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# MATRIX OF PRIORITIES FOR THE HEALTH AT SCHOOL PROGRAM: A PARTICIPATORY MANAGEMENT PROCESS

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## ABSTRACT

OBJECTIVE: To describe the participatory management process in the development of a prioritization instrument for the School Health Program.
METHOD: This is a quantitative, cross-sectional and evaluative study, focused on improvements in the management of the School Health Program. An instrument was developed to prioritize managerial aspects, based on criteria of magnitude, priority and potential for participation. A participatory methodology was used, developed through consensus workshops with local managers, in a municipality in the Midwest of Brazil, between July 2021 and June 2023. The data were analyzed using descriptive statistics.
RESULTS: Elaboration of a matrix of priorities, considering the potential participation of the actors involved. The areas led by the health sector showed the greatest potential for participation, including priorities such as vaccination, obesity prevention, articulation of actions, coping with vulnerabilities, longitudinal care, local diagnosis, operational capacity

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of health units, and information management. In turn, components of the educational context, such as the local diagnosis and the operational capacity of the schools, showed less potential for participation.
CONCLUSIONS: The health sector demonstrated greater potential for participation compared to the educational sector. The process stimulated a more effective integration among local managers to classify emerging demands and define managerial priorities. The group's engagement in the collective construction of the prioritization instrument suggests the need to include participatory strategies that enable the exchange of experiences and good intersectoral practices, improving monitoring and evaluation in key areas. This process allows for horizontality, promotes collaborative work in response to territorial vulnerabilities, strengthens the operational capacity of institutions and information management. It also contributes to longitudinal care and a more accurate local diagnosis, which can increase the potential for participation of all sectors involved, an essential factor for health promotion in this context.

**Keywords:** Evaluation of Health Programs and Projects. Participatory Planning. School Health Services.

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## INTRODUCTION

The School Health Program (PSE), an initiative of the Ministries of Health and Education in partnership with the United Nations Educational, Scientific and Cultural Organization (UNESCO), proposes strategies and mechanisms to strengthen local potential and address unfavorable social conditions, promoting actions that encourage healthier choices in the face of vicissitudes that compromise the school performance of children and young people and the quality of life of their families (Brazil, 2007; Farias *et al.*, 2016).

In force for 17 years, the PSE is structured in four dimensions: actions, objectives, guidelines and planning. Each of them has guiding components for health promotion and disease prevention, considering psychosocial and pedagogical aspects in the care of the target population. Over time, the program has undergone modifications to improve its implementation and performance in the municipalities (Lopes; Walnut; Rocha, 2018), and, in its most recent version (Ordinance No. 1,857, of July 28, 2020), COVID-19 prevention actions were included (Brasil, 2020). The PSE uses the Health Information System for Primary Care (SISAB) and the e-SUS Primary Care software (e-SUS APS) to record the Collective Activity Form, in which the activities developed by the municipalities are described (Brasil, 2022).

Validated by the National Primary Care Policy (PNAB), which represents a state response to the efforts of social movements to revitalize the Unified Health System (SUS), in line with the National Health Promotion Policy (PNPS), which highlights intersectoriality to face multifaceted problems and establish more horizontal relationships, the PSE represents a milestone in the promotion of student health, seeking to overcome hygienist models that previously focused on sanitary planning and the inclusion of a medicalizing logic as tools to meet school failures associated with health demands (Farias *et al.*, 2016; Silva, 2019; Brazil, 2012, 2018).

However, it is necessary to recognize that strengthening the protective factors for children, young people and families through health education is a complex challenge, as the municipalities have unique characteristics that influence the development of the program, such as location, urbanization, team preparation and infrastructure. In addition, the need for coordination between the various sectors, adaptation to territorial specificities and the guarantee of active participation of the school community require efficient and integrated management. With a tripartite governance structure, the different levels of

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government must establish integrating mechanisms to face these challenges and ensure longitudinal care (Farias *et al.*, 2016; Köptcke, 2023).

Although the implementation of activities that encourage healthy habits and the development of intersectoral pedagogical actions aimed at health, citizenship and human rights is essential to achieve the objectives of the program, advancing in the reduction of vulnerability and improving health indicators requires the improvement of management mechanisms and practices. Furthermore, it is essential to consider the limitation of resources and the projected increase in demands, due to educational delays and care gaps triggered by the COVID-19 pandemic, which require careful mapping of priorities. In this context, the use of soft technologies offers the possibility of improving the management process, valuing the knowledge and experience of the professionals involved. In addition, active and coordinated listening to local demands makes management more efficient, promoting comprehensive care (Cohen; Franco, 1999; Tamaki *et al.*, 2012).

Based on fundamental principles such as intersectoriality, which promotes collaboration between the different governmental and social sectors; territoriality, which ensures that the program's actions are adapted to local needs; and participation, which involves the school community in decision-making and in the implementation of actions, the Ministry of Health highlights the need to develop local instruments that allow a technical analysis of priorities and value the collective construction of solutions, based on the work of the Municipal Intersectoral Working Group (GTIM) and managers of health units and schools, both included in the Annual Agreement Plan (Ferreira *et al.*, 2014).

The GTIM is responsible for integrated planning, including permanent education actions, intersectoral articulation, and incorporation of local perceptions, in order to fulfill commitments made with the Ministries of Health and Education (Brasil, 2022).

In turn, health unit managers are responsible for preparing, implementing, monitoring, and evaluating strategic plans, in addition to managing resources and promoting intersectoral actions based on knowledge of local demands (Brasil, 2022).

School managers, on the other hand, must develop a pedagogical agenda that includes the actions predefined by the PSE, in addition to leading the school team to achieve the program's objectives (Brasil, 2022).

At this point, the importance of the involvement of the GTIM in the coordination of participatory strategies is highlighted, promoting engagement and commitment of local

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managers in identifying the components with the greatest potential for implementation in the territories (Köptcke, 2023).

Thus, the present study presents a matrix of priorities for the PSE, with the objective of offering an instrument for prioritizing managerial demands. Using participatory methodology, it allows the analysis of the work process, identifies the potential for participation of the actors involved and guides decision-making, considering territorial singularities.

This approach was applied in the municipality of Campo Grande, MS, but can be used in other places with similar managerial contexts.

## METHODOLOGY

This article is part of a quantitative, cross-sectional and evaluative doctoral study, whose objective was to describe the development of a participatory management process in the elaboration of a prioritization instrument for the PSE.

Eleven managers participated in the study: four working in the GTIM and seven working in Family Health Units (USF) inserted in each of the health regions that make up the municipality of Campo Grande (Centro, Prosa, Segredo, Anhanduizinho, Imbirussu, Bandeira and Lagoa). Although school managers do not have managerial responsibility for the PSE, their participation was encouraged to enrich the process. However, there was no adherence.

The research proposal was presented to the GTIM during a meeting held at the Municipal Health Department (SESAU), in July 2021, in view of its composition, since it represents the areas of health and education, and its responsibility for planning, execution, intersectoral articulation, monitoring, and evaluation of the program at the municipal level, ensuring the integration of health and education policies (Brazil, 2022).

On this occasion, a "brainstorming" was held based on the guiding question: "PSE management: what are we talking about?". The perceptions of the GTIM were recorded, highlighting the most recurrent terms.

Sequentially, two logical models of the PSE available in the literature were presented (Ferreira; Cassiolato; Gonzales, 2009; Fontenele *et al.*, 2017), with the objective of "revisiting the daily practices" and knowing the most important elements for the municipal management of the program. To this end, another guiding question was raised: "Considering the aspects that participate in the institution of a Logical Model (resources,

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inputs, actions, results), what are the most important elements for the management of the PSE in the municipality?". In a dialogued construction, mediated in the light of the "circles of culture" applicable to the development of a critical perspective in plural contexts (Freire, 2003), the group recorded its considerations on cards, resulting in a table of elements that composed a visual model of management and work. This stage provided a clear and organized view of the aspects that interact with the execution of the actions, being essential to the planning and management of the program, as highlighted by Baroni and Silva (2022) and Köptcke (2023) regarding the institution of logical models used in their studies.

On the same occasion, a roadmap for the survey of priorities was presented, consisting of 33 items distributed among the dimensions of the program — I. Actions; II. Guidelines; III. Objectives; IV. Planning — in order to evaluate a specific component within each dimension, allowing detailed analysis of management priorities. These components, predefined by the Ministries of Health and Education for the implementation of the PSE, are available in the PSE Instructional Manual (Brasil, 2011) and were updated by Ordinance No. 1,055, of April 25, 2017 (Brasil, 2017).

Initially, the disposition and criteria for evaluating priorities were designed in light of the GUT (Severity, Urgency, and Trend) matrix, according to Silva, Kersting, and Griboggi (2023). However, in order to better meet the singularities of the program, the script was revised and improved with the active participation of the GTIM, which contributed with its practical experiences and specific knowledge about management, adjusting the evaluation criteria and the arrangement of the items for better reflection on the needs and priorities in relation to the dimensions and their components.

The modifications included the reorganization of the items (Stage I) and the adaptation of the evaluation criteria (Stage II) to include specific aspects of the PSE and facilitate the application and interpretation of the results. Based on the Adapted Delphi method (Revorêdo *et al.*, 2015), the study dispensed with the anonymity and exclusivity of specialists, allowing the interaction of the group at all stages and the inclusion of perceptions of local managers of health units. The inventory was improved in terms of item structure and arrangement during three consensus workshops. The intersectoral articulation with managers from each health region allowed the incorporation of territorial singularities that influence the school environment. The contact with the local managers of

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schools and health units was made by e-mail, accompanied by an informative video that presented the research proposal and the inventory of priorities.

To evaluate each component of the program's dimensions, the criteria of magnitude (size of the demand in relation to management), priority (level of importance), and potential for participation (ability to involve the community and integrate health and education teams in the territory) were considered, defined and scored from 1 to 3, according to the scoring matrix of the evaluation of the PSE dimensions and their respective components, created by the group and illustrated in Table 1.

Table 1. PSE Management Priorities Scoring Matrix

| PSE PRIORITY MATRIX | | | | |
|---|---|---|---|---|
| Stitches | M<br>Magnitude of demand | P<br>Priority for management | PP<br>Potential for participation | M x D x PP |
| 3 | This is a priority demand | Requires immediate action | High participation potential | 3 x 3 x 3 = 27 |
| 2 | It is an urgent or moderate demand | Medium-term action needed | Moderate participation potential | 2 x 2 x 2 = 8 |
| 1 | Does not represent a demand | No need for differentiated managerial action | Low participation potential | 1 x 1 x 1 = 1 |

Source: Prepared by the authors.

The determination of the priority level of each component was obtained by multiplying the triad magnitude (M), priority (P) and participation potential (PP): M x P x PP, ranging from 1 to 27. The multiplication widened the differences between the values attributed to each criterion, highlighting demands that require priority attention from management and ensuring the interdependence between these criteria.

This is an innovative adaptation of the GUT matrix by replacing severity (G) with magnitude (M), urgency (U) with priority (P) and trend (T) with participation potential (PP), which allowed a clearer differentiation between the elements that make up each of the dimensions of the PSE.

The script was validated and approved by the GTIM (Stage III), and was subsequently applied to all participants (GTIM and USF managers).

The collected data were analyzed quantitatively using descriptive statistics, and the highest frequency score was considered as the final score of the group.

In order to establish relationships between the management process and local needs, local records made by FHU managers regarding territorial vulnerabilities were made available for consultation by the GTIM and used in the present study.

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The inclusion of the participants occurred after the acceptance of the Informed Consent Form, respecting the principles of voluntariness and autonomy. The research, from which this article was produced, was approved by the Research Ethics Committee of the Federal University of Mato Grosso do Sul, under opinion No. 4.164.583/2020.

## RESULTS

Following the national scenario, where the coverage of the PSE has already reached 97% of the territory, with 5,422 municipalities, 97,389 agreed schools and 23,426,003 benefited students, the municipality of Campo Grande, whose Human Development Index (HDI) is 0.784, maintains a coverage of 92%. It continues to encourage schools to join the program through the work of the GTIM and the Family Health Teams (ESF), which offer 80% coverage to serve a plural and border population, including immigrants, gypsies, indigenous people, and quilombolas (Brasil, 2022; Campo Grande, 2022).

In this context, the GTIM's perception of the management of the programme is decisive for an effective and sustainable implementation (Chiari *et al.*, 2018). To understand it, a guiding question was presented: "PSE management: what are we talking about?", highlighting the recurrent expressions.

We sought to relate these perceptions to the work process and its most important elements, based on the guiding question: "Considering the aspects that participate in the institution of a Logical Model (resources, inputs, actions, results), what are the most important elements for the management of the PSE in the municipality?". This stage stimulated the elaboration of a visual model of management and work, linking challenges of the management process and expected results.

Figure 1 illustrates the elements of brainstorming and their relationship to the visual model of management and work.

The reflections on the management of the program prepared the group to improve a roadmap of priorities regarding the dimensions of the PSE and its respective components. In consensus workshops, essential aspects such as the arrangement of items (Stage I) and the criteria applied (Stage II) were discussed, with the aim of ensuring a model that is coherent with the daily practice and sensitive to local demands.

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Figure 1. Brainstorm and its relationship with the visual model of management and work of the PSE, Campo Grande, MS, 2023


Source: Prepared by the authors.

The group's engagement resulted in a participatory management instrument (Stage II), which used a scale of points to classify actions and establish priorities based on the potential for participation in the territories. The instrument was applied to all study participants and resulted in the priority matrix expressed in Table 2.

Table 2. Prioritization of managerial aspects related to the dimensions of the School Health Program and its components, Campo Grande, MS, 2023

| PSE EVALUATION MATRIX | M | P | PP | M x D x PP |
|---|---|---|---|---|
| I. ACTIONS | | | | |
| 1. Verification and updating of the vaccination schedule | 3 | 3 | 3 | 27 |
| 2. Healthy eating and prevention of childhood obesity | 3 | 3 | 3 | 27 |
| 3. Fighting the *Aedes aegypti mosquito* | 3 | 3 | 2 | 18 |
| 4. Alcohol, tobacco, *crack* and other drugs | 3 | 3 | 2 | 18 |
| 5. Prevention of violence and accidents | 3 | 3 | 2 | 18 |
| 6. Oral health and fluoride application | 3 | 3 | 2 | 18 |
| 7. Sexual and reproductive rights and prevention of STI/AIDS | 3 | 3 | 2 | 18 |
| 8. Culture of peace, citizenship and human rights | 3 | 2 | 2 | 12 |
| 9. Hearing health | 3 | 2 | 2 | 12 |
| 10. Physical activities and leisure | 2 | 2 | 2 | 8 |
| 11. Signs of aggravation of diseases in elimination | 2 | 2 | 2 | 8 |
| 12. Eye health and signs of change | 2 | 2 | 2 | 8 |
| II. OBJECTIVES | | | | |
| 1. Articulation of integrated actions | 3 | 3 | 3 | 27 |
| 2. Coping with and reducing vulnerabilities | 3 | 3 | 3 | 27 |
| 3. Effects on integral formation | 3 | 3 | 2 | 18 |
| 4. Integrated and effective communication | 3 | 3 | 2 | 18 |
| 5. Stimulation and strengthening of social participation: school, health, families | 3 | 3 | 2 | 18 |

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| | | | | |
|---|---|---|---|---|
| 6. Health promotion, disease prevention and strengthening of networking | 3 | 2 | 2 | 12 |
| 7. Strengthening a social care system | 3 | 2 | 2 | 12 |
| III. GUIDELINES | | | | |
| 1. Care over time | 3 | 3 | 3 | 27 |
| 2. Integration and networking | 3 | 3 | 2 | 18 |
| 3. Territoriality | 3 | 3 | 2 | 18 |
| 4. Social control | 3 | 3 | 2 | 18 |
| 5. Permanent monitoring and evaluation | 3 | 3 | 2 | 18 |
| 6. Decentralization and respect for federative autonomy | 3 | 2 | 2 | 12 |
| 7. Interdisciplinarity and intersectoriality | 3 | 2 | 2 | 12 |
| 8. Completeness | 2 | 2 | 2 | 8 |
| IV. PLANNING | | | | |
| 1. Local diagnosis – health context | 3 | 3 | 2 | 18 |
| 2. Operational capacity of health units | 3 | 3 | 2 | 18 |
| 3. Adequate records in SISAB and information management | 3 | 3 | 2 | 18 |
| 4. Alignment with the school curriculum and the comprehensive education policy | 3 | 2 | 2 | 12 |
| 5. Local diagnosis – school context | 3 | 3 | 1 | 9 |
| 6. Operational capacity of schools | 2 | 3 | 1 | 6 |

Legend: M = magnitude; P = priority; PP = potential for participation./Source: Prepared by the authors.

In the dimension of Actions, the managerial priorities identified were a) verification of the vaccination schedule and b) healthy eating and prevention of childhood obesity. In the dimension of the Objectives, they were a) articulation of integrated actions and b) confrontation and reduction of vulnerabilities. In the dimension of the Guidelines, the priority was care over time. Finally, in the Planning dimension, the managerial priorities identified were a) local diagnosis in the context of health, b) operational capacity of health units, and c) adequate records in SISAB and information management.

The lowest potential for participation was identified in areas of domain of the educational sector, such as the local diagnosis in the school context and the operational capacity of schools.

Local records carried out by the health teams (2021-2022 Cycle) pointed to vulnerabilities in all health regions, including the use of alcohol, tobacco, and other drugs, sedentary lifestyle, poor hygiene habits, non-adherence to vaccination, bullying, gender, race, and color issues, self-injury, suicide attempts, family and intellectual abandonment, violence, precarious bonds, dysfunctional families, unemployment, and absence of leisure areas.

The activities registered in SISAB through the Collective Activity Form (2021-2022 Cycle) were focused on the priority action to prevent COVID-19 and combat the Aedes aegypti mosquito.

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Comparing these data with the fundamental actions pointed out by the GTIM and with the mapping of priorities, obtained with the participation of USF managers, it is observed that the planning of the PSE actions and the management strategies were not always aligned with the needs of the school environment. With similar findings, Chiari *et al.* (2018), Fernandes *et al.* (2022) and Köptcke (2023) have already highlighted the need to promote a more harmonious connection between the work developed by the GTIM and the territorial demands to ensure longitudinal care in the face of the vicissitudes that permeate this population.

In this context, the PSE Priority Matrix provided a systematized presentation of managerial priorities, incorporating the complexity of aspects that influence everything from planning to execution of actions, according to magnitude, managerial priority and potential for participation.

## DISCUSSION

Supported by the triad of intersectoriality, territoriality, and social participation, the PSE is strengthened as a model of health promotion based on the performance of the ESF in the municipality of Campo Grande (Brasil, 2022). As shown in Figure 2, these fundamentals represent a series of complex challenges that must be faced by their tripartite management, considering vulnerabilities pointed out by USF managers who participate in the daily routine of the services. In unequal contexts, establishing priorities is essential to ensure the continuity of this care model, designed to address and mitigate vulnerabilities in the school environment (Silva, 2019).

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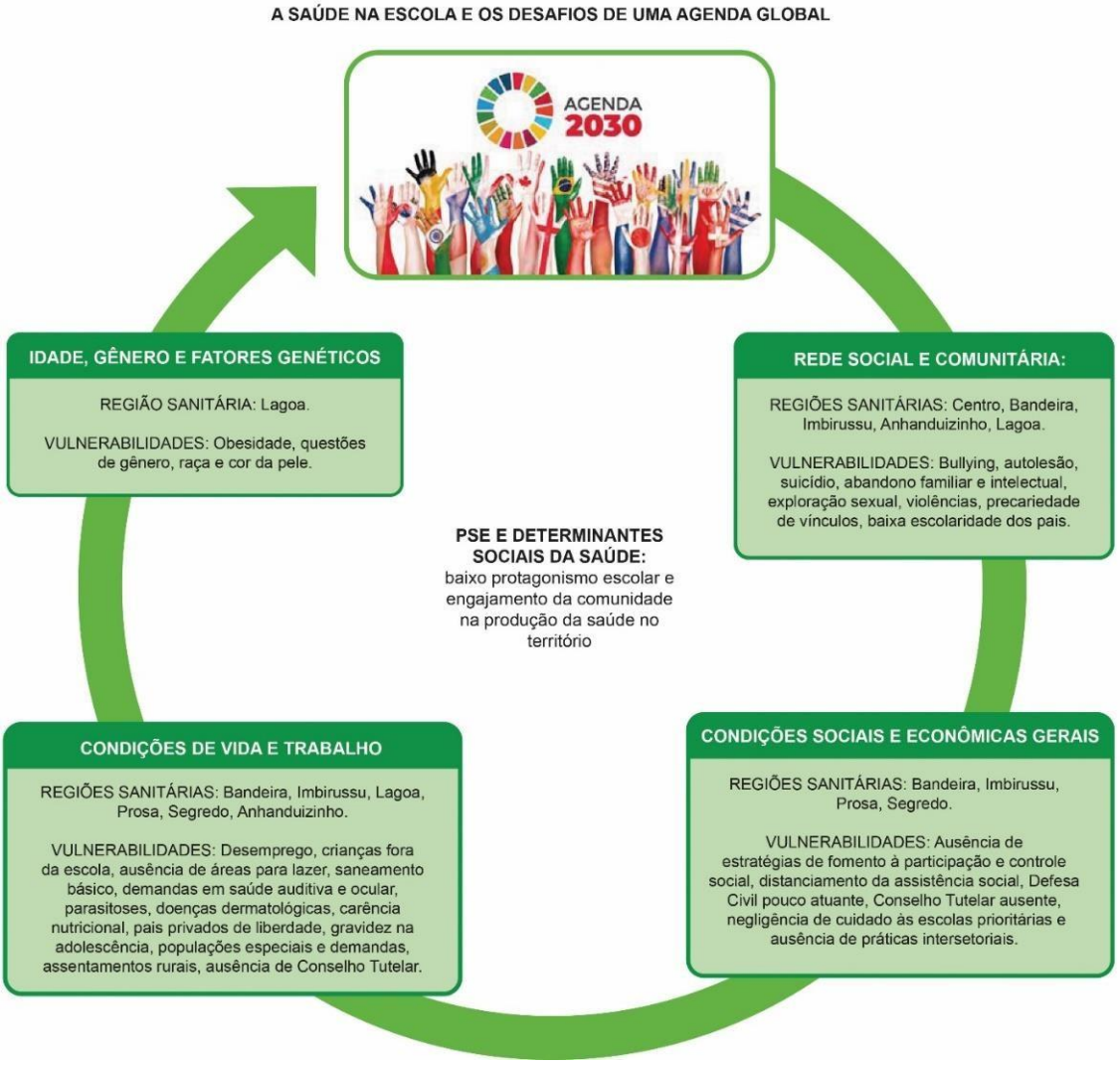
Figure 2. PSE and challenges of a global agenda: Social vulnerabilities identified by health district in the municipality of Campo Grande, MS, 2023




Source: Prepared by the authors.

Understanding how the actions of the PSE are thought, discussed, planned and executed in the municipality proved to be fundamental to develop a participatory process in the elaboration of a prioritization instrument. Cohen and Franco (1999) emphasize that spaces for critical-reflexive analysis in the services allow the emergence of more solidary and feasible solutions, which are indispensable for the operational survival of social programs.

In general, this operational survival requires a thorough analysis of the Social Determinants of Health (SDH), that is, socioeconomic, cultural, ethnic-racial, psychological, and behavioral factors that influence living and working conditions and produce effects on the health of people and communities impacted by these programs. Following a specific model of analysis (Dahlgren and Whitehead), they relate global health and social equality

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(Buss; Pellegrini Filho, 2007) and, therefore, are essential for intersectoral and effective planning within the scope of the PSE (Silva, 2019).

Expressed in the brainstorm and described in local reports, the SDH present in each of the health regions (Figure 2) reflected the need to consider the potential participation of the actors involved for a more effective implementation in the territories, seeking support from those who experience complex singularities that limit the performance of health professionals and discourage the pedagogical team. With similar findings regarding vulnerabilities, Anunciação *et al.* (2022) address the relevant role of Primary Health Care to include issues of gender, race and color, socioeconomic, living and working conditions, as well as the lack of social and community resources in the pedagogical agenda, suggesting the establishment of new intersectoral arrangements, with more participatory characteristics, in order to resignify the role of the school within the scope of the PSE.

The brainstorm, which stimulated the elaboration of the management and work model, shed light on the need to enable a managerial design that considers these social determinants, as well as the community's interest in the planning of intersectoral practices, still carried out by health professionals, as highlighted by Fernandes *et al.* (2022). The model, which related resources and results, presented managerial gaps such as the effective training of teams, local diagnosis, and the application of didactic materials inherent to the agreement with the municipality's schools.

The production of health in the territories requires, among other aspects, the protagonism of the school community (Fernandes *et al.*, 2022; Köptcke, 2023), an area in which the lowest potential for participation was identified. The non-adherence of school managers, although it was a limitation of the study, also revealed the influence of work overload on intersectoral movements. In a pandemic context, many schools faced significant challenges such as the transition to remote learning, the implementation of restrictive measures, and the management of a health crisis without the proper structure (Menezes, 2021). From this perspective, the educational sector was represented by the GTIM, which recognized the limitation and highlighted the need to establish a pedagogical agenda with the schools. This reality was also identified in the studies by Corrêa, Toassi and Firmino (2018) and Köptcke (2023), indicating that the sustainability of the program depends on managerial advances, overcoming management failures, consistent investments in training, improvements in communication, local records and strategic planning, continuous monitoring, engagement of the school community, overcoming

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cultural taboos, better aligning the program with the priorities of schools, as well as robust mechanisms to evaluate the entire process of implementing and carrying out actions. The fundamental role of intersectoral participation and collaboration for the success of the PSE is highlighted, attributing to the municipalities the adaptation and prioritization of actions, according to their specific needs.

To this end, it is salutary to reflect on the management and work model, highlighted by Contandriopoulos (2006), which considers, among other aspects, that the construction of the operational design among the stakeholders (interest group) improves the intervention mechanisms and identifies management challenges — and it was precisely the identification of these challenges from the model built that contributed to the involvement of the GTIM in the participatory process proposed from this study.

The participatory methodology used in this study, with adaptations of the Delphi method and the GUT matrix, including consensus workshops to improve a prioritization instrument based on criteria contextualized with the PSE, promoted creative solutions to local challenges and encouraged managers to reflect on the importance of participation and its influence for effective implementation. Despite the magnitude of some demands, the priority attributed to them was directly related to the potential for participation. Thus, this adaptation considered the objective need and valued the managers' ability to mobilize and engage (Köptcke, 2023).

Although the scope of the study was directly related to managerial priorities, it is recognized that the inclusion of the school community in future studies can enrich the decision-making process based on the critical analysis of demands experienced in the territories, visible not only to managers and health professionals. There are many challenges in this context, given that the possibilities of action are not linear (Köptcke, 2023).

The incorporation of soft and inclusive technologies represents a spark of contribution to the management of the PSE, an initiative that has been improved to meet the demands of schoolchildren, closely aligned with global aspects such as the principles of Health Promoting Schools (HPS) and the challenges of the 2030 Agenda, as provided by the United Nations (UN) (Moreira *et al.*, 2019).

Thus, the present study presented the development of a participatory management process in the elaboration of a prioritization instrument, proposing the PSE Management Priorities Matrix.

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The instrument organizes and classifies the program's territorial demands based on specific criteria. It systematizes management data, ensures strategic alignment through intersectoral articulation and improves productivity through participation. This results in clearer and more objective communication, making the implementation of the program more efficient and horizontal.

## CONCLUSION

The health sector demonstrated greater potential for participation compared to the education sector. The process stimulated a more effective integration among local managers to classify emerging demands and define managerial priorities. The group's engagement in the collective construction of the prioritization instrument suggests the need to include participatory strategies that enable the exchange of experiences and good intersectoral practices, improving monitoring and evaluation in key areas. This process allows for horizontality, promotes collaborative work in response to territorial vulnerabilities, strengthens the operational capacity of institutions and information management. It also contributes to longitudinal care and a more accurate local diagnosis, which can increase the potential for participation of all sectors involved, an essential factor for health promotion in this context.

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