

# CUIDADO É FUNDAMENTAL

Escola de Enfermagem Alfredo Pinto – UNIRIO

RESEARCH

DOI: 10.9789/2175-5361.rpcfo.v15.10955

## INTERSECTORAL PRACTICES IN PRIMARY HEALTH CARE: FROM ACHIEVEMENT TO CHALLENGES

*Práticas intersetoriais na atenção primária à saúde: da concretude aos desafios**Prácticas intersectoriales en atención primaria de salud: del concreto a los desafíos*Edna Mara Mendonça<sup>1</sup> Maria Marta Amancio Amorim<sup>2</sup> Selma Maria da Fonseca Viegas<sup>1</sup> Fernanda Moura Lanza<sup>1</sup> 

### ABSTRACT

**Objective:** to understand the concreteness and challenges of intersectoral practices in Primary Health Care. **Method:** qualitative research developed in a medium-sized Brazilian municipality from February to July 2018. The source of evidence was the semi-structured interview with 59 professionals and managers linked to Primary Health Care and the data were analyzed according to the Thematic Content Analysis. **Results:** intersectorality is realized in view of the users' demand for comprehensive care in Primary Health Care. The Extended Family Health Center and Family Health Teams seek the necessary arrangements for the formation of an intrasectoral or intersectoral network. **Conclusion:** it was perceived the primary role of management to induce intersectoral actions in the territories, such as promoting the insertion of intersectoral practices in the work agenda; and in spaces of collective construction as potentializers of public policies.

**DESCRIPTORS:** Unified health system; Health policy; Intersectoral collaboration; Primary health care; Health personnel.

<sup>1</sup> Universidade Federal de São João del-Rei, Divinópolis, Minas Gerais, Brazil

<sup>2</sup> Centro de Estudos de Migração e Relações Interculturais, Universidade Aberta, Lisboa, Portugal

Received: 03/13/2021; Accepted: 02/25/2022; Published online: 03/1/2023

**Corresponding Author:** Fernanda Moura Lanza, E-mail: fernandalanza@ufsj.edu.br

**How cited:** Mendonça EM, Amorim MMA, Viegas SMF, Lanza FM. Intersectoral practices in primary health care: from achievement to challenges. *R Pesq Cuid Fundam* [Internet]. 2023 [cited year month day];15:e10955. Available from: <https://doi.org/10.9789/2175-5361.rpcfo.v15.10955>



## RESUMO

**Objetivo:** compreender a concretude e os desafios das práticas intersectoriais na Atenção Primária a Saúde. **Método:** pesquisa qualitativa desenvolvida em um município brasileiro de médio porte no período de fevereiro a julho de 2018. A fonte de evidência foi a entrevista semiestruturada com 59 profissionais e gestores ligados à Atenção Primária a Saúde e os dados foram analisados segundo a Análise de Conteúdo Temática. **Resultados:** a intersectorialidade é concretizada perante a demanda dos usuários por cuidado integral na Atenção Primária a Saúde. O Núcleo Ampliado de Saúde da Família e as Equipes de Saúde da Família buscam os arranjos necessários para formação de rede intrasectorial ou intersectorial. **Conclusão:** percebeu-se o papel primordial da gestão para indução das ações intersectoriais nos territórios, como o fomento à inserção de práticas intersectoriais na agenda de trabalho; e em espaços de construção coletiva enquanto potencializadores das políticas públicas.

**DESCRITORES:** Sistema único de saúde; Política de saúde; Colaboração intersectorial; Atenção primária à saúde; Pessoal de saúde.

## RESUMEN

**Objetivo:** comprender la concreción y los desafíos de las prácticas intersectoriales en Atención Primaria de Salud. **Método:** investigación cualitativa desarrollada en un municipio brasileño de tamaño mediano de febrero a julio de 2018. La fuente de evidencia fue la entrevista semiestruturada con 59 profesionales y gerentes vinculados a la Atención Primaria de Salud y los datos fueron analizados según el Análisis de Contenido Temático. **Resultados:** la intersectorialidad se concreta ante la demanda de atención integral de los usuarios en Atención Primaria de Salud El Centro de Salud de la Familia Extendida y los Equipos de Salud de la Familia buscan los arreglos necesarios para la conformación de una red intrasectorial o intersectorial. **Conclusión:** se percibió el rol primordial de la gestión para inducir acciones intersectoriales en los territorios, tales como promover la inserción de prácticas intersectoriales en la agenda de trabajo; y en espacios de construcción colectiva como potencializadores de políticas públicas.

**DESCRIPTORES:** Sistema único de salud; Política de salud; colaboración intersectorial; Atención primaria de salud; Personal de salud.

## INTRODUCTION

Since the Alma Ata Declaration in 1978, Primary Health Care (PHC) has stood out in the organization of health systems. Health began to be seen in a broader way and as a phenomenon of multiple determinations, which required the transformation of health services in the search for comprehensive care.<sup>1</sup> After 40 years of this historic milestone in public health, in 2018, the Global Conference on PHC was held in Kazakhstan, where the defense of social justice, health for all, and overcoming inequalities between and within countries was reaffirmed, resulting in the Astana Declaration.<sup>2</sup>

In recent years, favored by the World Health Organization (WHO), the "Health in all Policies" (HiAP) approach has emerged, based on the interest in expanding health promotion research on the social determinants of health.<sup>3</sup> Thus, health promotion should be prioritized in order to reduce social inequalities and improve the health of the population. This context includes intersectoral practices involving different sectors, such as economic, labor and employment, education, transportation, housing, environment, among others.<sup>4</sup>

Since 2015, the United Nations (UN), together with its member countries, launched the 2030 Agenda in recognition of the challenges that all countries must overcome with regard to sustainable development in its three dimensions: social, economic, and environmental. The Sustainable Development Goals (SDGs) replaced the Millennium Development Goals and guide national policies and international cooperation activities with an integrated approach to the goals and targets.<sup>5</sup> The 2030 Agenda puts health in direct relation to the other development goals, supporting so-

cial justice, economic prosperity, and environmental protection. SDG 3 stands out, making universal health coverage central to achieving the main goal of improved quality of life and well-being for all at all ages.<sup>6</sup>

In the context of strengthening PHC and the performance of the Family Health Strategy (ESF), the Family Health Support Center (NASF) was created, today called the Extended Family Health and Primary Care Center (NASF-AB) with the objective of expanding the network of services, as well as the resoluteness, scope, and target of actions, which must be constituted by a multidisciplinary team.<sup>7</sup>

Among the attributions of PHC, intersectoriality emerges as a tool for health workers to expand the completeness of care, accountability, and resoluteness, such as the development of listening skills and the promotion of negotiation spaces for knowledge sharing, in addition to partnerships with the community and the various sectors of society.<sup>7</sup> Thus, intersectoriality refers to the sense of complementarity of practices and is not opposed to sectoral action. The Final Report of the National Commission on Social Determinants of Health (CNDSS) brings intersectoriality as actions and/or interventions on social determinants in a dynamic of co-responsibility by public organizations and partners with the construction of a network of relationships.<sup>8</sup>

The challenge of producing health in the daily routine of services demands constant changes in the work process, such as the creation of collectives (with managers, professionals, community), composition of networks and partnerships with the involvement of different social actors.<sup>9</sup> This means a new logic of work, of potentialization of meetings to qualify the listening,

in order to know the needs and seek possible solutions within the available care networks.<sup>10</sup>

PHC is responsible for establishing a link between health professionals and the population, obtaining knowledge of the reality of the families for which it is responsible, detecting the predominant health problems and risk situations to which the population in its territory of coverage is exposed to provide comprehensive care.<sup>7</sup> Based on the assumption that health production is a work that is done and re-done as an effect of a collective – professional and community – according to personal interests and social interactions, this study was proposed with the aim of understanding the concreteness and challenges of intersectoral practice of PHC managers and professionals.

## METHOD

Qualitative research approved by the Ethics Committee on Research Involving Human Beings of the Federal University of São João Del-Rei – Midwest Campus, Divinópolis, Minas Gerais, under CAAE 79985917.9.0000.5545, opinion 2.469.057. This research was conducted according to the ethical standards required by Resolution 510/2016 of the National Health Council.<sup>11</sup>

Qualitative research is the experience, understood as a product of personal reflection on experience, being its object, summarized by relationships, representations, and intentionality and delves into the universe of meanings. It is disposed by experience, living, common sense and action.<sup>12</sup> This research followed the criteria of the Consolidated Criteria for Reporting Qualitative Research (COREQ), which are the consolidated criteria for reporting qualitative research following the three proposed domains – research team and reflexivity, study concept and analysis of results.<sup>13</sup>

The study setting was the PHC of a medium-sized Brazilian municipality with 25 ESF teams (93% population coverage) and four NASF-AB teams. For this study, ESF and NASF-AB teams were randomly selected, without defining selection criteria, and the number of ESF and NASF-AB teams that participated in the study was later defined by data saturation. At the end of data collection, the scenario consisted of five ESF and four NASF-AB units.

The main criterion for the choice of participants was the possibility of exercising intersectoral practices promoted in PHC. The criteria for inclusion of participants considered all members of the EAF or NASF-AB of the city who had been working for more than one year in the service. The exclusion criteria were being on vacation or any other reason for leave of absence during the data collection period. All PHC managers were also invited to participate in the study.

The collection instrument consisted of a script organized in two sections, the first composed of questions to characterize the participants, and the second, by five questions: 1. How do you understand intersectorality? 2. What strategies have been adopted for intersectoral networking? 3. Tell me a little about the intersectoral network in the municipality. Which services make up the network and how are they organized? 4. How have the

municipality's teams acted in intersectoral actions? 5. What are the challenges and priorities to improve intersectorality in the municipality? To assess the suitability of this instrument and the quality of data collection, a pilot test was conducted in another municipality, in health services with characteristics similar to those of this study.

Data collection was conducted according to the following stages: contact with the field and presentation of the proposal, individual interviews, and preparation of the field diary. The interviews occurred in the period from February to July 2018, were conducted by the main researcher, fully recorded with the use of an Iphone device, and had an average duration of eight minutes and 20 seconds, with 45 interviews lasting less than ten minutes. The collection ended when the evidence was saturated, i.e., when there was a recurrence of responses, but without neglecting important content for the study.<sup>13</sup> There was no repetition of any interview.

In total, there were 59 participants, of which: (a) 36 ESF professionals, among these, two physicians, five nurses, eight nursing assistants/technicians, 17 community health agents (ACS), two dentists and two dental office assistants; (b) 20 NASF-AB workers, being two psychologists, one social worker, four physical therapists, four nutritionists, two physical education teachers, three speech therapists, three pharmacists and one nurse responsible for Integrative and Complementary Health Practices (c) three Managers of the Municipal Health Secretariat.

The people who did not meet the inclusion criteria were 29 in total, of which: 18 due to length of service, six due to vacation, three due to voluntary resignation, one due to recent retirement, and one refused to participate in the research without justification. Of these, 20 were from the ESF and nine from NASF-AB.

The individual interviews were scheduled according to the availability of the participants, held at their own workplace, in a reserved room to preserve the confidentiality of information and avoid interruptions. The contents of the individual interviews were carefully transcribed in full, and were not returned to the participants for comments and/or corrections. Measures were taken to protect the anonymity of the information from the individual interviews. Confidentiality was maintained by adopting the letter E (Interviewee) followed by a sequential number to the subsequent interviews conducted (E1, E2...).

After this step, the Content Analysis was performed, defined by the semantic criterion, that is, by the analysis of the "meanings", according to the phases described by Bardin: pre-analysis, exploration of the material, categorization, treatment of the results, inference, and the interpretation to what has already been described in the scientific literature.<sup>14</sup> The content analysis was conducted by a single researcher.

The pre-analysis aimed to operationalize and systematize the initial ideas, conducting a precise design of the development of the successive operations in an analysis plan. The first activity performed was "floating" reading, which consists in recognizing the text, appropriating its content, so that the reading gradually becomes more precise and comprehensive.<sup>14</sup>

The exploration of the material consisted of coding and categorizing the data obtained. Coding is the transcription of specific characteristics, allowing us to achieve a representation of the content or its expression was structured by the "coding operations". It is the concretization of the decisions made in the pre-analysis, that is, what represents the meanings expressed in the floating, precise, and comprehensive reading.<sup>14</sup>

The categorization consisted, first, in the classification of the textual elements by differentiation and, then, by grouping, by means of the common characteristics or meanings of these elements. Considering also the exploration of the material, categorization was carried out, which consisted of classifying and grouping certain subjects by divergences or convergences of the results.<sup>14</sup> We carried out a floating reading that favored the identification of the nuclei of meanings that emerged in the content of the speeches. The material exploration consisted in coding and categorizing the data obtained.

The analysis of the individual interviews resulted in three thematic categories: 1) "The conceptions of health and articulation of care in everyday PHC: intersectoriality versus intersectoriality"; 2) "Intersectorial dialogues in search of comprehensive care: ways to promote intersectoriality in ESF and NASF AB" and 3) "Intersectoriality: potentialities, weaknesses and challenges".

## RESULTS AND DISCUSSION

The data analyzed in this article were obtained from a survey in which 59 health professionals participated, 51 (86.5%) were female; their age ranged from 24 to 57 years, mean 37.8 years and most of them (56%, n=33) had college education. Regarding the place and time of service, 61% of the participants (n=36) are ESF professionals with an average time of service of 7 years and 1 month; 20 (33.9%) NASF-AB workers, with an average time of service of 3 years and 8 months; and 3 (5.1%) health managers, with an average time of service of 1 year and 8 months. The professional categories with longer time in PHC were the ACS (average of 9 years), followed by nurses (7 years), nursing technicians (6 years and 2 months), and physicians (1 year and 8 months).

Among the three categories raised in the content analysis of this research, we selected category number 3) "Intersectoriality: potentialities, weaknesses and challenges" to be analyzed in this article. The category addresses the facilitating and hindering aspects reported by professionals working in ESF and NASF-AB when practicing intersectoriality in their daily work.

The intersectoral practice in the view of health professionals involves working together, according to the speeches described below.

*"When we arrive and tell people what intersectoriality is, what the goal is, many times, people confuse intersectoriality with pushing the problem to them, and this is not it. It is about us working together. It is our problem, not a sector's problem. So, when they start to see that this is it, that we are*

*co-responsible for a common problem, it makes it easier.* (E5 – manager)

*"The chiefs have to wear the shirt, want to have this action, because everything, the articulation starts with them, if the articulation is not good, we cannot achieve anything.* (E19 – manager)

*"Sometimes we should work together more, you know?! .... We are part of the same network and the work is separate [...] but I think there is a lack of knowledge [...] is where you keep accusing the other, talking about the other, because you have no knowledge of the other's work."* (E8 – ESF)

*"The patient is not mine, he is not yours, he is ours. So we will look for alternatives together, we will know how to guide, we will know how to give a support and take care of this patient."* (E41 – NASF-AB)

The intersectoriality must be taught to be practiced, being a work performed together with health professionals and managers must "wear the shirt" of this practice, articulating joint and networked actions. For this, "the professional interactions must be nourished with the expanded concept of health to overcome the practices anchored in the biomedical model, still so present in the services".<sup>15:159</sup> Thus, intersectoriality represents the overcoming of policy fragmentation, besides being a tool for collaboration of care and/or management practices, and has been seen as a driver of health policies aimed at changing models of care.<sup>16</sup>

In the context of PHC, actions related to health promotion emerge with prioritization of real and concrete problems of the territories with an approach to the social determinants of health.<sup>4,17</sup> Qualitative research conducted in a Health Region of Rio Grande do Sul (Brazil) showed that nurses coordinators of PHC teams feel the need to perform care in an interprofessional and intersectoral manner due to the social diversity and health problems presented by the population they care for.<sup>9</sup> But, how is it possible to give legitimacy to intersectorialism – as a structuring axis for the health sector, in management and care practices?<sup>16</sup>

In this research, the training of health professionals is placed by a manager as a facilitator of intersectoriality practices

*"So what facilitates a lot is that I have seen some trainings, precisely to remove this barrier that people have to leave their core and go beyond [...] this will facilitate the issue of working intersectoriality"*. (E5 – manager)

The trainings on intersectoriality are important tools in the understanding of health professionals about the process of complementarity of practices, when seeking alternatives in other sectors. The pedagogical political strategy that occurs in health services is called Permanent Health Education (PHE) – established by Decree 198/2004 and reformulated by Decree 1996/2007 – in which learning and teaching are incorporated into the work processes. PHE emerges as a pillar of democratic management with reinvention and improvement of practices,



leading to reflective, ethical, critical, and humanizing actions based on experience and knowledge exchange.<sup>18</sup>

Health professionals should be encouraged to participate in PHE, considering that it is a tool for construction and strengthening of PHC care, as it allows reflection on the team's work process and can contribute to the transformation of health practices.<sup>19</sup> In this study, spaces for debates and reflections, such as events and meetings, were mentioned by a NASF-AB professional and a manager as a facilitator of intersectoral practice.

*"When you have a bigger event you get to know the professional from another sector. The meetings, the events end up bringing us together and facilitating the contact". (E23 – NASF-AB).*

*"I constantly have meetings with the team from the sports secretariat, because the issue of health promotion that we work with physical activity, we articulate together with the secretariat of leisure, tourism and sports [...] we articulate several actions together". (E5 – manager)*

The analysis of the narratives shows that the workers identify the need to compose knowledge to expand their practices, either in events, when they meet new professionals, or in intersectoral meetings when they articulate the health secretariats with others, with leisure, tourism, and sports.

ESF professionals participate in health sector meetings to discuss cases, plan together with NASF-AB focused actions for a particular group or disease, in addition to the intersectoral agenda between institutional and non-institutional devices in the region where they work.<sup>17</sup> The PHE is a facilitator of intersectoral practices because it favors partnerships with other policies, interaction between services and population, allowing greater effectiveness and innovation to overcome social inequities.<sup>18</sup>

The findings show as a hindering aspect of intersectorality practices the lack of dialogue:

*"It's difficult because of the lack of dialogue. The work process in another sector is not what maybe the person is looking for, and we get a little lost. For example, the patient is referred to NASF and the patient is not there. So I think that if there is a dialogue beforehand, discussing the case in the matriciamento meetings works better when there is support from the teams. (E22 – NASF-AB)*

*"We need to improve even more this communication, this relationship, as much as we have this articulation that we do actions together. (E40 – NASF-AB)*

The lack of dialogue was the keynote of these speeches. Intersectorality happens when the ESF actors identify the demand for integral care to be provided by the professionals and together they think of possible solutions for the treatment of the patient in the matrix support.

Clear and unambiguous communication has been placed as a determining aspect in both formal organizational settings (aligned to policies and procedures) and interpersonal settings.

Thus, efficient communication about decisions and guidelines among the various actors from different sectors is configured as part of the intersectoral practice, i.e., it establishes the link between mistakes and successes, problems and solutions, and at the same time, enables joint action, the recognition of ignorance, and makes conflicts generated by power relations and working conditions explicit.<sup>18</sup>

The adherence of professionals to work in an intersectoral manner is another complicating factor.

*"Some professionals have a certain limitation in going outside their core of knowledge. I see that sometimes they can't see beyond. They see a specific problem in their core of knowledge, but they don't understand what is causing it, don't they? So they try to solve that specific issue there, but they are not trying to understand the context of that complaint at the moment, of that problem that we are facing. That, to me, is the biggest complicating factor. (E5 – manager)*

*"The difficulty is the adherence of the professionals to the way of working. The population adheres well, but there are some teams that have difficulty in adhering to work together, because the work is more individualistic. I sit in my room and solve my problem since it is easier than discussing the problem. (E17 – manager)*

Some health professionals have difficulty in solving problems in a joint manner, because they are limited, preferring to work alone, without understanding the genesis of the patient's complaint. "The maintenance of this type of individualized practice to the detriment of collective and social issues leads the network to function in a restricted and sectorialized manner, (...) unable to intervene on the determinants of the health-disease process."<sup>15:158</sup>

For the sectors to have acceptance of the health management policy of intersectoral collaboration, with broad adherence of the participants, its objectives must be met equally, without privileges or greater importance, always considering the agendas of those involved in policies and programs, benefiting all parties. However, it is necessary to involve the actors in the planning, execution, and monitoring of actions, and not only for case-by-case care.<sup>17</sup>

Thus, those involved in PHC, whether in management, care, or research, by adopting the broad concept of health as an object of work, advocate specific changes in government policies, because multidimensional problems require intersectoral practices and sometimes require qualified training with dialogue between the health and education sectors.

Health education requires the multidisciplinary team in PHC, especially nurses, physical therapists, and ACS, which proved to be the key to such educational practices in the analyzed articles, ensuring the completeness of care. However, there are major structural difficulties resulting from inadequate local planning, such as the lack of space to perform PHE activities; inefficient territorialization; delays in scheduling exams and lack of specialists; lack of transportation and work overload due to the high demand for individual care.<sup>21</sup>

On the other hand, the great management bureaucratic demands (meetings, information systems, team management) emerged as a complicating factor, because, according to the participants, it becomes an object that limits the time available for other actions:

*"And I see that what makes this difficult are the agendas, the ways they are thought of today. The agendas today are very focused on numbers and, in this sense, NASF comes to try to deconstruct this a little bit, but it is still a big challenge. Because many times, we intend to think about some joint actions and the agendas never match. There are always deadlines to be met, I need to deliver some action to say that I did it, time is very scarce and what you say that makes it difficult are the agendas".* (E21 – NASF-AB)

*"It is very difficult in this logistical issue because we have a programmed schedule and we have to meet these required goals, and many times, to get different trained professionals and put them together, at the same time, demands an organization of times and schedules, a time... so I think this is the biggest difficulty in this management. This is the most difficult to connect".* (E18 – ESF)

*"What makes it difficult sometimes is the time for you to get in touch, for you to call, or to be together, I think the complicating point is time."* (E16 – ESF).

*"It's the time, the rush! Each one has so many attributions... today, many papers, there are many reports that have to be typed, which takes time away from you."* (E28 – ESF)

The difficulty in the articulation with other sectors is the lack of time as presented in the speeches described. Calling and meeting with people, typing reports and meeting the scheduled agenda demands time. It is worth mentioning the importance given to the management's role in assuming the strategy of sustaining the balance of the work process. In the quest to overcome the challenges, managers have municipal agendas for partnerships between secretariats for focal events, session of professionals for non-institutional equipment, and with the municipal councils. These initiatives have shown the creation of professional bonds and the perspective of sharing care with network complementarity.

In public policies, innovation becomes necessary to satisfactorily achieve economic or social indicators, or else the system becomes fragile. However, the work processes need to be monitored in a logic of integrated and continuous management without losing sight of sustainability. In Brazil, the direction of public policies for the coming years is the greater approximation of the territorial dimension of the conception and execution of programs and public policies arranged around the valorization of local potentialities.<sup>22-23</sup>

However, to better understand the implications of the SDGs and their proposed goals, it is essential to understand the vulnerabilities in order to act according to the real situation of each municipality. "Public policies require integration to achieve social determinants in a collective way, taking into account vulnerabi-

lities, needs, and local arrangements".<sup>15:161</sup> For this, it is necessary a very detailed situational diagnosis about the determinants that imply health and are related to the SDGs, such as: poverty; hunger; low education; unemployment and social exclusion; disorderly population growth; and lack of access to water, and that serve as a subsidy for the prioritization of actions, as well as the formulation of public policies for better development of quality of life.<sup>20</sup>

Local managers have very unique realities for the implementation of intersectoral practices, but even so, pragmatic guidelines to facilitate actions in loco are necessary.<sup>6</sup> The territories demand constant reduction of the distance between managers and workers, and it is essential that there is proximity between these actors, so that together they can face their problems with mobilization of resources and skills necessary for quality care.<sup>23</sup>

## CONCLUSIONS

This article addressed from the concreteness of actions to the challenges of care production in intersectoral network in PHC, being the ESF professionals and NASF-AB the actors of intersectoral and intrasectoral articulations. Reflecting on the limits imposed on health care strategies, we can consider that intersectoral actions are practiced as the perception of the concept of health of each network actor, taking as a reference that each actor is the manager of its work process.

This study sought to understand intersectorality in the daily routine of the ESF and NASF-AB and it is believed that it can bring reflections to managers and health professionals working in PHC services and also actors of other public policies that work intersectorially with health, about the planning and development of actions that are effective in restructuring the current model of care with a view to addressing the social determinants of health.

However, management plays a key role in inducing intersectoral actions in the territories, such as: having well-defined work objectives and strategies with clear communication regarding the strategies for the achievement of health indicators; spaces for collective construction instituted or recognized as enhancers of public policies; sharing experiences with horizontal technical cooperation; encouraging the insertion of intersectoral practices in the work agenda and investment in professional training on public policies and new approaches to health with a view to equity in health.

In this context, the manager must be able to analyze and interpret the social, political, and institutional context, as the spaces for negotiation and pacting are inserted, where numerous difficulties are faced due to the diversity of interests, limitations, and perspectives of care.

Finally, it is worth highlighting the SDGs and the Astana Charter as international guidelines for universal health systems in force. The SDGs were defined with a view to sustainable development in the economic, social, and environmental dimensions to be achieved by 2030 through intersectoral actions and action on social determinants. The Astana Charter brings the renewal

of political commitment to PHC. Collective efforts, especially in the context of PHC, are necessary to overcome the challenges and uncertainties imposed on the management and expansion of intersectoral actions in the territories.

## REFERENCES

1. Molina J. Saúde universal com equidade, sem deixar ninguém para trás. *Rev. panam. salud pública*. [Internet]. 2018 [acesso em 11 janeiro 2019];42. Disponível em: <https://doi.org/10.26633/RPSP.2018.173>.
2. World Health Organization (WHO). Declaración. In: II Conferência Internacional sobre Atención Primaria de la Salud: Hacia la Cobertura Universal de Salud y el Desarrollo Sostenible [Internet]. 2018 out 25-26. Astaná: WHO; 2018 [acceso el 10 noviembre 2018]. Disponible: [https://www.paho.org/bra/index.php?option=com\\_content&view=article&id=5711:declaracao-de-astana-sobre-atencao-primaria-a-saude-de-alma-ata-rumo-a-cobertura-universal-de-saude-e-os-objetivos-de-desenvolvimento-sustentavel&Itemid=0](https://www.paho.org/bra/index.php?option=com_content&view=article&id=5711:declaracao-de-astana-sobre-atencao-primaria-a-saude-de-alma-ata-rumo-a-cobertura-universal-de-saude-e-os-objetivos-de-desenvolvimento-sustentavel&Itemid=0).
3. Shankardass K, Muntaner C, Kokkinen L, Shahidi FV, Freiler A, Oneka G et al. The implementation of Health in All Policies initiatives: A systems framework for government action. *Health res. policy syst.* [Internet]. 2018 [cited 2018 nov 10];16(1). Available from: <https://doi.org/10.1186/s12961-018-0295-z>.
4. Fiorati RC, Arcêncio RA, Segura del Pozo J, Ramasco-Gutiérrez M, Serrano-Gallardo P. Intersectorality and social participation as coping policies for health inequities-worldwide. *Gac. sanit. (Barc., Ed. impr.)*. [Internet]. 2018 [cited 10 2018 nov 18];32(3). Available from: <http://dx.doi.org/10.1016/j.gaceta.2017.07.009>.
5. Lim SSK, Allen L, Dandona MH, Forouzanfar N, Fullman EM, Goldberg, S et al. Measuring the Health-Related Sustainable Development Goals in 188 Countries: A Baseline Analysis from the Global Burden of Disease Study 2015. *Lancet* [Internet]. 2016, [cited 2018 nov 10];388(10053). Available from: [http://dx.doi.org/10.1016/S0140-6736\(16\)31467-2](http://dx.doi.org/10.1016/S0140-6736(16)31467-2).
6. Buss PM, Magalhães DP, Setti AFF, Gallo E, Netto FAF, Machado JMH et al. Saúde na Agenda de Desenvolvimento pós-2015 das Nações Unidas. *Cad. Saúde Pública* [Internet]. 2014, [acesso em 10 janeiro 2019];30(12). Disponível em: <https://doi.org/10.1590/0102-311XAT011214>.
7. Ministério da Saúde (BR). Portaria nº 2.436, de 21 de setembro de 2017. Aprova a Política Nacional de Atenção Básica, estabelecendo a revisão de diretrizes para a organização da Atenção Básica, no âmbito do Sistema Único de Saúde (SUS). Brasília, DF: Ministério da Saúde, [Internet]. 2017. [acesso em 30 novembro 2019]. Disponível em: [https://bvsms.saude.gov.br/bvs/saudelegis/gm/2017/prt2436\\_22\\_09\\_2017.html](https://bvsms.saude.gov.br/bvs/saudelegis/gm/2017/prt2436_22_09_2017.html).
8. Comissão Nacional Sobre Determinantes Sociais da Saúde. CNDSS (BR). As causas sociais das iniquidades em saúde no Brasil. Relatório final da Comissão Nacional Sobre Determinantes Sociais da Saúde. [Internet]. Brasília: CNDSS; 2008. [acesso em 10 janeiro 2019]. Disponível em: [www.cndss.fiocruz.br/pdf/home/relatorio.pdf](http://www.cndss.fiocruz.br/pdf/home/relatorio.pdf).
9. Reuter CLO, Santos VCF, Ramos AR. O exercício da interprofissionalidade e da intersetorialidade como arte de cuidar: inovações e desafios. *Esc. Anna Nery Rev. Enferm.* [Internet]. 2018 [acesso em 2019 Jan 19];22(4). Disponível em: <http://dx.doi.org/10.1590/2177-9465-ean-2017-0441>.
10. Yasui S, Luzio C, Amarante P. Atenção psicossocial e atenção básica: a vida como ela é no território. *Rev. polis psique*. [Internet]. 2018 [acesso em 19 de janeiro 2019];8(1). Disponível em <https://seer.ufrgs.br/PolisePsique/article/view/80426/47195>.
11. Conselho Nacional de Saúde (BR). Resolução 510/2016. Publicada DOU [Internet]. 2016. [acesso em 16 de julho de 2018]. Disponível em: <http://conselho.saude.gov.br/resolucoes/2016/Reso510.pdf>. Acesso em 20 out 2020.
12. Minayo MCS (Org.). *Pesquisa Social: Teoria, método e criatividade*. 32. ed. Petrópolis, RJ: Vozes; 2020.
13. Souza VR, Marziale MH, Silva GT, Nascimento PL. Tradução e validação para a língua portuguesa e avaliação do guia COREQ. *Acta Paul. Enferm.* [Internet]. 2021 [cited 2021 jun];34:eAPE02631. Disponível em: <http://dx.doi.org/10.37689/acta-ape/2021ao02631>.
14. Bardin L. *Análise de conteúdo*. Lisboa, Portugal: Edições 70; 2011.
15. Mendonça EM, Lanza FM. Conceito de Saúde e Intersetorialidade: Implicações no Cotidiano da Atenção Primária à Saúde. *Psicol. Saúde Debate* [Internet]. 2021 [acesso em 1º de fevereiro de 2022];13(2). Disponível em: <https://doi.org/10.20435/pssa.v13i2.1090>
16. Mendonça EM, Lanza FM. Perspectivas da intersetorialidade no cotidiano da Atenção Primária à Saúde no Brasil: uma reflexão teórica. *Res., Soc. Dev.* [Internet]. 2020, [acesso em 12 novembro de 2021];9(11). Disponível em <http://dx.doi.org/10.33448/rsd-v9i11.9834>.
17. Prado NMBL, Santos AM. Promoção da saúde na Atenção Primária à Saúde: sistematização de desafios e estratégias intersetoriais. *Saúde debate* [Internet]. 2018 [acesso em 10 de janeiro 2019];42(spe1). Disponível em: <http://dx.doi.org/10.1590/0103-11042018s126>.
18. Costa CK, Marques R, Ceccim R, Silva K. Educação permanente em saúde e modelo assistencial: correlações no cotidiano do serviço na Atenção Primária a Saúde. *Rev. APS* [Internet]. 2019 [acesso em 7 setembro 2019];1(2).

Disponível em: <https://apsemrevista.org/aps/article/view/28>.

19. Julio VA, Silva J, Amorim MMA, Silva JF, Mendonça EM, Engela MHT et al. O cotidiano dos técnicos de enfermagem na Estratégia Saúde da Família. *Res., Soc. Dev.* [Internet]. 2021 [acesso em 10 outubro de 2021];10(13). Disponível em <http://dx.doi.org/10.33448/rsd-v10i13.21095>.
20. Toohar R, Collins J, Braunack-MA, A, Burgess, T, Skinner, SR, O'Keefe, M et al. Inter-sectoral collaboration to implement school-based health programmes: Australian school-based health programmes: Australian perspectives. *Health promot. Internation.* [internet]. 2017 [cited 2018 set 23];32(2). Available from: <https://doi.org/10.1093/heapro/dav120>.
21. Barbosa SP, Lage CEB, Amorim MMA, Furtado ODA, Oliveira LV, Rodrigues PL et al. Ações de educação em saúde para idosos na Atenção Primária à Saúde: uma revisão integrativa. *Res., Soc. Dev.* [Internet]. 2021 [acesso em 14 dezembro de 2021];10(16). Disponível em: [//dx.doi.org/10.33448/rsd-v10i16.23974](http://dx.doi.org/10.33448/rsd-v10i16.23974).
22. Carmo MEGFL. Desafios da intersetorialidade nas políticas públicas de saúde e assistência social: uma revisão do estado da arte. *Physis (Rio J.)* [Internet]. 2017 [acesso em 03 fevereiro de 2019];27(4). Disponível em: <http://dx.doi.org/10.1590/s0103-73312017000400021>.
23. Sena A, Freitas CM, Barcellos C, Ramalho W, Corvalan C. Medindo o invisível: análise dos Objetivos de Desenvolvimento Sustentável em populações expostas à seca. *Cienc Saude Colet.* [Internet]. 2016 [acesso em 01 fevereiro de 2019];21(3). Disponível em: <http://dx.doi.org/10.1590/1413-81232015213.21642015>.