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INTERSECTORIALITY AND HEALTH IN THE FAMILY HEALTH STRATEGY: INTEGRATIVE REVIEW

INTERSETORIALIDADE E SAÚDE NA ESTRATÉGIA SAÚDE DA FAMÍLIA: REVISÃO INTEGRATIVA

INTERSECTORIALIDAD Y SALUD EN LA ESTRATEGIA SALUD DE LA FAMILIA: REVISIÓN INTEGRADORA

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ABSTRACT

Objective: to discuss the links between intersectoriality and health in the context of the Family Health Strategy. **Method:** integrative review from the following research question: How intersectoriality and health are linked in the framework of the Family Health Strategy? with search in LILACS database and SciELO virtual library from 1994 to 2012. After reading the summaries and results, we selected 11 articles and constructed two analytical categories: 1) Persistence of the biomedical model and link between intersectoriality; and 2) Health in the individual scope. **Results:** we confirmed conceptual and operational confusion regarding intersectoriality in health, leading to a work isolated from various sectors, motivated by individual initiatives of domestic and informal characteristics, permeated by a still fragmented assistance, predominantly curativistic. **Conclusion:** little progress was observed in health intersectoriality, reflecting on the low resolution of the issues of life and health of the population. **Keywords:** Intersectoral Action; Health; Family Health Program.

RESUMO

Objetivo: discutir a articulação entre intersectorialidade e saúde no contexto da Estratégia Saúde da Família. **Método:** revisão integrativa a partir da seguinte questão de pesquisa: Como a intersectorialidade e a saúde se articulam no âmbito da Estratégia Saúde da Família? com busca nas bases de dados LILACS e na biblioteca virtual SciELO no período de 1994 a 2012. Após a leitura dos resumos e resultados, foram selecionados 11 artigos e construídas duas categorias analíticas: 1) Persistência do modelo biomédico e articulação entre intersectorialidade; e 2) Saúde no âmbito individual. **Resultados:** constatou-se confusão conceitual e operacional sobre a intersectorialidade na saúde, conduzindo a um trabalho isolado de vários setores, motivado por iniciativas individuais, de caráter doméstico e informal, permeado por uma atenção ainda fragmentada, de cunho predominantemente assistencial curativista. **Conclusão:** evidenciaram-se poucos avanços em matéria de intersectorialidade na saúde, refletindo-se na baixa resolubilidade das questões de vida e saúde da população. **Descritores:** Ação Intersectorial; Saúde; Programa Saúde da Família.

RESUMEN

Objetivo: discutir la relación entre intersectorialidad y salud en el contexto de la Estrategia Salud de la Familia. **Método:** revisión integradora a partir de la siguiente pregunta de investigación: ¿Cómo la intersectorialidad y la salud se articulan en el ámbito de la Estrategia Salud de la Familia? con búsqueda en las bases de datos LILACS y la biblioteca virtual SciELO en el período de 1994 a 2012. Después de leer los resúmenes y los resultados fueron seleccionados 11 artículos y construidas dos categorías analíticas: 1) Persistencia del modelo biomédico y articulación entre intersectorialidad; y 2) Salud en el ámbito individual. **Resultados:** fue observada confusión conceptual y operacional en la intersectorialidad en salud, llevando a una trabajo aislado de diversos sectores, motivado por iniciativas individuales, de carácter doméstico e informal, impregnado por una atención aún fragmentada, predominante curativista. **Conclusión:** se observaron pocos avances en materia de intersectorialidad en salud, reflexionándose sobre la baja resolución de las cuestiones de vida y salud de la población. **Descriptores:** Acción intersectorial; Salud; Programa Salud de la Familia.

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INTRODUCTION

Intersectorality emerged as a working tool in the health sector, as a result of many developments observed in recent decades, with emphasis on the definition of health in the 1988 Federal Constitution as a right of all and duty of the State, and the creation of the Unified Health System (UHS). This is based on the principles of universal access, integral care and equity, and should cover services for health promotion, protection and recovery of damages.¹

The Law 8080 of September 19th, 1990 is one of the legal bases of UHS and associates the concept of health to determining and conditioning factors. With this, the concept of health is connected with the quality of life, understood as the ability of an individual to meet the minimum standards of human dignity. This way, there is a need for a system of assistance which exceeds the limits in the health sector, proposing the articulation of systematic and intersectoral actions in order to cover social, economic and cultural factors that influence directly or indirectly the health conditions of the population.²

Intersectorality is a strategy for overcoming these limits, since it is linked to articulation, linkages, complementary actions, horizontal relations between partners, and interdependence of services. It allows the establishment of shared decision-making spaces between institutions and government sectors in the production of health, formulation, implementation and monitoring of public policies that can have positive impact on the health of the population. In this way, the individual is considered in its entirety, in order to cover the individual and collective needs, showing that resolute actions in the area of health require partnerships with other sectors, thus ensuring the completeness of the actions.³

The Family Health Strategy (FHS) is seen as a form of implementation of intersectorality, since it is driven from the definition of territories, regarded as the area of influence linked to a team, which provides greater proximity and link between the professionals and the users of the system. Its focus is geared to preventive actions; however, it does not neglect the curative factor in the search for resolution of the problems, highlighting aspects favoring intersectorality. In this context, it is expected that the FHS has greater sensitivity in the identification and aggregation of partnerships beyond the health system. The goal is that intersectoral actions

have a most effective and resolute character in this environment.⁴

Intersectorality is a possibility regarding the resolution of the problems of the population, situated in a given territory, in an integrated way with the articulation of various sectors. It aims at adding forces, potential and resources for solving a common problem. It makes the health system more effective, with health policies aimed at integration of all levels of complexity and the intersectorality of actions and services provided.⁴⁻⁵

Considering the importance of intersectoral actions for health care within the framework of the FHS, this study aims to discuss how intersectorality and health are articulated within this context, in order to visualize the design of this relationship in daily life basic health care services.

METHOD

This study is based on integrative review and it aims to analyze various aspects of a theme, contributing to a future more structured search. In this sense, we drafted the following research question: How are intersectorality and health articulated within the framework of the FHS in order to meet/reorient health care models to achieve significant changes in the living conditions of the population?

For the collection of data, we drew up an instrument containing: article title; journal name; year of publication; and main results. With this, a search was held in LILACS and SciELO databases, from April to May 2012, comprising national publications from 1994 to 2012. The choice of these criteria for inclusion is justified in the light of the objective set out in the research, i.e., studying the context of FHS regarding the relationship between intersectorality and health and, consequently, the Brazilian reality from 1994 on, which was the year of the emergence of that strategy.

Using the key words *intersectorality*, *health*, and *FHS*, we found 124 articles and, after careful reading of abstracts and results, we selected 11 articles that included the objectives proposed. The analysis of the articles was held by the authors of this study, taking into consideration the quality of the information. Together with this analysis, we prepared a structured form containing the following topics: title article; journal name; year of publication; methodology; results; and conclusions, which formed the basis for the construction of the following categories of analysis: 1) Presence of the biomedical model and articulation between intersectorality;

and 2) Health within the individual scope. For the interpretation of results, we included all the articles selected, articulating them with the categories of analysis.

RESULTS AND DISCUSSION

◆ Presence of the biomedical model

The practice of the biologicistic model in basic care is a reality in which health is understood as the absence of disease, and the role of health professionals is to treat it without understanding its cause and without understanding the individual in a holistic view, generating a process of medicalization in the form of these health professionals' practice.

The process of social medicalization in the service provided to users by health professionals is still present in the UHS. It should be noted that biomedicine practiced in health units is intended to give supreme importance to ready prevention forms and formulas for any kind of diseases. Ready-made recipes are used without opening space for questioning on the part of users regarding the appropriate preventive measures, as well as the predetermined lifestyle in care provided.⁶

Care practices of health professionals are guided by the biologicist model and, consequently, medicalization becomes active. However, if the understanding of the health-disease process is under the prism of social production of health, there will be an understanding that this process is influenced by multiple factors, not only health.⁷

Following the paradigm of social health production, the professionals involved should incorporate assistive care practices to the individual, through strong partnerships, permeating the planning and execution of actions coming from other sectors of society. However, to enable the intersectoriality in health, it is necessary to review this assistance and invest in academic education of professionals working in the FHS—the primary basis of the implementation of the UHS—as a way to ensure the consolidation of these new working methods in health.⁸

The construction of these professionals' training needs to approach a more humanist, critical and reflective profile, sensitized to provide care with affection and understanding, valuing the cultural and ethical conceptions and promoting social citizenship. To that end, there is no question with respect to the insertion of courses on Social Sciences in curricular matrices. Training should be focused on regional health situations, highlighting the beliefs and customs, with an emphasis on promotion,

prevention, recovery and rehabilitation of health, articulating higher education and health, in accordance with the Laws of Basic Education Guidelines.⁹

In a study conducted by the Ministry of Health in 2006, on the adherence of medicine, nursing and dentistry undergraduate courses to the National Curricular Guidelines (NCG), showed that, in most cases, the NCG, even referenced in educational projects, were not yet inserted or reflected in the implementation of the courses. After five years of legalization and requirement of incorporation of NCG by universities, only the course of nursing showed to be the only profession closest to the appropriate model of health-care management.¹⁰

The inappropriateness of the current educational model can contribute to the definition of intersectoriality in the view of a large number of professionals, even though it might still be wrong. A study that explored the intersectoral teams and the perception of managers about these actions revealed that the concepts of interdisciplinarity and intersectoriality are confused with great frequency in the discourses of professionals.¹¹

Interdisciplinarity consists of various academic courses, with intense exchange among experts, effects of which no one can predict and the potential results do not appear individually.¹² However, intersectoriality arises from articulation, bindings and complementary actions between partners referring to the interdependence of services to ensure the completeness of the actions.³ The lack of consensus among health, education and social assistance, along with the questions about the role to be fulfilled by the different professionals and the uncertainty about intersectoral work, evidence obstacles that oppose the implementation of intersectoriality.⁷

The action of FHS professionals in the practices of these intersectoral health actions, searching for a comprehensive care to the individual, allows highlighting the cases of domestic violence against children. Regarding these situations, professionals pay more attention to the physical consequences than the consequences that violence brings to children, and they often despise the value of protection and complaint, as well as the importance of referrals to the Guardianship Council.¹³

A research conducted in the FHS of the city of Belo Horizonte, State of Minas Gerais, stresses through the testimonials of the subjects that the professionals who most play the role of intersectoral articulators in the

community are the nurses, although their actions are limited by excess of activities within the family health team.⁷

It is worth noting the need to insert all health professionals who perform health care actions in the UHS in this intersectorality process, making them reflect on the importance of seeking and planning partnerships to achieve the success of social health production.

♦ Intersectorality and health articulation within the individual sphere

The expanded concept of health, constructed with the UHS beyond the absence of diseases, called attention to issues historically invisible in the scenarios of health services in Brazil. The various determinants of health and the understanding that its absence extrapolates the work carried out by the health services gained visibility. This fact required the setting of new arrangements able to meet to the more diversified demands of the population, through the relationship with all political forces aiming to ensure health as a right of citizenship.

These arrangements include teamwork focused on the users as active individuals in the process of identifying their needs, in recognition of the limitations of health services to care for these users in their entirety and in the development of articulations with other sectors, as a strategy able to solve or relieve the numerous problems that health professionals have to face.

On the other hand, the current scenario of the FHS reveals professionals attached to a biologicistic vision of health, fragmenting assistance while orienting it for curing diseases, in the isolated use of knowledge and the work unlinked from an entire network of health care, disregarding intersectorality as potential tool for integral care provided to the community. In addition, the absence of a clear understanding of the meanings of intersectoral action is observed, fostering a conceptual confusion and, consequently, an operational confusion in everyday health services.

The complexity of health work requires responsibility in certain situations, which demand the search for partnerships with other sectors for the resolution of various problems affecting users. This represents the sense of leadership that the health sector has in relation to other social sectors. However, the search of articulations remains within the individual scope and not the institutional

sphere, as it is expected in an intersectoral policy.¹⁴

The relationship established between the FHS and the other sectors and services is guided by individual and sporadic experiences, devoid of systematic planning.⁸ In fact, it is an individual task of professionals in view of the problems that arise and depend on the commitment of each one, regarding intersectorality as a particular resource of the team and not as institutional.¹⁴

Within this discussion, the school environment stands out as a scenario of choice for health services, configuring the articulation between FHS and school as a common intersectoral experience frequently mentioned. Despite the possibility of access to a large number of people, this relationship is marked by informal actions designed and defined by a single sector, generating only temporary positive results.

Intersectoral action brings as imperative the construction of objects of common intervention between different sectors with a view to achieving integrated planning for the confrontation of the priority problems identified.¹⁵ However, with regard to the materialization of intersectorality in health, there is no use of planning as an instrument of work, nor monitoring and evaluation of an operational plan, leading to a fragmented and fragile process without articulation, profoundly permeated by informality.⁵

This informality is perceived in health services with the emergence of the idea that the search for solutions of the problems are, in the vast majority of times, marked by individualized needs. Intersectoral practice requires a broad negotiation, reaching a transectorial dimension from the possibilities of creating new perspectives and introducing new values, considering the respect for differences and the incorporation of the contributions of each social policy in the understanding and overcoming of social problems.¹⁴

The lack of awareness of the collective dimension of the needs in health services contributes to individual attitudes. These do not reach the complexity and the magnitude of the problem that permeates health, which is only made possible by the participation of multiple sectors and actors, sharing responsibilities and actions.

Other gaps gain visibility when the relationship between intersectorality and health is assessed. Among them, we highlight the difficulty of reconciling institutional times of various sectors, sectoral commitment and involvement, and the sensitivity of the

actions, in addition to the absence of protocols which guide the development of intersectoral actions.¹¹ This shows that the articulation of health with other social policies sectors has not been the approach adopted by the managers in the three levels of government responsible for the execution of health policies.¹⁵

The result of this lack of support is the dissatisfaction on the part of health professionals, who in the daily routine of their work cannot meet the demands of the community. Far from developing a full service, they perpetuate health actions that fragment the subjects and disfavor the creation and maintenance of links between users and health services. These actions do not include the guarantee of health as a human right.

In practice, intersectoral work requires greater degree of institutionalization, clarity, definition of responsibility, and regularity.¹⁶ Intersectoral action is more comprehensive when it complies with municipal policies and integrated modes of governmental action, other than emergency or specific projects.¹⁷

In this way, it is observed that intersectoriality is best experienced when there is political support of managers and specific public policies of government actions, recognizing that good local management is an important and necessary resource for the development of intersectoral actions.^{5,11} However, in general terms, health management is crossed by a significant problem that concerns the occupation of positions of trust, used as guarantee of governability and, above all, as a bargain between party agreements. The reduction of positions of trust and their replacement by professional technical and administrative staffs can contribute to a more qualified management of the UHS.⁴

One of the pillars of the FHS is building a bond with the community, which in a way implies greater responsibility of professionals with regard to the health of the population. This way, for the reorganization of basic care in order to provide quality of life for the population, it is very important that the teams feel supported and stimulated by the municipal administrations, which should act in a competent, technical and political way.⁴

The absence of this support has generated isolated attitudes in the FHS scenario, which do not meet broader needs set to health workers, requiring the involvement of multiple actors through the organization of networking, in which responsibilities are shared in joint actions. In reality, there is an

urgency to develop policies that make intersectoral measures viable in order to promote health and well-being of people who are, above all, citizens, to whom the rights have been denied.¹⁸

Within this context, intersectoriality is understood as an expanded conception of planning, execution and control of service provision, in order to ensure equal access to unequal people, assuming to change all forms of articulation in the various sectors of governmental organization and interest. When establishing these processes, the needs of the groups will be articulated in the pursuit of intersectoral solutions, which lead to understand the population as subjects and not as the object of intervention. The view of shortage and the provision of most individualized needs is extrapolated, in order to increase citizens' rights to a better quality of life.¹⁴

In this discussion, we highlight the importance of a full integration of the community in a critical survey of their needs and problems, ensuring a dialectical and transdisciplinary interpretation of reality. We understand that an intersectoral health approach allows not only the discussion of issues that affect the community, but enables the collective construction of intervention strategies.¹⁹

The participation of society appears as essential ingredient in this process, so that the health teams can develop working tools with the active participation of patients, families and organized segments of the community in order to include them as social actors in the control of health problems and, in particular, in the improvement of living conditions of the population.¹⁸

The construction and the political viability of an intersectoral project goes through a new look and a new action regarding reality, under the logic of priority problems democratically defined. The reduction or control of these problems require knowledge, skills and commitments of various sectors, whose subject must find new forms of relationship with one another.¹⁹ Thus, there is a need to strengthen completeness and intersectoriality in health actions and services.²⁰

The difficulties faced by the population cannot be dictated and faced by a single sector, which is an understanding that must be incorporated by the managers and institutions. Health issues need to overcome the walls of the basic health units and the professionals have to expand their view beyond their specific object of action.

FINAL REMARKS

Health and intersectoriality are articulated within the context of the FHS from the incipient action of professionals unprepared for this relationship, anchored in a formation dedicated to the biomedical model, without contemplating the social production of health and performing caring/curative-oriented actions.

The cognitive gaps lead to operational gaps, transforming intersectoriality in health into individual and informal experiences, dependent on the individual action of health workers and without representing an institutional strategy for meeting the health needs of the population. They are fragmented actions, with no political support and encouragement, as well as devoid of systematization, planning, monitoring and evaluation.

We highlight the construction of an institutional intersectoriality culture, based on scientific capacity, technical and political expertise of health managers and professionals as a promising path. In addition, there is an urgent need for greater articulation of sectors with a commitment to developing the autonomy of the community in order to overcome the timid participation of actors involved with a view to ensuring health as a human right.

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