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A Promoção de práticas intersetoriais no cotidiano da atenção primária à saúde: quais caminhos?

Promotion of daily intersectoral practices in primary health care: which paths?

La promoción de prácticas intersectoriales en el día a día de la atención primaria de salud: ¿qué caminos?

RESUMO

Objetivo: Compreender a intersetorialidade no cotidiano da Estratégia Saúde da Família e do Núcleo de Apoio à Saúde da Família e Atenção Básica. **Método:** Pesquisa qualitativa realizada em um município de médio porte de Minas Gerais. A coleta de dados foi realizada, por meio de entrevista semiestruturada, aplicada a 59 profissionais. Para interpretar os dados, adotou-se a análise de conteúdo. **Resultados:** A intersetorialidade se apresenta com a proatividade dos atores da Estratégia Saúde da Família, identificando a demanda e convocando o Núcleo Ampliado de Saúde da Família e Atenção Básica, para juntos pensarem a resolutividade, o que sinaliza o potencial articulador desse núcleo, para favorecer os arranjos necessários à formação de rede intrasetorial ou intersetorial. **Conclusão:** A produção de ações intrasetoriais e intersetoriais exige a formação de gestores e profissionais, para o planejamento, monitoramento e avaliação dessas práticas, para o alcance de resultados adequados perante os determinantes sociais da saúde.

Descritores: Sistema Único de Saúde; Atenção Primária à Saúde; Estratégia Saúde da Família; Colaboração Intersetorial; Enfermagem.

ABSTRACT

Objective: To understand the intersectoriality in the daily life of the Family Health Strategy and Support Center for Family Health and Primary Care. **Method:** Qualitative research developed in a medium-sized municipality in Minas Gerais. Data collection was carried out through semi-structured interviews applied to 59 professionals. To interpret the data, content analysis was adopted. **Results:** Intersectoriality happens when Family Health Strategy workers identify the demand and call the Support Center for Family Health and Primary Care to reflect upon resolvability, which also demonstrates the potential of this center to articulate the necessary arrangements for the formation of an intersectoral network. **Conclusion:** The performance of intrasectoral and intersectoral actions requires the training of managers and professionals to plan, monitor and evaluate these practices, and achieve adequate results in face of the social determinants of health.

Descriptors: Unified Health System; Primary Health Care; Family Health Strategy; Intersectoral Collaboration; Nursing.

RESUMEN

Objetivo: Comprender la intersectorialidad en la vida diaria de la Estrategia de Salud de la Familia y del Centro de Apoyo a la Salud de la Familia y Atención Primaria. **Método:** Investigación cualitativa realizada en un municipio mediano de Minas Gerais. La recolección de datos se realizó mediante entrevistas semiestructuradas aplicadas a 59 profesionales. Para interpretar los datos se adoptó el análisis de contenido. **Resultados:** La intersectorialidad se presenta con la proactividad de los actores de la Estrategia Salud de la Familia, identificando la demanda y convocando al Núcleo Extendido de Salud de la Familia y Atención Primaria a pensar juntos en la resolubilidad, lo que señala el potencial articulador de este núcleo para favorecer los arreglos necesarios para la formación de una red intrasectorial o intersectorial. **Conclusión:** La producción de acciones intrasectoriales e intersectoriales requiere la formación de administradores y profesionales para planificar, monitorizar y evaluar estas prácticas con el fin de lograr resultados adecuados frente a los determinantes sociales de la salud.

Descriptores: Sistema Único de Salud; Atención Primaria de Salud; Estrategia de Salud Familiar; Colaboración Intersectorial; Enfermería.

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INTRODUCTION

The years 2018/2019 were of relevance to analyze the practices of the health system and Primary Health Care (PHC) in Brazil, considering the milestones of the Declaration of Alma-Ata (40 years) and the Constitution of the Federative Republic of Brazil (30 years), guidelines of the Unified Health System (UHS)[1].

Since its conception, the health sector has stood out as the area that most promotes intersectoral actions, due to the vast networks of health-political intervention and the expanded concept of health[2]. In this context, intersectoriality is placed as a strategy to confront the problems of health and its determinants, besides being pointed as a way to change the care model and to overcome the fragmentation of policies[3-4]. Adopts as principles the integration of various knowledge, actors, and sectors, providing a broader understanding of the local reality and the production of health care[3].

The Family Health Strategy (FHS) and the Extended Nucleus of Family Health and Primary Care (ENFH PC) act together to share and support health practices, establishing an intersectoral action, with interdisciplinary actions, permanent education, notion of territory, integrality, social participation, popular education, health promotion and humanization, actions that are established as a major advance in public health[5].

In Brazil, studies related to intersectoriality place the FHS as a facilitating space for health promotion due to its intrinsic character of comprehensive care, being able to respond to the diversity of problems of the population. However, intersectoriality is seen as something complex and difficult to operationalize in the services[3,6-7], being one of the greatest challenges of UHS[5,8]. In Latin America, research has shown that the effectiveness of intersectoriality was linked to the level of coordination between PHC and other social policies or equity-based health promotion strategies[9].

International researches point out the potentiality of intersectorial action connected to Health in all Policies (HiAP) and, furthermore, call attention to the local level, where to act on the social determinants of health and operate with a focus on reducing inequities. However, they emphasize the need for local action plans and training of managers for planning, monitoring and evaluation of intersectoral actions [10].

In November 2018, the Global Conference on PHC took place in Kazakhstan, when the 40th anniversary of Alma Ata was celebrated. On that occasion, the Astana Declaration stated that addressing health challenges requires PHC that empowers people and communities to take ownership of their own health, addresses the social, economic, environmental, and commercial determinants of health through policy, evidence-based, and action across sectors, and ensures strong public health and PHC throughout people's lives as a fundamental core of integrated service delivery[11]. The potentiality of intersectoriality, as a health management strategy, in reaching the principles of universality, equity and integrality is verified[8].

On the other hand, the absence of initiatives to promote intersectoral action, the difficulties for workers to look beyond their specific area of expertise and break traditional labor relations are listed as factors hindering the implementation of intersectoralism in the daily life of health services. The challenge of producing health in the daily routine of services demands constant changes in the work process, such as the creation of collectives, networking, and partnerships with the involvement of different social actors[12].

Although UHS is 30 years old, it is necessary to understand how intersectoriality is effective in practice, since it was thought to achieve the social determinants of health. In this context, the question is: how is intersectoriality articulated in the daily life of the FHS and ENFH PC? Intersectoriality, as a powerful strategy to address health problems related to social determinants, is the concept that will guide this study[13] which aims to understand the intersectoriality in the daily life of FHS and ENFHPC.

METHODS

Qualitative research, approved by the Ethics Committee for Research Involving Human Beings, under CAAE 79985917.9.0000.5545, opinion 2.469.057, which used the Consolidated Criteria for Reporting Qualitative Research (COREQ) for the methodological description.

Qualitative research is the experience, understood as a product of personal reflection on experience, and 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[14].

The study setting consisted of five FHS units and four ENFH PC units of a medium-sized municipality in the state of Minas Gerais. These

teams were randomly selected, without defining inclusion and exclusion criteria, and the number of teams that participated in the study was later defined by the saturation of the data collected.

Based on the scenario, the participants were chosen. The criteria for inclusion of participants took into account all members of the respective FHS or ENFH PC of the municipality 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. Data collection was carried out according to the following steps: (a) contact with the field and presentation of the proposal, (b) approaching the participants and reading the Free and Informed Consent Form, and (c) conducting the individual semi-structured interviews and preparing the field diary.

The individual interviews were scheduled, after the professional's acceptance, and were carried out by a single researcher, after the objective of the study, its risks and benefits had been explained, according to the availability of the participants, in the workplace, in a reserved room so that there would be no interruptions. There was no need to retake any of the interviews. The questions were as follows: (1) How do you understand intersectorality? (2) What strategies have been adopted for intersectorial networking? (3) Tell me a little about the intersectorial network in the municipality. Which services make up the network and how are they organized? (4) How have the municipal teams acted in intersectorial actions? (5) What are the challenges and priorities for improving intersectorality in the municipality? To assess the suitability of the script developed and ensure the quality of data collection, a pilot test was conducted in health services with similar characteristics to the study, but in another municipality.

The interviews occurred in the period from February to July 2018, with 59 participants, as follows: (a) 36 ESF professionals, including two physicians, five nurses, eight nursing assistants/technicians, 17 community health agents (CHAs), two dentists, and two dental assistants; (b) 20 workers from ENFH PC, being two psychologists, one social worker, four physical therapists, four nutritionists, two physical education teachers, three speech therapists, three pharmacists, and one nurse trained in Integrative and Complementary Practices (PICS); (c) three managers from the Municipal Health Secretariat.

The interviews were fully recorded, using a smartphone, and had an average duration of eight minutes and twenty seconds, and 45 interviews lasted less than ten minutes. As for the people who did not meet the inclusion criteria, there were 29 in total, being: 18 (62%) for length of service, 6 (20.7%) for vacation, 3 (10.3%) for voluntary resignation, 1 (3.5%) for recent retirement, and 1 (3.5%) refused to participate in the research without any justification, among these, 20 were from the FHS and nine from ENFH PC.

The collection ended when the evidence was saturated, that is, when there was a recurrence of responses, but without neglecting important contents for the study[14]. The content of the individual interviews was carefully transcribed in full. The transcripts 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 using the letter E (Interviewee), followed by a sequential number for the subsequent interviews (E1, E2...). After this step, one of the researchers carried out the Content Analysis, defined by the semantic criterion, that is, by the analysis of the "meanings", following the phases[15]: pre-analysis, exploration of the material, categorization, treatment of the results, inference, and the interpretation that has already been described in the scientific literature, as well as in relation to the theoretical framework adopted in this study - Symbolic Interactionism[16]. In qualitative research, the use of symbolic interactionism, through its interpretative analyses, favors the understanding of the meaning that social actors give to symbols, objects, people, which construct their social world[16].

The pre-analysis aimed to operationalize and systematize the initial ideas, leading to a precise design of the development of successive operations in an analysis plan. The first activity performed was the floating reading, which consists in recognizing the text, appropriating the content, so that, gradually, the reading becomes more precise and comprehensive[15].

The exploration of the material consisted in the coding and categorization of the data obtained. Coding is the transcription of specific characteristics, allowing us to achieve a representation of the content or its expression structured by 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[15].

The categorization consisted, first, in classifying the textual elements by differentiation and then by grouping, through common characteristics or meanings of these elements. Considering, also, the exploration of the material, we carried out the categorization that consisted in classifying and grouping certain issues by divergences or convergences of the results[15].

The analysis of the individual interviews originated three thematic categories: (1) "The conceptions of health and the articulation of care in everyday PHC: intrasectoriality versus intersectoriality", (2) "Intersectorial dialogues in search of comprehensive care: ways of promoting intersectoriality in FHS and ENFH PC", and (3) "Intersectoriality: potentialities, weaknesses and challenges".

The last phase consisted of the treatment of the results, the inference and the interpretation to what has already been described in the scientific literature[15], as well as the theoretical framework adopted in this study - Symbolic Interactionism. Symbolic interactionism consists of a theoretical tool that enables the understanding of the phenomenon in a broader way based on three premises: "(1) people behave toward objects on the basis of the meaning those objects hold for them; (2) the social interaction humans have with each other results in meanings; (3) meanings are subject to a process of interpretation, that is, there is a formative process in which they are used or altered as means for guiding or constructing action in the process of social interaction"[16:111].

RESULTS AND DISCUSSION

The data analyzed in this article was obtained from a survey in which 59 health professionals participated, 51 (86.5%) were female; their ages 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 FHS professionals with an average time of service of 7 years and 1 month; 20 (33.9%) ENFH PC 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 CHAs (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 that emerged from the content analysis, the second one was selected to be presented in this article - "Intersectorial dialogues in search of comprehensive care: ways of promoting intersectoriality in the FHS and ENFH PC", which addresses intersectoriality in the daily routine of PHC.

The speech of a manager who works in PHC, when asked how the teams of the municipality have worked in intersectoral actions replied: "in the municipality, intersectorality, at least in my professional experience, I have worked with the social welfare sector, with the education sector, the sector of advice, which ranges from education, youth, alcohol, and drugs. We also work with the zoonosis sector, we work with the construction and infrastructure sector. So I think that here, practically, almost all the secretariats communicate; for example, sports, culture and leisure. We are also always working together. So, they are all these sectors, health, education, social assistance, the part of the councils that I think is also inside leisure, culture, sports, environment and the construction sector as well" (E5 - manager).

For this manager who works in social assistance, intersectoriality means that professionals should communicate with all the departments of the municipality, work together in the planning and execution of actions and interventions in the community, as in the example cited, the use of alcohol and drugs in youth. In a study conducted in municipalities of the metropolitan region of Belo Horizonte, "the speeches of sectoral managers and coordinators of health promotion practices revealed that there is recognition of the need for intersectoral actions to enhance the results"[13:4363]. Such evidence was corroborated by another study participant: "I cannot see a health system without intersectoriality and I think that, for us to promote quality health, it is necessary to connect other secretariats in intersectoriality. If this is not done, we will hardly manage to promote health" (E19 - manager).

Symbolic interactionism explains that human beings act toward things based on the meanings they attach to those things. These meanings are derived from or predate the social interaction that one has with others and society. These meanings are controlled and modified by an interpretative process used by people interacting

with each other and with the things they encounter[16].

Authors[13] emphasize the importance of building the network of relationships, by stating that intersectoriality comprises actions and/or interventions on social determinants, in a dynamic of cooperation by public organizations and other partners with the construction of a network of relationships.

In this network of relationships, the dialogue between sectors and the knowledge of the practices of each sector is important, as mentioned by managers and also a professional from ENFH PC. "I think this is very much a matter of us having a dialogue between the sectors, between the municipal departments. Be it sports, be it education, be it cooperation among the services and getting to know the service. I need to know the service, I need to know what education is proposing, I need to go to the school, see their calendar to be able to enter and propose an action that is effective for the school. Besides having the territorial survey, I also need to know the reality that I am working on to propose an action that is really effective. And that's it, I know their service, and they know my service, so that they can remember my work and I can remember theirs. So we can walk together and promote this action" (E12 - ENFH PC). "Intersectoriality is mainly made of sectors talking, one knowing the other's problem. Meetings, for example, between sectors in which a common goal is discussed, even if these sectors are separated, it is important that they meet and discuss the same problem that they are involved in. The intersectoriality has to be done in a way that moves everyone, a movement has to happen. This movement can be through communication, it can be within common policies between various sectors, right?" (E5 - manager).

The ENFH PC professional thoroughly reports that intersectoral actions must be based on the dialogue between the sectors in order to get to know each other's reality, by visiting the place, getting to know the proposed planning, and conducting a territorial survey. Thus, the sectors will be able to promote joint actions based on public policies in common. The manager, likewise, reinforces that, in meetings, the dialogue creates a movement towards intersectoral experience.

The strategy of knowledge exchange and interprofessional dialogue emerges as a space for guaranteeing rights, transforming realities, and achieving qualification in health care and management, with accountability and bonding involving different actors and work processes of the teams[6]. The constitution of communicative spaces allows the definition of common concepts and objectives, thus enabling the participative planning of actions that demand contributions from different sectors[3].

However, the network articulation - which can have an intersectoral character or not depending on the cases - emerges in the speeches of ENFH PC and ESF professionals: "through matricialization meetings, groups, care in other equipment that we contact" (E22 - ENFH PC), or "when we are with a patient, but need more care, we contact the HCS [Home Care Service] or ENFH to take care of that patient who was previously only from the unit. I think this is a network service, isn't it? (E26 - FHS).

The speeches of ENFH PC and FHS professionals described above highlight the intrasectoral network articulation (evidenced mainly by the FHS-ENFH and ENFH-FHS matricialization meetings), i.e., the care occurring among the devices of the Health Care Network (HCN). It is understood that the PHC has as its mission the communication between the different health services and, for this, it must manage the unique therapeutic projects and organize the flow of users between the points of the HCN[5]. ENFH PC is a health care team composed of professionals from different specialties who should act in an integrated and complementary way to FHS and PHC. Therefore, it is necessary to share knowledge, manage care in a network, conduct continuing education, and manage collectives in the territories under the responsibility of these teams[17].

The intersectoral experience by FHS and ENFH professionals and managers occurs through partnerships with professionals in the fields of education, social development, sports, culture, and leisure, as reported: "The matricialization performed in the units, depending on the case of each patient, each situation to be solved, we can encompass a lot of things, even the police. We can encompass social assistance (outside ENFH), CRE [Reference Center for Education], CREAS [Specialized Reference Center for Social Assistance], police, and the guardianship council. In the matricialization here, I think we work the most on intersectoriality. All the BHUs [Basic Health Units] must perform the matricialization as a project to be followed during the year. We do intersectorial matricialization according to the complaint. We always do the matricialization in the

BHU and with the participation of ENFH. It involves school, it involves everything. We call wherever we can help" (E17 - manager). "This partnership with SSRC [Social Service Reference Center], which is a fixed partnership, I think here, I don't know, but I believe it is the only FHS that meets monthly to discuss cases with a sector other than the health sector" (E53 - FHS). "A work that we do in daycare centers, schools, in the *Casa da Esperança*, to encourage, to educate the children. We apply fluoride, we control hygiene, we distribute toothbrushes, we teach how to use dental floss, and we always encourage the children to brush at school, too" (E52 - FHS). "SSRC [Social Service Reference Center], SRCSS [Specialized Reference Center for Social Service], RCE [Reference Center for Education], SRC II [Specialized Rehabilitation Center], COMAD [Municipal Council for Policies on Alcohol and Other Drugs], even if it is not within a specific sector, it is a partner, within social assistance there are projects that we are always building a very participative bridge with the people responsible. So that would be it: education, social assistance with the services that follow up, SRC II, and we have already had actions in a BHU where the military police participated" (E21 - ENFH PC).

According to the National Primary Care Policy[17], it is the responsibility of all the professionals that make up the FHS teams to develop intersectorial actions, through partnerships and community resources, that can enhance these actions, in addition to favoring the integration of social projects and related sectors oriented towards health promotion.

The intersectoral matricialization meeting at the BHU with the participation of ENFH involved the school, police, guardianship council, social assistance, among others, namely the partner sectors, such as the Social Service Reference Center (SSRC), the Specialized Reference Center for Social Service (SRCSS), the Reference Center for Education (RCE), the Specialized Rehabilitation Center (SRC II) and the Municipal Council for Policies on Alcohol and Other Drugs (COMAD). A similarity was found in another study conducted in PHC in which "social assistance revealed itself to be a potent space to trigger intersectoral articulations with actions that demand other sectors and social equipment, especially Health and Education"[13:4364]. For symbolic interactionism, human beings guide themselves according to their interests, giving rise to consequences in the social interactions established in the environment where they live and in interpersonal relationships[16].

The strategy of knowledge exchange and interprofessional dialogue emerges as a space for guaranteeing rights, transforming realities, and achieving qualification in health care and management, with accountability and bonding involving different actors and work processes of the teams[6]. In the interactionist view, it is stated that the workers identify the need to exchange information, knowledge, anguishes, and experiences for the expansion of practices. In this search for alternatives, they have shown to use encounters and affections as tools to solve daily problems and challenges[16]. It is worth highlighting the power of the constitution of communicative spaces that allows the definition of common concepts and objectives, thus enabling the participative planning of actions that demand contributions from different sectors[5].

In this sense, ENFH PC professionals and managers present the actions they develop intersectorially: "I participate in the network meeting, which is the part where we articulate health and social assistance, where we discuss together how the assistance will be directed to some situations here in the municipality. I constantly have meetings with the team from the sports secretariat, because the issue of health promotion, which we work with physical activity, we articulate together with the secretariat of leisure, tourism and sports, which here in the city became one, so we articulate several actions together" (E5 - manager). "I do a lot of work with education, as I work in a very vulnerable area and take care of many children, I work a lot with this direct contact. I don't spend a day without talking to the education reference center, the specialized rehabilitation center, to know how our patients are doing in schools, in other therapies that they do, in CASMUC [Center for Women's and Children's Health Care] too, where they offer assistance to some children" (E56 - ENFH PC).

To analyze the performance of PHC teams, questions about intersectoral initiatives were problematized. It was found the existence of partnerships with associations, schools, churches, and initiatives with emphasis on community development, being more frequent the leisure and cultural activities and activities in schools. "Another intersectoral area that we work a lot is education. Here we have been having meetings with the education team, to work on health issues inside the school, right? We want to work with prevention with the kids, with the children, and bring the health part as a part of education. We believe they

have to know about it to be able to take care of it and take this information home" (E5 - manager). "I have the issue of the activity that we do at the association, at ASSODIPAM (Diabetics Association), a very good work, and several professionals go there. There are even external people who are dance professionals, who go there and give the activity. I also have support there, with the physiotherapy with collective activities. We are trying to get into the schools to approach other subjects, such as the issue of weight adjustment of the backpack, posture, and so on. Identify the problems before they become major problems" (E12 - ENFH PC).

In the performance of the PHC teams, health actions are articulated with social assistance, physical activity with the secretary of leisure, tourism and sports, educational actions with the center of reference in education, health actions with schools emphasizing prevention so that the information is transmitted from children to parents, physiotherapy activities regarding the weight of backpacks in schools, dance classes in the diabetic association. When presenting and problematizing intersectorial actions and the concept of intersectoriality, researchers concluded that this process does not only include other care spaces, but actions to stimulate and develop communication between health, social assistance, work, leisure, and education areas[18].

Care coordination in PHC involves the integration between different actions and services of health professionals, to define flows, exchange information and needs, with the aim of favoring continuous and integral care[19]. There must be spaces that allow integration and sharing of information that can reflect in structures that facilitate the development of more comprehensive and successful interventions regarding intersectoriality to face problems related to social inequities[20].

ENFH PC professionals, in their speeches, revealed that there is recognition of intersectoral practice to enhance the results of care actions. "There is no way to fragment the patient too much. Even if we think of the concept of health as biopsychosocial well-being, I have to think of this subject as a whole. Of course, it is not every case that I will share with other sectors yet, because many issues are punctual, but there is a diversity of other cases that if I do not share this, if I do not seek this partnership with other sectors, I will even do my part, but the case will not be solved, because there are some health determinants that are related to other sectors that I do not work with. There is another sphere in the life of this patient, so I think that it is not possible to fragment. If I expand this, I also expand the chances of greater success for some cases and some situations in the territory" (E21 - ENFH PC). "Thinking about health, because we can treat the individual as a whole when necessary. Sometimes, there are things that are not within our reach. We need the other to help, and each one in their own sector doing their best" (E22 - ENFH PC).

The patient must be cared for as a whole, without fragmentation, to achieve his or her biopsychosocial well-being. Since health determinants are related to different areas, partnership with other sectors is necessary to solve the patient's problem. In the collective discourse of PHC professionals in Sobral, "intersectoriality presupposes developing articulated and integrated actions that produce positive impacts on the living conditions of individuals and communities. These actions should involve the articulation of knowledge and diverse experiences, aiming to plan together to intervene effectively in problem-situations that afflict the communities"[21:4374].

ENFH PC, in this research, had as its mission the strengthening of PHC with the incorporation of new practices and changes in care paradigms[4], reducing health inequities[8] and closeness with the community. The official guidelines indicate an organization of care based on collaboration among teams responsible for a given territory and on the sharing of knowledge and practices among ENFH PC and FHS professionals[5]. Alliances between institutional and non-institutional devices and the community can ensure comprehensive care, help to make UHS effective and social inclusion, which leads us to understand the processes of intersectoral collaboration to move towards more integrated forms of organizing public policies[22].

In PHC, the FHS identifies the demand and ENFH PC expands the care, either by offering individual or group care or by favoring the articulation of the network, according to reports: "The cases usually come through matricialization, right? So, for example, cases of abuse, neglect, I work a lot with the social worker, and we have already called SSRC [Social Service Reference Center], SRCSS [Specialized Reference Center for Social Service]. We also, among psychologists, we try to have an interlocution, and here there is also the RCE [Reference Center for Education], actually, which are the school psychologists, and we also have this articulation to first see if it is a known case

within the network and also to see if they have already worked with this patient, so that we can have a better care" (E57 - ENFH PC). "We now have this organization that the ENFH team is promoting, it does [...] it has direct intersectoral experiences with other areas" (E19 - manager).

The psychologist of ENFH PC receives the patients screened in the matricialization meetings and works together with the social welfare sectors and school psychologists, making an interlocution to find out about previous consultations with these patients. The demands are defined, based on work organization problems, considering the need to provide quality care, with completeness and resoluteness, and also the need to conduct actions and services in an intrasectoral or intersectoral network[5]. Authors[8,23] explain that intersectoriality, in the health field, stands out given the complexity of the social determinants that make it difficult for an institution to solve the problems in a single sector.

Technical cooperation, continuity of care, and complementarity of knowledge and services were the participants' justifications for the intentionality of intersectoral work. The need for joint and complementary work was mentioned by the managers as a daily practice, but it generates effort and demands time to integrate networks. "Because we can't do anything alone. One thing leads to another, it is not? So there is no way, I'm going to work on health when there are other factors that are influencing her issue. I won't be able to work alone. So, I need to work in an intersectoral way, I need partners. And then I see that the effectiveness of the action is much greater" (E5 - manager). "Because individually nothing works anymore. If we don't work together, if we don't speak the same language, if we don't integrate, the chance of the process disintegrating is very big. Today everything is very fast, people today don't expect an answer, they want an answer yesterday. So, if you don't work integrated, if you don't work together, if you don't have the support from other areas, we will hardly be able to treat all the problems that exist today in the health sector" (E19 - manager).

Patient health care is not carried out by a single professional, but in an intersectoral way, together with partner health professionals, speaking the same language, to have agility in the process. Thus, the production of health in the daily life of the services demands constant transformations in the work process, such as the creation of collectives, networking, and partnerships among different social actors that imply a new logic of work organization[24], without neglecting the "need for an active action in the search for sharing the production of care between workers and users, in a lively, symmetrical and singular way"[25:11]. These results are in line with one of the attributions of health professionals working in PHC described in the NPCP: "to perform interdisciplinary and team work, integrating technical areas, professionals from different backgrounds and even other levels of care, seeking to incorporate surveillance practices, expanded clinic and matricialization to the daily work process for this integration"[17].

This research contributed to the understanding of intersectorial practices in the daily routine of PHC and pointed out that intersectoriality has different meanings to health professionals, which shows that the abstract object studied - intersectoriality - "is a product of symbolic interactionism and comprises the meaning it has for the person to whom it constitutes an object. Such meaning determines the way in which he sees the object, by which he is prepared to react in relation to it and which he points to comment on it"[16:127].

FINAL CONSIDERATIONS

In understanding intersectoriality in the daily life of the FHS and ENFH PC, it was found that the emphasis of the speeches of health professionals fell on intersectorial actions that should be based on the planning and execution of actions and interventions in the community, on the dialogue between sectors, to learn about each other's reality, on the promotion of joint actions, based on common public policies; on communication with all municipal departments, such as health, education, leisure, culture, sports, environment, guardianship council, police, associations, alcohol and drugs, infrastructure and works.

The paths, for the promotion of intersectorial practices in this study, were the matrix support with intersectorial and intrasectorial character; shared intrasectorial and intersectorial care; network meetings; planning and execution of activities for a specific issue in order to promote health and use the clinical case as a guide for flows and actions; strategies that can be used in other municipalities for the implementation of intersectoriality in the daily care and management of PHC services in order to guarantee and protect health as an established social right.

It was evidenced that intersectoral actions happen when FHS professionals call the ENFH PC partners for support to promote broader actions that encompass other policies, often driven by institutional arrangements - the ways to promote intersectoral practices described in the previous paragraph - that favor such actions. In this context of the FHS, the Nurse can promote reflections and changes in the work process of the team, with a view to implementing the expanded concept of health in daily practices, which will favor sectoral and intersectoral articulation to provide a more precise response to problem situations in the territory.

As a contribution to the health field and all professions involved in addressing the social determinants of health, the study points to the need for conceptual alignment around the term intersectoriality, for the promotion of high-resolution practices and with operational sustainability, especially at this time when all have responsibilities in the implementation of the Astana Declaration. It is concluded, then, that it is necessary to promote and train managers and professionals for the planning, monitoring, and evaluation of intersectoral practices, in order to achieve more satisfactory results to meet the social determinants of health in a broad and sustainable way.

Among the limitations of this study is the fact that it was conducted in a single setting; however, the meanings attributed by the participants regarding the ways to promote intersectoral practices in the daily routine of PHC may be similar to those of many other Brazilian municipalities.

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