



SOCIAL INEQUITIES AND INTERSECTORIALITY: CHALLENGE TO PRIMARY HEALTH CARE

INIQUIDADES SOCIAIS E INTERSETORIALIDADE: DESAFIO À ATENÇÃO PRIMÁRIA À SAÚDE INEQUIDADES SOCIALES E INTERSETORIALIDAD: DESAFÍO A LA ATENCIÓN PRIMARIA A LA SALUD

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ABSTRACT

Objective: to investigate intersectoral actions aimed at confronting social inequities, in the level of Primary Health Care, developed with a view to reducing health inequalities in Brazil. **Method:** systematic review with search in LILACS and MEDLINE databases. As eligibility criteria, research developed in Brazil, from 2005 to 2015, in Portuguese, English or Spanish, with at least one title or summary descriptor was used. For the data analysis, the theoretical references, the variables governmental intersectorial action and intersectorial action with social participation and the PRISMA Guidelines Guide were used. **Results:** 40% of the studies dealt with intersectorial actions of governmental level involving initiatives of the federal government; 20%, of local intersectorial actions involving civil society; 40% of the two types; 40%, based on the World Health Organization's benchmark; 20%, in the reference of the Capital Stock; 20% in the World Health Organization and Lifetime referral guidelines and 20% in the World Health Organization and Social Capital benchmarks. **Conclusion:** intersectorial policies, together with society, increase the possibilities of achieving social equity in Brazil. **Descriptors:** Primary Health Care; Social Inequity; Social Determinants of Health; Intersectorial Action; Public Policies; Health Equity.

RESUMO

Objetivo: investigar ações intersetoriais voltadas ao enfrentamento das iniquidades sociais, em nível de Atenção Primária à Saúde, desenvolvidas com vistas à redução das desigualdades em saúde no Brasil. **Método:** revisão sistemática com busca nas Bases de dados LILACS e MEDLINE. Utilizaram-se, como critérios de elegibilidade, pesquisas desenvolvidas no Brasil, de 2005 a 2015, em português, inglês ou espanhol, com, pelo menos, um descritor em título ou resumo. Para a análise dos dados, utilizaram-se os referenciais teóricos, as variáveis ação intersectorial governamental e ação intersectorial com participação social e o Guia de Diretrizes PRISMA. **Resultados:** 40% dos estudos trataram sobre ações intersectoriais de nível governamental envolvendo iniciativas do governo federal; 20%, de ações intersectoriais locais envolvendo a sociedade civil; 40%, dos dois tipos; 40%, baseados no referencial da Organização Mundial da Saúde; 20%, no referencial do Capital Social; 20%, nos referenciais da Organização Mundial da Saúde e Curso da Vida e 20%, nos referenciais da Organização Mundial da Saúde e do Capital Social. **Conclusão:** políticas intersectoriais, em conjunto com a sociedade, aumentam as possibilidades de concretização de equidade social no Brasil. **Descritores:** Atenção Primária à Saúde; Iniquidade Social; Determinantes Sociais da Saúde; Ação Intersectorial; Políticas Públicas; Equidade em Saúde.

RESUMEN

Objetivo: investigar acciones intersectoriales dirigidas al enfrentamiento de las inequidades sociales, a nivel de Atención Primaria a la Salud, desarrolladas con vistas a la reducción de las desigualdades en salud en Brasil. **Método:** revisión sistemática con búsqueda en las Bases de datos LILACS y MEDLINE. Fueron utilizados, como criterio de elegibilidad, de investigación desarrollado en Brasil, desde 2005 hasta 2015, en portugués, inglés o español, con, al menos, un descriptor en el título o en el resumen. Para el análisis de los datos se utilizaron los referenciales teóricos, las variables acción intersectorial gubernamental y acción intersectorial con participación social y el Guía de Directrices PRISMA. **Resultados:** 40% de los estudios trataron sobre acciones intersectoriales de nivel gubernamental involucrando iniciativas del gobierno federal; 20%, de acciones intersectoriales locales involucrando a la sociedad civil; el 40% de los dos tipos; El 40%, basado en el referencial de la Organización Mundial de la Salud; el 20%, en el referencial del Capital Social; y el 20%, en los referenciales de la Organización Mundial de la Salud y el Curso de la Vida y el 20%, en los referentes de la Organización Mundial de la Salud y del Capital Social. **Conclusión:** políticas intersectoriales, en conjunto con la sociedad, aumentan las posibilidades de concreción de equidad social en Brasil. **Descriptores:** Atención Primaria a la Salud; Iniquidad Social; Determinantes Sociales de la Salud; Acción Intersectorial; Políticas Públicas; Equidad em Salud.

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INTRODUCTION

Health is an important and sensitive dimension for assessing the sustainable development of a country and represents, based on the combined effect of social, economic, political, cultural and physical factors, the fundamental human right that immediately determines the conditions of life, the principal engine of human and social development, increasing labor productivity and economic return for people, collectivities and populations, as well as increasing labor market participation, which creates opportunities for more inclusive and sustainable growth.¹

It is important to understand health not only as the absence of disease, because the health-disease process is also influenced by the social. Health can be broadened beyond the drug objective, and the intersectoral relationship between health and care practices, consolidates health promotion practices, encouraging greater participation of the actors involved.²

The Alma-Ata Declaration, and especially the recommendations of the World Health Organization (WHO) Commission on Social Determinants of Health, emphasizes the crucial importance of policies and actions on the social determinants of health (SDH) in reducing inequalities in and health promotion and equity.³

With a view to promoting sustainable development, the concept of universal health coverage has been expanded to cover the provision of continuous and coordinated care, including health promotion that addresses the social determinants of health at the primary health care (PHC) level.⁴

Structural inequalities, define social hierarchy among different countries of northern Europe, show successful experiences in health systems and services organizations that emphasize and prioritize actions on SDH with a central focus on solving social inequities and establishing social equity.⁵

Social injustice and economic inequalities produce disparities in access to health and well-being, and these social inequalities mark SDH, which have been a distinguishing characteristic of Latin America and Brazil.⁶

Studies show that economic and social factors interfere, in an incisive and unjust way, in the health of more socially vulnerable populations. In the same way, studies show that in this field, intersectoriality is essential, since these are problems that go beyond the ability of the health sector to respond alone

and thus depends on the interface of several other sectors in facing the related issues to SDH.⁷⁻⁹

DSS, such as social, economic, cultural, ethnic / racial, psychological and behavioral factors, that favor the occurrence of health problems and their risk factors in the population, have been marked by social and health inequities at the level of urban peripheral territories in Brazil, geographic and cultural locations far from the urban centers of large and medium-sized cities, and which constitute regions under the coordination of PHC.¹⁰

Studies show the increase and persistence in the territories of non-communicable chronic diseases of people in problematic use of alcohol and other drugs, as well as people with infectious diseases that often become vulnerable to precarious environments, violence and social network ruptures, which can result in early death.¹¹⁻¹³

In the broader context of health, social determinants, democratic progress and sustainable development are intrinsically related because change in one domain affects others. In this way, integrated health, social and economic actions are necessary in the elaboration of intersectorial public policies and their integration in health systems to achieve equitable health and well-being.¹⁴

The theoretical frameworks used in the study were: 1. The Model of Social Determinants of Health of the WHO Commission on Social Determinants of Health (CSDH-WHO) 3, which is defined in two areas - A) structural - linked to social stratification including socioeconomic factors, work and income, gender, ethnicity and culture, and B) intermediaries - living conditions, working conditions, food availability, population behaviors and barriers to adopting a healthy lifestyle; 2. Social Capital, a construct developed from the contributions of thinkers Robert Putnam, James Coleman and Pierre Bourdieu, is defined as a specific form of social organization in which there is a strong network of interpersonal relations based on reciprocities and social cooperation favoring development personal and collective determinants of development in all sectors (economic, cultural, political, social and health). In this sense, it proposes the importance of social support networks for the reduction of social inequities in territories of high social vulnerability.⁴ The theoretical construct of the Course of Life understands that the socioeconomic inequalities, present in certain regions, have effect throughout the life of people that are born and grow in these

regions. Thus, life-course epidemiology is defined as one that studies the long-term effects on health risk or disease arising from exposures during pregnancy, childhood, adolescence, young adulthood and post-life adult mortality.¹⁵ Thus, it is justified that regional actions, based on a territorial basis, at the community level and with follow-up from the gestational phase, following the life course of people and families in the territories, are recommended.^{3,4, 10} The operationalization of theoretical references is described in figure 1.

In this sense, considering the challenges for the Unified Health System (UHS) and for PHC in Brazil to integrate intersectoral policies aimed at coping with social inequities that generate health inequalities and implementing actions directed at SDH, a systematic review was carried out of literature.

It is observed, however, that gaps are found in the set of knowledge that deals specifically with the theme reflected in the work mentioned. Studies produced at the Primary Health Care level have not focused centrally on the social determinants of health and more rarely focus on actions, programs or policies with a focus on SDH, developed through intersectoral strategies. Therefore, the importance of such a study is important to provide a diagnosis of the panorama in question, to detect and highlight intersectoral strategies developed by the PHC services focused on the social determinants of health, as well as to propose recommendations and guidelines for future studies.

OBJECTIVE

- To investigate intersectoral actions aimed at confronting social inequities, in Primary Health Care, developed with a view to reducing health inequalities in Brazil.

METHOD

Systematic review, of a qualitative approach,¹⁶ characterizing itself as an analytic-interpretative study, because it was imported with a question whose discussion of its scientific evidence is based on processes of interpretation of conceptual themes, which are being constructed based on critical analysis and revisions of theoretical theses.

The systematic review is a research in the relevant literature, based on evidence-based practice, which consists of a synthesis of the research results and previous studies related to a specific

problem, which presents six steps: 1 - identify the main research question ; 2 - to collect preliminary data for the definition of the descriptors; 3 - search the databases and select the relevant studies; 4 - record, process and compile the data collected; 5 - read and evaluate the material for the selection of the final sample; 6 - compare, summarize, report and present results.¹⁷

The guiding question of the study was: which intersectoral actions aimed at confronting social inequalities in Primary Health Care were developed with a view to reducing inequalities in health in the Brazilian territory?

For the survey of the articles in the literature, searches were carried out from January to May of 2016.

Three paired searches were developed according to two different combinations:

The first combination was: "Social Determinants of Health" OR "Inequity" Social "OR" social vulnerability "AND" primary health care "AND" intersectorality. "However, the corresponding result was zero articles.

Therefore, the second search, in double, was developed from the following combination: (cross-sectoral OR intersectoral) OR (policy OR policies) OR (strategies) AND "health inequalities" OR "health inequities" OR "health inequality" OR "health disparities" OR "health disparities" OR "socioeconomic health inequalities" OR "social health inequalities" OR "Healthcare disparities" OR "Health disparities" OR "Social disparities" health "AND" primary health care ". The result of 91 articles was then obtained. After this second search, a third search was repeated from the last combination, in double and counting on a third researcher. In this third search we found 91 articles.

To search the articles in the literature, searches were conducted in the following databases: LILACS (Latin American Literature in Health Sciences) and MEDLINE (Medical Literature Analysis and Retrival Sistem on-line).

The following selection criteria were determined for the articles to be collected in the searches:

- Be studies dating back to the last ten years, that is, from 2005 to 2015. This criterion was thus determined in line with the WHO creation date, of the CDSH, in March 2005;
- Articles should be published in Portuguese, English or Spanish and should bring at least one descriptor in their title or abstract / abstract / summary;
- The articles selected should meet the following study designs: Clinical Trial; Comparative Study; Evaluation Studies; Government Publications; Comparative Study; Evaluation Studies; Multicenter Study; Observational Study; Practice Guideline; Review.

For the analysis of information related to article identification, methodological characteristics of the article and analysis of methodological rigor, the PRISMA Guidelines Guide for systematic reviews and meta-analyzes.¹⁸

1- Classification of articles regarding the methodological quality and bias of articles

The articles selected for review were evaluated in relation to the level and quality of evidence, using a hierarchy of evidence, based on:¹⁹

- Level 1- evidence resulting from the meta-analysis of multiple randomized controlled trials;
- Level 2-evidence obtained in individual studies with experimental design;
- Level 3-evidence from quasi-experimental studies;
- Level 4-Evidence from descriptive (non-experimental) studies or qualitative approach;
- Level 5- evidence from case or experience reports;
- Level 6- evidence based on expert opinions.

No bias analysis was performed because this is not recommended for meta-analyzes in systematic reviews with less than ten articles.²⁰

1- Visualization of the data found in the researched sources

For the analysis of the data in the articles selected for the review, the following variables were used, which, in turn, were analyzed in light of the following theoretical references²¹ presented in figure 1.

Variables	Theoretical references
Government Intersectorial Action (AIG): Merging or creating ministries to solve specific problems (poverty, gender, ethnicity, work, etc.). Initiatives from the Federal Government to address social emergencies such as, drugs, violence, among others, that hold the participation of local authorities and the organization of civil society in associations, as well as mobilization and decision-making. Government Programs and Strategies - Family Health Strategy, etc. Inter-sectoral Action with Social Participation (AIPS): Social Participation that integrates the governance system - the participation of communities and civil society, groups responsible for the implementation, development and evaluation of public policies. Corporate Councils: such as municipal health, among others. Associations of users of health services in regular dialogues with governments.	Model of the Commission on Social Determinants of Health - (CSDH) 21 Structural Determinants: socioeconomic factors, social and political contexts, gender, ethnicity, culture. Intermediate determinants: living conditions, working conditions, food availability, population behaviors and lifestyles. Social Capital (CS): social support networks, strengthening of social bonds and community empowerment through social networks of belonging. Course of Life (CV): actions regionally developed, based on territorial, at the community level and with follow-up recommended from the gestational phase following the course of life of people and families in the territories.

Figure 1. Variables and theoretical references operationalized in the analysis of articles. Ribeirão Preto (SP), Brazil. 2015.

Thus, the articles selected for the analysis according to AIG (A, B, C, D) and AIPS (A, B, C) variables were classified when they reflected intersectoral actions that were aligned with the classification corresponding to each variable or to the mixture of more than one. In the same way, according to theoretical references, when the described

action corresponded to one or more of the typologies recorded in figure 1.

The data of the articles thus analyzed were later computed according to the variables, that is, the type of intersectorial action addressed to the confrontation of the SDH and according to the theoretical reference which

represents the conceptual conceptual model of SDH linked to the developed intersectorial action. Computed articles will be presented in the results analysis.

The analysis and the synthesis were carried out in a descriptive way allowing the thematic classification of the main axes from the guiding question of the study (intersectoriality and PHC), expressed in the variables and theoretical references (described in the previous topic).

RESULTS

From the descriptors used and their combinations, a total of 91 articles were found, 70 in LILACS and 21 in MEDLINE.

Of these 91 articles, eight were excluded because they were duplicates resulting in 83. After reading titles and abstracts, eight articles were excluded resulting in 75 studies for the integral reading. Of these 75 articles, 67 were excluded because they did not present a relationship between PHC and intersectoral actions or policies, resulting in eight articles assessed as eligible. After the complete re-reading, three studies that did not present intersectorial action / policy were excluded in the context of PHC leaving, as a final result, a total of five articles that answered the guiding question.

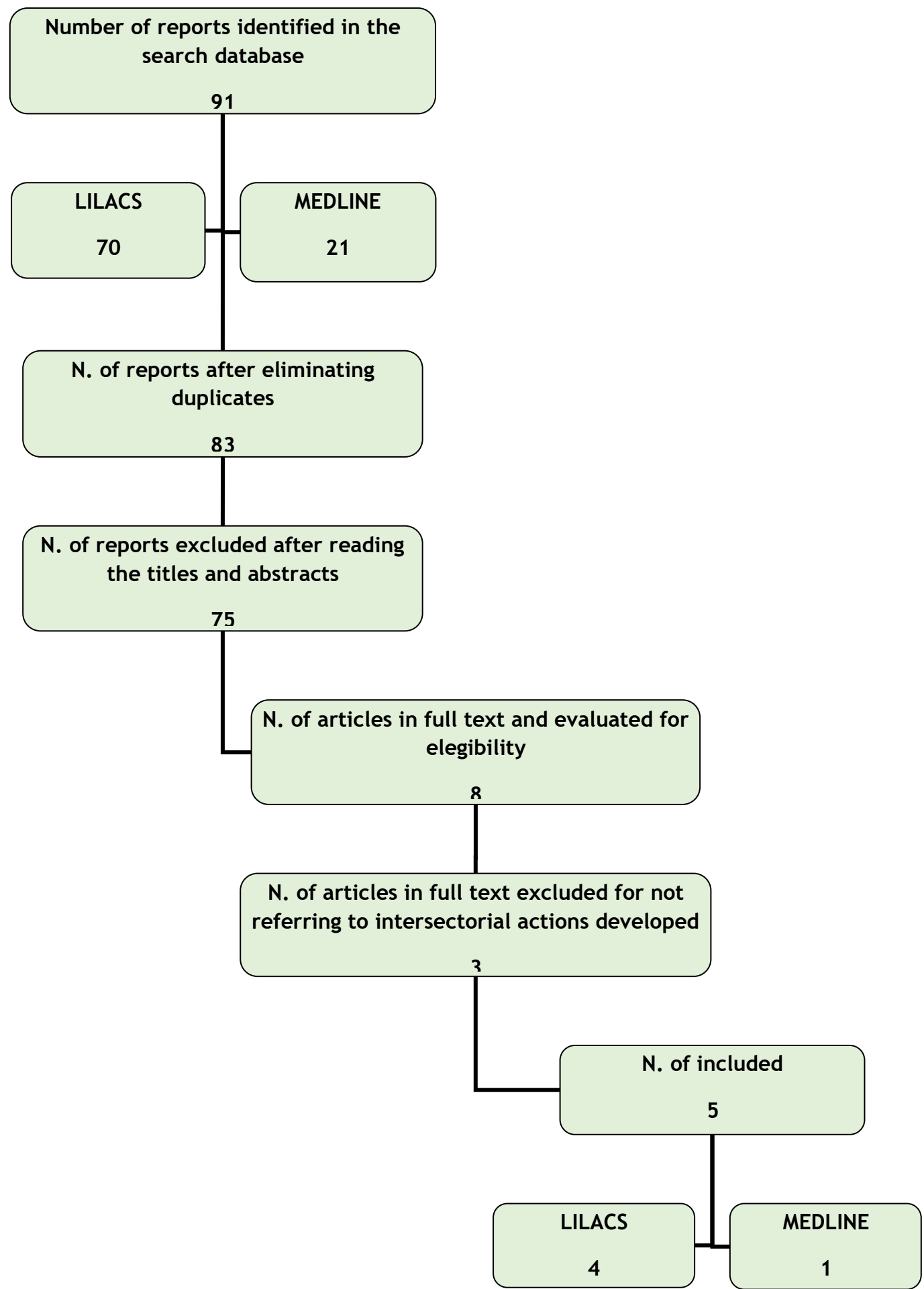


Figure 2. Flowchart with the process of selecting articles for review. Ribeirão Preto (SP), Brazil. 2015.

After the selection, the articles were analyzed based on the extraction and analysis of the data. The results are presented in figure 3 taking into consideration the sample, methodological design and scope of the study. The results are described by the surveys analyzed and observed from the intersectoral programs presented and the results referring to the analysis of the articles, according to the variables and theoretical references.

References	Database	Population/ sample	Type of study and scope of study development	Study objectives	Results presented by reviewed articles	Results of the analysis of the reviewed articles
Andrade LOM, Pellegrini-Filho A, Solar O, Rigoli F, Salazar LM, Serrate PCF, et al. ²²	MEDLINE	Government documents on intersectoral programs aimed at addressing poverty - Brazil: Bolsa Família Program.	Case study Qualitative Scope: Latin America: Brazil, Chile, Colombia, Cuba.	Analyze intersectoral public policies developed by the governments of the countries, as well as communities and civil society involved in the implementation of policies.	For this article will be presented only the case study of Brazil: - increasing access to health and education services; -pregnancy consultation increases from 49% to 61%; - increased immunization and reduction of child malnutrition, reduction of infant mortality below 5 years; - statement on the social determinants of health; - increase of income for families in extreme poverty and extension of the social and financial protection network.	Tipo de ação intersetorial: <i>Bolsa Família</i> (Brasil): Variáveis: AIG (B) Referencial teórico: CSDH (A)
Diba D, d'Oliveira AS. ²³	LILACS	Young people in social vulnerability of a city in the interior of São Paulo.	Ethnographic study Scope - Municipality of the interior of the State of São Paulo	To analyze the relationship of an experience in Theater and Community together with health teams dedicated to the promotion of health for young people with social vulnerability.	- increasing social capital and strengthening social support networks; -controlling the problematic use of alcohol and other drugs; - access to information; - social participation and community empowerment; -diminution of violence; -Promotion of health.	Projeto de teatro para jovens em vulnerabilidade social que integra Programa Arte, Cultura e Cidadania - Cultura Viva, do Ministério da Cultura do Brasil, implantado em 2004. Ação intersetorial centrada na comunidade. Cultura e saúde. Variáveis- AIPS (D). Referencial teórico - CS
Dawbor TP, Westphal MF. ²⁴	LILACS	Managers and professionals of Primary Health Care services of the Family Health Program of the city of São Paulo.	Case study with mixed approach: multiple correspondence analysis, clustering and correlation tests between variables and content analysis and thematic categorization. Scope - Brazil - Health services of the Basic Health Care and Family Health Strategy of the City of São Paulo -SP.	To analyze the work situation with social determinants of health within the scope of the Family Health Program.	-discrepancy between the determinants to be emphasized; - difficulty in addressing aspects beyond biological determinations; -various pattern of regularity in community participation in actions; -Establishment of partnerships in the territory with non-governmental organizations; - lack of understanding and difficulties of integration in intersectoral programs.	Variáveis: AIG (C) e AIPS (A,B) Referencial Teórico: CSDH (A,B)
Giovanella L, Mendonça MHM, Almeida PF, Scorel	LILACS	Professionals and managers of the	Qualitative case study Scope - Brazil capitals	Analyze the capacity of the Family Health Strategy	- Intersector forums with different scopes in the 4 cities.	Variáveis: AIG (C) e AIPS (A,B) Referencial Teórico: CSDH (A,B) e CS

<i>S, Senna MCM, Fausto MCR, et al.</i> ²⁵		Family Health Strategy of four Brazilian municipalities (Belo Horizonte, Aracaju, Florianópolis and Vitória.	of Brazilian states.	in relation to its integration in intersectoral projects.	-Vitória: Land more equal - Local social development; income generation; greater accessibility to services. -BH: citizenship and Vila Viva - reduction of social vulnerability in territories. - Participative Budget and Nucleus for the Prevention of Domestic Violence Aracajú: follow-up of Bolsa Família; improvements in urban mobility and the environment. -Commission of School Health Promotion Florianópolis: environmental improvements, accessibility to health services.	
<i>Nascimento PR, Westphal MF, Moreira RS, Baltar VT, Moysés ST, Zioni F, et al.</i> ²⁶	LILACS	Public policies and managers of local government agencies in 105 Brazilian municipalities.	Longitudinal ecological study Scope: Brazil - It analyzes how in 105 Brazilian municipalities that adhered to the WHO / PAHO / UN Agenda 21 obtained impacts and on living and health condition.	Analyze how agendas of 105 Brazilian municipalities are working with the DSS to reduce health inequalities.	Social and health impacts were detected in the municipalities that joined Agenda 21: - reduction of hunger; -increase in universal access to health and education; - the tuberculosis prevalence ratio decreased from 32 to 26%; - the percentage of the population served with running water increased; - the percentage of female councilors showed a significant increase; - proportional mortality of children under one year of age has decreased.	Identifica ações voltadas determinantes sociais da saúde e dentre estas, ações que foram desenvolvidas através de intersectorialidade e outras que foram desenvolvidas centradas no setor da saúde. Variáveis: AIG (A, B) Referencial teórico: CSDH (A,B) e CV

AIG: Governmental Intersectorial Action
CSDH: Model of the Social Determinants of Health of the World Health Organization
AIPS: Intersectoral Action with Social Participation
CS: Share Capital
CV: Course of Life
Figure 3. Analysis of articles selected for the review. Ribeirão Preto (SP), Brazil. 2015.

Three studies were developed according to the qualitative methodological design, being two case studies and an ethnographic study. These are evidence-level 4, according to the level and quality of evidence.¹⁹ The other two studies analyzed consisted of mixed studies involving a quantitative and qualitative approach. These are evidence level 3 and 4, according to the level and quality of evidence.¹⁹

The studies took place in the Brazilian territory, according to the selection criteria, involving cities from all regions of the country, with emphasis on the Southeast, Northeast and South regions.

There was a tendency in the increase of studies in the subject investigated according to the years, having been found, in 2009, 2013 and 2014, a study in each and two in the year 2015.

The results showed that, according to the variables, 40% of the studies dealt with intersectorial actions of governmental level involving initiatives of the federal government;^{22,24} 20% dealt only with local intersectorial actions involving civil society²³ and 40% involved actions of the two types.^{25,26} Regarding the theoretical references, 40% involved actions to reduce health inequities based only on the WHO framework,^{22,25} 20%, in the Social Capital benchmark,²³ 20% in the WHO reference frameworks and the Course of Life²⁴ and 20%, in the references of WHO and the Social Capital.²⁶

Regarding health outcomes, intersectorial actions at the PHC level and with a focus on SDH, described by the reviewed articles, showed the following results: increased access to health services and education; increase in prenatal visits from 49% to 61%; increased immunization and reduction of child malnutrition; reduction of infant mortality below five years; increased income for families in extreme poverty and extension of the social and financial protection network. In addition, they also showed an increase in social capital and the strengthening of social support networks; control of problematic use of alcohol and other drugs; access to information; social participation and community empowerment and reduction of violence; reduction of hunger; increasing universal access to health and education; the tuberculosis prevalence ratio decreased from 32 to 26% in some cities; the percentage of the population served with running water increased; improvements in urban mobility and environmental improvements and increased accessibility to health services.²²⁻⁶

DISCUSSION

According to the objective of knowing which intersectorial actions aimed at coping with social inequalities, at the PHC level, it was developed with a view to reducing health inequalities in the Brazilian territory, the revised articles presented advances in the reduction of social and health inequalities.

Regarding the issue of intersectoriality, although the articles show that there is a polysemy on the conceptual basis of intersectoriality, two types can be outlined that have marked a prevalence of the implemented actions: intersectoral action whose initiative, implementation and management departs and remains as government action from the federal level; and another modality that are local intersectoral actions, with initiatives of municipal or even federal governments, but involving participation and civil society organizations and are developed with local territorial base.²²⁻²⁶

Although governmental intersectoral actions constituted a significant part of the studies (40%), there is a tendency (40% reflect the two types AIG and AIPS) to a concept that defines intersectoral work, emphasizing the interface between governments and civil society, as well as the reciprocity and cross-cutting of the sectors towards co-participation and effective sharing of planning and management in the production of intersectoral projects and actions. There is also a tendency to overcome conceptual interpretations that delineate intersectoriality as a multisectoral enterprise through a serial logic, that is, a logic of summation of consecutive efforts without synergy.²²⁻⁶

Thus, the first study analyzed²² brings a deeper discussion of intersectoral action, as well as social participation, with the effective inclusion not only of members of public administration sectors, but, also, of the inclusion of civil society. This study defines intersectoriality as a political, technical and administrative process that involves negotiation and distribution of power, resources and capacities, technical and institutional, between different sectors. They also emphasize that, this process demands a social vision and political will of the governments, institutional arrangements and managerial training of agents, besides the participation of local community agents with the formation of partnerships with organizations of civil society forming arrangements with deliberative capacity. By emphasizing unconditional social participation, the authors emphasize the need for intersectoral actions to take place at the primary care level, involving health and other sectors, targeting SDH actions toward universal health and social equity coverage.

The authors of the second study analyzed point out that, in health promotion, issues go far beyond the sector and that actions in education and culture are necessary for health promotion. The prevalent idea is that health actions should be included in other sectors.²³

However, some problems are pointed out in relation to the intersectoriality developed at the PHC level²⁵. Thus, in the experiences analyzed in several primary care services through the Family Health Strategy in São Paulo, it was verified that the professionals can not decentralize from the biological referent of the health / disease processes, making it difficult for the actions on the SDH, as the most active teams within the clinical-biological field presented great difficulty in composing and integrating intersectoral projects. The authors also highlight the difficulty of understanding what intersectoriality is and the lack of discussion and training for the production of intersectoral actions and projects.

Another reviewed study²⁶ proposes intersectorial action closely linked to network integration mechanisms and show that in all projects analyzed by the study, involving municipalities in the Southeast, Northeast and South regions, intersectoriality was present, however, with several scopes. Some projects of an analyzed municipality are realized by means of centralized forums through municipal administrative policies, being composed by secretaries. In other municipalities intersectoral projects are established more widely, through articulated actions and with the collaboration of civil society organizations, using the territory as a common base of action.

The studies emphasize that successful intersectoriality is one that is holistic in nature involving governments, but, also, community empowerment, social participation, equity, multi-strategic actions and sustainability.²²⁻⁶

Regarding the interrelationship between intersectoriality and PHC, all articles deal with actions or programs that were developed at primary care level, and the territory is the stage on which the development of actions occurred. The studies highlight this link as being inherent in the process of intersectoriality being driven at the PHC level, especially when actions aim at intervention on SDH. This relationship is evident even when the intersectorial policies analyzed are federal policies, such as the Bolsa Família (Family Welfare) program, which is the focus of analysis in two studies.^{22,25} In this case, the importance of intersectoriality also occurs at

the level of primary care because it involve the inspection and management in the territory by three sectors: health, social assistance and education, as well as the involvement of participation and social control, also pointed out by other studies that have been concerned with defining intersectoriality.¹³⁻²¹

Other factors that interrelate intersectoriality and PHC are the notion and actions of health promotion, the coordination of the system, the integrality and actions on SDH, that must be networked.²²⁻⁶

Although one of the articles²⁵ points out problems inherent in the implementation and management of intersectoral projects in primary health care, all the studies showed positive results in relation to the intersectoral programs that they analyzed. The results showed that there was an increase in family income and poverty reduction, greater access to health and education services, extension of social protection, increase of social capital and empowerment of groups and communities, reduction of violence, environmental improvements and improvement of conditions of health. One study²⁴ in particular shows that comparatively the municipalities that joined the WHO /PAHO/UN agenda 21, that is, the implementation of intersectoral actions aimed at the social determinants of health, with an environmental focus, presented better levels of equity and living conditions than others who did not.

Regarding the theoretical references used to analyze the articles, it can be seen that the SDH model of the WHO Commission on Social Determinants of Health permeates most of the actions aimed at coping with health inequities reported by the revised articles 40%. However, it is noticed that several studies reflected the importance of increasing the social capital of a vulnerable community to face health inequities, as well as showing actions that interfered in the life course of children in social vulnerability and who showed themselves to be successful actions aimed at the Social Determinants of Health, increasing the chances of equity in territories of high social vulnerability.²²⁻⁶

The limitations of the study are related to the restricted number of studies accessed, which limits the generalization of the results and indicates the need for more extensive studies with strategies of search and extraction of articles and broader research.

CONCLUSION

The recommendations of the WHO and its Commission on Social Determinants of Health (CSDH) emphasize the need for intersectoral policies and actions to address social inequities that determine health inequalities and inequities in access to quality of life. The recommendations focus on a type of intersectoriality that is at the federal administrative level of national governments, mainly through the recommendation of "Health in all policies", which shows the importance of governments to follow a different logic, referring to centralization and sectoral dispute involving private interests over the public.

However, recent studies, such as those evaluated in the article, also emphasize, the need to include the participation of civil society in the decision-making spheres of government actions, decentralizing policy management, which is promising especially in intersectoral policies.

Although the conceptual and practical difficulties related to intersectoriality and the implementation of intersectoral policies and actions have still been important obstacles, the studies analyzed have shown that significant advances occur, including with the clear indication that social participation has increased, increase the chances of democratization of the social and political sphere, of the inspection, so that the interests of the Public Good are established. As well as, the studies analyzed show that intersectoral policies, with social participation, increase the possibilities of achieving social equity in the country.

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REFERENCES

1. Borrel C, Artazcoz L. Las políticas para disminuir las desigualdades en salud. *Gac Sanit* 2008; 22(5):465-73. DOI: 10.1157/13126929.
2. Santos LNM, Oliveira EAR, Silveira FDR da, Castro SFF de, Pedrosa JIS, Nogueira LT. Intersectorialidade e saúde na Estratégia Saúde da Família: Revisão Integrativa. *Rev enferm UFPE online*, Recife, 7(esp):4868-74, jul, 2013. DOI: 10.5205/reuol.4700-39563-1-ED.0707esp201307.
3. Marmot MG, Allen J, Bell R, Bloomer L, Goldblatt P. WHO European review of social determinants of health and the health divide. *Lancet* 2012; 380(9846):1011-29. DOI: 10.1016/S0140-6736(12)61228-8.
4. Friel S, Marmot MG. Action on the social determinants of health and health inequities goes global. *Annu Rev Public Health* 2011; 32:225-236. DOI: 10.1146/annurev-publhealth-031210-101220.
5. Lewis SJ, Leeder SR. Why health reform? *Med J Aust* 2009; 191(5): 270-272. [cited 2016 May 10]. Available from www.mja.com.au/journal/2009/191/5/why-health-reform.
6. Esteves RJF. The quest for equity in Latin America: a comparative analysis of the health care reforms in Brazil and Colombia. *Int J Equity Health* 2012;11(1):6. [Doi: 10.1186/1475-9276-11-6](https://doi.org/10.1186/1475-9276-11-6).
7. Pettcrew M, Platt S, McCollam A, Wilson S, Thomas S. "We're not short of people telling us what the problem are. We're short people telling us what to do": an appraisal of public policy and mental health. *BMC Public Health* 2008. [Doi: 10.1186/1471-2458-8-314](https://doi.org/10.1186/1471-2458-8-314).
8. Lal S, Mercier C. Intersectoral action to employ individuals with mental illness: Lessons learned from a local development initiative. *Work* 2009; 33(4):427-37. [Doi 10.3233/WOR-2009-0891](https://doi.org/10.3233/WOR-2009-0891).
9. Goeij MCM, Suhrcke M, Toffolutti V, Mheen DV, Schoenmakers TM, Kunst AE. How economic crises affect alcohol consumption and alcohol-related health problems: A realist systematic review. *Soc Sci Med* 2015; 131:131-146. [Doi: 10/1016/j.socscimed.2015.02.025](https://doi.org/10.1016/j.socscimed.2015.02.025).
10. Pellegrini-Filho A. Conferência Mundial sobre Determinantes Sociais da Saúde. *Cad Saúde Pública* 2011;27(11):2080-1. [cited 2016, June 13]. Available from: <http://www.scielo.br/pdf/csp/v27n11/01.pdf>.
11. Chaves TV, Sanchez GM, Ribeiro LA, Nappo AS. Fissura por crack: comportamentos e estratégias de controle de usuários e ex-usuários. *Rev Saúde Pública* 2011; 45(6):1168-75. [Doi: 10.1590/S0034-89102011005000066](https://doi.org/10.1590/S0034-89102011005000066).
12. Brito F. Transição demográfica e desigualdades sociais no Brasil. *Rev Bras Estud Popul* 2008; 25(1):5-26. [cited 2016, July 16]. Available from: <http://www.scielo.br/pdf/rbepop/v25n1/v25n1a02.pdf>.
13. Arcêncio RA, Arakawa T, Oliveira MF, Cardozo-Gonzales RI, Scatena LM, Ruffino-Netto A, et al. Barreiras econômicas na acessibilidade ao tratamento a Tuberculose em Ribeirão Preto. *Rev Esc Enferm USP* 2011; 45(5):1121-7. [cited 2016, July 18]. Available from:

<http://www.scielo.br/pdf/reeusp/v45n5/v45n5a13.pdf>.

14. Dias MAS, Parente JRF, Vasconcelos MIO, Dias FAC. Intersetorialidade e Estratégias de Saúde da Família tudo ou quase nada a ver? *Cien Saude Colet* 2014; 19(11):4371-82. Doi: 10.1590/1413-812320141911.11442014.

15. Kuh D, Ben-Shlomo Y, Lynch J, Hallqvist J, Power C. Life course epidemiology. *J. Epidemiol. Community Health*. 2003, 57:778-83. Doi: [10.1136/jech.2006.048694](https://doi.org/10.1136/jech.2006.048694)

16. Guanilo MCDTU, Takahashi RF, Bertolozzi MR. Revisão Sistemática: noções gerais. *Rev Esc Enferm USP* 2011;45(5):1260-6. [cited 2016, Aug 22]. Available from: <http://www.scielo.br/pdf/reeusp/v45n5/v45n5a33.pdf>.

17. Sampaio RF, Mancini MC. Estudos de revisão sistemática: um guia para síntese criteriosa da evidência científica. *Rev Bras Fisioter* 2007;11(1):83-9. Doi: 10.1590/S1413-3552007000100013 .

18. Moher D, Liberati A, Tetzlaff J, Altman DG. Preferred Reporting Items for Systematic Reviews and Meta-Analyses: The PRISMA Statement. *Epidemiol. Serv. Saúde*. Brasília 2015;24(2):335-42.

Doi:10.1371/journal.pmed.1000097.

19. Souza MT de, Silva MD da, Carvalho R de. Integrative review: what is it? How to do it? *Einstein*, 2010;8 (1):102-6. Doi: 10.1590/s1679-45082010rw1134.

20. Pereira MG, Galvão TF. Heterogeneidade e viés de publicação em revisões sistemáticas. *Epidemiol Serv Saúde*. Brasília, out-dez 2014;23(4):775-8. Doi: 10.5123/S1679-49742014000400021.

21. Akerman M, Franco de Sá R, Moyses S, Rezende R, Rocha D. Intersetorialidade? Intersetorialidade? *Cien Saude Colet*. 2014, 19(11):4291-4300. Doi: 10.1590/1413-812320141911.10692014.

22. Andrade LOM, Pellegrini-Filho A, Solar O, Rigoli F, Salazar LM, Serrate PCF, et al. Social determinants of health, universal health coverage, and sustainable development: cases studies from Latin America countries. *Lancet* 2015; 385:1343-51. Doi: 10.1016/S0140-6736(14)61494-X.

23. Diba D, d'Oliveira AS. Teatro e comunidade, juventude e apoio social: atores da promoção da saúde. *Cien Saude Colet* 2015;20(5):1353-62. Doi: 10.1590/1413-812320152005.01542014.

24. Dawbor TP, Westphal MF. Determinantes sociais da saúde e o Programa da Saúde da Família no município de São Paulo. *Rev Saude*

Publica 2013;47(4):781-90. Doi: 10.1590/S0034-8910.2013047004585.

25. Giovanella L, Mendonça MHM, Almeida PF, Scorel S, Senna MCM, Fausto MCR, et al. Saúde da família: limites e possibilidades para uma abordagem integral da atenção primária à saúde no Brasil. *Cien Saude Colet* 2009, 14(3):783-94. Doi: 10.1590/S1413-81232009000300014.

26. Nascimento PR, Westphal MF, Moreira RS, Baltar VT, Moysés ST, Zioni F, et al. Impact of social Agendas - agenda 21 and Health Cities - upon the social determinants of health in Brazilian municipalities: measuring the effects of diffuse social policies through the dimensions of Millenium Development Goals. *Rev Bras Epidemiol* 2014; suppl:1-14. Doi: 10.1590/1809-4503201400060001.

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