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Adolescent health promotion and the School Health Program: complexity in the articulation of health and education

Promoção da saúde de adolescentes e programa saúde na escola: complexidade na articulação saúde e educação

Promoción de la salud de adolescentes y programa salud en la escuela: complejidad en la articulación salud y educación

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ABSTRACT

Objective: To analyze the context of health promotion with adolescents in the health and education interface focusing on the actions of the Brazilian School Health Program. **Method:** Qualitative study conducted in 2015 with professionals working in the Regional Executive Coordination IV, in Fortaleza, Ceará. The data obtained in the interview were processed in the ALCESTE program. **Results:** 17 health professionals and 22 education professionals participated in the study. The organization of spontaneous demand causes disharmony in the scheduled visits and health actions in the school. The difficulties in the implementation of the School Health Program were demonstrated by the lack of knowledge, the lack of planning among the sectors and the different demarcations in the territory. **Conclusion:** The professionals' lack of knowledge regarding the program and the lack of action planning confirm the disarticulation of the education and health sectors, although they indicate the possibilities of this inter-sectoral practice.

DESCRIPTORS

Health Promotion; Adolescent; School Health; Intersectoral Collaboration.

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INTRODUCTION

Historically, the school is recognized as an environment to ask questions about health, which are problematized in everyday life. In Brazil, a number of models have been used, ranging from those aimed at domestication, to clinical care and, more recently, to proposals that stimulate the critical capacity and autonomy of the subjects in harmony with health promotion[1].

Health promotion was internationally highlighted with the Ottawa Charter (1986), the result of the First International Conference on Health Promotion and inspired by the principles of the Alma-Ata Declaration[2]. This event prioritizes primary health care, health care for 0-6 year olds and women, ergo, maternal and child protection services, with important advances in the health care of these groups. However, in contrast there was exclusion for health care for the group of schoolchildren, which include children from 7 to 10 years of age, turning to health care for the adolescent[1].

A study carried out in Portugal[3] warns that the concept of health promotion can be confused with that of disease prevention, the latter being related to the potential problems of the patient and the individuals' intrinsic or extrinsic risk factors. This way of conceiving health promotion is usually applied in actions directed towards adolescents.

The health promotion movement became the health policy in Brazil, and the school is a favorable environment for the use of educational resources for this purpose[4]. Although there is intense movement and actions for health promotion, the health services and the schools do not recognize the needs of the adolescent, as being a group people with risk characteristics, vulnerabilities and specific care demands of care[5].

In the primary care context, such care can be developed with the participation of health professionals from the Family Health Strategy (FHS), educators, managers, parents and adolescents. In this strategy, health professionals can focus on the promotion, prevention and care triad, emphasizing basic care as a privileged space to perform educational and health promotion practices, observing the clientele ascribed and forming a link with the community[6].

Thus, primary health care professionals should be aware of the potential of adolescents, with a view of protagonism which contributes to their care and collaborates with other subjects in the same age group, with dialogic attitudes. In a qualitative study with an educational intervention about sexuality and STD/HIV/AIDS prevention, active listening on expectations and needs was promoted, enabling not only learning, but also the formation of bonds and belief in the objectives of the intervention[5].

School Health Program (SHP) is a strategy that integrates education and health actions with the purpose of contributing to the integral education of students of the public basic education network through prevention, promotion and health care actions. The SHP also favors the strengthening of actions in the articulation of health and education in order to address the vulnerabilities in these population groups[7]. Thus, it should be implemented with effective participation with the FHS teams, integrating with the school within the same territory while respecting SUS (Unified Health System – *Sistema Único de Saúde*) principles.

Gaps in adolescents health care can be observed as well as difficulties in inserting health promotion actions in institutional planning, be it education or health. A study shows that adolescents showed difficulties in listening, to health promotion actions that support them in the development of social relations and healthy habits[5].

The disarticulation of the education and health sectors and the non-availability of professionals to work with the adolescent in health activities at school were highlighted in this research when the participants emphasized that the actions occur in a punctual and discontinuous way because of management orientation. In addition, disarticulation makes it impossible to develop and follow the actions of the SHP, which, in turn, do not follow the precepts of health promotion of schoolchildren configured in the objectives of this program. It should be emphasized there is a need in SHP for the articulation between health and education, the partnership between public sectors, the participation of users and families, ways of operating valuing different knowledge, specialized or lay people, resulting in innovative and articulated work processes which promote significant changes in the reality[1,8].

Thus, to support the context of health promotion for adolescents in school, the complexity was chosen as it inspires the articulation of knowledge cooperation. Complexity, understood as the fabric of events, actions and interactions, is a way of approaching reality by considering an interdependent, interactive and inter-retroactive structure between the parts and the whole, and the whole and the parts[9-10].

The effect of complex thinking on health management allows for care that permeates ideas of care networks and interconnections, a way of acting articulated between individuals and reality, between professionals themselves and support systems, as they reject reductive, disjunctive and simplified thinking[11].

It becomes a challenge for researchers and professionals to work with complex conditions, which requires facing reality, involving several actors and an interdisciplinary perspective. Therefore, the actions of health promotion performed by the professionals with the adolescent in the health and education interface and the implementation of the SHP were questioned. To answer this, the outlined objective was to analyze the context of health promotion with adolescents in the health and education interface focusing on the actions of School Health Program.

METHOD

An exploratory, analytical, qualitative study understanding the participants' point of view and their particularities[12]. Based on the complexity referential, we sought to understand the articulation of knowledge, the constitution of an object, simultaneously, interdisciplinary, through exchange, cooperation and multiple skills[10].

The study was carried out in the second half of 2015, in Fortaleza, Ceará, Brazil, in two Primary Health Care Units (PHCU) and two schools belonging to the Regional Executive Coordination IV. The administrative and managerial organization of the municipal executive power is

divided into six Regional Coordinations and one Special Coordination for the central area of the city. Therefore, each school is linked to a PHCU for the development of activities proposed in the inter-ministerial programs (health and education), and in this parity, the intentionally chosen units were characterized by the implementation of the SHP.

Thirty-nine professionals participated, 17 of these were health professionals (two physicians, six nurses, five dentists and four managers), while in education there were 22 participants represented by 13 teachers and nine managers. The inclusion of these participants was due to the need to learn their management experiences, as in the view of some professionals the implementation of the SHP depended on the managers for the development of health promotion actions for adolescents. The majority (22) of the participants belonged to the age group between 32 and 46 years old; 33 had specialization courses, five, master's and one doctorate; 14 had been working in the service for between 4 months and 2 years, and the others had worked for over 2 years; 26 were effective public servants and 13 had temporary contracts; 32 worked 40 hours a week and seven worked 20 hours a week.

The inclusion criteria included developing care/actions for health promotion and/or be directly involved in the management and education process of adolescents, with a minimum period of 6 months working in these activities. According to the theoretical-methodological orientation, we chose an intentional qualitative sample, selecting subjects who contributed information about the object with dimensions and diversities of two social sectors. In these terms, the number of participants was considered sufficient based on the theoretical saturation, as the research data, in the evaluation of the researcher, began to present redundancy or repetition, observing answers to the questions[13].

Initially, data collection was performed using free observation and was followed up with a semi-structured interview, which combines closed and open questions[12], including characteristics of the participants and questions of the study. This technique made it possible for the interviewees to discuss the health actions developed with the adolescents at school and how the proposals for health promotion in the implementation of the SHP occur. The interviews took place at previously arranged times and dates, in a reserved location in the PCU or schools, they were audio recorded and lasted between 35 to 40 minutes each. The interview was transcribed in its entirety by one of the researchers at the end of each interview.

The data were input into the ALCESTE software (*Análise Lexical Contextual de um Conjunto de Segmentos de Texto* – Contextual Lexical Analysis of a Set of Text Segments), version 2012. This software applies a significant amount of statistical tests, organized, and performs qualitative-quantitative analysis of textual data in order to distinguish classes of words representing different forms of discourses about a topic of interest. To understand the method it is necessary to define some key terms of the program. The Initial Context Units (ICU) correspond to a previous categorization made by the researcher on each subject that will issue the discourses, thus each interview corresponds to an ICU. After the recognition of the ICU program, the material was divided into Elementary Context Units (ECU), which are text segments of the same size, between three to six lines, with the least fragment in meaning[14-15].

The program provides the number of classes resulting from the analysis, as well as the reduced forms, the semantic context and the ECUs characteristic of each consolidated class[16]. The program generated a *corpus* of 39 ICUs and distributed them among 676 ECUs, consisting of 3,267 different words or vocabulary forms. This first classification by the program calculates the partitions of the *corpus* into lexical classes and reveals their oppositions, in a characteristic form, called a dendogram[17]. From the total ECU, 621 of them were selected, which makes up 91% of the *corpus*, which formed three analytical classes: prioritization of spontaneous demand; difficulties and possibilities for implementation of the SHP and health promotion actions. Upon acquiring this material, its content was explained, naming each class from the information provided by the software. These are presented in the results, and emerged around the work process of Primary Care Units (PCU) and health promotion actions for adolescents in school, focusing on the, difficulties and possibilities of the SHP.

The study was approved by the Ethics Committee in Research of the Universidade Estadual do Ceará, opinion nº 651.771 of 09/05/2014. The ethical procedures related to the institution (authorization) and the participants, which formalized the agreement with the signing of the Term of Free and Informed Consent were followed. In order to respect the anonymity of the participants, they were identified by the acronyms HP (health professionals), HM (health manager), EP (education professionals – teachers) and EM (education managers), the acronyms were accompanied by the numeral referring to the sequence of the interviews.

RESULTS

The classes organized by the program and the analytical treatment bring meanings to the health actions in the school, designated by the professionals as health promotion, difficulties and possibilities in their implementation supported by the SHP. Thus, the first class/thematic emphasizes the organization of the work process that prioritizes the spontaneous demand in the FHS. Therefore it expresses the experiences of the professionals acting in the PCU, to the detriment of scheduled visits or other activities with the population, including health actions in the school.

There is an imbalance, acute cases are our priority here, there are at least 100 per week, while there are 32 diabetic and hypertensive cases, eight prenatal, and then the other consultations (ECU 369, HP1).

You see, nowadays our agenda is for acute care, emergencies, a project that works from 7:00 am to 7:00 pm and there are shifts for you to attend the emergency (ECU 288, HP2).

You see, 15 hours a week dedicated to emergency care is a much longer workload than if you were to be dedicated to the hypertensive, diabetic and pregnant patients (ECU 302, HP1).

The discourses show that the greater workload of health professionals is allocated to an important activity, attending to a population demand, however, there is a deficit in the coverage of other actions such as chronic diseases, prenatal care, and childcare, among others which generates tension in this scenario.

I see 32 hypertensive patients per week, but there are a lot of emergencies per week, close to 150, an average of 30 patients per week (ECU 368, HP2).

So, this spontaneous demand, since it began, every afternoon, it's me, or it is my colleague attending the emergencies there are 30 patients in the afternoon, but we see that most patients are not in an acute condition (ECU 292, HP1).

We attend hypertensive, diabetes and pregnant patients and do home visits in the morning shift In the afternoon, we take care of these acute conditions within the emergency, but, you see, besides the clinic, it's not possible to attend to these emergencies, because often the patient arrives with a fever, in pain, because there is no injectable dipyrone, or aerosol at the health unit (ECU 289, HP1).

The spontaneous demand provides care and this should provide satisfaction for both the user and the workers, but it has been perceived that this organization has caused dissatisfaction due to reducing other activities, such as care for the pregnant woman and the child that could promote health promotion.

We do 40 hours a week here and it is completely filled up so that you do not even have time to do health education activities, if you look at primary care, which is supposed to be for the care of chronic conditions, such as hypertensive patients, pregnant women to follow the antenatal care, and for children to perform childcare (ECU 287, HP2).

Diabetic patients, pregnant women, home visits, emergencies, there is no time left in the schedule to see groups, you gather the hypertensive patients from one team and educate them about food and diet (ECU 317, HP1).

In the second class/theme, difficulties related to the implementation of the SHP were identified due to lack of knowledge of the program, lack of planning and interaction between the sectors, as well as different demarcations in the territory that involves PCU and school.

Since I do not work with the SHP, it gets difficult, because I don't even understand the program itself. If there was professional interaction from both sectors, I think it there wouldn't be any difficulty in it being implemented (ECU 634, HP3).

Even in the special projects that we develop, but I never had access to this project, no, here in school, no, but maybe other people have (ECU 26, EP1).

So, health, is very difficult. In a formal point of view, I do not know of any health program in the school itself, we never had the time to present this project in the school, we know that some actions are developed, to participate, we would like to integrate it (ECU 25, EP2).

The discourses also confirm the lack of planning and interaction among the sectors, due to the lack of structure and human resources, while causing repercussion in the performance of this health promotion activity.

In relation to planning, it's something that should exist, I do not know if there is, when it arrives in the school, the school directors pass the information on to us, the teachers do not plan, do not have meetings. The difficulties are caused due to the lack of resources, the family, the competent bodies, the lack 'of employees, there isn't enough to serve the community, and this is difficult (ECU 216, EP4).

The planning happens, but it is satisfactory, it could be better, the integration is very difficult, nowadays in Fortaleza, because there is no more planning on Saturdays (ECU 19, EP3).

My school was not implemented as I told you. I think the program is important, now I think, that there is still missing connection between health professionals and education professionals, because the program exists, but you do not see this interaction (ECU 631, HP4).

Other discourses of the health professionals problematized the different demarcations between the territory of the PCU and the school, influencing the family health actions, the idea of disarticulation in the health system, resulting in compromised access.

In the beginning this generated a bit of a problem, because sometimes, as the child had easy access to our health team, the parents did not understand why this child had this access, while they, the parents, did not have access (ECU 555, HP5).

I had to go to the original team, which was a very crowded team, we had this problem right at the beginning of getting the parents, the teachers to understand, I think the SHP has a very strong goal of improving the bonding of both services, to get to know each other better and to really work in partnership, this was one of the main objectives, of course (ECU 556, HP6).

The third class/theme discusses the possibilities of health promotion in the implementation of the SHP in the following terms: territorial approximation, experience of the *Programa Olhar Brasil* (Look Brazil Program), and the linking of services, showing that if there was structure, these conditions could favor health promotion actions with the adolescents.

In the case here I think the ease is the proximity of the school, which is a neighboring school, you have very easy access, let's say, if it was better structured, because, so, we also need feedback (ECU 408, HP7).

They are very good and capable people, that we know. The facilitating factor would be that is very close and if you already had a team reserved for it, you could do the activities, I think the principal, the school itself is very open to these activities, this is a facilitating factor (ECU 410, HP8).

The interviewees' experience on integration among sectors was highlighted in the Look Brazil Program an action which is linked to the SHP implementation.

We do not have a lot of feedback, we are get some from Look Brazil, so 20 students were supposed to go to the consultation, but only 10 came, only 10 were with the parents, the great difficulty is for the father to come, so we know (ECU 98, EM1).

The Look Brazil Program is aimed at education, we did the eye tests, the team of our students, the community, because it seems like the clinic makes more referrals to other services (ECU 164, HM1).

Other discourses reaffirm the possibility of health promotion in the imagery of health professionals who comment on the relationship with the school.

Health promotion actions are usually performed, the ministry schedule is already agreed, we have the meetings, today the diary is much more open, we have a very good relationship with the education district (ECU 134, HM1).

I think having a good relationship helps, the school is always open, there aren't any obstacles it's possible to align with teachers, align with some discipline, do something interdisciplinary, teacher who planned together (ECU 530, EP6).

The school always ask, there is usually a lot of parent meetings, they say when it will happen and the staff joins these meetings. I will be very honest with you, I do not have much difficulty because my school is very accessible, when you get an accessible coordination and when you have (an easy relationship) with your team (ECU 578, HP11).

The discourses highlight some actions that favor the dialogue between health and education, particularly in management, as well as the ease which the health team has to enter the school in order to carry out the health promotion activities.

DISCUSSION

The results of the first thematic class problematize the actions of health promotion in primary health care, in which PCU professionals show the reality of spontaneous demand, with a greater workload in this activity, even if the guidelines of the FHS state that the workload should be aimed at the care of patients with chronic diseases such as hypertension and diabetes, prenatal care, child care, among others. As primary health care, the FHS articulates the other levels of complexity, guaranteeing the integrality of the actions and the continuity of care. The actions to promote prevention and access to the system occur within the scope of primary care, especially through the FHS, making it possible to include territories and regions with greater population coverage[18].

A study carried out in the interior of the state of São Paulo highlighted that the FHS proposal emphasizes teamwork as a way of articulating different knowledge and practices in the production of health care. This states that the isolated work of any professional cannot cover the complexity of the issues that arise in the daily work of the FHS[19].

Thus, the effectiveness of care and articulation may be compromised in the scope of primary health care. A study carried out in the Federal District highlights that Primary Health Care (PHC) needs to advance in the perspective of social construction, as the supply structure is very restricted, and it is only able to partially respond to the demands for acute conditions and acute chronic conditions and the demands for preventive care, administrative demands, and sometimes home care[20].

This organization can provide answers to the health problems of users who frequently seek the PCU as an alternative to accessing the health care network. They are devices that could generate several health promotion actions with the users, however, in the relation to the care of the adolescent patients, it is noticed that the school environment still seems to be the most favorable for these actions supported in legal documents, like the SHP. Understanding that inter-sectoral partnerships and actions are most effective when they meet and dialogue with the plurality of institutional actors and not involved and interested institutional[1].

In this context, the professionals' dissatisfaction with the reduction of health promotion activities was noticed, although they assumed that it was impossible to replace the schedule of spontaneous demand for group activities, a fact that conforms to the current health care model of the municipality of Fortaleza. The workplace these professionals is organized to address community problems, which are complex, but should not devalue the health promotion of adolescent in their social and care contexts, since it is essential to act in the different contexts of care.

A study performed in Portugal showed that the majority of nurses identify the health situations of the population and the resources of the patient, family and community, taking advantage of hospitalization to promote healthy lifestyles and to provide information generating cognitive learning and new abilities for this patient[3].

In an international literature review on the improvement and well-being of students (children and youths) and their school performance based on the WHO Promoting Health Program, positive effects were found for some interventions for Body Mass Index (BMI) physical activity, physical fitness, fruit and vegetable intake, and tobacco use. The intervention effects were generally small in nature but have the potential to produce public health benefits[21].

The interviewed professionals have difficulties in perceiving and implementing practices that meet these dimensions, and not only the prevention of diseases. However, in recent decades, the importance of renewing higher education sustained through the *Bologna* process in order to respond to the demands of a new society is evident. This discussion in the European Higher Education Area has international repercussions linked to the health promotion movement, and can reorient educational policies to provide knowledge, skills and values to professionals in order to realize theory and research in policies and practices to promote global health[22].

Another regulatory framework is necessary in the formation of subjects that will be in the territories of adolescent life, among them, health and school. A regulatory framework should not neglect the power effects that the network of organizations and health discourses have on training and work[23]. Thus, it is not enough to bring together Ministries (Health and Education) and formulate specific policies, but the reorientation of training and participation practices in SUS.

The second class/theme highlights the various obstacles of health promotion in the SHP, such as the lack of knowledge of this interministerial directive, mainly of teachers, but also of the education and health managers who are distancing themselves from actions, which, in turn are discontinued and regulated by higher authorities and do not contemplate the principles of health promotion. They are characterized as punctual

activities, without planning and involvement of its own management and consequent disarticulation between health and education. Therefore, the actions are disconnected from the objectives of the program[7] and do not facilitate learning about health care. A similar study found that action planning is not guided by the needs of the students and that there are few opportunities for the involved actors to interact[23].

Based on complexity, it is noted that the disagreements in health promotion actions for adolescent health highlight uncertainty and lead to the facing of difficulties as a possible challenge to change a complex reality. The strategy can establish compromises, but it is not known to what extent, there are no answers, however context-based planning is necessary for the development and dialogue between ends and means[10].

It is understood that educational professionals should have an understanding of the program in order to share and facilitate its implementation. According to its regulations the SHP seeks to strengthen articulated actions between public schools and the Family Health Strategy[6]. In this context, intersectoriality is fundamental and favors health promotion. In a study that analyzes the inter-sectoral action developed between the health and education sectors in the implementation process of the School Health Program, the interviewees recognize that intersectoriality is a necessary work that requires partnership among the institutions, given the complexity of the existing social problems. It is considered that the program strengthened the relationship between the two sectors, however, aspects of the inter-sectorial articulation in the political-managerial process were shown to have weaknesses and limitations[24].

Similarly, interviewees in this study confirmed the disarticulation of the sectors for various reasons, such as surplus activities for teachers and health professionals, repercussions of temporary contracts and working conditions, which are considered obstacles in action planning and implementation of SHP. Although the proposal in the SHP indicates the priority of integral student education, the training the educators and the integration of the two sectors is necessary[7].

Therefore, the action planning of the SHP is essential so that there is a dialogue between the two sectors, developing the operational stages, considering the school and social context and the local health diagnosis. Thus, in the FHS, health planning and programming is part of the professionals' everyday life, aiming at identifying health needs in the community and developing strategies to improve conditions[25].

The development of health actions is not in line with what was established in the SHP proposal, which establishes the planning of the sectors and the identification of the health needs of school adolescents as a priority, as well as the prerogatives of health promotion, which have sought to implement territoriality principles, intersectorality and integral education[7,23]. This proposal, which adds to the well-being and school performance, has been encouraged by the World Health Organization with the strengthening of Health Promoting Schools[21].

In this perspective, an educational approach is necessary to enable the exercise of transformative learning, in which individuals and communities can construct skills and attitudes based on critical sense, perceptions about the benefits of health and their promotion in daily life, personal and collective development. Contrary to what was observed in the professional discourses, who understood that health promotion for adolescents occurs through preventive procedures[3] and healthy behavior orientation, without associating them with the socio-cultural context of the students and the development of criticality. But one of the components of the SHP has the purpose of promoting permanent education for the workers involved in the program[7], thus bringing a possibility of improving training in a problematic and critical perspective. A study with FHS professionals shows that health promotion for adolescents still presents in an incipient way, however, it is imperative that the health professionals' competence is conferred in order to deal with this target audience[6].

Regarding territorialization, it was discussed that the students access to the health unit strengthens this link, because they are part of the school/service territory and also due to the guidelines of the SHP. However, parents of schoolchildren, although from the same territory, do not have this access. Each unit with its Family Health Teams must organize itself to serve a target audience, represented by a set of families geographically aggregated, covering territories and regions with greater population coverage[18]. Territorialization maintains the geographic demarcation and the clientele registration, but it should not be an obstacle to other users' access, but rather make it possible to hold their demands accountable.

The intersectoriality in the implementation of the SHP requires the necessary integration and inter-professional cooperation[23]. This management method, developed through a systematic process of articulation, planning and cooperation between the different sectors of society and among the various public policies, favors interventions in social determinants[26]. However, studies on inter-sectoral and multidisciplinary work in schools indicate that there is a predominance of actions for the programmatic content to the detriment of extended approaches using these partnerships and interactions[27].

Although the interviewees highlighted many difficulties, the discourses denoted the possibility of developing actions with the adolescent in school, through territorial proximity and some partnerships between the districts of education and health, dialogues between the management of these sectors on the implementation of the SHP, referring much more to regulations and to the development of specific actions. Thus, it can be said that the inter-sectoral project is feasible for the development of actions related to adolescent health in school and that the complexity of this phenomenon involves, besides the supply of human resources, effective means of management and recognition of these places based on negotiation of the public interest[23].

In view of the discussion presented here, it is worth mentioning that the limits of the study occurred due to the data collection, limited interaction between the researchers and the participants, as more observations of the field of work of these professionals would broaden the information and the context of the analysis of a discussion that involves individual, collective practice and the integrated way of developing it. These gaps will be explored in other research. Moreover,

the description of participants' experiences, in particular of the education professionals is restricted, partly due to institutional issues, working conditions, and due to the non-implementation of SHP policy. There are few experiences of intersectoral participation, and even managers, who have more autonomy and conditions to manage actions in schools, are shown to be far from this practice.

On the other hand, the study gives rise to reflections and indicatives that bring about the necessary articulation between health and education, dialogues between professionals and managers to be inserted in the working agenda of the FHS spaces of action in the school. Thus, the study intends to support health promotion actions for adolescents that surpasses the restrictive, normative and disciplinary model and that promote the interdisciplinary exercise, strengthening dialogues for the implementation of interinstitutional projects which incorporate health promotion for adolescents in health care.

CONCLUSION

The study focused on health promotion actions for adolescents and the School Health Program (SHP) as an intersectoral policy which includes health promotion. Thus, the results show that health and education professionals emphasized the importance of health promotion actions highlighting the SHP in this integration. However, difficulties were reported such as the articulation of sectors based on the inter-sectoral concept.

Although participants mentioned many restrictive aspects of health promotion, even those exposed in the SHP, they highlighted the possibilities of territorial approximation, the brief experience in the Look Brazil Program and the harmonious relationship between the management of the two sectors. Inevitably, structural problems related to materials, in addition to human resources, are reflected in the implementation of SHP actions or in any other activity integrating health and education, with consequences in the training of students and in strengthening the protagonism aimed at promoting their health. Thus, the effectiveness of these actions depends on the structural conditions of the different work and interinstitutional spaces of the multidisciplinary teams, which should not act independently, but driven by the combination of various understandings and knowledge and applied practices considering it to be a complex reality.

It is necessary to overcome difficulties and limitations generated by the work process cited by health workers and to provoke mediation and negotiations in the relations with managers, in order not to deviate from the objectives of comprehensive care for SUS users. Thus, the complexity theory reiterates the importance of the integration of knowledge, in the constitution of an interdisciplinary object, since it will allow the exchange, cooperation, and dialogue. In this case, the need for an intersectoral practice to implement health promotion actions for adolescents in school promoting its role in health care.

Finally, it is considered that unfamiliarity and lack of planning in the performance of the actions of the SHP confirm the disarticulation of the education and health sectors and the distancing of health promotion proposals for adolescents in school, however there are some actions which indicate the possibilities of this intersectoral practice.

RESUMO

Objetivo: Analisar o contexto da promoção da saúde com adolescentes na interface saúde e educação focando as ações do Programa Saúde na Escola. **Método:** Estudo qualitativo realizado em 2015 com profissionais que trabalham na Coordenadoria Executiva Regional IV, em Fortaleza, Ceará. Os dados obtidos na entrevista foram processados no programa ALCESTE. **Resultados:** Participaram do estudo 17 profissionais da saúde e 22 da educação. A organização da demanda espontânea ocasiona desarmonia nos atendimentos agendados e nas ações de saúde na escola. Demonstraram-se as dificuldades na implementação do Programa Saúde na Escola pelo desconhecimento, pela falta de planejamento entre os setores e pelas demarcações diferentes no território. **Conclusão:** O desconhecimento dos profissionais sobre o programa e a falta de planejamento das ações confirmam a desarticulação dos setores educação e saúde, embora sinalizem possibilidades desta prática intersetorial.

DESCRITORES

Promoção da Saúde; Adolescente; Saúde Escolar; Colaboração Intersetorial.

RESUMEN

Objetivo: Analizar el marco de la promoción de la salud con adolescentes en la interfaz salud y educación enfocando las acciones del Programa Salud en la Escuela. **Método:** Estudio cualitativo realizado en 2015 con profesionales que trabajan en la Coordinación Ejecutiva Regional IV, en Fortaleza, Ceará. Los datos obtenidos en la entrevista fueron procesados en el programa ALCESTE. **Resultados:** Participaron en el estudio 17 profesionales sanitarios y 22 de la educación. La organización de la demanda espontánea ocasiona desarmonía en las atenciones programadas y las acciones de salud en la escuela. Se demostraron las dificultades en la implementación del Programa Salud en la Escuela por el desconocimiento, la falta de planificación entre los sectores y las demarcaciones diferentes en el territorio. **Conclusión:** El desconocimiento de los profesionales sobre el programa y la falta de planificación de las acciones confirman la desarticulación de los sectores educación y salud, aunque señalen posibilidades de esa práctica intersectorial.

DESCRIPTORES

Promoción de la Salud; Adolescente; Salud Escolar; Colaboración Intersectorial.

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