

ARTIGO

CARTOGRAPHY OF THE IMPLEMENTATION OF THE SCHOOL HEALTH PROGRAM (PSE): IMPLICATIONS FOR THE DEMEDICALIZATION PROCESS

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ABSTRACT: This article aims to present a cartography of the implementation of the School Health Program (PSE) and its effects on the demedicalization process in a small town in Southern Brazil. This cartographic study counted with the participation of 51 professionals from the sectors involved in the Program. For data production, conversation wheels, workshop groups, documentary analysis and participant observation were held. The analyses indicate that the actions performed through the PSE explained the medicalization process in the care of students, especially with a focus on prescription and use of psychotropic drugs. Through the intersectoral articulation promoted by the Program, the Health, Education and Social Assistance sectors were approached in order to understand the students' problems, as well as the range of actions promoted to confront them. This indicates the potential of the Program for the demedicalization process, which intersectorality proved to be determinant.

Keywords: Intersectorality, medicalization, School Health Program.

CARTOGRAFIA DA IMPLANTAÇÃO E EXECUÇÃO DO PROGRAMA SAÚDE NA ESCOLA (PSE): IMPLICAÇÕES PARA O PROCESSO DE DESMEDICALIZAÇÃO

RESUMO: O presente artigo objetiva apresentar uma cartografia da implantação e execução do Programa Saúde na Escola (PSE) e seus efeitos para o processo de desmedicalização em um município de pequeno porte no sul do Brasil. Trata-se de um estudo cartográfico que contou com participação de 51 profissionais dos setores envolvidos no Programa. Para a produção dos dados foram utilizadas rodas de conversa, oficina de grupo, análise documental e observação participante. As análises indicam que as ações realizadas por meio do PSE explicitaram o processo de medicalização no cuidado a educandos, especialmente com foco na prescrição e uso de psicotrópicos. Por meio da articulação intersetorial promovida pelo Programa, aproximaram-se os setores Saúde, Educação e Assistência Social, ampliando-se a compreensão das problemáticas que envolviam os alunos, bem como o leque de ações

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promovidas para enfrenta-las. Isso indica o potencial do Programa para o processo de desmedicalização para o que a intersectorialidade mostrou-se determinante.

Keywords: Intersetorialidade, medicalização, Programa Saúde na Escola.

CARTOGRAFÍA DE LA APLICACIÓN Y EJECUCIÓN DEL PROGRAMA DE SALUD ESCOLAR (PSE): IMPLICACIONES PARA EL PROCESO DE DEMEDICALIZACIÓN

RESÚMEN: Este artículo tiene como objetivo presentar una cartografía de la implementación y ejecución del Programa Salud en la Escuela (PSE) y sus efectos en el proceso de desmedicalización en una pequeña ciudad en el sur de Brasil. Es un estudio cartográfico con la participación de 51 profesionales de los sectores involucrados en el Programa. Para la producción de los datos, se utilizaron ruedas de conversación, talleres grupales, análisis de documentos y observación participante. Los análisis indican que las acciones realizadas a través del PSE hicieron explícito el proceso de medicalización en la atención de los estudiantes, especialmente con un enfoque en la prescripción y el uso de drogas psicotrópicas. A través de la articulación intersectorial promovida por el Programa, los sectores de Salud, Educación y Asistencia Social se acercaron, ampliando la comprensión de los problemas que involucraban a los estudiantes, así como la gama de acciones promovidas para enfrentarlos. Esto indica el potencial del Programa para el proceso de desmedicalización, para el cual la intersectorialidad resultó ser decisiva.

Palabras clave: Programa de intersectorialidad, medicalización, salud en la escuela.

INTRODUCTION

There is a growing demand for children and adolescents in the health sector due to learning and/or behavior problems at school, such as aggressiveness, difficulty to learn, difficulty to stay seated, etc. The complaints and referrals support diagnoses, indication of treatments and prescription for medications to control signs shown in the classroom, a phenomenon that characterizes the current medicalization in the care of students, with reflections on education (SIGNOR, 2013).

The indices of mental disorders diagnosed in the school-age population have also been indicated as an effect of the process of medicalization of health (CONRAD, 2007, MOYSES AND COLLARES, 2010, ROSE, 2006, TIMIMI, 2002 AND WHITAKER, 2016). This perspective disagrees with the research data found by Thiengo et al. (2014), who investigated the prevalence of mental disorders in childhood and adolescence and possible associated factors in a systematic review of the literature on population-based studies. This study shows prevalence ranging from 0.6% to 30% for depression; 3.3% to 32.3% for anxiety; 0.9% to 19% for Attention Deficit Hyperactivity Disorder (ADHD); 1.7% to 32.1% for substance use disorders; and 1.8% to 29.2% for conduct disorders.

The negative consequences of medicalization include: excessive use of medications, with possible adverse effects; appropriation of situations by the health sector that could be resolved without the interference of professionals in this area; commercial use of human suffering by large health companies; and lack of support and social reflection on the configuration of our own society and its institutions (BRZOZOWSKI, CAPONI, 2013).

At the same time, school health concepts and practices have been problematized, from discussions at international level, such as global health promotion conferences, reinforcing the ideals of the school as a potentially health-promoting environment (BRASIL, 2006). From these debates, health promotion in the school environment implies interventions that require intersectoral articulation and social participation, through the development of integral health actions. The health and education sectors should establish partnerships to build healthy environments and safe spaces, so that students can enjoy appropriate conditions to study, live and develop themselves (BRASIL, 2015).

The Presidential Decree no. 6.286/2007, which creates and establishes the School Health Program (PSE) in Brazil, represents an initiative to reorient the implementation of public health policies in the school environment. The Program emerges integrated into Primary Care as an intersectoral strategy for articulation of knowledge and integral health promotion. Thus, it represents an innovative strategy for school health services in Brazil, qualifying health promotion actions in this context. Instead of punctual, fragmented and isolated actions, focused on the biomedical vision that prioritizes the clinical evaluation approach, diagnosis and treatment of intercurrents, this Program proposes the development of articulated actions between health and education and, with this, provides integral care to students, considering the social and mental aspects involved in their development (FIGUEIREDO, MACHADO, ABREU, 2010; BRASIL, 2009; BRASIL, 2015).

The PSE management process is organized in the logic of shared management, in which both the planning and the implementation of the actions are performed collectively, in order to meet local needs and demands. Decision-making should be carried out through intersectorially constructed analyses. Thus, the implemented actions would become more effective and integral, guaranteeing

greater solvability and, consequently, improving the situations of vulnerability present in the school environment (BRASIL, 2015).

This new conception of health presupposes co-responsibility, that is, the creation of partnerships to identify determinants and health constraints, as well as the need to work together to develop health promotion actions. The inclusion of other sectors in the process takes the health promotion as social production and allows joint strategies, in the construction of public policies that favor health (CARTA DE OTTAWA, 1986; BRASIL, 2015).

The focus of the PSE concentrate on strengthening the relationship between health and education networks and motivating the communication between them, linking the actions of the Unified Health System (SUS) with the actions of the basic education networks, aiming at community participation, integral training of students and the reduction of vulnerabilities. Intersectoriality, integrality, articulation of public education and health networks, permanent monitoring and evaluation of actions are guidelines for the Program (FERREIRA *et al.*, 2014).

This article aims to present a cartography of the implementation of the School Health Program (PSE) and its effects on the demedicalization process in a small town in Southern Brazil.

METHOD

The methodological strategy used in the study was the cartography, modality of intervention research that focus on the network of forces that compose the field, integrating production of collective knowledge and actions (PASSOS, KASTRUP, ESCÓSSIA, 2009).

This study was conducted in a small municipality, with an estimated population of less than 2,000 inhabitants, of whom approximately 75% reside in a rural area, located in the southern region of Brazil. At the time of the study, the municipality had a structured PSE, with an implementation trajectory initiated in 2013.

The study was developed with the participation of professionals linked to the three sectors integrated to the PSE in the municipality, including Education, Health and Social Assistance. The services involved were a Basic Health Unit (BHU), a Referral Center for Social Assistance (CRAS), a Specialized Referral Center for Social Assistance (CREAS), and three municipal schools. Fifty-one professionals from the aforementioned services participated in the study, 29 of whom worked in the Education sector, 17 in Health and five in Social Assistance, including the manager of each sector. The inclusion criteria were to be linked to the activities of the PSE and to be available to participate in the study.

For data production, we used the techniques and research instruments of conversation wheels, workshop group, documentary research and participant observation recorded in field diary⁴.

The participant observations began before the completion of the conversation wheels and workshop and were extended during and after them, considering that one of the researchers performed

⁴ The participants were identified by names of flowers, accompanied by the letter “C,” corresponding to the conversation wheel, or by the letter W, corresponding to the workshop group. Four conversation wheels and a workshop group were developed, being C1, C2, C3, C4 or W, respectively. In order to identify the sector where the participant works, we added to the identification the word Health, Education or Social, for example: (Acacia, Education-C3).

the articulating function along with the PSE, which made that a usual field. According to Kastrup and Barros (2009), during participant observation, the cartographer participates in people's lives "at the same time modifying and being modified by the experience" (p. 56), a sharing of the existential territory in which subject and object of research are constituted.

The construction of the conversation wheels and the workshop group was mobilized by the dialogical recognition of collective needs and difficulties arising from the realization of the School Health Program. Four conversation wheels were held involving professionals from the three sectors, one of them with the public administrators and articulators of PSE, who are the reference people of the Program. The conversation wheels were structured aiming to promote the protagonism of the participants and the shared construction in the intersectoral logic. To this end, they consisted of discussions based on a guiding question, using didactic images as a dynamizing tool.

The workshop group included 42 participants. During its execution, an external guest spoke about the theme "How to approach the different in the classroom." Then a fictitious case study was carried out, in which the participants, in small groups, considered possibilities of family reception, given the situation analyzed. After the discussion, the participants socialized and discussed the proposals formulated, reflecting upon their own experiences.

The documentary research, in turn, served as the basis for mapping the trajectory of the PSE in the municipality. This step was made through the identification and appraisal of documents such as the PSE Commitment Term, the minutes of the Program meetings and reports of the PSE.

Following the clues of cartography, the data analysis produced occurred during the intervention in the research field, characterized as an ongoing process. First the data were constructed in the process of immersion in the field, composed of the following sources: transcription of the recordings of the conversation wheels, records of documentary research, as well as records of the workshop groups and participant observations in the field diary. At each stage developed, the material produced was skimmed and, from the identification of the relevant points, a process of establishing connections and agency was initiated, setting up the territory on a large map, possible to be analyzed and contextualized, from the analysis of implications.

The project was submitted to the Research Ethics Committee with human beings (CEP), through the Platform Brasil, approved under the Substantiated Opinion no. 1,663,784.

PROBLEMATIZING THE MEDICALIZATION FROM THE PSE

The School Health Program (PSE) was established in the country by the Presidential Decree no. 6.286/2007. However, it was initially accessible to some municipalities considered by the Ministry of Health as priorities, as defined in Ordinance no. 1.861/2008. In 2013, through Ordinance no. 1,413, the universalization of the Program occurred, and all the Primary Care teams were linked (BRASIL, 2013).

According to documentary research, the municipality adhered to the PSE in 2013, through a commitment term signed by the public administrators with the Ministry of Health. This document formalizes the goals for the implementation of the Program for a 12-month period between the Health and Education Secretariats. At the time, the PSE was composed of the BHU and the three schools of the municipality, which had 390 students back then.

The Commitment Term defines the actions and goals to be achieved, being the instrument that should guide the development of the actions in the PSE. In the municipality studied, these actions were planned at the beginning of each year by the Municipal Intersectoral Working Group (GTI-M), along with representatives of the management and the intersectoral team, being verified the existence of the annual schedule of activities (field journal notes).

When cartographing the speeches on the PSE, we observed that the implementation of the program discuss a problem largely pointed out by Brazilian studies such as Lima and Lima (2017), which is the medicalization of care in students, with reflections on the education field. One participant points out:

[...] talking to the teachers when the discussion began: “we have to do something.” There was too much referral to the neurologist! These children were always returning with medication; they were spending a lot on exams, specialists, and didn’t have that result. We thought they would, but they didn’t. They were medicated, but something was still missing. (Veronica, Health-C1)

The medicalization phenomenon in the school environment generates unnecessary referrals to health professionals. As pointed out by Cruz, Okamoto and Ferraza (2016, p. 704) “in the search for the ideal daughter/son and student, parents and teachers seek, in the medical-neuropsychiatric knowledge, the solution to their difficulties.” These referrals lead to a considerable increase in diagnoses related to mental and behavioral disorders among children and adolescents, turning the school into an environment that does not accommodate the differences, but favors medicalizing practices, regulated by medical knowledge (BRASIL, 2011).

As shown by Meira (2012), the relationship established between behavioral and/or learning difficulties and neurological problems was frequent in the context studied, which mobilized the problematization of professionals based on PSE actions. The lack of dialogue between health and education professionals appears as a possible cause of the lack of resolutionability of referral to the specialist: “[...] we need to dialogue more with the neurologist, because it seems that he is there, distant, with one thought, and we are here!” (Veronica, Health-R1).

The reflection made by the health professional shows that some professionals, although they identify communication limits between the education and health sectors, do not call into question the student’s referral. Others, in turn, signal for excessive referral and indicate that the attempt at standardization does not occur only at the school that tries to erase the differences among students, but also in the diagnoses and treatments.

When we identified the problem of high referral rates, we also observed that every patient who went to the neurologist, had the appointment, exam and came with the medication. The funny thing is that all the prescriptions were the same way. (Lily, Health-C1)

Medication such as psychotropic drugs are used in the scenario in question in the search for a quick solution to the signals presented, without analyzing or solving the conflicts or the cause of the problems.

They think of early childhood education, two, three years old! There’s the case of a student of ours who did [psychotropic drug]. With us she was quiet; but, when the effect of the medicine faded, the student came back, the daughter was again agitated, began to behave unpleasantly,

both at school and at home and, at the same time, heading toward deconcentration, which makes us concerned. (Heliconia, Education-C4)

As Brazil signals (2011), with the medication, some situations presented are mitigated; however, others arise as a result of the drug or the unresolved underlying cause, which mobilizes education professionals and makes them question the effects of the drug: “[...] the medication soothes. But is the medication doing well for this child?” (Heliconia, Education-C4).

The professionals indicate the medicalization of care to students in the context studied, in which the subjectivity is reduced to organic aspects and often turn “problems in living into symptoms of diseases” (MEIRA, 2012, p. 136). The restriction of the therapeutic approach to drug use only labels and blames the subject, without actually seeking measures to qualify the student and the institution to solve the problem. Thus, the health sector, by establishing contact with the education sector, produces a fragmented, individualized and biologizing assistance, without considering the social context from which the child comes, or problematizing the school institution as part of the problem. “[...] if it is a neurological problem, goes to the neurologist; if it is a concentration problem, goes to the psychologist [...]” (Heliconia, Education-C4).

The participants emphasized the importance of understanding the social context of the child, which may be related to the difficulties presented, indicating they should not restrict the comprehension of the difficulty only to the child’s performance in the classroom. They cite that situations experienced at home can affect the performance and behavior of students at school, such as: “[...] violence, relationship between father and mother, the psychological issue!” (Veronica, Health-C1); “the parents are either separated, or the father is in jail!” (Globe amaranth, Health-C1); “alcoholism” (Veronica, Health-C1); coercive practices of parental education, such as “cases of aggression, rape” (Globe amaranth, Health-C1).

Despite the attempt to broaden the understanding of children’s psychic suffering and their relationship with the teaching-learning process, we observed that many professionals do not call into question the institution and the limits and difficulties of the pedagogical process itself, to which it is worth evoking the celebrated phrase of Mannoni (1988) when reflecting that the school instructs the “medicine to answer where the teaching failed” (MANNONI, 1988, p. 62). Thus:

If, on the one hand, education professionals are deprived of their possibility of action with the children by the hegemony of the discourse of the specialties; on the other hand, by assuming and validating the medical-psychological discourses, pedagogy does not cease to maintain this same practice, disregarding the school and blaming the children and their families for their failures. (Guarido, 2007, p. 157).

According to Silva, Bodstein and Cele (2016), the strategies adopted in the prevention of diseases and health promotion of students in the school environment presuppose an approach that values the diversity of subjects and knowledge, considering still the social context in which they are inserted. In this sense, the existence of innovative proposals that seek to break with a hegemonic biomedical discourse constituted historically is important, recognizing the school as an environment conducive to health promotion, knowledge and experience sharing, through more dialogical and reflexive initiatives (BRZOZOWSKI, CAPONI, 2013).

The intersectoral work, networked, as proposed by the PSE, requires professionals to leave the biomedical logic, individual care, centered on healing through medications and the exclusive care of the

health professional. It requires critical reflection on the therapeutic approach conventionally provided to students with learning disabilities and/or behavior problems. It requires the network to believe that appropriate answers and possible solutions will be built together, in the collective and mutual accountability (FIGUEIREDO, FURLAN, 2010).

CONTRIBUTIONS OF INTERSECTORIALITY PROMOTED BY THE PSE FOR THE DEMEDICALIZATION OF HEALTH CARE

The articulation between school and BHU, proposed by the PSE, aims to strengthen the adoption of a new model of care focused on health promotion, through the intersectoral action of multidisciplinary teams (BRASIL, 2009). It is noteworthy that, although there is no explicit indication in the program documents at national level, in the municipality studied, the Department of Social Assistance is inserted in the activities of the PSE since the beginning of its implementation.

In this study, we observed an effective involvement of the Health, Education and Social Assistance secretariats in the definition of goals, planning and execution of actions. It is important to reflect on the tendency of greater involvement of a specific sector in these programs, resulting in fragmented and centralizing actions, in which those involved are unable to overcome the boundaries of their sector or recognize the potential of other sectors to cope with problems that constitute common demands. This reality is verified by Sousa, Esperidião and Medina (2017), who highlight the protagonism of the health sector in planning, performing the activities, and evaluating the PSE in a municipality in the northeast region of the country.

Although the Ministry of Health does not require the insertion of sectors beyond Health and Education in the PSE, trials for effective approximations already exist, as shown by the study by Ferreira et al. (2014) in order to expand the scope of the Program's actions. These authors conducted research with managers from five municipalities in different regions of the country, most of which mentioned the approximation between health and education, as well as signaled approximations with other sectors such as universities, non-governmental organizations and Social Assistance policy.

The importance of communication at all levels of the intersectoral network must be reinforced to achieve effective work from the perspective of integrality of care. The valorization of intersectoral action, as well as the integral approach with interventions that consider the existing diversity in the school community, enables the establishment of a new meaning to health, where there is no more conceivable a look restricted to biological dimensions, risk factors and illness. Instead, the comprehension of health is broadened, as a process consisting of multiple dimensions, being influenced by an environment where the individual's experiences are considered (SILVA, BODSTEIN, CELE, 2016).

Despite the obstacles, the participants recognize advances in networking, involving other sectors to think about the difficulties recognized in the school:

[...] I think it's important to emphasize this work done together. I remember that years ago, in our class councils, when we raised our concerns about student learning, we realized that it would require a larger set of people for the benefit of the student. Firstly, we reached out to the family, which often did not answer or give the help expected. When we started working together, which was an idea that came from health, we started thinking, and we began to have a greater support and a greater courage to start investigating the origin of the problems and, consequently, seek solutions for them [...]. (Chrysanthemum, Education-C3).

To involve the health sector in the discussion of problems observed at school can broaden the understanding of the problems observed. However, it may also lead to the medicalization of daily difficulties and/or related to the pedagogical process, which begin to be understood as health problems.

Thus, when working from the perspective of integrality of health and under an intersectoral logic, support is generated for the education sector, as a teacher points out “[...] we don’t feel so alone, because we consider the student as a whole, all together. The student is not only a problem of mine, they are a problem of the whole team.” (Begonia, Education-C3). However, it is also a challenging process, permeated with obstacles and that requires questioning and constant reflexivity of the teams to be effective without further medicalizing the care directed to learners in the education field:

[...] I think working together was one of the most positive points of the last few years, this network that was formed. We can analyze that there are still many things that could be improved. Such as the time for us to gather, time to visit the family, time to arrange the meeting, bring the family. But, anyway, it’s a start and some results already show, and I think the right thing to do is continue [...]. (Chrysanthemum, Education-C3).

This new organization of health care, regulated by public policies, implies the adoption of collaborative practices. Thus, it is necessary to reinvigorate the principle of intersectoriality cited in the National Health Promotion Policy (PNPS), since this concept refers to the articulation of knowledge and the development of shared actions in order to reduce gaps, increase bonds and take the co-responsibility in formulating and managing common goals (BRASIL, 2014). Dias et al. (2016, p. 1797) contextualize that this new scenario of health services organization constitutes the “permanent exercise of defragmentation of actions and services to promote and enhance cooperative and resolute networks.”

In this sense, intersectoriality represents an initiative in the municipality to understand the biological, psychological, educational and sociocultural dimensions of the problems experienced by the students, as it allows the sum of individual knowledge, for the development of jointly planned actions, potentiated by the communication of collective knowledge.

We also emphasized the importance of developing the actions of the PSE in consonance with the political-pedagogical project of schools, as foreseen in the Program (BRASIL, 2015). With joint and integrated actions, between schools and health services, a favorable scenario is created to work in intersectoral mode from the perspective of integrality in health.

It is noteworthy that in the municipality studied, there are records from 2014 that point to intersectoral actions in the political-pedagogical project of municipal school units. However, when examining the data regarding the actions developed in the PSE, we found that, although these were planned in the intersectoral logic, some were implemented sectorially, with emphasis on actions of a clinical nature developed by the health sector, such as: anthropometric assessment; evaluation in oral health and ocular health. What is questioned and discussed is not the actions themselves, which are among the competencies of the health professional field, but the fact they are not articulated with actions of an educative nature, mobilizing reflection and promoting autonomy in the self-care of subjects, as reported by the PNPS (BRASIL, 2014).

If, historically, education and health policies were structured in a fragmented and sectorial functioning logic, the implementation of the PSE sought to break with this premise and allowed the

narrowing of the bonds between school, BHU and Social Assistance. To this end, joint actions between these services should be optimized, as the school is an institution with favorable scenarios to work in an intersectoral way, from the perspective of integrality of health. By achieving a large share of the population with a focus on education, the school becomes a potential agent of change, which can provide important elements for students in the construction of a healthy life (CARVALHO, 2016; FARIAS *et al.*, 2016).

To rethink the actions developed in the mental health field in the school environment and aiming at the best approach of the situations involving children and adolescents, the municipality studied agreed, in its Commitment Term, in 2013, with the action: “Mental health promotion in the school environment: creation of intersectoral groups of discussion on mental health actions in the school environment, along with the GTI-M.”

With the implementation of the PSE, the possibility of organizing the mental healthcare network for children and adolescents was raised, which generated the expectation of change in relation to the panorama of medicalization presented. Thus, in August 2014, the project “Health School Program: constructing intersectoral networks to demedicalize the school environment” began in the municipality studied. In this project, a group of professionals from the Health, Education and Social Assistance sectors, as well as the professionals who are members of the GTI-M, gathered periodically to discuss the demands and program actions aimed at students in the mental health field.

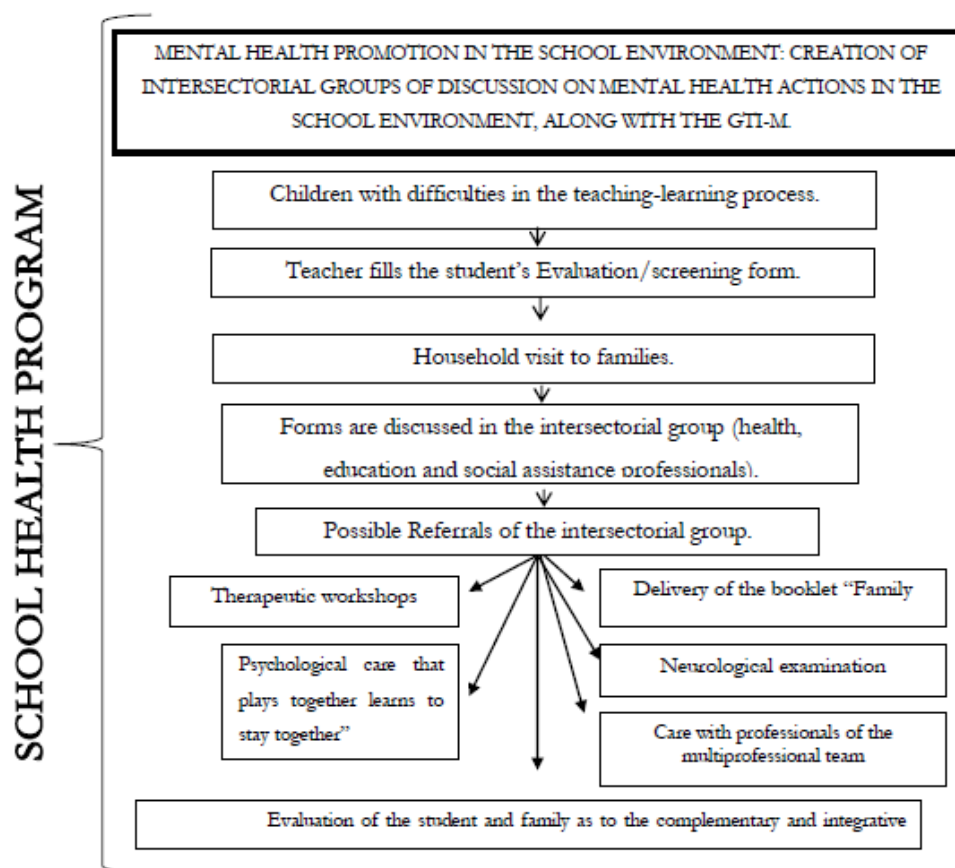
For the construction of the mental healthcare network and the establishment of a flow of attendance, the partnership between the intersectoral and multiprofessional team was established. Therefore, the first stage of the project, which subsequently constituted a continuous strategy, “was the survey of the difficulties of children who were struggling at school [...]” (Jasmine, Health-C2). This survey was carried out by the teacher who, “[...] by identifying difficulties in the teaching-learning process of a student, fills an evaluation form to refer to the GTI-M.” (BRAMBILLA *et al.*, 2016, p. 40).

The initiative to identify children’s difficulties in the teaching-learning process and discuss with the multidisciplinary and intersectoral team requires care from all those involved, so that the problem is not restricted to the student. As Pais, Menezes and Nunes (2016) says “the school brings up the first impressions about the need for a closer look at a potential problem that can lead to medicalization.” (p. 445).

After the referral of the assessments by the school, the records were discussed in a meeting of the Intersectoral Working Group, in order to understand specificities of the situation of each student, as well as to identify weaknesses and potentialities, which served as support to future referrals (BRAMBILLA *et al.*, 2016). To value information on the potentialities of the learner enables professionals to use welcoming strategies, as well as relief and minimization of suffering.

The figure below presents the flowchart of attendance to students with teaching-learning difficulties, organized from the project developed in the municipality.

Figure I – Flowchart proposed for attendance of students with difficulties in the teaching-learning process



Source: the authors (2017), from municipal documentary records.

According to the PSE management notebook, if there is a need to refer students to the healthcare network, the PSE teams, as well as the FHS and the Family Health Support Nucleus (NASF) must be involved, allowing the decision to be taken together, after exhaustive discussion of the case and joint construction of possible solutions, aiming at the integral health care of this student (BRASIL, 2011). This way, the individuality of each child is respected, avoiding the homogenization of the practices embraced and hypermedicalization.

After the GTI-M discussed the individual evaluation form, a household visit was conducted, in order to know the family dynamics, its social context and to get closer to the family. In this sense, “[...] the closeness to the family, the information about the individuals’ lives in the spaces they occupy, assists in the understanding of the phenomena that are present in the school.” (BRASIL, 2011, [s.p.]).

In the sequence, considering the skills and difficulties of each student, a follow-up was offered, namely: psychological care, referral to the neurologist, insertion in groups to strengthen bonds with the Social Assistance department, complementary and integrative practices, and psychopedagogical actions such as play therapy (BRAMBILLA *et al.*, 2016).

Regarding integrative and complementary practices, the PES articulators cite the use of Bach flower remedies as a measure employed to find “the best possible and less aggressive way to help” (Veronica, Health-C1). The participants emphasize that the approach with flower remedies not only makes the active principle available, because it would remain focused on the child, but it anticipates the change of focus, which considers social determinants of the health-disease process and the principle of

integrality in the definition of the therapeutic process. Moreover, it values the biopsychosocial context, as it inserts the family into the process and values the subjectivities of the learner.

In addition, we verified that the team sought strategies to enhance the potential of the healthcare network and other sectors, such as the development of groups, in which children and, at certain times, their families, would be mobilized through differentiated techniques such as play therapy.

For this change of route, we count with integrated actions of the reference team of Primary Care, school professionals and CRAS and CREAS. Thus, the participants argue that the project allowed advances in care, from the perspective of intersectoral work: “[...] with the creation of the GTI, with the formation of these three sectors, Education, Health and Social Assistance, I think we improved the condition of deciding these cases in a broader way to have a correct referral [...]” (Lily, Health-C1). “This marriage, Health and Education, was perfect! Of course nothing is perfect; but, anyway, very pertinent! Because the questions about what Health or Education have marry with the Social, there is no way to separate it.” (Globe amaranth, Education-C1).

To strengthen the implementation of PSE actions in the municipality, the participants highlight the importance of qualification, corresponding to component III of the agreement: “and we need support. We need lectures, we need qualification.” (Rose, Education-C4).

Training activities were organized by members of the GTI-M and Program articulators and were aimed at the three sectors: Health, Education and Social Assistance. In addition to the moments when the team was meeting for training processes, there were discussion meetings on specific subjects, according to evidence in documentary records. I highlight the title of article published in 2014 in local circulation newspaper: “MUNICIPAL GTI OF THE PSE HAS ORGANIZED MEETINGS,” which deals with the cycle of meetings in schools. The action was organized intersectorially to discuss the implementation of the mental health project.

In this sense, the professionals emphasize that the PSE enabled important advances related to education, signaling for themes related to sexuality and medicalization. Regarding medicalization, the participants emphasize that, based on the PSE actions, they began to reflect on the challenges of the context that permeates this theme.

Given these considerations, the intersectoral articulation, proposed by the PSE, proved to be an important tool for contemplating and addressing more appropriately the complexity of the relations that permeate the process of medicalization of care provided to students in the school environment. Although there are several obstacles in the process, the intersectoral team has built a service network, with significant potential to contribute to the integrality of care in the school environment of the municipality. In this sense, we can visualize the positive impact of PSE on the territory through the flowchart of attendance developed in the project. This is a healthcare network (RAS) that is gradually being consolidated from the intersectorial perspective.

FINAL CONSIDERATIONS

The cartography performed in this study showed that the PSE helped the public policy professionals involved to recognize and face, even if not uniformly, the process of medicalization of care provided to students in the school environment present in the territory. In this movement, we observed the predominance of actions centered on the health sector, especially regarding the neurologist, which triggered a fragmented, medicalizing and standardized care, without solving the difficulties of children, schools or families.

The PSE, through intersectoral articulation, planned and performed actions aimed at integral care that generated demedicalization. This articulation, despite the challenges, was set up as a potentiality of the Program in the municipality studied, because it promoted the implementation, unprecedented in that context, of planned actions involving the sectors Education, Health and Social Assistance, broadening the perception of the problems involving the students, as well as the range of actions promoted by the professionals.

Thus, confronted with a difficulty previously faced only with psychotropic drugs, with a restricted communication between school and health service, we discussed the cases in multidisciplinary teams and intersectorally. In the care of the health sector, the therapeutic offerings were diversified, including, for example, the PICs and involving other professionals other than the physician. We sought other strategies to involve families in the actions and to promote psychopedagogical actions to address the limitations of the pedagogical process.

The project implemented in the municipality, through the PSE, was a strategy for integral care with potential for the demedicalization of care in students in the school environment, to which the cartographic work also contributed, aiming at its interventive dimension, which is visible with conversation wheels and workshops. However, it also evidences that the simple approximation between the health and education sectors, which does not involve reflected practices and the co-responsibility of the different professionals, can strengthen the medicalization of health by expanding students' access to health professionals.

Funding institution: Research Support Fund of the Community University of Chapecó Region – UNOCHAPECÓ.

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Submission: 14/12/2018

Approval: 03/09/2019