MINISTRY OF HEALTH OF BRAZIL

HEALTH PROMOTION

APPROACHES TO THE TOPIC

1
NOTEBOOK

BRASÍLIA – DF 2021

MINISTRY OF HEALTH OF BRAZIL
Secretariat of Health Surveillance
Department of Health Analysis and Surveillance
of Non-Communicable Diseases

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SUMMARY

PRESENTATION

Discussions about health promotion date back to the beginning of the last century, with a growing presence in the debate on health, especially from the 1970s, with the publication of the Lalond Report, a milestone in health promotion for Canada and the world. The worldwide constructions on health promotion reverberated in the 8th National Health Conference, in 1986, which presented the bases for the construction of the Brazilian Unified Health System (SUS).

Over these years, health promotion has strengthened in the structure of the Ministry of Health, State and Municipal Health Departments and the Federal District transcribed into departments, offices, coordinations, superintendencies and other forms of organization of the management of health policies and programs.

With the publication of the National Health Promotion Policy (PNPS), fronts were opened for the transfer of financial incentives, training of professionals, production of technical and informative materials, national plans and indicators that contributed to the strengthening and recognition of the promotion of health in surveillance, assistance and health care actions, especially in Primary Health Care.

In addition to the SUS, health promotion extended its objectives and guidelines to national plans to combat violence and traffic accidents and to prevent the use of alcohol and other drugs, and laid the foundations for intersectoral programs aimed at schoolchildren.

The publication of this notebook starts the celebrations of the 15 years of the National Health Promotion Policy, which established the objective, guidelines and actions for the implementation of health promotion in the Brazilian Unified Health System. It also represents the maturation built over years of debate

and implementation of health promotion initiatives, led by the Department of Health Analysis and Surveillance of Non-Communicable Diseases (DASNT) from the Secretariat of Health Surveillance (SVS).

The content was developed based on actions, technical and theoretical constructions, perspectives experienced in moments of collective construction, as well as in attention to current agendas related to health promotion and public health in Brazil and worldwide.

It is an introductory notebook that paves the way to deepen the topics in new publications. It aims to bring together and sensitize managers and public health workers and related managers for the implementation of strategies favorable to health promotion as a guide to the praxis in health work and necessary extrapolations for changes that positively impact the population's quality of life.

The content is distributed in three chapters, with the first two interlinked dialogically and the third as a contribution to the history of Health Promotion in Brazil.

The first chapter is intended to present the concept and relationship of health promotion with the social determinants of health, with the aim of elucidating and consolidating understandings that recognize the importance of promoting health, in addition to the other responsibilities intrinsic to the Health and areas affected by social determinants.

Chapter 2 discusses health promotion from a practical perspective with the aim of taking it off the pedestal of theory and supplanting the idea that it is difficult to conceive of it as a living process and results. Therefore, it presents the National Health Promotion Policy as one of the legal resources of the Brazilian Unified Health System for health promotion in the areas of Health Surveillance and Primary Care. There is also a discussion with strategies for the implementation of health promotion actions, with emphasis on the strategy of networks, *advocacy* and changes in cities to make them smart.

Finally, as an institutional responsibility to keep alive and updated the memory of the path of health promotion in Brazil related to its global development, Chapter 3 presents a timeline of its historical route, through which it is possible to envision the transformations and advances achieved up to the present times.

We wish you an excellent reading and new knowledge in the process of implementing health promotion actions across the Country.

Signature
Secretary of Health Surveillance

1 HEALTH PROMOTION: APPROACHES TO UNDERSTANDING AND APPROPRIATING THE MEANING OF THE TOPIC

You may have read or heard that health promotion is physical activity, not smoking and eating healthy foods, for example.

In part, we can consider that these statements have structural elements of the concept of health promotion, but they do not translate it. So what is health promotion?

According to the Charter of the 1st International Conference on Health Promotion, better known as the Ottawa Charter, health promotion "is the name given to the process of empowering the community to act to improve their quality of life and health, including greater participation in the control of this process" (WORLD HEALTH ORGANIZATION, 1986, p. 1).

To support the construction of this understanding of health promotion, there is the expanded concept of health that overcomes the absence of disease and is reinterpreted based on elements that constitute the objective conditions of life, that is, what is essential to guarantee the exercise of living. They are: peace; housing; education; food; income; stable ecosystem; sustainable resources; social justice; and equity.

The discussion of health promotion involves the recognition that health is constantly being built. It presupposes an intertwining between individual and collective weaknesses and potential, and the responsibility of governments to guarantee rights, access to essential services and possibilities for the full development of people in an equitable manner. Therefore, the years following the Ottawa Conference strengthened the role of governments in health promotion in subsequent Charters.

For the community to develop the potential foreseen in 1986, the guarantee of rights is necessary; the freedom to fully exercise citizenship; the institutionalization of spaces so that people can participate and decide on public policies; access to the conditions necessary for a dignified life; protection against predatory international interests; the guarantee of protection for work; not adopting austere policies; among others, which must be led by local governments.

Health Promotion has as principles equity, intersectorality, empowerment, social participation, sustainability, autonomy and integrality. These are good markers for identifying whether an action or policy is aimed at health promotion. They are constructed by social, economic, political, environmental and cultural contexts that determine, in a dynamic and visceral way, the production of life. These contexts form the relations of power and production present in micro or macro universes – that is, in the neighborhood where you live, even in a country – and are what determine the production of health.

The Social Determinants of Health (SDH) are the focus of health promotion with a view to overcoming inequalities and inequities in health. The relationship between them and health promotion is directly proportional, that is, the worse the situations of vulnerability – such as the absence of guaranteed rights, the non-participation of the population in political and management decisions ("top-down policies", violence, teenage pregnancy, lack of access to basic services, among others –, health promotion principles and actions should be placed more strongly.

1.1 Social Determinants and Health Promotion

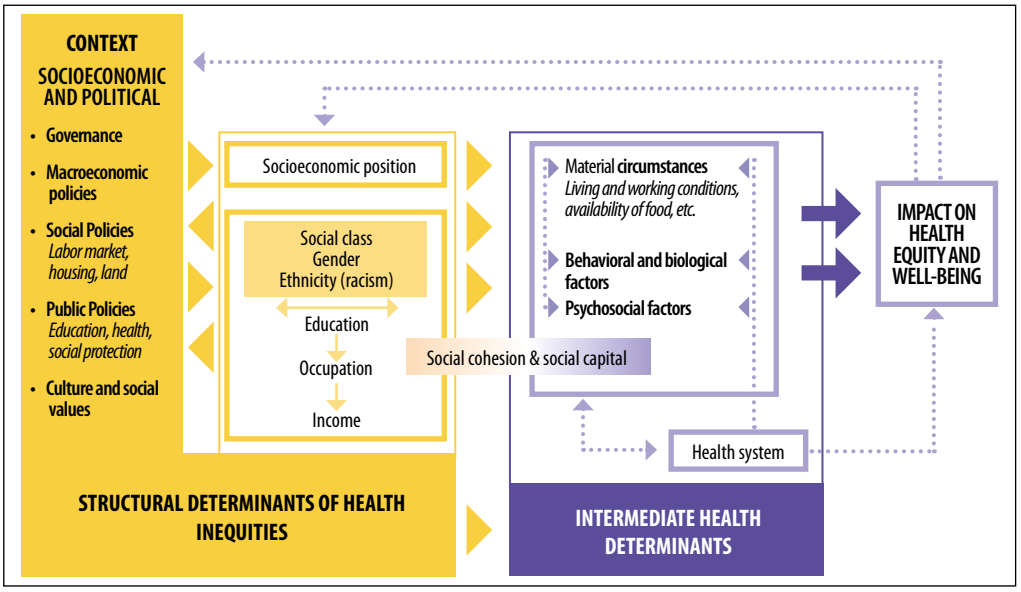
The Social Determinants of Health are the conditions in which people are born, live, work and age (ORGANIZAÇÃO MUNDIAL DE SAÚDE, 2011).

Figure 1 dynamizes the interrelationships of SDH in health and the consequences for individuals and governments. In orange are the structural determinants of health related to the individual's socioeconomic position in society, the cause of serious health inequities. Social positions that place the individual at a disadvantage and in a vulnerable situation can be intensified for the existence of structural racism, prejudice related to gender, disability and origin; for the lack

of adequate distribution of income and for superficial government policies or based on personal merits, while ignoring that inequality is at the base of relations, as is the case in Brazil.

The authors emphasize that this social inequality can be sustained by formal or informal structures, such as education, the market or social security, all structural mechanisms that alter the individual's social position and that are responsible for the main inequities in health. When these elements do not act positively, we have a State that does not creates equity.

Figure 1 – Conceptual framework of Social Determinants of Health



Source: Solar and Irwin, 2010.

The blue part in the figure represents the intermediate determinants directly produced by the former and that feedback them causing impact on health equity and well-being.

The authors' exercise of reflection is not the investment of governments and societies in one of the determinants. The orientation from the conceptual model is to intervene in structural determinants to bring about changes in others. Promoting health implies intervening in these determinants.

Therefore, it is said that health promotion makes it possible to expand the reality and see the structuring processes that maintain situations that detract from the health of individuals or favor their overcoming. How can this be achieved? Exercising the principles (pillars) of Health Promotion in daily practice, in the formulation of projects, programs and policies and in political decisions, be they local, regional or national.

The publication of the PNPS presented a priority agenda with health promotion actions covered by the objectives and guidelines of this policy. Next, we will exercise this reflection in the context of the Prevention of Chronic Non-Communicable Diseases (NCDs) highlighting one of them.

Let's say the problem is the low prevalence of physical activity, one of the risk factors for NCDs. The first action proposed is the reversal of this situation by promoting the increase in the practice of physical activity by the population. We call this an increase in prevalence, which can be achieved when those who already do continue to do and those who do not start to do.

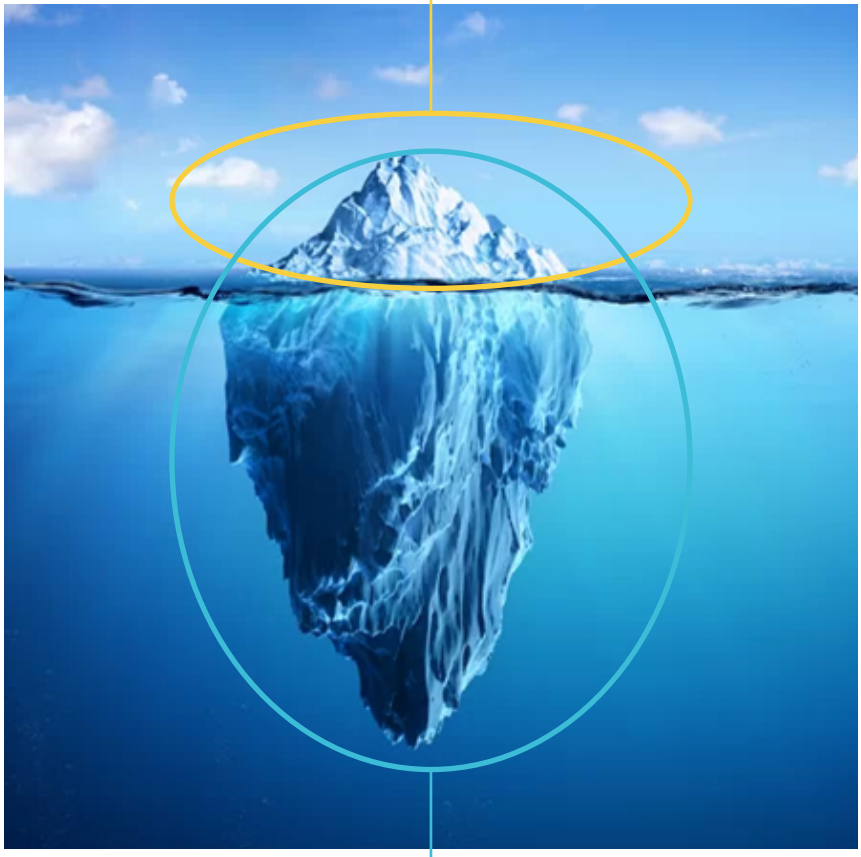
Before thinking about the strategies to be developed to achieve the objective, it is necessary to know the structuring elements that determine behaviors, choices, postures and perceptions of individuals and groups in relation to the action of practicing physical activity.

Among the elements presented in the literature that are linked to "doing" in relation to the practice of physical activity, there are: years of schooling, income, free time, color, gender, safety in cities, distance from places of practice and social support.

Note, in the figure below, the difference in approaching this phenomenon considering and not considering its structural determinants.

Figure 2 – Difference in approach and relationship with Health Promotion

Exclusive focus on changing the behavior of the individual.



Source: https://br.depositphotos.com/stock-photos/iceberg.html.

Focuses on the change of behaviors, policies and physical structures in cities aimed at the construction of contexts that favor the increase in the practice of physical activity: promotion of active, safe and sustainable displacement and active urban mobility; requalification and construction of leisure spaces with increased access routes, especially in places of greater social vulnerability; improvement of lighting and public safety; construction of cycle lanes and cycle paths; reduction of the speed of cars; improvement and expansion of public transport; construction of healthy sidewalks; promoting workers' health, closing streets for leisure and strengthening Physical Education at school.

The initiative covering the elements that determine the choice process – that is, that puts "doing physical activity" as a possible option for the entire population, regardless of social class, gender and color – is the one that comes closest to the concept of health promotion.

1.2 Health Promotion and Disease Prevention

It is a fact that there are several understandings circulating that sometimes reduce health promotion to disease prevention or elevate the latter to the level of the former. Far from being a dispute over what is most important, the issue here is to understand the dimension and intentions of these two fundamental constructions for health and be clear when applying them to actions, whether structured or not in projects or programs.

The following table presents a comparison between health promotion and disease prevention in order to contribute to this understanding. Let's check it out!

Table 1 – Comparative characteristics of disease prevention and health promotion

Features	Disease prevention	Health promotion
Conceptual framework	Natural History of Diseases	Social Determinants of Health
Meaning of the term	Prepare; arrive before; arrange in a way that prevents damage or harm; prevent it from happening.	Boost; foster; originate; generate; change.
Goals	Avoid emergence or proliferation of diseases, prevent.	Promote general well-being through the transformation of health conditions.
Focus	Disease (causes, forms of transmission, epidemiological behavior, risk and protective factors).	Changes in structural determinants that cause health inequities.
Approaches	Dissemination of information and recommendations (campaigns) to change habits.	Structural changes in cities, economic and social policies, construction of spaces for participation.
Operationalization	Punctual, unilateral, intersectoral action.	Multi-strategic, intersectoral action.
Place of the subject	Responsive, responsible for change.	Participatory, co-responsible for change.
Expressions and classic terms	Adopting a healthy lifestyle / Avoid! / Use! / Prevent is the best remedy! / Get to know to prevent / risk and protective factors for health / Do your part! / Search for a Basic health Unit / Move!	Building ways of life / Participate! / Sustainable / Healthy / Leisure / Environments / Quality of Life / Equity / Development / Policies / Cities.

Source: adapted from Czeresnia, 1999; Santos et al., 2006, Coutinho *et al.*, 2013 and campaigns of the Ministry of Health, 2007 to 2010.

The differences between disease prevention and health promotion presented in Table 1 aim to clarify the intentions of each of them, essential for understanding when to invest in one or both, in an integrated way. The most important thing is to know how to locate, in the process of health production and care construction, which of the approaches is being developed. This understanding is essential to avoid, for example, expected results or outcomes that are not characteristic of a certain approach, or to perform actions typical of one of them with established purposes for the other. Knowing the differences is important to identify the potentialities.

It is healthy to understand that both are essential and can coexist in the same space and time.

1.3 Health Promotion and Health Surveillance

Health Surveillance is defined as

> [...] continuous and systematic process of collecting, consolidating, analyzing data and disseminating information on health-related events, aiming at planning and implementing public health measures, including regulation, intervention and action on conditions and determinants of health, for the protection and promotion of the health of the population, prevention and control of risks, injuries and diseases (CONSELHO NACIONAL DE SAÚDE, 2018, art. 2).

By carefully observing the above definition, we can visualize an organizational seam that aligns the various processes that make up a health surveillance action. Far from trapping them in a bureaucratic sequence, but with the intention of demonstrating the necessary connections for effective work, it starts with an accurate knowledge of the health situation of the territory for planning aimed at addressing and overcoming problems, health risks and vulnerabilities found, making use of technologies, methods and resources related to the accumulated knowledge for actions of protection, health promotion and prevention of diseases and injuries. This macro-process is fed back with information that, in new analyses, add knowledge about the territory with measures to monitor the results of actions already taken or services implemented.

A model of comprehensive health care should consider health surveillance as an inseparable component of the production of care.

To see success in health surveillance actions, we need to integrate it into the process of health production in the territory. It is not about fitting it or adding it to the actions and services that are already developed. As a dimension of health policy, it will require changes in the health care model, in the work process, in the training of professionals and in the management of health networks.

We will think about this in the context of Primary Health Care (APS), based on the need to structure five dimensions necessary to form a set:

Integration of territories – The integration of Health Surveillance and Primary Care territories is a recurrent subject when it comes to articulating health surveillance and APS.

It goes through the synchronization of professionals' routines to the dimension of reorganizing this level of health care. On this topic, we recommend reading the material *National Primary Care Policy Guide Module 1: Integration, Primary Care and Health Surveillance*, available at **http://189.28.128.100/dab/docs/portaldab/publicacoes/guia_pnab.pdf**

The central points that we want to highlight in this discussion are: there are several surveillances (epidemiological, sanitary, environmental, worker and nutritional) that must be considered in the integration of territories; and, in addition to communicable diseases, non-communicable diseases and injuries (violence and accidents) are objects of Health Surveillance – we are talking here about different technologies and processes that need to guide this integration. In other words, the "dengue territory" should not be the only one considered in this complex integration action.

The previous points cross the following three dimensions, which are:

Organization of the work process – Includes the organization of meetings, including frequency, diversity of topics, times and everything that guarantees the representation of the intended integration. Having the Basic Health Units (UBS) as a reference for the provision of services in the APS, it is worth discussing the reorganization of the space and the construction of a reference for the actions of Health Surveillance in these places.

Planning – Expanded, contemplating surveillance actions in the set of actions and services in APS. This should reflect on the goals and targets, now drawn from this perspective.

Monitoring and evaluation – Classics in Health Surveillance, they need to compose APS actions. This dimension requires exercises for optimization and communication between systems, such as the e-SUS, and joint analyzes that include indicators from the two major areas. Above all, this dimension must compose planning, not only to justify it, but to give substance to objectives and goals.

Permanent Health Education (PHE) – This dimension should align the others, keeping technical, pedagogical, institutional, managerial, political and scientific resources present, updated and strong for managers and health professionals. We'll talk about PHE later.

There are many elements that emerge when a complex process such as the integration of Health Surveillance with APS begins. One of them is care.

1.4 Health Promotion and Production of Care in APS

Even if it is not immediately possible to expand a certain health promotion action to interfere with macro-determinants, in the universe of surveillance and health care, this essay can start by integrating it into the health care process.

The National Primary Care Policy is the main reference for organizing actions at this level of care. Its principles and guidelines are closely related to health promotion. In addition, health promotion is one of its components.

Composing care requires that initiatives be visible in the work process and organization of actions.

A first strategy is to organize health promotion initiatives within the framework of care, making them visible in the work process and monitoring. This can favor transformations with positive potential in the production of health care.

In this sense, it is pertinent to provide for health promotion actions in the instruments of care practice, such as health protocols; in the portfolio of services of the health unit in Primary Health Care; in the permanent education of professionals; in the lines of care with which they are related; and in the profile of professionals to be hired to compose health teams.

Programs that form APS are not appendices, they are part of the model of this level of care and attention to people's health. When not integrated, they reveal fragmentation and dispersion of work, in addition to favoring independent standards of professionals, which are weak in ensuring the integrality of care and collective work.

Programs such as School Health Program (PSE) and Health Academy should feed the field of health knowledge and practices, enriching the possibilities of approaches and technical skills of APS Health professionals and Health Surveillance.

Not trapped in schools and poles, the PSE and the Health Academy are great paths for building networks. In the PSE, for example, the dialogue of approaching education must be redefined, surpassing the procedures and expanding to the concern with the guarantee of permanence in school and the continuity of studies achieved with the reduction of dropouts for health reasons.

At Health Academy, working with sectors of sport, leisure, education, culture and public safety favors the design of goals aimed at comprehensive health and health promotion.

WANT TO KNOW MORE ABOUT THE HEALTH ACADEMY PROGRAM?

Access the material available on the APS Portal with the history, actions, funding, methodological resources and monitoring in **https://aps.saude.gov.br/biblioteca/visualizar/MTQ0MQ==**

About the School Health Program, the materials are available at **https://aps.saude.gov.br/ape/pse**

The Ministry of Health launched an online teaching open to the public with a workload of 30 hours on the origin, principles, characteristics and operationalization of the School Health Program. Access **http://modelo.sedis.ufrn.br/avasus2dev/** and click on Implementing the School Health Program.

As more general strategies, it is recommended to include health promotion in the management instruments (health plan and respective annual health programs and the management report), with goals, targets, indicators and foreseen financial resources.

It is important and strategic to present and agree, with the Health Council, proposals for the promotion of Health in the local network. This strategy can ascend to the Regional Inter-Management Commission (CIR), in which the request can be to plan for the entire health region.

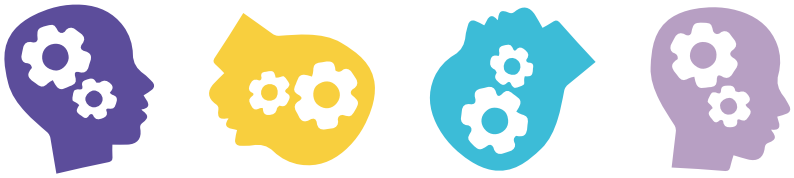
Articulating users, especially community leaders, to discuss the topic is a strong strategy to guide health promotion in the interest and conception of people about health. Social control has the potential to, among other things, amplify the debate on the topic and shorten the time that this agenda would take to be recognized by managers with due importance.

Another gain with the articulation of users from the perspective of health promotion is to expand the classic care actions (consultation, groups of diseases) to more substantial interference in people's lives.

Keep in mind that approaches from the perspective of health promotion tend to transcend the health sector. For example, an action, initially for primary prevention of diabetes mellitus in APS, has the potential to advance from nutritional

guidance and lectures to community organization around greater availability and access to healthy foods, which could lead to the organization of community food fairs which, in turn, can result in a municipal law that positively interferes with the population's access to them. Think about it!

We have reached the end of the chapter. Now that you know what characterizes health promotion, in your opinion, which initiatives and/or strategies in force in the SUS is approaching this perspective?



Did you think of anything? If so, now think about what caught your attention in the choices to consider them for health promotion.

We will continue this discussion in the next chapter, which addresses the principles of health promotion and how they, together with the axes provided for in the National Health Promotion Policy, are structuring in processes of strengthening health actions for significant changes in contexts unfavorable to their full development.

Before, check out the summary of what we have seen so far.

This chapter addressed the concept of health promotion, its organic relationship with the social determinants of health and differences in disease prevention.

The expected conclusions are:

- Health promotion needs an expanded concept of health.
- Talking about health promotion is addressing the Social Determinants of Health. Promoting health means provoking positive changes in these determinants.
- Health promotion is beyond the health sector, but it needs to be an articulator.
- Health promotion is different from disease prevention.
- Health promotion is a practical concept.

2 PRACTICING HEALTH PROMOTION

2.1 Opportunities and Resources for the Implementation of Health Promotion

We will start this discussion by presenting the most important publication of the Ministry of Health on the subject: the National Health Promotion Policy (PNPS).

The PNPS was launched in 2006, with the general goal of: promoting equity and improving conditions and ways of living, expanding the potential of individual and collective health and reducing vulnerabilities and health risks arising from social, economic, political, cultural and environmental determinants (BRASIL, 2006).

The advent of the PNPS brought, to public health, the rise of agendas related to CNCDs, especially their risk and protection factors, the promotion of the Culture of Peace and Non-Violence, healthy eating and sustainable development. Initiatives such as Schools Promoting Health, Health and Prevention in Schools, Healthy Municipalities, the School Health Program and numerous projects on physical practices and physical activities became, at the time, strategic for the strengthening of health promotion in the country.

In 2014, the PNPS was revised to update its content in light of advances and new challenges to public health and the "commitments assumed by the Brazilian government" (ROCHA *et al*., 2014, p. 4315).

The current PNPS expanded the scope of health promotion actions in the Health sector, brought education and training to the center of discussions and added, among other elements, operational axes that dialogue with primary care and health surveillance in an integrated manner, united by the territory and dynamized by the Health Care Networks (RAS). Structuring health promotion actions in the SUS requires strengthening the principles in the operational axes.

The Health Promotion Policy presents eight priority themes that serve as an agenda for its implementation, which can be increased by federal entities according to local demands and challenges that arise in the face of the interest of implementing health promotion actions.

The themes address training and permanent education as a strategy to strengthen the action of health professionals and managers aimed at promoting health and sustainable development, and protective factors against Chronic Non-Communicable Diseases, violence and traffic accidents, which together they are responsible for almost all deaths in the country.

It should be noted that, in addition to the epidemiological magnitude, the themes were defined in view of the international agendas to which the Country is a signatory, the social relevance and the health of the population.

Let's look at the PNPS topics with some recommendations for their development in the mosaic below.

Figure 3 – Mosaic of PNPS topics with recommendations

ENCOURAGEMENT OF BREASTFEEDING:
Encourage fresh or minimally processed foods as a basis for nutrition; promote fiscal measures to reduce the prices of fresh and minimally processed foods and discourage consumption of ultra-processed foods; enhance regional food culture; guaranteeing food as a right.

BODY PRACTICES AND PHYSICAL ACTIVITIES:
Urban planning aimed at safe, healthy and sustainable urban mobility; encouragement of bodily practices and physical activities in the school environment; construction and rehabilitation of public leisure spaces; inclusion in workers' health actions; inclusion of recommendations in health actions and services; conducting campaigns.

COPING WITH THE USE OF TOBACCO AND ITS DERIVATIVES:
Increased taxes on cigarettes; increased inspection at ports, airports and borders to reduce smuggling; health education in PHC and in the school environment; plan to replace tobacco crops with alternative crops; disclosure of the Anti-Smoking Law (Law No. 12.546, of December 14, 2011); training actions with professionals from the public and private sectors; provision of health services to support smoking cessation.

COPING WITH ALCOHOL ABUSE AND USE OF OTHER DRUGS:
Fiscal measures to increase the prices of alcoholic beverages; regulation of accessibility and physical availability; restriction of advertisements and publicity; increased inspection of compliance with Law No. 13.106, of March 17, 2015, by commercial and entertainment establishments that sell alcoholic beverages.

PROMOTING SAFE MOBILITY:
Urban planning aiming at the construction of signposted and illuminated access and displacement routes; reduction of the maximum speed of motor vehicles on urban roads and control on rural roads; development of actions to curb driving vehicles under the influence of alcohol and cell phone use; carrying out advertising campaigns focused on priority groups.

PROMOTING A CULTURE OF PEACE AND HUMAN RIGHTS:
Training of a prevention and care network for victims of violence; organization of health services to identify and receive victims of violence; training for responsible reporting; limited access to pesticides, weapons and high places (suicide prevention); actions in schools involving the entire school community to prevent bullying.

Source: Own elaboration.

The topics of the PNPS should be operationalized wrapped by the principles and operational axes presented below:

Table 2 – Principles and related operational axes for the implementation of Health Promotion actions

Principles of health promotion	Operational axes of PNPS
Equity, intersectoriality, empowerment, social participation, sustainability, autonomy and integrality.	Territorialization; Intersectorial and intersectorial articulation and cooperation; Health Care Networks; Participation and social control; Management; Education and training; Surveillance, Monitoring and Evaluation; Production and Dissemination of knowledge and knowledge; Social Communication and Media.

Source: Own elaboration.

What is expected in the practical application of the PNPS topics is that the initiatives are implemented around the proposed axes, that is, that they are guides from the elaboration to the execution.

But where to start? Among the various paths, thinking from the territory can be an advantageous alternative, as this dimension contains dynamics of mutual influence with people's lives, with services, the work process and professional health care.

Territory is clearly a delimited geographical space. However, it is a space activated by the people who live, work or circulate in it. This was translated by geographer Milton Santos as living territory. In the territory, the geographical boundary is important, but it should not be the main feature, since often these boundaries are expanded, reduced or redrawn by the people who inhabit it.

Territorialization applied to health, on the other hand, is the "occupation" of the territory with services and actions arranged and organized based on mapped and known health demands; that is, it is necessary to know the territory to carry out the territorialization. This is one of the principles that guides Primary Health Care, which is the level of health care closest to the subject living in the territory. Therefore, it is referred to as the main gateway to health services.

The action of territorializing is an action of learning and production of knowledge. In action, for example, support networks, exchange contacts, are essential for actions aimed at promoting health.

2.1.1 How to know a territory?

Both Primary Care and Health Surveillance have several tools and strategies for recognizing the territory and organizing services and actions.

Let's start with the classic Health Situation Analysis (Asis). Asis is an analytical process that allows to identify the health and illness profile of people living in the territory. It is based on official information provided by systems. It is continuous, strategic and should guide the organization of health services (BRASIL, 2015). Here are some essential indicators for the construction of the Asis of the population of a territory:

PROMOTING SAFE MOBILITY:

Types of data for mapping health and disease situations in the territory

- **Demographics:** they refer to the population, such as the number of inhabitants of an area or the distribution by age, sex, color or race, density and urbanization.
- **Environmental and living conditions:** they refer to the characteristics of households, sewage network and social variables (for example, income, education) that characterize the context of life of the population or individuals.
- **Morbidity and risk factors for chronic non-communicable diseases:** refer to the occurrence of diseases and health problems, available in the information systems (Information System of notifying diseases – Sinan) and health surveys (National Health Survey, Vigitel, National School Health Survey, Violence and Injuries Surveillance (Viva) etc.).
- **Mortality:** it refers to deaths. The death declaration is the main source of information about the causes of death of the population that are recorded in the Mortality Information System (SIM).
- **Health services:** they describe the resources and production of health services, available in health information and research systems (National Register of Health Establishments (Cnes), Outpatient Information System (Sia), Hospital Information System (SIH), among others).
- **Primary Health Care Coverage:** it verifies the ratio of the total teams and the number of people covered, as recommended by the National Primary Care Policy (Pnab).
- **Production of teams (procedures and activities):** it verifies the Basic Health Care Information System (Sisab) and identifies the demands and types of services and actions developed and their coverage.

The data of the main demographic and health information systems and surveys can be accessed on the websites: **https://www.ibge.gov.br/** and **http://datasus.saude.gov.br/**.

So far, we have been talking about the mapping and the recognition of the territory in the perspective of the analysis of the health situation. Now, let's go further with the perspective of health promotion.

The mapping of the territory with a view to territorialization needs to be a shared action among health professionals. The construction, completion and analysis of it must be included in the stages of health planning for that territory or municipality.

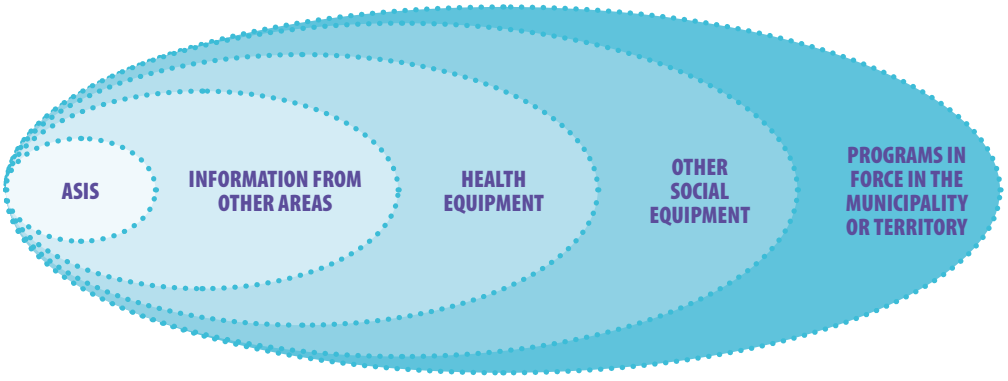
Considering the SDH, it is essential to obtain other information in order to learn more about the local reality.

In addition to health equipment, other social equipment must be mapped, such as schools, day care centers, Regional Social Assistance Center (Cras), Specialized Reference Center for Social Assistance (Creas), public spaces for sport and leisure (squares , parks, courts or similar) and those used for such purpose, such as streets and open spaces; religious spaces (churches, worship places, temples, centers and the like); community spaces; residents associations, Urban Social Centers; unions; police stations; between others.

EsIt is important to map the potentialities of the territory.

Other important information is to know which federal, state and municipal health programs and other related areas are in force in the municipality or territory. This is essential to, in the process of forming networks, strengthen actions; increase coverage; establish flows; capture audiences that commonly do not use the health services of basic units; cover the life cycle (child, adolescent, youth, adult and elderly); amplify the dissemination of information; and knowing the various technologies developed by each initiative that can enrich the individual and collective work process in the logic of mutual gain in interaction.

Figure 4 – Components of the mapping process and knowledge of the territory from the perspective of health promotion



Source: Own elaboration.

Territorializing is scaling.

Regarding information, it is important to recognize that surveillance is not only the prerogative of health. The survey, monitoring and analysis also take place in other sectors, but with different names. So, it is essential to know other information to compose the profile of the territory. For example: the literature points to the school as the place with the greatest chance of effectiveness of actions of healthy eating and physical activity. So, in addition to knowing the number of schools, it is necessary to know how many people are enrolled. This same logic serves to map the beneficiaries of programs such as Bolsa Família and the Continuing Monthly Benefit, for example.

The following box shows the main addresses and guidelines where this information can be found.

School Census: held annually, it presents, among other information, the quantity of enrolments per municipality in the respective units and levels of education. http://portal.inep.gov.br/censo-escolar

Center Specialized in Homeless Population (POP Center): it has information on homeless population.

Social Assistance Reference Center (Cras): in addition to information on homeless people, they can inform how many are the beneficiaries of the Bolsa Família programs and the Continuing Monthly Benefit (BPC).

OR

The law that created the Bolsa Família Program (Law No. 10.836, of January 9, 2004, art. 13) provides that the list of beneficiaries must be publicly accessible, with the respective amounts transferred. This disclosure is made in electronic means — the relationship can be seen on the website of Caixa Econômica Federal (Caixa) and also on the transparency Portal, the responsibility of the Comptroller General of the Union (CGU). Access http://mds.gov.br/Plone/assuntos/bolsa-familia/o-que-e/como-funciona/ lista-de-beneficiarios and find out how to search this information.

Bolsa Família Program Management System (PBF) in Health: it has information such as the number of families benefiting from the PBF; anthropometric (weight and height) and nutritional profile of children under 7 years of age and of monitored women; access of pregnant women to primary care prenatal services; location of families in the municipality; vulnerable population (indigenous, quilombolas).

With a consolidated understanding of territory and territorialization, we will follow our dialogue with network strategies for the construction and implementation of health promotion actions.

2.1.2 Health promotion networks

Networks are strategies and organizational structures adopted in sectors of the economy, technology and administration and, more recently, in public sectors that provide the capture and articulation of individuals and institutions around related causes. This is done in a democratic and participatory way by breaking the pyramidal organization to a horizontal relationship with points that communicate.

To better represent the meaning and potential of networks, some features are presented below:

> [...] they provide the emergence of a multiplicity of leaders; they grant autonomy of decision-making power to the members about their own actions; they divide equal level of responsibility among the agents; they allow the free movement of information; they favor the conscious individual and group engagement; they promote the work together for the realization of related objectives (BENELLI, 2016, p. 271).

In health, networks are strong institutional arrangements for optimization of services, comprehensiveness of care and ensuring access to health care levels. The communication center of the Health Care Networks is the Primary Health Care, which reinforces the territory as a good starting point for the materialization of health promotion actions, since this is the level of health care more decentralized and closer to the people.

Networks can be considered tools to fight against centralization of policies (AVELAR; MALFITANO, 2018). They are not exclusivity of health. There are several types – computers, systems, organizations, countries, etc. However, social networks are what interest us here. In addition to the affinities and friendships that make up the design of social networks, the ability to bring groups and individuals together around issues relating to social demands is the central usefulness of the discussion.

In recent years, social networks have become an interest of health promotion for the strong potential previously mentioned, as special resources to be used to achieve goals (MENDES *et al*., 2013).

Networking requires time, dialogue and shared management. Intersectoriality is one of the operational axes of PNPS and is a condition for the formation of networks.

Contrary to what many believe, intersectoral action does not mean combining what is done separately. It's not sum. It is a dialectical relationship that creates something belonging to everyone who has done it. Therefore, it essentially presupposes the horizontality of relationships, exchanges of knowledge and common goals.

It is known that intersectoral practice is not a natural thing in public bureaucracy. On the contrary, experience is bureaucracy acting as a barrier to the practice of intersectoriality. In addition, the convenience of people in mono thematic work, imprisoned in "boxes" by bureaucracy and compensated by mastering a certain subject, makes it difficult to propose intersectoral work. But, possibly, the structural resistance to intersectorality is due to the fact that it requires and provokes strong changes in the organizational model and work processes.

How much do you encourage or carry out intersectoral initiatives in your work?

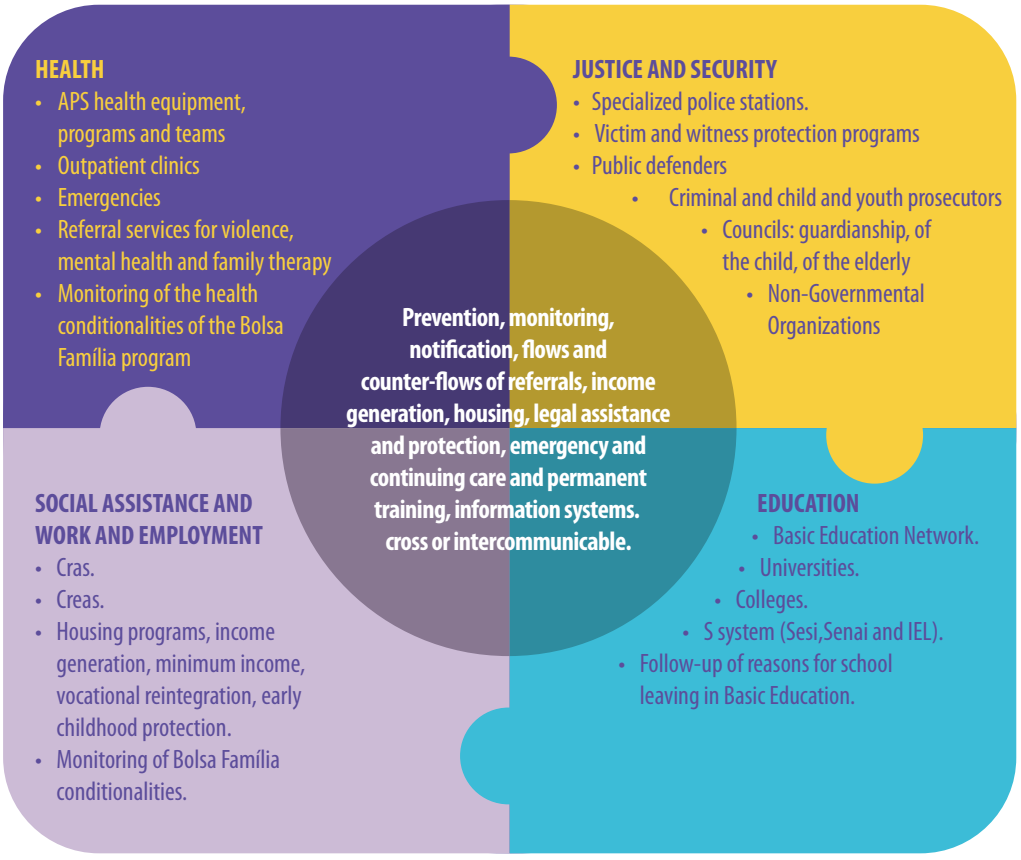
Intersectoriality is exercised, for example, in policies or programs that deal with complex issues, such as hunger, poverty, violence and accidents, chronic non-communicable diseases, drugs, school dropout and school leaving, among others.

It is a fact that health is one of the most sought-after areas to develop it. There are numerous examples that dismantle the maxim that "doing with the other" is something that does not hinder the uniqueness of the area. On the contrary, they add new knowledge and practices that strengthen the construction of health actions.

Take violence as an example. Structuring an intersectoral initiative to deal with situations of violence implies building a support network that covers health care, security, legal protection, assistance, work and education. It should provide for articulation between the points of attention through logistical, support and governance systems.

Figure 5 shows the necessary intersections, permeated by the systems that promote the intercommunication of points and the reinforcement of common goals.

Figure 5 – Structures and intersections for setting up a protection and care network for victims of violence within the scope of public administration



Source: Own elaboration, updated in 2019.

The common goal of the exemplified network is to confront violence and provide attention and assistance to victims. The relationship between the sectors is established by this objective and can be energized by joint plans, regulations, flows, protocols, transversal information systems, a panel of monitoring indicators and a strong governance system with committees, commissions, forums, public hearings and the like.

The trainings to act in this or any network must be integrated, with exchange and construction of knowledge related to the purpose of the network.

In this network, there are multiplicity of communication centers, since the event can occur in various situations and places.

But attention! The social network needs to ensure the presence of strategic actors, such as representatives of the government and those whose actions the network will achieve. In the example of Figure 5, it is an eminently governmental network that organizes services to ensure a whole line of care and protection for victims of violence. Victims in this network are assisted, supported and cared for, including legally and economically with income generation. For its completeness, civil society groups or individuals related to the root causes of the network theme should be included as active actors in its functioning.

Another aspect to be observed is that the social network – in addition to being an alternative to undemocratic processes, negligence and centralization – must seek to resolve the problem from the root of the problem. Drawing an analogy with a fishing net, the social network, aimed at promoting health, must drag itself from the bottom to the surface; otherwise, it will run the risk of becoming an organizing system of problems and demands, not of facing them.

One net "pulls" another. The contacts of the sectors of a thematic network may, temporarily or permanently, be triggered to contribute to the processes of that network. From this, the network is made with new points and intercommunication arrangements.

There are no ready formulas to set up a network, but some steps to set up an institutional network, involving public sectors, are necessary for its success. They are:

- Building technical and scientific subsidies to support the identified problem and justifying the construction of a network.
- Mapping the areas or sectors that relate to the problem and that have objectives similar to those proposed for the network.
- Mapping the social actors (people, group or organization) of the territory.
- Contacting the mapped actors.
- Training and instituting institutional supporters to articulate the network.
- Building a joint plan. When building a network involves financial resources (budget), the ideal is that financial planning is integrated. However, if there are impossibilities, it must be guaranteed in the joint plan and in the respective financial plans of the areas involved.
- Defining the roles of each area and their respective actors in the network.
- Establishing communication arrangements between network components.
- Establishing network governance (forum, committee, working group or similar). It is also possible to elect an existing governance space to include the network's discussion.
- Agreeing on the constructed plan with actors from higher hierarchical levels.
- Providing for network monitoring and evaluation mechanisms.

2.1.3 Smart cities for health promotion

It is undeniable the dynamism and strong influence on behavior change printed in the last 20 years with the advent of mobile devices with high technology and long-range communication and transmission networks around the world. "Being connected" to other people was re-signified with the technological revolution. The person does not need to be physically close to be part of groups or to make decisions or contribute to them.

The impact of digital technologies includes, on the global agenda, discussions on the use of technologies to define, organize, optimize, monitor and evaluate processes of all kinds.

In the scope of cities, this discussion comes with *smart cities*, which advocate the use of information and communication technologies to improve the lives of citizens.

According to the *Cities in Motion Index*, from the Business School of Navarra, in Spain (UNIVERSITY OF NAVARRA, 2019), smart cities have components linked to the following aspects:

Human capital – Linked to valuing people for innovation, ability to attract and retain talent, carry out the construction of plans to improve education, encourage the development of research and construction of new knowledge.

Social cohesion – It is a sociological dimension of cities that portrays the degree of consensus of social groups or the feeling of belonging to common projects and goals. It is the social interaction fostered by the management of the city.

Economy – It involves all the elements linked to the economic development of the territory: economic plans, industrial research, innovation, encouragement of entrepreneurial initiatives, local agriculture (large and small producers).

Development – The word that accompanies this aspect of the Integrated Cities is sustainable. Plans to reduce air pollution, preserve and increase green areas, sustainable buildings, urban gardens, encourage active, healthy and sustainable transport, investment in alternative energies, rational use of water, preservation of rivers, correct disposal of waste (end of dumps), among others.

Mobility and transport – It is about the ease of moving and accessing places of interest and public services quickly and safely. It deals with infrastructure plans, with the construction of access roads, increasing the quantity and improving the quality of non-polluting public transport.

Urban planning – Component directly linked to sustainability. One must be attentive to the plan for the city and ensure green areas, spaces for public use and planned expansion of the city. In Brazil, City Master Plans are the main tool to discuss this component.

International reach – It refers to the implementation of initiatives that become references for the world. Cities known for their sustainable architecture, urban mobility system, ecotourism, among others.

Technology – It refers to the implementation of initiatives that become references for the world. Cities known for their sustainable architecture, urban mobility system, ecotourism, among others.

Governance – This component refers to the capacity of the government to promote the participation of citizens in monitoring and decisions, as well as to be able to articulate with social actors for the development of policies. Governance, in the context of technologies, requires high transparency from governments (*accountability*) with the provision of processes in the planning phase, progress or completed, decisions planned or taken, use of public resources and guarantee of citizen participation, from the issuance of opinion to the formal request for information on public action.

In the logic of networks, governance through technologies is called e-governance (electronic governance), which enables the participation of citizens via the internet (CONFEDERAÇÃO NACIONAL DE MUNICÍPIOS, 2015).

DID YOU KNOW?

In 2011, the federal government created Law No. 12.527, on Access to Information (LAI), which regulated the constitutional right of access to public information. The Law applies to the three Powers of the Union, states, Federal District, municipalities and Courts of Account and Public Ministry. Private non-profit entities are also obliged to give publicity to information regarding the receipt and allocation of public resources received by them (LIBARDONI, 2000).

Access **http://www.acessoainformacao.gov.br/** and learn more about LAI and how to request information.

The concept of smart cities is the present representation of how structural aspects are fundamental to changes whose objectives are broad in scope, aimed at large groups and aimed at lasting results.

Strategies for the implementation of health promotion actions can take advantage of the various aspects that make up smart cities, including becoming feasible using them as a route.

2.1.4 *Advocacy* to strengthen the agenda of health promotion in public management

Convincing is an attitude that we do daily, either with another person or with ourselves. We use various artifices to make an opinion or idea count. This action, when carried out in a healthy way, strengthens the debate, broadens knowledge and can even put on the agenda important issues that have been neglected.

When we talk about argumentation for something as a practice and tool in management and politics, it is necessary to broaden this understanding and use robust means and materials to make the arguments sound. At this moment, it is no longer a routine, almost natural practice, for a specialized technique that proposes to influence social actors, such as deputies, supervisors, mayors, coordinators, work teams and civil society. The argumentation is called *advocacy*.

DID YOU KNOW?

The term *advocacy* originates from the Latin word ***advocare***, which means "to help someone in need". In Portuguese, the relationship with the words advocacy and advocate translated *advocacy* as "defense and arguing for a cause". Over the years, *advocacy* has also come to be used to connote the mobilization of sectors and social actors to defend an agenda with the objective of giving visibility and causing effects that can be exemplified as the change of a certain policy or the creation of others that meet the interests claimed by the collective.

Possibly, for most professionals who work in health services, the *advocacy* action is translated as preparation of technical reports or a Health Situation Analysis to support a decision by the public manager. These two components are key parts, but they are not the only ones.

Advocacy in public policies, which is our focus of discussion, must aim at the collective. It seeks to elevate the idea, issue or proposal to the highest level of decision, including it in important political agendas and agendas. For this, in addition to excellent information provided by an expanded Asis, it is fundamental that experiences with proven success, technical and scientific information are aggregated.

Another central element that strengthens the *advocacy* process is the social actors, already mentioned here when we talk about networks. In fact, networking is essential in this process. Advocates need to be supported by one or more stakeholder groups on the agenda; otherwise, it runs a serious risk of failure. Convincing, in this approach, cannot be a solitary task.

In this context, the action of *advocacy* has a line of construction that has been tested and used successfully in the world to guide various issues on local, regional, national and global agendas (ALIANÇA DE CONTROLE DO TABAGISMO, [201-]).

Let's learn about it!

1. Define the problem or issue. What do you want to modify and why? The problem needs to be aligned with the goals and mission of the source sector. This increases the chances of internal membership and support for the initiative.
2. Set desirable goals and targets with argumentation. Where do you want to go? What are the central points on which the chosen question needs to move forward? What is the deadline to meet the defined targets?
3. Collect data and information about the problem or issue – experiences in other municipalities or even countries; opinion polls, scientific evidence, proven success stories, documentaries.
4. Get to know the local, state and national political contexts, especially if the objectives include the elaboration and publication of a law. Know the government's plans and identify if there are already any guidelines or actions close to the problem or issue raised.
5. Identify the audiences of the argumentation action for health promotion. Social actors are institutions, groups or key people to be convinced of the agenda and with greater potential to bring it to the fore in decision-making spaces and strengthen it with the population. Here, the government, the parliament and the courts already need to be included.

6. Form and empower the network: identify and invite key partners for the action's success. The training of the network presupposes exposure of the arguments that support the problem or issue as something socially and politically relevant, of the objectives and targets outlined, in addition to agreeing on the role of each one to achieve collective success. Training should be continuous to reinforce the agenda, referrals and commitments that may have been made by the network.
7. Draw up a communication and mobilization plan. This includes campaigns, messages, communication with the press, preparation and distribution of materials, and the holding of events.
8. Build and strengthen spaces and e-governance (electronic governance), which presupposes the participation of citizens through the internet. To this end, it is necessary for public management to have electronic portals or internet pages with information on policies under development, investment, expected results, monitoring, etc., and spaces for consultation and citizen participation. At the other end, digital inclusion of people is needed.
9. Identify sources of resources and allocate in planning. Attention! The organizational capacity of the network can be strongly influenced by the financial and personal resources available to develop the proposed actions. As we have seen, the sectors involved should provide resources for the operation of the network.
10. Ensure monitoring and evaluation of actions. It is essential that the targets are followed. Systems must be structured that produce cross-sectional information or perform the combination of banks to compose complete information. For this to happen, it is essential that there is at least one identifying variable in all banks that will be combined. This step is cyclical and will provide subsidies to strengthen, modify or suppress non-effective actions.

Remember that the networks and the process of guiding collective themes in government agencies seek structural changes, including, internally, in the sectors and organizations that participate in the network. It is necessary to build alignments so that the changes are understood as necessary and guaranteeing the agreements and the functioning of the network.

2.1.5 Health promotion training: contributions of Permanent Health Education

The training of professionals inserted in the SUS and the teaching-service integration with professional training institutions for the Health sector have as main orientation the National Policy for Permanent Health Education (Pneps) published in 2007, republished in the consolidation Ordinance No. 2, annex XL, chapter I (BRASIL, 2017).

Permanent Health Education (PHE) is learning-work, that is, it happens in the daily lives of people and organizations. It is made from the problems faced in reality and takes into account the knowledge and experiences that people already have. It proposes that the processes of education of health workers are made from the problematization of the work process, and considers that the training needs and development of workers are guided by the health needs of people and populations (CECCIM; FERLA, 2009; BRASIL, 2017).

The processes of Permanent Health Education have as objectives the transformation of professional practices and the organization of work itself.

The understanding of permanent education at Pneps addresses all possibilities for updates; in-service training for work; social control, for networks; in addition to encompassing the construction of subjectivities and significant learning to respond to the complexity of health work. This broadening of understanding is characteristic of the health sector, which systematized and built knowledge to call it Permanent Health Education.

More than a new terminology, Permanent Health Education has elements to be considered in its implementation, such as: the formation and experience of the subjects; the articulation between teaching and learning; the interaction with work for its transformation; the context and its interaction with the health production; and the ability to respond to health problems from the understanding and appropriation of its genesis (CECCIM, 2005).

In this sense, the proposed training actions for the Health sector should take into account precious elements such as the pedagogical time for the produc-

tion of knowledge and the relationship with the practical needs that need to be solved to improve work, especially in the sense of "appropriation", professional performance and the resolution of health problems.

PHE is both responsible for the change in the care model that we emphasize as necessary to promote health and for keeping it in motion. It has the potential to break with uniprofessional training, focused on specific skills, with little contribution to shared work between professions.

An PHE plan aimed at comprehensive care, matrix support, shared work, building skills and competences for readings and interventions in complex and varied contexts should take into account interprofessional training models (COSTA, 2017); interests guided by the health problems that affect the population; use of active methodologies with problematizing approaches to the themes; and instrumentalization for the construction and use of effective technologies to improve work and health outcomes.

A continuing education process aimed at building skills and technical skills to approach the production of care and "doing" in health in an intersectoral way, in a network, and considering the social determinants of health, is the closest to the idea of health promotion.

Tavares and collaborators (2016), when defending a specific training for health promotion, justify with the presentation of three aspects to respond to the work with the expanded concept of health and the difficulty of its implementation. Knowing:

> [..] the 5 fields of action – the elaboration and implementation of healthy public policies, the creation of favorable environments, the reinforcement of community action, the development of personal skills and the reorientation of services; the 3 strategies, – *advocacy*, mediation and training – and, priorities for action to be built loco regionally with the participation of individuals and collectivities in their territories (TAVARES *et al*., 2016, p. 1800).

All the above-mentioned aspects fall within the training for health promotion in health services and training to work in this sector, whether technical or higher. It is undoubtedly a complex response to health problems, and could not be different.

Let's continue this conversation in the following topic, knowing a little more about health promotion.

2.1.6 Who is interested in health promotion?

This question seems to have a unique answer: all people. However, when we involve it in the structure and bureaucracy of public services, we see that each sector has a "great interest", which does not necessarily pass-through health, especially when the understanding about health is absence of disease.

It is common to reduce Health to hospitals, ambulances, illnesses or doctors. Along with Education, in this social imaginary, is also reduced to schools, students, assessments or teachers; infrastructure for works, asphalt or sanitation; or Social Assistance to registrations, benefits or unassisted. Corresponding, institutionally, to this imaginary is a detriment to the discussion and implementation of structuring processes aimed at health promotion.

Aware of this and other issues, the International Meeting on Health in all policies, held in 2010 in the city of Adelaide, Australia, ratified the need for a joint commitment by governments with health as a common policy objective, established in documents government planning, which seeks intersectorality and shared agendas to overcome the structural determinants of health that go beyond this sector.

The strategies proposed by the document "Health in All Policies" are characteristic of the construction of networks, which we discussed earlier. Among the common points are the integrated budget, multi-sector teams, community consultation, the development of evaluative studies and systems with transversal information.

The interest in health as a product of policies does not mean that everyone will work for the Health sector. The goal is to make everyone's health and well-being a common goal for policies, no matter whether municipal or global.

Health promotion can be the great core of convergence of the various sectors, whether governmental or not, to target structural changes that positively impact the lives of populations. Imagine the infrastructure area contextualizing your planning in the perspective of health promotion. Certainly, the actions of lighting, tree pruning and road resurfacing, for example, would aim at a clean, safe and possible city project to move in an active, safe and non-polluting way.

Similarly, for education, including APS health teams in their planning and expanding their indicators to “reduce dropout due to health” or ensuring health as curricular content, and no longer as one-off actions in schools.

In health, health promotion should guide the structuring of processes and care. This implies, among other things, changes in work processes, targets and ways of conceiving care. In planning, there should be space for the construction of networks, with intersectoral meetings, including the community.

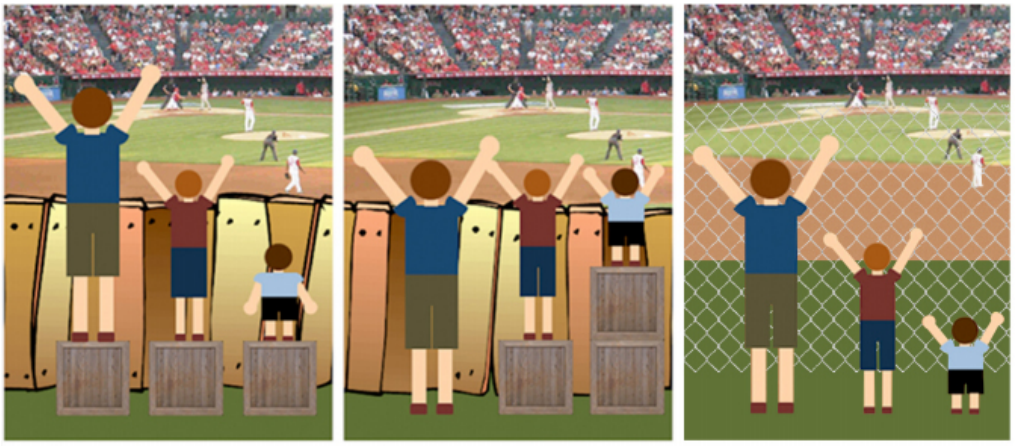
For this, it is necessary to shift focus, such as: from the isolated subject to him and his family or support references; from the disease to the process of illness; from the consultation to build a bond; from the nuclei of professional knowledge to the fields of knowledge and practices in health; from problems to potentials.

Is there room for these changes in the daily practice of health care?

Regardless of the answer, it is a fact that health sector needs to be prepared to understand, identify and contribute to the resolution of complex problems that are built from the contradictions of modern society. These contradictions changed the illness profile (epidemiological transition), created a social life that was unfavorable to adequate and healthy eating (food and nutritional transition) and free time (increased physical inactivity), in addition to building a mortality profile with a strong presence of violence and accidents, especially traffic accidents, while making people live longer, but not necessarily betterr.

Contradictions produce inequities – which are unfair but avoidable factors – that persist in the production of social inequalities. These inequalities strongly impact the health conditions of individuals. Equity would be the opposite and would seek to guarantee in form, quantity and means what is suitable for certain needs. It is not to offer the same thing to everyone; it is to tailor the offer according to the need. In this sense, it is different from equality. Take a look at Figures 6.

Figure 6 – Equality and equity



Source: Adapted from Canada, 2015.

The figure on the left shows the equal access to the object – a crate – to watch the baseball game. In this case, the solution did not solve everyone's need. The figure in the center brings the same object distributed appropriately to the needs so that everyone can watch the game.

The comic strip on equality and equity gained a third figure, on the right, which brings the equity represented by the removal of barriers.

The reduction of inequities and guarantee of equity is the role of the state through mechanisms that guarantee rights, increase opportunities for those who need them (direct policies) and offer public services with wide access and quality.

From the perspective of health promotion, there is a fourth figure in the comic strip that demonstrates the inclusion of the three subjects in the stands so that they can participate in the game of the appropriate place.

Discussions on health promotion extrapolate the Health sector, as we have already learned. However, this sector should be the main articulator of this discussion and the materiality of health promotion in public policies.

2.1.7 Health promotion is global!

The robustness of health promotion is able to confer relevance to its differences in the local, regional, national and world spheres.

The various meetings that deal with health promotion and reinforce their directives in documents alluding to the events held – letters and statements from Ottawa, Santafé of Bogotá, Curitiba, etc. – these are milestones that guide the construction of the concept and its implementation through policies and actions.

In relation to the interweaving aimed at decent, sustainable, productive, creative, safe, protective life and in a way extended to natural resources and other living beings, the Sustainable Development Goals (SDGs) globally represent this milestone.

The 17 SDGs constitute a global agenda of 169 targets to be achieved by 2030, related to actions aimed at eradicating poverty, food security, agriculture, health, education, gender equality, reducing inequalities, among others.

Brazil is one of the signatory countries of the 2030 Agenda of the SDGs and has the support of states and municipalities to achieve the goals. In this sense, disseminating and discussing the SDGs locally, in addition to aligning the political and social agenda with national and global guidelines, can opportunize the strengthening of networks, since the 17 goals are strong candidates to be common themes, unifying several areas of public management.

Get to know the SDGs!

Figure 7 – Sustainable Development Goals

Source: https://nacoesunidas.org/pos2015/.

For the management of the SDGs in the municipality or in the state, there is a recommendation for the formation of commissions to ensure the development of activities related to the implementation of the 2030 Agenda.

The following are some steps for local or regional organization of the governance of the 2030 Agenda of the SDGs:

Identification of the technical areas of Health and other government sectors related to the SDGs and that will make up the local Monitoring Commission.
Conducting a public notice or call for the selection of entities (universities, research institutes, etc.) and civil society organizations (policy councils, associations, non-governmental organizations) with an interest in composing the commission.
Publication of normative act establishing the Local Commission.
Selection and adaptation of national targets and indicators to local reality.
Include and agree on SGD targets in planning (PPA) and budgeting.
Map public policies related to SGD targets.
Define the responsibilities, the flows, the periodicity of sending the information that will be monitored.
Discuss and analyze the indicators and propose recommendations for the sectors responsible for implementing the related policies.

In the impossibility or delay in establishing a specific commission for the SDGs, it is recommended to include discussion and monitoring in already established governance spaces. Governance spaces are provided for by national, state and local ordinances. From the perspective of building networks and linking the objectives, it is recommended to map these spaces and dialogue to guide the SDGs.

Learn more about the Sustainable Development Goals by accessing: https://nacoesunidas.org/pos2015/agenda2030/

We finish the second chapter with some points of the content summarized below:

- PNPS is one of the main legal resources for health promotion in the SUS.
- Health promotion should be strengthened as a component of care, both in APS and in Health Surveillance.
- Health promotion actions must make use of strategies capable of dealing with the complexities inherent to processes that involve confronting the Social Determinants of Health.
- Intersectoriality is a condition for health promotion action to reach its full potential.
- Networks are organizational processes contrary to pyramidal organization, which promote participation, governance and, by nature, require a democratic context.
- Health in All Policies is a reinforcement of building fields of convergence between policies to leverage actions that, even coordinated by sector, have their scope expanded to improve the population's quality of life.
- The 2030 Agenda of the Sustainable Development Goals is an opportunity to resume and strengthen health promotion in its broader aspects, of the macro-determinants.

3 TIMELINE: HISTORY AND INSTITUTIONAL MEMORY OF HEALTH PROMOTION

Telling a story is one of the oldest human actions. Drawn, spoken, written or translated into films; world, national or local, the stories follow us for life. They usually inspire us with care, memories and dreams. In essence, they teach us.

This chapter presents facts that marked one of the most interesting stories in the construction of collective health: that of health promotion.

Organized chronologically, by year, the events that made up the timeline presented here represent the milestones directly and indirectly linked to health promotion in the world and in Brazil. It includes international events, meetings and agreements, as well as policies, programs and government measures taken to strengthen their health.

Far from summarizing the history so far constructed, but close to the commitment to create an institutional memory, the timeline seeks to show how events, even separated by decades, intertwined to provide the advancement of health promotion in the world and nationally. Each one with its importance, related as cause and consequence, as echo or apparently disconnected, the mosaics drawn in time represent the protagonism, effort and ideas of people and groups that responded to the “spirit of their time”.

We wish you a good reliving of this story.

3.1 Health Promotion Timeline

1970s:

- Brazil: the Health Movement proposed and guided, from the expanded concept of health, changes in the area that culminated in the 8th National Health Conference.

1974:

- The Canadian government launches the document "A New Perspective on the Health of Canadians", which became known as the Lalonde Report. It proposed that health could be classified into four general elements: biology, environment, lifestyle, and organization of health care.

1976:

- Sérgio Arouca presents the thesis the preventive dilemma – contribution to the understanding and criticism of preventive medicine.
- Created the Brazilian Center for Health Studies (Cebes).

1977:

- 30th World Health Assembly, held by the World Health Organization (WHO), launched the Movement "Health for All in 2000".

1978:

- International Conference on Primary Health Care in Alma Ata and launch of the goal "Health for all by 2000".

1979:

- Created the Brazilian Association of Postgraduate Studies in Collective Health (Abrasco).

1984:

- Sustainable Cities Movement, Canada. Congress Beyond Health Care.

1986:

- 1st International Conference on Health Promotion in Ottawa, Canada. Launch of the Ottawa Charter, most famous document on health promotion.
- 8th National Health Conference, Brazil.

1988:

- 2nd International Conference on Health Promotion, Adelaide, Australia. Reaffirms the five lines of action of the Ottawa Charter.
- Federal Constitution of Brazil (BRASIL, 1988, art. 196):

> Health is the right of all and the duty of the state, guaranteed through social and economic policies aimed at reducing the risk of disease and other diseases and universal and egalitarian access to actions and services for their promotion, protection and recovery.

1991:

- 3rd International Conference on Health Promotion, Sundsvall, Sweden – Inclusion of the topic Health and Environment in the health agenda.

1992:

- United Nations Conference on the Environment and Development (ECO 92), Brazil – Interface of support environments for health promotion.
- 9th National Health Conference with the topic “Municipalization is the way”.
- Latin American Conference on Health Promotion, Colombia – It deals with Health Promotion in Latin America and launches the Bogotá Charter.

1993:

- First Caribbean Health Promotion Conference, held in Port of Spain, Trinidad and Tobago – Focused on the well-being of Caribbean people.

1995:

- Congress of the National Council of Municipal Health Secretaries (Conasems) – Preparation of the Fortaleza Charter, a document that expressed the interest of municipal health secretaries in health promotion proposals.

1997:

- 4th International Conference on Health Promotion, Jakarta, Indonesia – "New Players for a New Era: Guiding Health Promotion into the 21st Century". Inclusion of the private sector in health promotion support.

1998:

- 10th National Health Conference – The theme "Comprehensive Health Care" is incorporated into the set of deliberations.
- 1st Meeting of Healthy Municipalities, in Sobral, Ceará. Articulation of a Brazilian network of healthy cities and municipalities from Conasems.
- United Nations Program-Project – Health Promotion, a new care model.

1999:

- National Commission for the Control of Tobacco Use in the Ministry of Health.
- National Food and Nutrition Policy.

2000:

- 11th National Health Conference – Highlighting the social determinants of health in the SUS.
- I Workshop on Health Promotion in SUS, Brazil, Ministry of Health and National Council of Municipal Health Departments.
- 5th International Conference on Health Promotion, Mexico – Focus on equity.
- The United Nations (UN) launches eight Millennium Development Goals, with the support of 191 nations, to be achieved by 2015.

2001:

- National Policy for the Reduction of Morbimortality from Accidents and Violence (Ordinance GM/MS No. 737, of May 16, 2001).

2002:

- Morbimortality Reduction Project from Traffic Accidents is implemented in Brazil.
- Preliminary document of the National Health Promotion Policy – Considered the first initiative at the federal level for an official proposal for a Health Promotion policy.
- Creation of the Thematic Group on Health Promotion and Sustainable Development of the Brazilian Association of Collective Health (GT PS/Abrasco).

2003:

- WHO Framework Convention on Tobacco Control – International Public Health Treaty led by WHO to reduce the tobacco epidemic in the world.
- Publication of the National Humanization Policy of the Brazilian Unified Health System (PNH).

2004:

- Implementation of the National Network of Centers for the Prevention of Violence and Health Promotion (Ordinance GM/MS No. 936, of May 19).
- 12th National Health Conference, with the theme “Health: a right of all and duty of the State. The health we have; the SUS we want”.
- The World Health Organization launches the Global Strategy on Healthy Eating, Physical Activity and Health.

2005:

- 6th Global Health Promotion Conference, Bangkok, Thailand.
- Institution of the Management Committee of the National Health Promotion Policy (Ordinance GM/MS No. 1.190, of July 14).
- National Agenda on Violence, Prevention and Control of Accidents and Violence (2005 to 2008).
- MS Ordinance No. 2,608, of December 28 – Decentralizes resources to the 27 capitals, states and the Federal District to develop actions to prevent smoking and promote healthy eating and physical activity, in line with the Global Strategy on Healthy Eating, WHO Physical Activity and Health.

2006:

- The Ministry of Health launches the National Health Promotion Policy.
- 1st National Seminar on Health Promotion and Healthy Brazil.
- 1st funding announcement of the National Health Promotion network, consisting of State Health Departments (SES) and Municipal Health Departments (SMS), involving 132 states and municipalities.
- Creation of the National Commission of Social Determinants in Health.
- The Pact for Life was launched, in Defense of SUS and Management, with the promotion of Health among its priorities.

2007:

- Creation of the health promotion budget line in the federal government.
- Decree No. 6,286, of December 5, was launched, which instituted the School Health Program (PSE), in the Ministries of Health and Education.

2008:

- 13th National Health Conference with the topic “Health and quality of life: State policies and development”.
- Commemoration of World Health and Physical Activity Day by the Ministry of Health.
- MS Ordinance No. 79, of September 23, was launched, which decentralized resources for health promotion actions to 523 federated entities.
- Publication of the National Health Surveillance Policy through Resolution No. 588, of July 12, 2018.

2009:

- The Ministry of Health launches the National Plan of Physical Activity.
- Emergency Plan to Expand Access to Treatment and Prevention of Alcohol and Other Drugs (Pead 2009-2010).
- 7th International Conference on Health Promotion in Nairobi, Kenya.
- Resolution of the World Health Assembly on the social determinants of health and equality in health.

2010:

- International Meeting Health in All Policies, Adelaide Declaration, Australia: on the Path to Shared Governance for Health and Well-being.
- Start of the project Vida no Trânsito, a partnership between the Ministry of Health and the WHO.

2011:

- World Conference of Social Determinants of Health, Brazil.
- Decree No. 7.508, of June 28, expresses, in Article 3, that:

> The SUS is constituted by the combination of actions and services for the promotion, protection and recovery of health, carried out by federative entities, directly or indirectly, through the complementary participation of the private sector, being organized in a regionalized and hierarchical manner.

- Strategic Action Plan for Confronting Chronic Non-Communicable Diseases (NCDs) in Brazil, 2011-2022.
- Health Academy Program (Ordinance GM/MS No. 719, of April 7).
- Term of Commitment by the Ministry of Health and food companies to reduce the sodium content in processed foods in Brazil.

2012:

- Rio+20 – People's Summit, Mayor's Summit.

2013:

- 8th International Conference on Health Promotion, Finland, "Health in all policies""
- Publication of Ordinance No. 2.761, of November 19, 2013, which instituted the National Policy of Popular Education in Health within the Brazilian Unified Health System (Pneps-SUS).

2014:

- New National Health Promotion Policy (Ordinance GM/MS No. 2.446, of November 11). Introduction of values, principles, guidelines and competences of the three spheres of management for its implementation.
- Launch of the Intersectoral Strategy for the Prevention and Control of Obesity.

2015:

- Launched the 2030 Agenda of the 17 Sustainable Development Goals (SDGs).
- The ministries of Health and Sport launch the second edition of the National Physical Activity Plan.

2016:

- 22nd World Conference on Health Promotion, Curitiba, Brazil, with the theme “Promoting health and equity”.

2017:

- 9th Global Health Promotion Conference, Shanghai. It discusses the principles of the Ottawa Charter and launches the Shanghai Declaration.

2018:

- Global Primary Health Care Conference, Astana, Kazakhstan.
- Agreement between the Ministry of Health, the National Health Surveillance Agency (Anvisa) and Food Industry Associations for the establishment of national targets for the reduction of sugar content in industrialized foods.
- WHO launches the Global Action Plan on Physical Activity and Health, 2018-2030.

2019:

- Publication of the Report of the 164th Session of the WHO Executive Committee – Strategy and action plan on health promotion in the context of the Sustainable Development Goals, 2019-2030.
- Creation of the Department of Health Promotion in the Department of Primary Care of the Ministry of Health.

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