed goals, there is a shortage of human resources. However, they justify that the difficulties encountered are inherent in a

program that is in the process of being implemented. Most of the professionals are unaware of the assessment process of SHP and those responsible for this assessment, whose counterpart of the management group about the data of the health assessments performed had not happened until the moment of this study, as the statement reveals:

[...] we send it to the secretariat, to the DIS and they organize it there. So I'm not aware, I don't know to tell you about this feedback [...]. (E4)

Identified health problems

The main health problems identified through the health assessment of the students, according to the participants' reports, were dental, visual and nutritional alterations, delayed vaccination status and social risk conditions. Among these, the most prevalent were clinical cases with evidence of cavities, overweight and obesity, as evidenced by the reports:

[...] problems with the vaccination card [...] and with teeth too, a lot of cavities [...]. (E4)

[...] several cases of obesity [...] decreased visual acuity [...] related to social issues [...]. (E11)

The nurses had the autonomy to carry out the referral for specialized assessment after identifying clinical alterations in the students. They first informed the school and, through notes, communicated to the parents or other responsible person for the child or adolescent the alteration identified (ophthalmological, dental, nutritional or vaccine). From this communication, the person in charge had to attend the Basic Health Unit to withdraw the referral form to the referral service and, later, to attend the school on the proper service, on the day and at the scheduled time, as the statement reports:

[...] after assessment [...] the problem was detected, a note was sent to the parents. And then, the parents seek the BHU [...] a note was also sent to the parents by the children, to come to have the vaccines [...]. (E10)

In order to ensure that children and adolescents in the city of Cascavel, identified with health problems through health assessments inherent to the development of SHP, could be attended without delay, a partnership was established with the referral service *Centro Especializado de Atenção à Criança* (CEACRI), which provides care for ophthalmology, nutrition, speech therapy and psychology. A specific waiting list was created for students assessed at SHP, as confirmed by the testimony:

[...] everything goes to CEACRI [...]. [...] we can go to the ophthalmologist, a nutritionist, a phonoaudiologist. Only a psychologist, it's the physician who refers. [...]. It is the nurse who does this referral. (E13)

Although created this parallel list for agility in the process of specialized care, there is more waiting for care for some specialists, such as ophthalmologist and nutritionist, as confirms the testimony:

[...] the ophthalmologist took at least four months to start scheduling these children [...] As for nutrition, children haven't had any response until now [...]. (E14)

The students in need of dental care were scheduled and received care in the basic unit of their area of coverage. Of the changes in students' health, according to the participants' report, it is the dental ones with the greatest potential for resolution, as the report points out:

[...] on the dentist part we can discuss right now. We have a day of the week that is scheduled only for school changes [...]. (E12)

It is reported that clinical assessment of the students by health professionals of each basic unit occurs, but there was, until the moment of the study, a broad analysis of the health of the students of the municipality by the managers. Participants indicate the valorization of the data by managers to power the information system, which conditions the financing of the program, without the diagnosis of health problems to establish strategies to prevent prevalent diseases and promote the health of the school. This fact is noticed in the statements:

[...] we are collecting the data to power the system. [...] there is the detection of early cases, to refer to specific professionals, but there isn't interaction in the prevention [...]. (E8)

[...] I don't know if the managers are involved [...] they are caring more about figures [...] to be able to get money [...]. (E9)

Regarding the students' assessments and their referrals, logic of discontinuity in the referral and counter-referral process is evident, since the student was assessed in Primary Care and referred to the referral service, according to clinical or psychosocial problems detected, but there was no counter-referral of the specialized service.

Challenges of intersectorality

In some reports, the participants reported that the education professionals were receptive to the health professionals and, after the health team's inclusion in the school, the collaboration of the education professionals enabled the students' health assessment process, which reached a proportion of assessments. Therefore, the occurrence of participatory and collaborative interaction between health and education professionals:

[...] about the school... people there already knew that we would go there. So, they were waiting for us, they gave us a warm welcome... we've got coverage of more than 90% of the children agreed [...]. (E1)

In other reports, the participants point out that there was no receptivity, cordiality and collaboration expected from the teachers. Discomfort and disturb pervaded in some relationships between health professionals and the school. The interaction was mainly troubled by the education professionals of the state schools, requiring intervention by education and health managers. The reports point out to this:

[...] the school isn't receptive for this, they think that we are there hindering their service [...] there was no interaction [...] we realized that it was breaking the routine of the school, and then we felt like intruders [...]. (E8)

[...] the teachers didn't release the students to go to the assessment [...]. (E14)

It is possible to relate the resistance of the teachers to the activities of SHP, a priori of the state schools, because the development of the program started immediately after the return of a long strike period of the teachers of the state education network. Activities outside the curriculum can compromise the teaching of delayed content to be contemplated in a new and reduced school calendar.

Finally, in the understanding of the participants, the main potential of the program was to provide greater interaction of the health, school and family triad, bringing the family closer to the Basic Health Unit, whose maintenance of this link is a challenge. Other potential of the program mentioned are the possibility of early detection of the health problems of children and adolescents, whose parents do not always perceive them or their risks; the knowledge of the school community (of the students and their families) and their health conditions to plan actions for health promotion and disease prevention.

DISCUSSION

For the introduction of the actions foreseen by the SHP, it is indispensable initial and continuous training, in a procedural way, of the professionals of both areas⁽⁹⁾. Training, as a form of training, is important to promote the approach of the professionals involved, to promote the discussion of strategies, so that professionals can qualify the communication and understanding of the conceptual bases of SHP. They can be done in different ways, both classroom and online⁽¹⁰⁾. However, in this and other studies it is identified that the initial training of the professionals is not being prestigious; being developed in a superficial way, without integrating the different intersectoral areas^(1,10,16).

In the studied reality, the program is in the initial stages of introduction, focused on component one, that is, in the assessment phase of the health conditions of the school. In this sense, there is a need for integrality of the actions and subjects involved, with procedural and permanent activities, since episodic or decontextualized occurrences are discouraged^(9,17).

The selection of SHP participating schools is defined by the Brazilian State and Municipal Secretaries of Education and Health, and the priorities and goals of the program are observed⁽¹⁰⁾. Criteria for joining SHP are the areas of greatest social vulnerability and coverage of health and education networks in these communities⁽⁹⁾. These criteria were unknown to most study participants.

The Ordinance 3,146, of December 17, 2009, establishes financial resources for Municipalities with Family Health Teams (FHT), which join the SHP. The amount of resources corresponds to an extra portion of the monthly incentive to the FHT, which are transferred from the National Health Fund to the Health Funds of the Municipalities. They should be part of

the Variable Component of the Primary Care Financing Package and are paid after the municipality joins the program in a single installment⁽¹⁸⁻¹⁹⁾.

The distribution of didactic-pedagogical and clinical material is carried out by the Ministry of Education for all contracted schools. The transfer of financial resources and materials to municipalities is conditional on the signing by the Municipal Secretaries of Health and Education of the Term of Commitment, of the instrument of contracting, and the management of intersectoral resources is decentralized and accountable to the *GTI-M*⁽⁹⁾. In this sense, the precariousness of material resources is not justified, as the study participants explained.

In a study carried out in the city of Fortaleza, Ceará State, students' assessment activities were developed by nurses, dentists and primary care physicians⁽¹¹⁾. Nevertheless, in this study, we identified a small participation of physicians. There is a need for intersectoral coordination⁽¹⁻²⁾, but also multiprofessional coordination to achieve the objectives of the program.

Commonly, there is a tendency to hold professionals accountable for the failure of health programs. However, it is necessary to consider the structural conditions for its development⁽²⁰⁾. A similar study corroborates the difficulties of health professionals in reconciling the agenda of the Basic Health Unit to implement SHP and place it as a routine of Primary Care, and also points out the limited acceptance of education professionals⁽¹⁰⁾.

In this sense, it is understood that the unsatisfactory development of SHP actions, in its initial phase, according to the study participants, is related to structural conditions⁽¹⁹⁾, lack of time⁽¹⁷⁾ and consequent accumulation of routine tasks⁽¹¹⁾, insufficient financial and human resources, limited support to school administrators^(17,21), unprepared health professionals and education to develop integrated actions and deadlines that do not consider the conditions pointed out. These are some of the factors that hinder the success of the program.

According to the Ministry of Health⁽⁹⁾, in this study, students identified with health problems, through clinical assessment, were referred to the basic unit or specialized health unit, as needed, with timely care family. As well as a study that reports the experience of SHP deployment by the FHT⁽¹¹⁾.

Primary Care Professionals and schools are responsible for monitoring school care in the health care network. The difficulties of reception and treatment of the school must be reported to the management bodies of the SHP (*GTI-M* and *GTI-E*)⁽⁹⁾. However, this study revealed difficulties of students' access to certain specialties, with consequent failure to meet the needs of their specialized assessment.

Regarding the changes in the health of students, cavities, overweight and obesity were highlighted. The presence of cavities from infancy is not unique to this study. In Los Angeles, California, oral health programs offered in schools were designed to improve access to oral health care, with participation of school nurses and oral health, dentists, parents, teachers and researchers in pediatric health services for respond to stakeholders within and outside the education system⁽⁷⁾. In the study in question, curative/restorative actions were necessary and the dental care of the basic units seem to have met the demand of the students assessed by SHP. However, there is a need for investments in

prevention, such as health education and supervised brushing, to avoid new events or aggravation of existing ones.

As for overweight and obesity, biopsychological, socio-economic and behavioral factors interfere with overweight and obesity, with inadequate diet and lack of regular physical activity being the variables that most contribute to this situation. The more intense and precocious the increase in body fat, the greater the risk of persistent obesity throughout life⁽²²⁾. The promotion of physical practices and physical activity at school is one of the actions proposed in component two of SHP⁽⁹⁾. However, there is no evidence that they are being increased. This would be a tool to combat students' overweight and obesity⁽²¹⁾.

In addition to body-movement practices, obesity prevention practices such as teaching cooking, community gardening, among others developed in Canada, involve not only students but their families, school staff and the community, represent an economic intervention in health, integrated into school, for obesity prevention and reduction of risk of chronic disease throughout life⁽⁴⁾.

In Argentina, due to the evidence of overweight in children, the intergovernmental program *Mi Escuela Saludable* (MES) was created, which also uses the school as an effective tool for health promotion and education. As in Brazil, the program is operated in a multiprofessional and interdisciplinary way⁽⁸⁾.

For the sustainability of SHP, it is necessary to overcome the biomedical model with application of the health promoting proposal, which considers the specific needs of students in a condition of greater vulnerability and promotes the care of problems not only to the individual, but also to the collective of students, parents, among other members of the community. For this, the interaction and permanent integration of these professionals, health professionals and managers⁽¹⁰⁾ is implied.

The school has relevance in the construction of a new health culture and nurses have competence to approach school and health, a condition already proven in other countries, making health interventions faster and more efficient^(3,6-7), contributing for the creation of spaces of health education in the school, highlighting the principles guiding the promotion and its ethical values, adapting the actions according to the reality of the students and stimulating them to think and reflect on their own health condition. Through the knowledge transfer and reflexive critical thinking, questioning and co-authors of their health are constructed⁽²³⁻²⁴⁾. For this reason, students' participation must be valued and respected⁽¹¹⁾, considering them co-participants and involving them as proponents and protagonists of the process.

In this sense, in this study, it is observed that the activities and actions carried out by SHP bring the students closer to the Basic Health Units, especially the adolescents, who come to attend this service^(11,25). Thus, the approximation of school and health results in better programs and services, and nurses are at the forefront of community health interventions⁽³⁾.

The minimum actions proposed in the three components of the program (assessment, promotion, and prevention and training) are proportionately relevant. The initial diagnosis, performed through the students' health assessments, stands out as one of the most notorious stages. However, the stage of health promotion and prevention is an opportunity for behavioral transformation and a search for the empowerment of students for their health.

On the other hand, the training stage with permanent education and training of the teams, besides enabling the professionals, serves as a tool to create links between the areas and can be used to follow the actions and their results. These steps, in order to be successful, need to occur concomitantly, in a procedural way, which is not observed in the study in question.

In the city of Cascavel, the intersectoral action among the health and education teams is shown in a construction and deconstruction movement of practices model, which are still poorly integrated, connected and associated with each other, without evidence of a systematized process. Similarly, in the city of Olinda, Pernambuco State, there is an attempt to create an intersectoral relationship between health and education, which does not permeate other sectors. This process is considered difficult and not spontaneous, which requires the skills of the members of the different sectors to deal with daily conflicts and divergences, such as distinct agendas of sectors and work overload⁽¹⁶⁾.

It is undeniable the importance of health professionals' participation in school and the performance of health professionals in the school to consolidate successful SHP actions. Some teachers already recognize this⁽²⁶⁾. But the nurses still do not feel connected to the school, which can be linked to the leadership of the school⁽³⁾ and the way of managing the program. However, the challenge is to institute an understanding of the permanent articulation between education and health, supporting the proposal of intersectorality⁽¹⁾, so that the union of efforts transforms what is now recognized as important and useful through a joint and systematic planning of actions in health care to students.

For the effectiveness of school health as a public policy for health promotion and quality assurance of students, it is necessary that coordination and intersectoral planning have adequate training and improvement so that they can meet the needs of the target audience. The attention needs to be focused on the real problems that each school environment presents and the identification of possible solutions so that the goals that SHP highlights are fulfilled^(17,27). Like Cuba, which presents excellent health outcomes, which are related to the way health determinants are addressed intersectorally⁽²⁾.

It is understood that each intersectoral action tends to present an individual character, built in a gradual and historical way. It will be up to the social actors and institutions involved to elaborate a structure that favors the achievement of the objectives set forth in the intersectoral program, since the complexity of the social issues found in the school makes small the possibility of only one sector being able to be effective in its resolution or mitigation⁽²⁷⁾.

Therefore, in order to face the social problems inherent to students and their families, it is necessary to approach multiple perspectives and share different knowledge and practices for the integrated elaboration of successful strategies that consolidate the program⁽¹⁰⁾.

Study limitations

The study has as limitation the participation of only nurses, without integrating, at this moment, other professionals of the health team of Primary Care.

Contributions to the area of nursing, health or public policy

The results constitute an important contribution to the nursing area and public health, a priori as protagonists of a new national health program of broad objectives.

FINAL CONSIDERATIONS

SHP in the city of Cascavel, PR, was implemented with speed, with evidence of fragile training of professionals to perform in the program, whose actions were based on the health assessments of the students. The main obstacles in the introduction of the program were the structural conditions of schools, the accumulation of professional tasks related to the lack of human resources and material resources, and the difficulty of establishing intersectoral interaction. However, the triad of health, school and family, with the approximation and linkage of students and families to the health unit was understood as

potentiality, being challenges the maintenance of this link and intersectoral articulation.

To improve and qualify SHP actions and goals, it is necessary for Primary Care professionals and program managers to discuss and analyze the identified obstacles and challenges in order to propose improvement strategies that enable the achievement of all the proposed objectives. In this sense, it is recommended not only to increase the supply of human resources to act in the program, but also to qualify them, not only through training, training, but with a specialization in school nursing, as in other countries, as well as promote greater intersectoral articulation and provide health units with material resources to make the program viable, which requires greater emphasis on preventive practices and health promotion in its set of actions. Further studies are recommended to assess the process of developing the program in this and other realities, involving nurses and other professionals from the health and education team.

REFERENCES

1. Sousa MC, Esperidião MA, Medina MG. A Intersectorality in the 'Health in Schools' Program: an evaluation of the political-management process and working practices. *Ciênc Saúde Colet*[Internet]. 2014 [cited 2017 Oct 13];22(6):1781-90. Available from: http://www.scielo.br/pdf/csc/v22n6/en_1413-8123-csc-22-06-1781.pdf
2. Spiegel J, Alegret M, Clair V, Pagliccia N, Martinez B, Bonet M, et al. Intersectoral action for health at a municipal level in Cuba. *Int J Public Health* [Internet]. 2012 [cited 2017 Oct 13];57:15-23. Available from: <https://link.springer.com/content/pdf/10.1007%2Fs00038-011-0279-z.pdf>
3. Becker SI, Maughan E. A descriptive study of differing school health delivery models. *J Sch Nurs* [Internet]. 2017[cited 2017 Oct 11];XX(X):1-11. Available from: <http://journals.sagepub.com.ez89.periodicos.capes.gov.br/doi/10.1177/1059840517725788>
4. Ekwaru JE, Ohinmaa A, Tran BX, Setayeshgar S, Johnson JÁ, Veugelers PJ. Cost-effectiveness of a school-based health promotion program in Canada: a life-course modeling approach. *PLoS ONE* [Internet]. 2017[cited 2017 Oct 12];12(5):1-13. Available from: <http://journals.plos.org/plosone/article?id=10.1371/journal.pone.0177848>
5. Moore G, Littlecott HJ, Turley R, Waters E, Murphy S. Socioeconomic gradients in the effects of universal school-based health behaviour interventions: a systematic review of intervention studies. *BMC Public Health* [Internet]. 2015[cited 2017 Oct 13];15(907):1-15. Available from: <https://bmcpublichealth.biomedcentral.com/track/pdf/10.1186/s12889-015-2244-x>
6. American Academy of Pediatrics. Role of the School Nurse in Providing School Health Service Pediatrics [Internet]. 2008[cited 2017 Oct 13];121(5):1052-6. Available from: <http://pediatrics.aappublications.org/content/pediatrics/121/5/1052.full.pdf>
7. Dudovitz RN, Valiente JE, Espinosa G, Yepes C, Padilla C, Puffer M, et al. A school-based public health model to reduce oral health disparities. *J Public Health Dent*[Internet]. 2017[cited 2017 Oct 13];1-8. Available from: <http://onlinelibrary.wiley.com/doi/10.1111/jphd.12216/epdf>
8. González VB, Antún MC, Soria MLC, Di Paola M, Eisenberg MP, Escasany M, et al. Experiencia del Programa Mi Escuela Saludable. *Actual Nutr*[Internet]. 2015 [cited 2017 Oct 13];16(2):51-61. Available from: http://www.revistasan.org.ar/pdf_files/trabajos/vol_16/num_2/RSAN_16_2_51.pdf
9. Brasil. Ministério da Saúde. Secretaria de Atenção à Saúde. Departamento de Atenção Básica. Passo a passo PSE. Programa Saúde na Escola: tecendo caminhos da intersectorialidade [Internet]. Brasília: MS; [cited 2017 Oct 13]. Available from: http://bvsmms.saude.gov.br/bvsm/publicacoes/passos_a_passo_programa_saude_escola.pdf
10. Ferreira IRC, Moysés SJ, França BHS, Carvalho ML, Moysés ST. Percepções de gestores locais sobre a intersectorialidade no Programa Saúde na Escola. *Rev Bras Educ* [Internet]. 2014 [cited 2017 Oct 13];19(56):61-75. Available from: <http://www.scielo.br/pdf/rbedu/v19n56/v19n56a04.pdf>
11. Santiago ML, Rodrigues MTP, Oliveira Jr ADO, Moreira TMM. Implantação do Programa Saúde na escola em Fortaleza-CE: atuação de equipe da Estratégia Saúde da Família. *Rev Bras Enferm* [Internet]. 2012[cited 2017 Oct 13];65(6):1026-9. Available from: <http://www.scielo.br/pdf/reben/v65n6/a20v65n6.pdf>
12. Brasil. Ministério da Saúde. Conselho Nacional de Saúde. Resolução nº 466, de 12 de dezembro de 2012 [Internet]. 2012 [cited 2017 Oct 13]. Available from: http://bvsmms.saude.gov.br/bvsm/saudelegis/cns/2013/res0466_12_12_2012.html
13. Brasil. Ministério da Saúde. Conselho Nacional de Saúde. Resolução nº 510, de 7 de abril de 2016 [Internet]. 2016[cited 2016 Dec 12]. Available from: <http://conselho.saude.gov.br/resolucoes/2016/Reso510.pdf>

14. Minayo MCS. O desafio do conhecimento: pesquisa qualitativa em saúde. 11. ed. São Paulo, 2008.
15. Cavalcante RB, Calixto P, Pinheiro MMK. Análise de Conteúdo: considerações gerais, relações com a pergunta de pesquisa, possibilidades e limitações do método. *Inf Soc [Internet]*. 2014[cited 2017 Oct 13];24(1):13-8. Available from: <http://www.ies.ufpb.br/ojs/index.php/ies/article/view/10000/10871>
16. Farias ICV, Franco de Sá RMP, Figueiredo N, Menezes Filho A. Análise da Intersetorialidade no Programa Saúde na Escola. *Rev Bras Educ Med [Internet]*. 2016 [cited 2017 Oct 13];40(2):261-7. Available from: <http://www.scielo.br/pdf/rbem/v40n2/1981-5271-rbem-40-2-0261.pdf>
17. Penso MA, Brasil KCTR, Arrais AR, Lordello SR. A relação entre saúde e escola: percepções dos profissionais que trabalham com adolescentes na atenção primária à saúde no Distrito Federal. *Saúde Soc [Internet]*. 2013[cited 2017 Oct 13];22(2):542-53. Available from: <http://www.scielo.br/pdf/sausoc/v22n2/v22n2a23.pdf>
18. Brasil. Ministério da Saúde. Portaria nº 1.861, de 4 de setembro de 2008. Estabelece recursos financeiros pela adesão ao PSE para municípios com equipes de Saúde da Família, priorizados a partir do Índice de Desenvolvimento da Educação Básica (IDEB), que aderirem ao Programa Saúde na Escola (PSE) [Internet]. 2008 [cited 2017 Oct 13]. Available from: <http://atencaobasica.saude.rs.gov.br/upload/arquivos/201510/01114724-20141104053935portaria-n-1861-2008.pdf>
19. Brasil. Ministério da Saúde. Portaria nº 3.146, de 17 de dezembro de 2009. Estabelece recursos financeiros para Municípios com equipes de Saúde da Família, que aderirem ao Programa Saúde na Escola – PSE [Internet]. 2009[cited 2017 Oct 13]. Available from: <http://atencaobasica.saude.rs.gov.br/upload/arquivos/201510/01114723-20141104053759portaria-n-3146-2009.pdf>
20. Cavalcanti PB, Lucena CMF, Lucena PLC. Programa Saúde na Escola: interpelações sobre ações de educação e saúde no Brasil. *Textos Contextos [Internet]*. 2015[cited 2017 Oct 13];14(2):387-402. Available from: <http://revistaseletronicas.pucrs.br/ojs/index.php/fass/article/view/21728/13961>
21. Silvestre C, Almeida J, Conceição MH, Albuquerque AM. Análise de promoção das práticas corporais e atividade física propostas pelo Programa Saúde na Escola nas escolas de Samambaia/Distrito Federal. *Atas CIAIQ [Internet]*. 2016[cited 2017 Oct 13];2:1645-52. Available from: <http://proceedings.ciaiq.org/index.php/ciaiq2016/article/view/1103/1075>
22. Guimarães ACC, Feijó I, Soares A, Fernandes S, Machado Z, Parcias SR. Excesso de peso e obesidade em escolares: associação com fatores biopsicológicos, socioeconômicos e comportamentais. *Arq Bras Endocrinol Metab [Internet]*. 2012 [cited 2017 Oct 13];56(2):142-48. Available from: <http://www.scielo.br/pdf/abem/v56n2/08.pdf>
23. Rasche AS, Santos MSS. Enfermagem escolar e sua especialização: uma nova ou antiga atividade. *Rev Bras Enferm [Internet]*. 2013[cited 2017 Oct 13];66(4):607-10. Available from: <http://www.scielo.br/pdf/reben/v66n4/v66n4a22.pdf>
24. Faial LCM, Silva RMCRA, Pereira ER, Refrande SM, Souza LMC, Faial CSG. A escola como campo de promoção à saúde na adolescência: revisão literária. *Rev Pró-Uni [Internet]*. 2016 [cited 2017 Oct 13];7(2):22-9. Available from: <http://editorauss.br/index.php/RPU/article/view/344>
25. Costa GM, Figueredo RC, Ribeiro MS. A importância do enfermeiro junto ao PSE nas ações de educação em saúde em uma Escola Municipal de Gurupi – TO. *Rev Científ ITPAC [Internet]*. 2013 [cited 2017 Oct 13];6(2). Available from: <http://www.itpac.br/arquivos/Revista/62/6.pdf>
26. Casemiro JP, Fonseca ABC, Secco FVM. Promover saúde na escola: reflexões a partir de uma revisão sobre saúde escolar na América Latina. *Ciênc Saúde Colet [Internet]*. 2014[cited 2017 Oct 13];19(3):829-40. Available from: <https://scielosp.org/pdf/csc/2014.v19n3/829-840/pt>
27. Carvalho FFB. A saúde vai à escola: a promoção da saúde em práticas pedagógicas. *Physis [Internet]*. 2015 [cited 2017 Oct 13];25(4):1207-27. Available from: <http://www.scielo.br/pdf/physis/v25n4/0103-7331-physis-25-04-01207.pdf>