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Integral Attendance of Adolescence: Health and Education Brazilian Policies and The Health in School Program

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Abstract: This article intends to discuss the need for comprehensive care for adolescents, whereas this phase of human development is complex, interdisciplinary and intersectoral actions are required, such as the proposal of the Pan American Health Organization (PAHO) on the Health Promoting School. Through bibliographic research it was possible to identify how much the two most comprehensive policies of the Brazil are unified in the quest for the integrality care of adolescence. According to the IBGE/PNAD, 94.2% of school-age young people are enrolled in school, but few of them have a link with health units. To reach the magnitude of these two public policies, the evolution of health and education policies in Brazil will be discussed. It is worth highlighting that there are many contradictions in conceptions and practices until we reach the 2007 meeting the policies with the Health in School Program, based on the guidelines of the PAHO Health Promoting School, and even though there is much to go of each sector, however, the partnership between them contributes to the consolidation of SUS principles, comprehensiveness, universality, equity and social control, as well as the emancipatory purpose of LDB, resulting in good indices in the agreed units.

Key words: health promoting school, education, health promotion

1. Introduction

This article appears in a scenario in which adolescence is a poorly served public in the health services, due to several characteristics of this public and limitations of professionals and health services. When seeking a theoretical basis for health care for adolescents, the proposal of the Health Promoting School of the Pan American Health Organization (PAHO), which proposes an alliance between the education and health sectors, aims to improve the quality of life.

For this work will be considered adolescence, the period determined by the World Health Organization (WHO), which is 10 to 19 years. According to data from the PNAD (National Survey by Sample of Domiciles), in 2017 Brazil had around 33.685 million adolescents.

Considering adolescence, a stage of human development marked by profound biopsychosocial transformations that are directly influenced by external factors such as the values and behavior of friends, which gain increasing importance as a natural distance from parents arises towards a greater independence. It is noteworthy that adolescents are also heavily influenced by the media, and the entertainment industry.

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Thus the adolescent population of Brazil is susceptible to all existing social inequities. The country has a large proportion of these adolescents living in poverty or extreme poverty, with low access to higher levels of schooling, which in itself already has a direct impact on health and wellness indicators. Adding to these inequities, risk behaviors that further aggravate health are also increasing.

While Brazil has been improving its general health indexes in other population groups, in relation to adolescence there is little that is celebrated, some indicators have risen and others slowly declining or stagnating. Highlighting the following:

- between 2006 and 2016, the number of new cases of adolescents infected with HIV tripled - Ministry of Health, Epidemiological Bulletin, 2017.

- between 1990 and 2014. The number of homicides doubled, from 5 thousand to 11.1 thousand/year - Datasus, 2014.

- an average of 68.4 babies born to every 1,000 adolescents. The average in Latin America is 65.5 WHO / 2018.

- 55.5% of final year students in public and private schools between the ages of 13 and 15 have already experienced alcohol. National School Health Survey (PENSE) 2015.

- 9% of final-year students in public and private schools between the ages of 13 and 15 have used illicit drugs. National School Health Survey (PENSE) 2015.

In view of this scenario, the objective of the present study is to reflect on public health and education policies in Brazil and the partnership between these two sectors, made possible by the proposed Health Promotion School, as a possibility to consolidate the principles of SUS and the purpose of Education.

In order to explain the proposal of the Health Promoting School, the history of health and education policies in Brazil will be approached, emphasizing common points that support the approximation between the two most disseminated sectors throughout the country, present throughout the territorial extension. From then on, systematizing the PAHO/WHO proposal and making it feasible to achieve health in an expanded way, considering the multidimensionalities of the human being, as advocated by health promotion. And the copy of this PAHO guideline in Brazil, the Health in the School Program, describing its advances and challenges.

2. The Two Policies

2.1 Health Policy in Brazil

Health policies in Brazil until 1988 were governed by a liberal state, one that only intervened in what the individual or the private sector did not act, but that was essential to the economy, so the health was characterized by a sanitarist campaign, a medicine social security, that is, had access to health services who could pay for them or who contributed to Social Security, so a large part of the population was subject to the care of philanthropic institutions and a simplified medicine.

It was not until 1975, under Law 6.229/75, that a National Health System was created, which defined the attributions of the Union, the State and the municipalities in relation to health, but which centralized power at the federal level, and which carried out programs (Meningitis Campaign, National Immunization Program, among others), institutionalizing a medical-curative model.

At the end of the 1970s, the Health Movement questioned health thinking, relating it to the quality of life, which was legitimized at the VIII National Health Conference in 1986.

> Health is conceived in this forum as a result of the conditions of access to housing, education, income, environment, work, transportation, employment, leisure, freedom, access and land tenure and access to health services. A fundamental aspect of this forum was the fact that attention was paid to the interdependence between these elements and their *sinequa non*-condition for achieving health (Garbois, Vargas & Cunha, 2008).

The Health Movement and the demands of social movements made the concept of health described above incorporated into the Federal Constitution of 1988, so health became a right of all and a duty of the State, which Campos (2006, p. 29) indicates that it is a citizenship right that amplifies the possibility of emancipation of individuals, since it suggests improvements in and access to services, which is very different from the context of inequality still experienced in the country.

Since the promulgation of the Constitution in 1988, which created the Unified Health System (SUS). And in the face of a scenario of economic instability and high inflation, in 1990 the Organic Health Law (Law 8080/90) was sanctioned, which regulated the Unified Health System (SUS), which regulated the conditions for the promotion, protection and recovery of throughout the national territory. In the same year of 1990, Law 8,142 was also sanctioned in December, which dictates the popular participation in the control of services.

> In this process, the country thus had a health policy clearly defined constitutionally in the sense of social policy, as public policy, implying, therefore, substantive changes for its operation in the politico-legal, political-institutional and technical-operational fields (Almeida de Castro & Lisboa, 1998).

SUS has social welfare and organizational rationality as founders of its principles and guidelines, described below:

> - Universality: all citizens have the right to access to health services;
>
> - Integrality: considers the various dimensions that influence the health-disease process of citizens;
>
> - Equity: priority of actions and services to the most vulnerable segments of the population;
>
> - Decentralization: it is the only command in each sphere of government (Federal, State, Municipal), which emphasizes the municipalization of management;
>
> - Regionalization: rationalized and equitable organization in the territories;
>
> - Hierarchy: it orders the system in levels of attention and establishes the care flow between them, being the basic attention the one of greater contact and of frequent use of the population;
>
> - Community participation: organization of social participation in Conferences and Health Councils in the three spheres of government. Participation assured by Law 8.142/90 (Vasconcelos & Pasche, 2006, p. 535).

With SUS millions of Brazilians became individuals with health rights, however, there was a decrease in health investments, making the health model based on the doctor's figure and the "cure" of diseases prevail. Because the complexity, the scope of the changes and the implications of the interests involved in a transitional period from the "New Republic" to the Collor government, made it difficult to implement SUS health policy, due to the health reform ideas.

> The political context of the Collor government was a "regression in politics and public administration", with intense participation of society in denunciations and criticisms, demands for changes and advances, including the area of health, seriously affected and involved in this crisis (Almeida de Castro & Lisboa, 1998).

With the process of decentralization and regionalization of health services, the territory is constituted as elementary, since it organizes the actions of the health services according to the needs of each region and with the population's demand, as it ties the population closer and enables a knowledge of the health, social, leisure and cultural situation of the territory.

In order for these processes to be effective they have to be permanent and dynamic, health units in the territory can not be isolated, they have to be functional and with development of actions at all levels of prevention and articulated intra and intersectorally, it is necessary an orientation of the care model. For this, it is necessary to invest in mechanisms and devices that enable the articulation between health services at different levels (primary, secondary and tertiary).

After 28 years of SUS, there is still much to fight for principles and guidelines to become reality. According to Vasconcelos and Pasche (2006), the political achievements achieved by the SUS are still insufficient to face the challenges that still need to be addressed in health and the right to health, this path of transposition from the biomedical model to the expanded health conception is also a challenge world.

2.2 Education Policy in Brazil

Until the arrival of the Portuguese in Brazil, the Indians learned by the transmission and construction of knowledge between the elders and the younger, in a non-rigid way as proclaimed by the Jesuits. They brought not only Catholic dogmas, but they were also the first to formalize pedagogical methods in Brazil. The Jesuits were responsible for a catechetical pedagogy for the "deprived of culture" in Brazil until 1759, with colleges and seminaries, when they were expelled by Marques de Pombal. From then on the educational actions were isolated and unsystematic, and did not constitute a system, according to Bello (2001), "the most absolute chaos .... The Jesuit system was dismantled and nothing that could get close to them was organized to continue a work of education."

In 1808, there were the first faculties, due to the coming of the royal family, but still nothing that could be called educational system. Education is only considered again in 1824 in the First Constitution of Brazil, in its article 179, which said that "primary education is free for all citizens", but still without solid structures.

According to Bello (2001):

> Rivadavia Correa Reform, of 1911, intended that the secondary course should become a citizen's trainer and not as a simple promoter to the next level. Resuming the positivist orientation, it preaches the freedom of teaching, being understood like the possibility of offering of education that is not by official schools, and of frequency. (Bello, 2001).

With the Revolution of 30, education became a Salvationist character, from it the country would reach the prosperity of the first world countries. Brazil needed skilled labor and it was necessary to invest in education. Thus, in 1930, the Ministry of Education and Public Health was created, and in 1931, the provisional government sanctioned decrees, which organized secondary education and Brazilian universities still non-existent. These Decrees became known as "Francisco Campos Reform". In the same decade, new pedagogy began to be discussed, with the conception of a more democratic school, with knowledge centered on the student, his experiences, not only in the transmission of knowledge.

With the highly valued importance assigned to education in 1934, the new Constitution provides for the first time that education is the right of all, and must be administered by the State, from there there is universal access to education and also the dichotomization of purpose with education for the manual labor, for the children of workers

and intellectual labor for the children of the ruling classes.

> Even when this state education is offered in quantity for all (which in unequal societies only tends to happen at the basic level of schooling), its unequal quality is a structurally necessary factor, together with others, for the unequal reproduction of society classes. The unequal quality of state education does not happen by chance, but it is just one of the many weapons used by the ruling classes to maintain domination over the popular / exploited classes (Davies, 2004, p. 27).

In 1942, reiterating the need for skilled labor, some branches of education are reformed. These Reforms have been called the Organic Laws of Teaching, and are composed by Decree-Laws that create the National Service of Industrial Learning — SENAI and values vocational education.

Against the background of the ideology of professional-only formation, in 1950 began the initiatives to rethink education to a different, less dissimilar society in 1950, in Salvador, Bahia, Anísio Teixeira inaugurates the Popular Center for Education (Centro Educacional Carneiro Ribeiro), starting his idea of school-class and park-school, and in 1961 a literacy campaign began, whose didactic work, created by Paulo Freire from Pernambuco, proposed to literate in 40 hours illiterate adults (Bello, 2001).

These attempts were stifled by the military period, which in 1971 made professional training prevail, by Law 5,692, the Law on Guidelines and Bases of National Education, in 1971, marked by compulsory professionalization in secondary education, thus concealing the citizen formation of the student .

Only with the promulgation of the Law of Directives and Bases of Education (LDB), Law no. 9394 of December 20, 1996, which states in its title II, on the Principles and Purposes of National Education, article 2 that places the purpose of education as the full development of the student, his preparation for the exercise of citizenship and its qualification to the work.

At present, the discussion of a new approach to education is based on the report prepared by Jacques Delors for UNESCO of the International Commission on Education for the 21st Century, entitled Education, a Treasure to be Discovered (1996), which explores the Four Pillars of Education: learning to be; learn to live together; learn to do; learn to learn. Conception that tries to adapt education to the needs of the market, but also not lose sight of the production of knowledge, culture.

To this day much has moved into educational planning, but education continues to have the same characteristics practiced in many countries of the world, which is more to maintain the *status quo*, for those who attend school units, and less to offer basic knowledge, to be used by students in their daily lives and to actually have emancipatory conditions.

2.3 A Strategy - Health Promoting School

Overcoming watertight models of health requires very different practices than biomedical practices. To leave the traditional place of care was an outlet found for the reach and greater appropriation of the territory of each healthcare unit. As Silva, Oliveira, Nunes and Torres (2001) put it, the territory of a Basic Health Unit is more than the area of coverage, it is a process territory, it is characterized by social dynamics, it is a "pulsing life space" therefore it is necessary to leave the counter, the service desk and go where the person in charge is, to take ownership of all the devices of the community, the determinants of health.

Health seeks tools for health promotion and schools seek tools for reaching citizenship. An alliance between the two sectors was conceived from 1991 onwards at the III International Conference on Health Promotion, held in Sweden, with the theme "Favorable Environments for Health", in which the interdependence between

environment and health was reaffirmed. the most important ally of health is the school, the largest socializing agent in the country, an excellent communication channel for carrying out activities and transmitting messages about health (Abrocesi-Lervolino, 2000, p. 43). Power of dissemination confirmed by IBGE/PNAD data, which in 2015, 94.2% of children and adolescents from 4 to 17 years old were enrolled in elementary education. The scope of citizenship, also an objective of health, is located as:

> The school is a space of great relevance for the promotion of health, especially when this question is part of the constitution of the knowledge of the critical citizen, stimulating it to autonomy, the exercise of rights and duties, the abilities with option for healthier attitudes and in control of their health conditions and quality of life (Brasil, 2006, p. 24).

Therefore, PAHO/WHO to strengthen health promotion defines the Health Promoting School as a tool, and thus defines it:

> Schools that have a safe and comfortable building with adequate drinking water and sanitation facilities and a positive psychological atmosphere for learning that foster healthy human development and constructive and harmonious human relationships that promote positive attitudes toward health are considered "Health Promoting Schools". (Abrocesi-Lervolino, 2000, p. 52).

The Health Promoting Schools have three basic components:

- Health education with a holistic approach;
- Creation of healthy environments;
- Provision of health services.

These components are based on the fundamental principles and roles of health promotion embodied in the Ottawa Charter of 1986, which states that health promotion is not the sole responsibility of the health sector but is the responsibility of all. By redefining the concept of health, it is no longer only a responsibility of health professionals, it also involves the professionals of education, and the individual is not seen in isolation from the context in which he or she lives, and then enables people to assume the destiny of their lives and the society in which they live.

Understanding oneself as a citizen involves clarifying the stages of human development, possessing self-esteem, clarifying the way society functions. Therefore, the Health Promoting School should address issues such as nutrition, physical activity, peace culture, issues related to violence, sexuality and prevention of sexually transmitted diseases and AIDS, oral health, adolescent health, healthy environments, communication and health practices and to cultural movements in their different languages, such as theater, music and dance (Brasil, 2006, p. 27). Therefore, the contents of the Health Promoting School must be transversal, since all areas of knowledge contribute to the development of health related content. Gomes (2009), still argues that it is not about the work of an isolated teacher, but about the integration between all school staff and health professionals.

Interdisciplinarity is needed then, not only for health professionals, but also for education workers. Just as it is also necessary the intersectoriality between the workers of the two sectors, to stimulate the integral conception of the human being.

> When reviewing the interaction between the education and health sectors, the process of humanization of health care services is highlighted as an important contribution to strengthening health promotion. This process facilitates a better interrelationship between health professionals and users, as well as between health units and other sectors of society, such as schools and the community (Brasil, 2006, p. 25).

In Brazil, the Health Promoting School proposal was concretized in the promulgation of Decree no. 6286, dated December 5, 2007, which establishes the Health Program in School — PSE — which aims to contribute to the integral formation of students through actions of promotion, prevention and health care, with a view to coping with vulnerabilities which jeopardize the full development of children and young people in the public school system. The PSE occurs with the partnership between teams of the Family Health Strategy and schools in the territories of the teams, with the local diagnosis in health planning actions aimed at prevention, promotion, recovery and maintenance of the health of individuals and human collectives. The Ministries of Health and Education state that more than a strategy for the integration of sectoral policies, the PSE proposes to be a new design of education and health policy since:

(1) treats health and integral education as part of comprehensive training for citizenship and full enjoyment of human rights;

(2) allows for the progressive expansion of the actions carried out by the health and education systems with a view to comprehensive health care for children and adolescents;

(3) promotes the articulation of knowledge, the participation of students, parents, school community and society in general in the construction and social control of public policy.

The PSE is organized into four components: assessment of health conditions; health promotion and prevention; continuing education and training of education health and youth professionals; and health monitoring and evaluation of students. The strategies used by the PSE are group discussions, case studies, community work projects and distribution of printed material.

Currently according to the new Ordinance, the PSE now has two-year membership, that is, it will have a two-year cycle. This means that the municipality pays twelve actions and others that you want to include to be held in each year of the cycle. At the end of each year of the cycle the federal management informs the balance of the monitoring carried out from the information recorded, sent and validated in the SISAB. The twelve actions are thus defined:

1) Actions to combat the mosquito Aedes aegypti.
2) Promoting food and nutritional security and healthy eating and combating childhood obesity.
3) Sexual and reproductive rights and STD/AIDS prevention.
4) Prevention of alcohol, tobacco, crack and other drugs.
5) Promotion of the Culture of Peace, Citizenship and Human Rights.
6) Promotion of corporal practices, physical activity and leisure in schools.
7) Prevention of violence and accidents.
8) Identification of students with possible signs of diseases of elimination.
9) Oral Health Promotion and Assessment and Topical Application of Fluoride.
10) Verification of the vaccination situation.
11) Promotion of hearing health and identification of students with possible signs of change.
12) Promotion of eye health and identification of students with possible signs of change.

Considering data from the National Survey by Household Sample — PNAD, from IBGE, that in 2015, access to school was 98.5%, for the population aged 6 to 14 years, and 84.3%, for the range age of 15 and 17 years (Synthesis, 2015). Schools are remarkably potential for expanding access and health care to adolescents.

In 2017 the PSE reached 79 thousand schools and reached approximately 18 million students, involving 32

thousand primary care teams distributed in 4,787 municipalities[1].

Thus the possibility of adolescents studying health information is potentially significant. Second newsletter of the National Student Health Survey - PENSE, with a sample of more than 102 thousand students who attend the 9th grade (old 8th grade) of elementary education in 3,040 public and private schools in rural and urban areas throughout Brazil , in the period between April and September 2015 revealed that:

> Most students were between 13 and 15 years old. The result reflects the behavior of more than two and a half million adolescents in the 9th grade ... In the units where the interviews were conducted, the indicators showed positive results on the performance of the Health in the School Program: health promotion activities with the objective of stimulating physical activities and social integration carried out by the PSE are changing the reality of Brazilian schoolchildren. The show says 55.3% of 9th grade students have turned to a health care professional or health unit in the country last year. Among the health services most sought by them: 45.1% reported having gone to a Basic Health Unit (UBS) (Portal do Brasil).

The PSE in addressing health issues at school empowers adolescents to seek health services and to initiate a process of better choices for their health and well-being. The data of the Pense/2015, in the schools attended by the PSE, was remarkable the improvement in food, with a decrease in the intake of sweets, also occurred a decrease in alcohol intake and use of cigarettes and other drugs, besides behavioral improvement with ...

> Another important achievement was the drop in cases of bullying among the students interviewed, the bullying free environment (characterized when there are no students who practice or receive bullying) was 48.8% among the students of the schools that joined the Program and 45 , 6% in those of non-adherent schools (Portal do Brasil).

Thus, since 2007, the PSE has shown to be an effective strategy in the comprehensive health care of children and adolescents in Brazil.

3. Considerations

In view of the above, it is possible to conclude that health and education begin to interpermeat with potentiality to break conceptions and paradigms on both sides, and the PSE solidifies itself as a national strategy that can be used to reach the integrality in the care of adolescents in Brazil. The consolidation of SUS principles impels a new model of health care, in order to break with the practices of curative, specialized and hospital medicine, which until then have led to an excess of technological and medical procedures aimed at the fragmentation of the individual. Focusing on the subjects in an integral way, focusing on the family and the social context in which they are inserted, is a challenge that strikes the education and health workers.

It is undeniable that the PSE has the potential to expand further and achieve more results in favor of children and adolescents. However, there are limitations in the health care of the health professionals, who are still less accustomed to intersectoral actions and outside the health unities care setting, but this difficulty is also of the professionals of the schools, who are also less accustomed to the intersectoral work and to conclude that the school needs to go beyond what is expected in educational curriculum. It is therefore necessary, to encourage the adhesion of municipalities to the Health in School Program and the continuing education of professionals in the health and education sectors so that intersectoral actions can be even more effective, integral and strengthened.

[1] http://www.brasil.gov.br/saude/2017/04/programa-saude-na-school-spanish-for-students.

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