Trajectory of the 15 years of implementation of the School Health Program in Brazil

Trajetória dos 15 anos de implementação do Programa Saúde na Escola no Brasil

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ABSTRACT The aim of this study is to analyze the evolution of the implementation of the School Health Program (PSE) over its 15 years in Brazil. A mixed methodological approach was used, involving a combination of document analysis and ecological study with secondary data from 2007 to 2021 recorded in the historical process of implementing the PSE in Brazil. It was observed that in these fifteen years the PSE has advanced not only significantly impacting the percentage of municipalities that joined the Program, but also in its structure and format, having the territory as the main locus of its development, and the articulation between health and education as the driving strategy of local arrangements. Furthermore, the PSE's intersectoral management model helps the articulation of health and education networks in an interfederative manner. Therefore, this historical analysis gives an overview of school health in Brazil from the perspective of the PSE and provides the perspective of improvement necessary for the sustainable and qualified continuity of the Program.

KEYWORDS School health services. Intersectoral collaboration. Health promotion. Primary Health Care. Public policy.

RESUMO *O objetivo deste estudo foi analisar a evolução da implementação do Programa Saúde na Escola (PSE) ao longo dos 15 anos no Brasil. Utilizou-se a abordagem metodológica mista, envolvendo a combinação de análise documental e estudo ecológico com dados secundários de 2007 a 2021 registrados no processo histórico de implementação do PSE no Brasil. Observou-se que, nesses 15 anos, o PSE avançou não somente impactando expressivamente no percentual de municípios que aderiram ao Programa, mas também na sua estrutura e formatação, tendo o território como principal lócus do seu desenvolvimento e a articulação entre saúde e educação como a estratégia propulsora de arranjos locais. Ademais, o modelo de gestão intersetorial do PSE auxilia a articulação das redes de saúde e de educação de forma interfederativa. Portanto, esta análise histórica dá um panorama da saúde escolar no Brasil sob o prisma do PSE e provê a perspectiva de aprimoramento necessária para a continuidade sustentável e qualificada do Programa.*

PALAVRAS-CHAVE *Serviços de saúde escolar. Colaboração intersetorial. Promoção da saúde. Atenção Primária à Saúde. Política pública.*

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Introduction

Interlocution between the health and education sectors has been registered in Brazil since the last century, evolving from hegemonic models to more participatory school health models in the late 1980s, influenced by the global discussion on health promotion endorsed at the I International Conference on Health Promotion, in 1986. In the same period, in Brazil, the VIII National Conference on Health, based on a concept of health consistent with the expanded project of citizenship, solidified the social right to health and education guaranteed in the Federal Constitution of 1988. This norm, in turn, is the great regulatory framework for national public policies for each of these sectors, with provision for integrated policies, that is, that unite efforts in favor of both social rights[1,2].

The post-constituent educational system of 1988 already contemplated the integration of several themes through the National Curriculum Parameters (PCN). In 1997, the transversal themes stood out. In this approach, the transversal treatment of themes that considered social problems in relation to ethics, health, environment, cultural plurality, sexual orientation, work and consumption was prescribed, in order to contemplate them in the school in their complexity. The PCNs ended up attaching the health theme in the political-pedagogical projects of schools and are still present to this day in textbooks and curriculum guidelines[3]. The Unified Health System (SUS), launched in 1990 based on the Federal Constitution of 1988 and the VIII National Health Conference, brings health in an expanded concept, listing education as one of its determinants and conditions[1–3].

Some school health initiatives at the national level at the time also favored dialogue between the sectors, and the Ministries of Health (MS) and Education (MEC), for the construction and consolidation of this intersectionality. This process was supported by international organizations, such as the Pan American Health Organization/World Health Organization (PAHO/WHO), in developing the Regional Initiative of Health-Promoting Schools in 1995, and in devising the Latin American Network of Health-Promoting Schools in 1996[4]. The proposal of the WHO Health Promoting Schools and its initiatives helped to reflect on the school health model adopted by Brazil and to value the existing practices in each locality, later reflecting in new partnerships, such as the 'Schools Project' between 1994-1999, the 'Leap to the Future' from 1999 to 2000, the 'Health and Prevention in Schools' from 2003 to 2006, and the 'More Education Program' from 2007 to 2016[1,4,5].

It is worth noting that these efforts stemmed from the concern for the achievement of the Millennium Development Goals in the region in the Americas, therefore, other organizations also participated, such as the United Nations Educational, Scientific and Cultural Organization (UNESCO) and also the United Nations Children's Fund (UNICEF), among others, in various agendas aimed at the school public[4,5].

Thus, in the 2000s, the ground was prepared for the construction of a genuinely Brazilian proposal of public policy for school health, based on the rights and organization of Brazil, and with recognition of international practices on the subject, reflected in its guidelines. Therefore, the School Health Program (PSE), established in 2007 by Presidential Decree No. 6,286, was formulated and structured in an intersectoral way as a response by the federal government to an international demand for health promotion and disease prevention in children, adolescents and young people in school age, and with the objective of contributing to the integral formation of students in the public basic education system[6].

In the field of health, the SUS represents this guarantee of comprehensive health care, which organization includes decentralized and basic services such as Primary Health Care (PHC), as in education, basic education as a segment that represents decentralized

access to processes training courses for full development and preparation for the exercise of citizenship. In this way, the PSE looks at the public school as a social space capable of moving actors in the territory towards a common objective: the full development of the student. In this sense, since its institution, in 2007, until the present day, the PSE is added to several milestones in this trajectory of responsibility for the integral development of the Brazilian student.

Considering the progress of schoolchildren's health in Brazil, especially from the formalization of the PSE, the objective of this study is to analyze the evolution of the implementation of the Program in Brazil in its 15 years of existence.

Material and methods

A mixed methodological approach was used, involving the combination of document analysis and the ecological study of secondary data from PHC information systems from 2007 to 2021. This methodology was used to analyze the historical course of the PSE in Brazil, passing through the description of the implementation process of the Program throughout its 15 years of existence, celebrated in 2022.

The documentary corpus gathered manuals, technical notes, guidelines and normative acts obtained through the analysis of the files made available by the Program in the MS and MEC, as well as by searching the legislation registration systems. Data was submitted to thematic content analysis.

A descriptive analysis was carried out of the data from the adhesions to the Program, namely: number of adhered municipalities, schools and students associated, and total activities carried out and participants in the PSE actions. This information was obtained through the e-Gestor PHC platform, which brings together the records contained in the Health Information System for Primary Care (SISAB) and other PHC systems[7].

Data on activities carried out and participants in PSE actions comprise information from the Collective Activity Sheet from 2014 to 2021, which was extracted on April 22, 2022, according to the methods adopted on the monitoring of the Program[9]. Microsoft Excel® and Statistical Package for the Social Sciences (SPSS®) software were used to process the data. As for the statistical procedures, descriptive statistics of the PSE actions were performed by calculating absolute and relative frequencies. The distribution of adhered municipalities was performed using the georeferencing application QGIS® version 3.18.

It is noteworthy that, for the activities and participants of the PSE actions from 2008 to 2013, it was not possible to extract data from the MS and MEC information systems due to the absence or lack of information comparison.

Results and discussion

The structure and formatting of the PSE has the territory as the main locus of its development, and the articulation between health and education as the driving strategy of local arrangements to guarantee its realization. Thus, it follows the same logic of structuring the PHC, which has territorialization as a guideline, and as an assignment to carry out intersectoral actions in health education, according to the population's needs. This territory goes beyond geographic demarcation and is in constant movement, being produced and shared by the social networks that form it. In this way, the PSE established this notion of shared territory as the core of its actions, considering that the demarcation of territory, for the actions of the health sector and for the education sector, is different. For education, the territory is reduced to the school, with autonomy within that space. As for health, within the scope of PHC, the territory is structured through horizontalities that constitute a network of services that must be offered by the State

to every citizen, with its organization and operationalization in the geographic space guided by the Federative Pact and by normative instruments that ensure the principles and guidelines of the SUS[1,6,8].

The PSE's intersectoral management model proposes the articulation of health and education networks in an intra and inter federative way, based on this strategic view of the territory, in cooperation processes in each administrative sphere and between the three, based on the federal, state and municipal Intersectoral Working Groups (GTI), which are configured as governance spaces and act with autonomy for the adjusted execution of the Program proposals in line with local conditions and demands, without prejudice to the technical and legal identities of the PSE, in view of overcoming fragmentation and integrating actions across sectors. This shared management space came from the regional and local articulation of health experiences in schools prior to the PSE, which training listed representatives of health, education and social assistance, and other local sectors that are necessary for comprehensive management, which remains present in the coordination of the PSE to this day[1,4,5].

At the federal level, the coordination of the program is shared between the MS and the MEC. Therefore, the PSE decree determined the constitution of an inter-ministerial commission in a joint act; and, therefore, the Intersectoral Commission on Education and Health at School (CIESE) was created, through Inter Ministerial Ordinance No. 675, of June 4, 2008, with the purpose of establishing guidelines for education and health policy at school. In this way, it replaced the expanded discussion committee on the creation of a National Policy on Health Education at School, created in 2005, which had the participation of representatives from the Ministry of Health, the MEC and from various areas and agencies and foundations, such as the National Health Surveillance Agency (ANVISA), the National Health Foundation (FUNASA), the Oswaldo Cruz Foundation (FIOCRUZ)[6,9,10].

Currently, CIESE is not active as determined in the ordinance, however, in place of and in recognition of the GTI, at the federal level, meetings are held between the PSE management areas in each ministry. In MS, the management of the Program is in the Office of the Department of Health Promotion of the Secretariat of Primary Health Care (DEPROS/SAPS/MS) – having previously been linked to the former Office of the Department of Primary Care (DAB/SAS/MS), the General Coordination for Food and Nutrition (CGAN/DEPROS/SAPS/MS) and the General Coordination for the Promotion of Physical Activity and Intersectoral Actions (CGPROFI/Depros/Saps/MS). At MEC, the PSE was in the General Coordination of Complementary Educational Actions (CGAEC) of the Directorate of Integral Education, Human Rights and Citizenship (DEIDHUC), in the then Secretariat of Continuing Education, Literacy, Diversity (SECAD), moving on to the Coordination-General of Integral Education (CGEI) of the Management of Curriculum and Integral Education (DCEI), in the Secretariat of Basic Education (SEB)[11] – later, it was in the Management of Policies and Regulation of Basic Education (DPR/SEB/MEC), and today it can be found at the Management of Policies and Guidelines for Basic Education (DPD), specifically in the General Coordination of Strategic Management of Basic Education (COGEB/DPD/SEB/MEC).

In another broader and more technical space of federal management, there is the participation of representatives of several federal institutions and agencies: the Technical Collective of the PSE. This Collective is configured as a plural space for discussion on materials, results and products of the Program, bringing together technical areas from various secretariats of the MS, the MEC, the Ministry

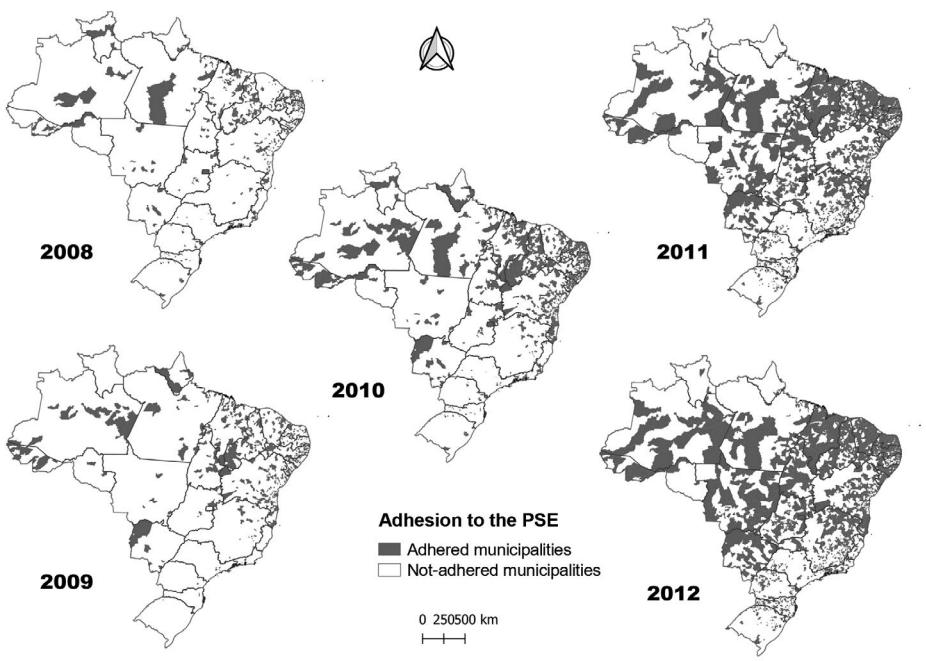
of Women, Family and Human Rights and the Ministry of Citizenship, and others institutions such as: UNESCO, PAHO/WHO, UNICEF, National Fund for the Development of Education (FNDE), National Cancer Institute (Inca), Fiocruz/Brasilia, among others.

In this way, the MS and MEC make up the federal GTI and are responsible for managing, encouraging and monitoring the implementation of the PSE at the national level, in order to be a mobilizer in the states and in the Federal District (DF) for the construction of collectives spaces, for exchanges and continuous learning, in order to increase the ability to analyze and intervene in health and education processes. The state GTI is responsible for offering institutional support and mobilizing the municipalities in its territory, while the municipal GTI supports the implementation of the PSE and enables integration and joint planning between school teams and PHC teams[10].

Adhesion to the PSE

Since the launch of the PSE, the Program has been voluntarily agreed upon by the municipalities through the Municipal Health and Education Secretaries, according to varied participation rules defined over the years. In 2008, the PSE was implemented in a small number of municipalities that expressed their intention to participate in the Program, following criterias that were initially based on the vulnerability profile of students in the public school system. These criteria were gradually modified and expanded so the Program could cover larger numbers of municipalities. Thus, in 2008, about 11% of Brazilian municipalities participated in the PSE, while, in five years, this percentage reached 44.8% of the country. *Figure 1* shows the distribution of municipalities participating in the PSE over the years, with an initial concentration predominance of the North, Northeast and Central-West regions.

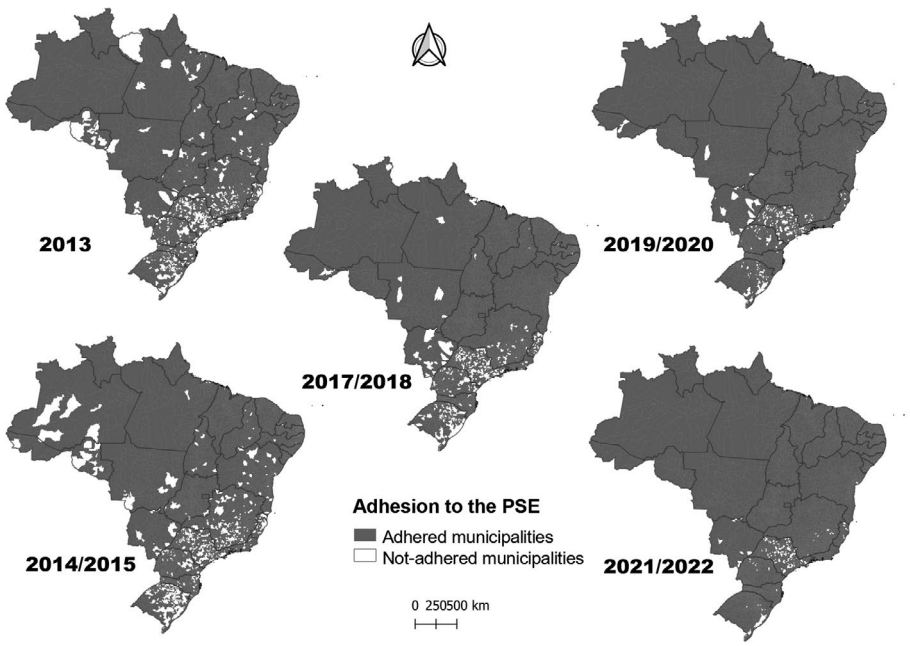
Figure 1. Spatial distribution of municipalities adhering to the PSE from 2008 to 2012. Brazil, 2022



Source: Own elaboration.

Since 2013, the PSE has become widespread, allowing all Brazilian municipalities to adhere to the Program, a fact that significantly impacted the percentage of participating municipalities. This expansion is reflected in the percentages of Brazilian municipalities adhering, which reached 87.3% of the country in 2013 – and the increase remained in the 2014/2015 bienniums, in which 85.9% adhered; in 2017/2018, with 90.5% of municipalities; and in 2021/2022, in which 97.3% of the territory is included in the Program. *Figure 2* shows the increase in adherence in the North, Northeast and Central-West regions, to the point that all municipalities in certain states of these regions adhere to the PSE, while there are municipalities in the Southeast, mainly in the state of São Paulo, which remain unaffiliated adhered. The total number of municipalities and the characteristics of the adhesions are described in *box 1*.

Figure 2. Spatial distribution of municipalities adhering to the PSE from 2013 to 2022. Brazil, 2022



Source: Own elaboration.

Adherence to the PSE, throughout this 15-year implementation process, involves the selection of public schools from the basic education network, the number of students at all levels of education and the included health teams. In the beginning, it was necessary to sign a Term of Adhesion, later published in the Government Gazette, and the elaboration of a municipal project to carry out the actions, which was submitted to management bodies for later validation by the MS and MEC.

In 2011, the Term of Adhesion was replaced by the Term of Municipal Commitment, with the same objective as the previous one, however, in this instrument, the program's actions began to be divided into the following Components: Component I – Psychosocial Clinical Assessment (later stated as Assessment

of Health Conditions); Component II – Health Promotion and Disease Prevention; and Component III – Continuing Education and Training of Health and Education Professionals and Young People (later called Training). From that moment on, the submission of a municipal action project to state and federal management bodies was no longer requested[12].

The components resumed a conflict between the paradigms of biomedical school health and those of health promotion, especially by Component I, which focused on the physical health of students when assessing oral, eye, hearing, mental health, verification of vaccination status, or even the early detection of arterial hypertension. On the other hand, Component II addressed the promotion of physical activity, healthy eating, prevention of violence, as well as incorporating the Health and Prevention in Schools project, which worked on sexual and reproductive health and the prevention of the use of alcohol, tobacco and other drugs[11]. In 2012, a workshop was held with the participation of the state GTI and the Technical Collective for conceptual alignment on the PSE components and the actions to be developed in each component, such as changing the titles of the components, withdrawing the detection of hypertension of Component I and the inclusion of actions on topics such as promoting a culture of peace and human rights, mental health and environmental health in Component II[10,13].

Thus, in 2013, a list of essential actions of the Program was established, of mandatory agreement by the municipalities, based on the main Government Plans and Projects then in force: No-misery Brazil Plan – Tender Brazil Action; Crack Cocaine Program, It's Possible to Win; Living Youth Plan; National Plan to Combat Chronic Noncommunicable Diseases; Project Brazil Look; Smiling Brazil Program; Care Line for the Prevention and Treatment of Overweight and Obesity; Promotion of a Culture of Peace and Human Rights.

During this period, the Municipal Term of Commitment was made available annually, published on official websites for completion by the municipality's Intersectoral Working Group, this time without the requirement of passing through collegiate bodies. As of 2017, and until the present day, the signing of the Term takes place on the e-Gestor APS platform, available on a biennial basis during the period of adhesion to the Program[14].

Between 2008 and 2012, the membership criteria were based on the Basic Educational Development Index (IDEB); in the coverage of the Family Health Strategy (ESF); in the municipalities that had schools participating in the Mais Educação Program in their territory; and in schools with more than 50% of students benefiting from the Bolsa Família Program. In other words, only municipalities that had this profile could join the PSE until 2012. As of 2013, the Program allowed all municipalities to join, and the criteria became related to the adherence of at least 50% of schools considered a priority – with specific characteristics based on aspects of social vulnerability (*box 1*).

Box 1. Criteria and characteristics for joining the PSE from 2008 to 2021. Brazil, 2022

Adhesions*	Adhesions Criteria	Adhered municipalities	Agreed Schools	Agreed Students	Agreed health teams**	Adherence reference ordinances	Other published PSE ordinances
2008	100% ESF coverage, IDEB less than or equal to 2.69, and municipalities with schools participating in the More Education Program	613	16,470	1,941,763	5,130	Ordinance No. 1,861, of September 4, 2008; and Ordinance No. 2,931, of December 4, 2008	Interministerial Ordinance No. 675, of June 4, 2008
2009	70% ESF coverage and IDEB less than or equal to 3.1	640	20,422	6,560,649	3,884	Ordinance No. 3146, of December 17, 2009	-
2010	70% FHS and IDEB coverage less than or equal to 4.5, and municipalities with schools participating in the More Education Program	1,253	36,892	8,502,412	9,014	Interministerial Ordinance No. 3,696, of November 25, 2010; and Ordinance No. 3,918, of December 10, 2010	Ordinance No. 790, of April 12, 2010; Ordinance No. 1,537, of June 15, 2010
2011		2,271	50,545	10,835,238	12,899	Interministerial Ordinance No. 1910, of August 8, 2011; Interministerial Ordinance No. 1911, of August 8, 2011; and Ordinance No. 3014, of December 20, 2011	-
2012	70% FHS coverage and IDEB less than or equal to 4.5, municipalities with schools participating in the More Education Program, and municipalities with schools with more than 50% of beneficiaries of the Bolsa Família Program	2,495	56,157	11,946,778	14,237	Ordinance No. 2,693, of November 29, 2012; and Ordinance No. 298, of February 28, 2013	Ordinance No. 357, of March 1, 2012; Ordinance No. 524, of March 26, 2012
2013	All municipalities with 50% priority schools	4,864	80,435	18,726,458	30,068	Interministerial Ordinance No. 1413, of July 10, 2013; Ordinance No. 2,608, of October 31, 2013; and Ordinance No. 3210, of December 26, 2013	Ordinance No. 364, of March 8, 2013; Ordinance No. 1,302, of June 28, 2013; Ordinance No. 1,835, of August 27, 2013
2014/ 2015***		4,787	79,167	18,313,214	32,317	Ordinance No. 1067, of July 23, 2015	Ordinance No. 220, of March 25, 2014; Ordinance No. 798, of June 17, 2015; Ordinance No. 1,260, of August 27, 2015; Ordinance No. 1,337, of September 8, 2015
2016*	-		-		-	-	Ordinance No. 2,744, of December 16, 2016
2017/ 2018	Every 2 years, all municipalities with 50% of priority schools	5,040	85,700	20,521,416	36,990	Interministerial Ordinance No. 1055, of April 25, 2017; and Ordinance No. 2,706, of October 18, 2017	Ordinance No. 895, of June 19, 2018; Ordinance No. 3,662, of November 14, 2018

Box 1. (cont.)

Adhesions*	Adhesions Criteria	Adhered municipalities	Agreed Schools	Agreed Students	Agreed health teams**	Adherence reference ordinances	Other published PSE ordinances
2019/ 2020		5,289	91,659	22,425,160	-	Ordinance No. 2,264, of August 30, 2019	Ordinance No. 564, of July 8, 2020; Ordinance No. 1,857, of July 28, 2020; Ordinance No. 2027, of August 7, 2020; Ordinance No. 2,141, of August 14, 2020; Ordinance No. 2,306, of August 28, 2020
2021/ 2022		5,422	97,389	23,426,003	-	Ordinance No. 1,320, of June 22, 2021	Interministerial Ordinance No. 5, of August 4, 2021

Source: Own elaboration.

*In 2016, there was no adhesion. **Primary Health Care teams were linked to the schools agreed upon at the time of joining, however, as of 2017, there is no longer a need to link. ***The 2014 membership was maintained in 2015.

In the 2013 and 2014/2015 adhesions, at least 50% of the total number of educational establishments selected to participate in the Program should have the following characteristics to be considered priority schools: public or private day care centers; rural schools; schools participating in the PSE in the previous year; schools participating in the Mais Educação Program in the previous year; schools that had, in the previous year, adolescents enrolled in compliance with socio-educational measures; schools that have at least 50% of the enrolled students belonging to beneficiary families of the Bolsa Família Program. As of 2017, these criteria remain in effect for membership, except for the criteria of prior agreement and participation in the Mais Educação Program. These vulnerability criteria, added to the increase in the adhesion of the municipalities over time, allowed the agreement of more than 97 thousand schools and 23 million students in the adhesion of 2021/2022, the highest result of the period (*box 1*).

PSE funding incentive

The financial incentive for the maintenance of PSE actions is part of the Public Health Actions and Services Costing Block, that is, it must be used for the implementation and maintenance of the Program's funding actions, its use being prohibited for the acquisition of permanent material[15]. This resource is transferred, as a rule, annually by the MS in a single installment, fund by fund, from the National Health Fund to the Municipal Health Funds, and from 2008 to 2012, an extra monthly installment was transferred to the PHC teams that worked in the PSE. In addition, there was also a transfer of funds by the MEC, aimed at financing materials for the implementation of the PSE.

As of 2011, the transfer was structured in such a way that 70% of the total amount of the financial resource from the PSE would be paid from the signing of the Term of Commitment and the remaining 30% of the total amount of the financial resource would be paid after the fulfillment of 70 % of agreed municipal targets. In 2012, with the beginning of the expansion

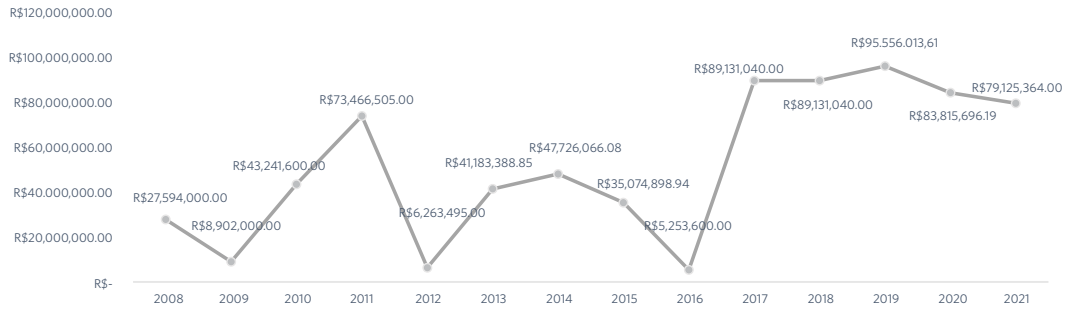
process of the PSE, fund transfer bands were established according to the number of students, adding R$ 1 thousand, per year, from 1 to 200 students, plus the same amount for each range. In 2013, the transfer of the signing was carried out in 30% of the amount corresponding to an extra portion of the incentive transferred to the PHC teams, and the remaining 70% upon compliance with the agreed municipal targets. In addition to these transfers related to adherence and monitoring, transfers related to the activities of the Health Week at School were provided, and in 2013, the amount of approximately R$ 558.30 per participating FHS was transferred.

The School Health Week, established by Ordinance nº 357, of March 1, 2012, is a mobilization of the school community based on an annual theme defined by MS and MEC, with the aim of drawing attention to the importance of good practices and health conditions to improve student development. Financial transfers were foreseen between the years 2012 and 2014 for the municipalities that expressed interest and informed the actions carried out in a defined period, in the PSE monitoring system. Since 2015, this mobilization has been redefined by Ordinance No. 798, of June 17, 2015, becoming the free initiative of federal entities interested in participating in the mobilization, without the need for prior adhesion[7,10].

Interministerial Ordinance No. 1,413, of July 10, 2013, which redefined PSE membership and expanded membership to all Brazilian municipalities, also changed the amounts and the form of transfer when considering the amount of R$ 3 thousand for the band from 1 to 599 students, and the addition of R$ 1 thousand for each band from 1 to 199 that exceeds 599 students. The financial resources were transferred upon joining the Program, in the percentage of 20% of the agreed annual amount, and the remaining 80%, transferred upon reaching, at least, 50% of the agreed target. Thus, consolidating the form of annual transfer in the adhesion to the Program and a second transfer referring to the accomplishment of the goals, according to the monitoring of actions[13].

The current financial incentive is expressed in Interministerial Ordinance No. 1,055, of April 25, 2017, with values corresponding to R$ 5,676.00 for the range from 1 to 600 students and the addition of R$ 1 thousand for each range from 1 to 800 that exceeded 600 students, transferred upon enrollment. In addition, the transfer related to the monitoring and conditioned to the fulfillment of the monitored targets, based on the same amount transferred in the adhesion[7,14]. The history of transfers until 2021 is shown in *graph 1*, which represents this variation in transfers, between values corresponding to adherence and compliance with agreed targets. Currently, this amount corresponds to approximately 89 million reais per year. As a result, from 2008 to 2021, more than BRL 725 million in ordinary PSE resources were transferred to municipalities.

Graph 1. History of PSE annual transfers from 2008 to 2021. Brazil, 2022



Source: Own elaboration.

Extraordinary transfers may occur as described in Interministerial Ordinance No. 1,055/2017. In this sense, the most expressive amount of extraordinary transfer was the incentive for the safe resumption of face-to-face classes in the context of the COVID-19 pandemic, an amount of R$ 454,331,202.00, transferred, in 2020, by Ordinance nº 1,857, of July 28, 2020. This transfer in a single installment was intended to encourage activities to prevent COVID-19 within the scope of the PSE, in addition to the other actions of the Program[14-16].

PSE actions

In 2017, the PSE actions were no longer grouped into components, leaving, in joining the PSE, the commitment to carrying out actions to: combat the *Aedes aegypti* mosquito (later adopted the term environmental health as a technical alignment); promotion of bodily practices, physical activity and leisure in schools (later called physical activity promotion); prevention of the use of alcohol, tobacco, crack cocaine and other drugs (with the focus on crack cocaine removed later, in detriment of other drugs); promotion of a culture of peace, citizenship and human rights; prevention of violence and accidents; identification of students with possible signs of diseases in process of elimination (or Prevention of neglected diseases); oral health promotion and assessment, and topical application of fluoride (or just Oral Health); verification and updating of the vaccination status; promotion of healthy eating and prevention of childhood obesity; promotion of hearing health and identification of students with possible signs of alteration (or just Hearing health); eye health promotion and identification of students with possible signs of alteration (or just Eye health); and Sexual and Reproductive Right and Prevention of Sexually Transmitted Diseases/Acquired Immunodeficiency Syndrome (STD/AIDS) (renamed to Sexual and Reproductive Health and HIV/STI Prevention)[10,14].

As mentioned, in 2019, based on the discussions of the PSE Technical Collective, the nomenclature of the actions was revised, and the new denominations were adopted in the Program's materials and publications. Thus, currently, the PSE presents a list of 13 actions, with the 12 actions listed above plus the COVID-19 prevention action, included in the Program by Ordinance No. 564/SAES/MS, of July 8, 2020, as a result of of the new coronavirus pandemic[16].

The mental health action, provided for in the decree establishing the PSE and implemented until 2015, initially focused on verifying the civil registration of schoolchildren, later on discussing the topic in the GTI;

however, its current approach was restricted to actions to promote a culture of peace and human rights, prevention of accidents and violence, and prevention of alcohol, tobacco and other drugs[6,10-14].

Monitoring of PSE actions

During the implementation of the Program, the monitoring of actions and the evaluation indicators were reviewed. Between 2008 and 2010, monitoring and evaluation in the PSE involved monitoring only the planning of actions through a MS web form (FormSUS), which was discontinued in 2021 by the MS itself. As of 2011, the actions were actually recorded, according to the components, by health and education professionals, exclusively in the PSE module in the Integrated Monitoring, Execution and Control System of the Ministry of Education (SIMEC). With the creation of SISAB by MS, in April 2013, Component I records started to be monitored by SISAB while Component II was registered with SIMEC, until 2015, and goals were defined for each action, being a quantitative number of agreed students[10].

Only in 2017, with the redefinition of the Program by Ordinance No. 1,055/2017, SISAB became the only information system for monitoring PSE actions, which registration occurs only by health professionals and managers, and the indicators and targets are defined by a guiding document of evaluation standards for the adhesion cycle to which the transfer of resources is linked. Thus, in 2017, it was established that all participating schools should carry out Program actions and that actions to combat *Aedes aegypti* should be carried out in 100% of schools. In 2019, these goals were changed, and the participating municipalities needed to carry out at least one of the actions considered a priority in that cycle, namely: environmental health, promotion of healthy eating, promotion of physical activity, verification of the vaccination status and prevention of the use of alcohol, tobacco and other drugs. In 2021, due to the pandemic and the drop in the execution of the Program's actions (even with the possibilities of carrying out remote or hybrid activities), municipalities were instructed to carry out, at least, actions to prevent COVID-19 and other two other PSE actions, according to municipal planning[7,14].

SISAB is a PHC system that gathers validated health information data, whose registration takes place through the e-SUS strategy, through the data collection tool called Collective Activity Form, that presents the reference fields for the PSE[9] monitoring. The annual monitoring process was little disseminated and appropriated by PSE managers between 2014 and 2018, so in 2019 the federal management employed the preparation of national technical notes, the submission of state reports, and the publication of studies using these bases for transparency and dissemination of the Program's monitoring processes[17].

When analyzing the data from SISAB (*table 1*), it is observed that the number of activities and participants in the PSE actions gradually evolved from 2014 to 2019, reaching a greater number of agreed schools, with a coverage percentage of 18.8% and 63.3% respectively. This progression was interrupted in 2020, by the pandemic of the new coronavirus, with results presenting the lowest value of the period, reaching only 17.8% of the agreed schools; however, in 2021, these numbers rose again (40.9%). This demonstrates that the record of actions carried out within the scope of the PSE was expanded – and the reach of the agreed schools followed the growth – and that, after the first year of the pandemic, this process was resumed, reflecting the improvement of the scenario and driven by the guidelines of federal management[7,16].

Table 1. Absolute number of activities, participants and schools, and percentage of coverage of PSE actions from 2014 to 2021*, Brazil, 2022

Variables	2014	2015	2017	2018	2019	2020	2021
Activities of PSE actions	228,675	347,101	693,462	999,427	1,417,916	135,495	540,200
Participants in PSE actions	10,961,177	13,695,398	31,795,291	43,964,215	59,854,094	6,851,005	25,087,567
Schools that carried out actions	14,895	22,039	38,349	45,420	58,010	16,290	39,792
Percentage of coverage of actions in agreed schools (%)	18.8	27.8	44.7	53.0	63.3	17.8	40.9

Source: Own elaboration based on Sisab data in April/2022[7].

*In 2016, there was no adhesion.

Association of PSE with BNCC

An important convergence between the health and education sectors, which dialogues with the approach of PSE actions, occurred with the publication of the National Common Curricular Base (BNCC), in 2017, a document that defines the set of essential learning that all students should develop throughout basic education, guaranteeing their learning and development rights. The PSE actions are present in the health and multiculturalism macro areas of the BNCC, especially in the contemporary cross-cutting theme 'health – food and nutrition education', however, it is possible to identify the PSE themes in other macro areas. In this way, all health actions at school, listed throughout the article, and other health topics are covered in competencies and skills of the curricular components of basic education[18].

The health theme is present in the eighth competence of the BNCC, in which the student, at the end of the educational process, must know himself, appreciate himself and take care of his physical and emotional health, understanding himself in human diversity and recognizing his emotions and those of others, with self-criticism and the ability to deal with them, in addition of being discussed in several areas at all stages of basic education, such as natural sciences and human sciences, which, in turn, resumes principles of the National Promotion Policy of Health when addressing health and its determinants that transcends the transmission of knowledge about the health-disease process[19].

Thus, the health theme in the BNCC and its relationship with the PSE, not only in the document, but also in the insertion of the Program in the Directorate of Policies and Guidelines for Basic Education of the MEC, as well as in the Department of Health Promotion of the Ministry of Health, is a favorable conjuncture to overcome the focus on disease and injury prevention processes through fragmented practices[20], for a model of health at school truly based on the principles of health promotion, aiming at the integrality and the full development of students, and the result of the intersectoral work in all administrative spheres.

Final considerations

The national scope of the PSE, present in this 2021/2022 cycle in 97% of the national territory, mentioned above, demonstrates the power of work in health promotion, from the expanded concept of health and integral education, in which all are considered the aspects of life. In this way, the high acceptance of the Program by the states and municipalities is verified, noting that the path traced with respect to the specificities of the different Brazilian realities of childhood, adolescence and educational processes has proved to be

effective, in accordance with what the National Health Promotion Policy recommends.

In this sense, the historical analysis of public policies makes it possible to know the management strategies adopted for implementation and the impacts generated in the lives of the population. In this way, the attentive look at the PSE – in its nuances and intra and intersectoral challenges – proposed by this work, allowed the consolidation of the positive results of its implementation and development in these 15 years of existence. Thus, through the PSE, the sum of efforts of these two areas – health and education – for the well-being of children and young students, constitutes a national reality with results for the country. Furthermore, in line with the recognition of this trajectory, it is considered that this historical analysis provides the perspective of improvement necessary for the sustainable and qualified continuity of the Program.

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