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An assessment of the National Policy on Health Promotion by SUS managers, employees, health counselors, and users

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Abstract *Emergence of a subject into the public agenda is a complex process that involves interpretation of the current reality, and consensus-building. This paper analyzes assessments made by managers, employees, health counselors and users of Brazil's Unified Health System (SUS) on the inclusion, exclusion or revision of components of the Brazilian National Health Promotion Policy (NHPP). The survey is part of the process of review of the NHPP. It is a descriptive study, carried out by web questionnaire in November 2013 – March 2014, with 1,545 participants. The questionnaire assessed the components of the first version of the NHPP – published in 2006 (objectives, guidelines, specific actions), and the central operational guidelines constructed for the second version (2014). The participants concluded that the components of the 2006 NHPP were adequate for the demands of the field in the current situation. However, they suggested some contributions to complement the Policy, including, among others: management and planning; social determinants of health; intra-sectoral and intersectoral actions; equity; and development of personal skills. Participants emphasized professional education and the sustainability of actions in operational strategies. The contributions that the participants made do indeed point to the present needs in the field. We suggest that the NHPP should be evaluated in the various public spheres.*
Key words *Public health policy, Health promotion, Assessment*

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Introduction

There are several challenges in formulating a public policy. One of the first aspects that guides the process is the definition, itself, of what a policy is. There are contributions that define it as an action by the government, and others that state it to be the translation of gains, motives and changes[1]. A possible criticism of these propositions can be made as to the absence of debates on conflicts, interests and ideas, but we can recognize the fact of their giving a *locus* to this action (the government) as an advance.

Another aspect that is always important in studies on public policies relates to understanding of how a question or specific subject gains importance in the political context to the point of setting an agenda and influencing the development of a public policy[2,3]. The emergence of a subject into a public policy is a process that involves social interpretation of the reality[4] as well as an effort to disseminate and build consensus around images of issues[2].

Many sources pointed to the need for changes in the agenda of the Brazilian National Health Promotion Policy (NHPP): Brazilian policies and documents of the health sector, such as the National Basic Healthcare Policy (*Política Nacional de Atenção Básica* – PNAB)[5], and the Strategic Action Plan to Combat Chronic Non-Communicable Diseases (CNCD), Brazil, 2011-2013[6]; international actions against CNCD[7]; and those centered on the Social Determinants of Health (SDH)[8], and on the *Health in All Policies* initiative[9,10].

The emergence of new issues in the field of health promotion indicated by these documents, also in events of the area, and by the community of policy and practices associated with the subject, related with an institutional environment that is favorable to review of the NHPP, gave rise to a broad-based updating of Ministerial Order 687 MS/GM, of March 30, 2006 – NHPP 2006[10], operating not only in the updating of the agenda, but also in the reformulation of objectives, principles, guidelines, and other factors[11]. This process was oriented by the principle of participation – seeking, through listening to various actors involved with this policy, to build an image and consensus around ideas related to the problems that would need to be dealt with, the possible alternatives and solutions to them, and the search for political support for such a movement[11].

This vision of a process and of a shared taking of decision on the planning of public policies could contribute to successful consensus-building; generation of networks of trust between various players; and their contextualization beyond a technical production[12].

The process of review of the NHPP was carried out on the basis of a group of methodologies[11]: 1) consultation of health professionals, SUS users, representatives of social movements, and managers and technical staff of departments of the Ministry of Health, via a web questionnaire named FormSUS; 2) regional workshops seeking a more locally contextualized analysis of the NHPP, and also consolidation of commitments for implementation of the revised version of the policy; 3) intersectoral listening, through the Delphi method, involving other ministries, departments of the government, and Non-Governmental Organizations (NGO); and4)holding of intra-sectoral and intersectoral consensus workshops for agreement and construction of the NHPP final text.

In the specific case of the FormSUS, this instrument gives priority to participation by a public connected to Brazil's Unified Health System (*Sistema Único de Saúde*–SUS)and to partner public bodies[13], thus making it possible to hear the views of players that operate in the day-to-day translation of a policy into practice[12]. This is the context in which this paper analyzes the assessment made by managers, employees, health counsellors and users of the SUS about the inclusion, exclusion and revision of the Brazilian National Health Promotion Policy (NHPP) components.

Methods

This is a descriptive study, carried out over the months November 2013–March 2014, with managers and technical staff of the Health Ministry, States Health Departments, Municipal Health Department (MHD) of the capital cities of the Brazilian states; members of the National Council of Municipal Health Departments (CONASEMS) and the National Council of Health Secretaries (CONASS); Councilors of the National Health Council (CNS), Municipal Health Councils (CMS) and State Health Councils (CES); workers linked to Inter-management Regional Committees (CIR); employees; and users of the SUS.

For collection of data a self-filled-in questionnaire was developed, comprising 51 questions, predominantly quantitative. These were collected via web in the domain of the Ministry of Health, using the tool known as FormSUS.

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Access to the questionnaire was through the site of the Department of Surveillance for Non-Communicable Diseases and Health Promotion, of the Secretariat of Health Surveillance. With the exception of the general public (the users of the SUS), who accessed the questionnaire through a free link, the other respondents received an email containing a letter from the Ministry of Health presenting the process of review and the means of access to the FormSUS questionnaire.

The questionnaire was organized in four parts. The first comprised questions that characterized the participant in terms of institutional representation/connection, age, gender, schooling and location of home region. The second part dealt with general aspects of the NHPP, asking to what extent the respondent was aware of the existence of the policy, or had participated in any health promotion actions; and asked the subject to identify elements that should orient the process of NHPP review. The third part contained the components of the NHPP[10]: the overall objective, the 12 specific objectives, six directing guidelines, and eight specific actions. For the overall objective, respondents were asked to assess its appropriateness to the demands of health promotion field in the current situation, and whether any specific issues or approaches were lacking. The latter, if any, were to be marked in the space provided for open-ended questions.

The components of the policy were assessed as to whether they should be maintained in the text of the new NHPP (the 2014 NHPP)[14], and the respondents were stimulated to indicate a choice, between: (1) "Essential – must be included, obligatorily"; (2) "Very important – it would be good to include it"; (3) "I consider it to be an interesting topic, but if something has to be cut, this could be excluded"; (4) "I would not include this policy, but I would think of other policies on the subject"; or (5) "I disagree – I don't see the slightest need to include this topic". Then, in a space for free expression, it was asked whether any absence was perceived in these items – the participant being stimulated to describe the lack that he perceived, with no limit on the amount of words.

For the quantitative analysis, a decision was taken to re-categorize the answers to the items described above, with the options (1) and (2) being joined into a new category "Essential/very important", option 3 maintained and renamed "Could be excluded" and options (4) and (5) also brought together into a single category: "I would not include/I disagree".

The last block of the questionnaire comprised 11 questions which presented operational directions, proposed by the Managing Committee of the NHPP, to comprise the new policy. These items were assessed and analyzed according to the same structure described for the components of the 2006 NHPP[10].

The quantitative questions were tabulated and the results expressed in terms of relative and absolute frequency using Microsoft Excel 2010. Statistical analysis was carried out with the help of the application *Statistical Software for Professional* (*STATA*), version 7.0, seeking to identify association between knowledge of the NHPP and social-demographic characteristics such as schooling and region of residence, the results being expressed in simple and absolute frequencies. To verify the statistical significance, the χ^2 test and Fisher's exact test were used, adopting $p < 0.05$.

The analysis of the qualitative questions was initially carried out by isolation of the phrases of the respondents considering their *locus* of where they were written: General objective, Specific objectives, Directive guidelines, Specific actions, and Overall operational directions. These statements were read and emerging categories of analysis were extracted from them. After various readings, a table of categories and subcategories was arrived at, and it was then possible to group the statements which were used to provide an optimum illustration of the contributions found[15].

This study was analyzed and approved by the Research Ethics Committee of the Federal University of Goiás. Due to the method of collection of data (web questionnaire), the informed consent form was replaced by a question included on the FormSUS in which the respondent indicated consent, or otherwise, to participate in the study.

Results and discussion

A total of 1,545 people responded to the questionnaire. The variations found in the total number of answers to each item are because respondents could opt to leave any question unanswered.

Of the total of participants (n = 1,545), 32.2% (n = 497) stated their age as 30-39 years; 67.2% (n = 1,039) had a postgraduate degree (Table 1). A large proportion (n = 183, 57.2%) also reported a link to the Municipal Health Department (MHD), and73% (n = 1,128) identified themselves as female (Table 1). Similar data were found in a survey held by the Brazilian Geography and Statistics Institute (IBGE), in 2014, on the profile of management and state and municipal health managers, where it was found that more than half

(52.8%) of these were women[16]. This trend was found in municipalities with population of up to 50,000, and changed as the population of the city increased[16].The so-called feminization which has been taking place in the health profession calls attention to the need to debate subjects such as the work process, health promotion, workers' healthcare and quality of life taking into account still persistent gender inequalities[17].

Various types of effort were made seeking to increase the number of participants linked to Health Councils (CS), but this representatives continued to be lower than expected. For the record, we list the action taken in communication with these councils: A mailing to the Management Committees of the councils of the various federal spheres; participation in a meeting of the CNS, with presentation of the survey and answering of questions; and dissemination of the questionnaire on the CNS webpage. Broader participation of different sectors and social players in a process of change of policies can favor better results when the policy is put into effect, as well as achieving differentiated visions on the health promotion process[3].

As to participation by region, in this study the higher numbers of respondents were in the Southeast and Northeast – respectively 43.4% and 21.2% (Table 1). This same predominance of a regional link was found in a study with health managers in 2014[16]. The state of Tocantins (n = 37) had the highest number of participants in the Northern Region; Ceará (n = 80) the highest in the Northeast; Goiás (n = 105) in the Center-West; São Paulo (n = 287) in the Southeast; and Rio Grande do Sul (n = 72) in the South (Table 1). Together, these states had 44.7% of the respondents.

Adoption of a method of data collection that gave wide access to various segments linked to execution of the NHPP favors what Almeida and Paula[18] stated to be the use of evaluation of public policy as a mechanism of social participation.

The majority of respondents (90.7%, n = 1,401) said they were aware of the 2006 NHPP[10]. However, a statistically significant difference was found when considering distribution by schooling (p = 0.000) and by region (p = 0.003) (Table 2).

The five elements most cited as orienting factors for the process of review were: (1) professional training – qualification for workers – permanent education; (2) monitoring and assessment; (3) social control/social participation; (4) humanization; and (5) intersectorality.

And the least cited were: Social justice, advocacy, cooperation, intra-sectorality, and legitimacy. Each interviewee was able to mark up to five items presented in a list.

In relation to the question on the general objective of the 2006 NHPP[10], 74.6% (n = 1152) of respondents stated that the 2006 NHPP met the demands of the field for the present day. When

Table 1. Distribution of respondents by social characteristics and knowledge of the National Health Promotion Policy (NHPP) published in 2006.

Variable	Frequency	
	n (1545)	%
Gender		
Female	1128	73.0%
Male	417	27.0%
Age (years)		
< 20	07	0.4%
20 - 29	259	16.8%
30 - 39	497	32.2%
40 - 49	372	24.1%
50 - 59	319	20.6%
≥ 60	91	5.9%
Schooling		
Primary[a]	04	0.3%
Secondary[b]	102	6.6%
Higher education	393	25.4%
Post-graduate[c]	1039	67.2%
Never studied	07	0.5%
Connection		
Ministry of Health	126	8.2%
State Health Department	102	6.6%
Municipal Health Department	883	57.2%
Councils of Secretaries	26	1.7%
CIR[d]	05	0.3%
Regional Health Council	12	0.8%
Health worker	200	12.9%
Users	41	2.6%
Social movement	20	1.3%
University	73	4.7%
Other	57	3.7%
Region[e]		
North	91	7.0%
Northeast	275	21.2%
Center-West	250	19.2%
Southeast	564	43.4%
South	120	9.2%
Are you aware of theNHPP[f]		
Yes	1401	90.7%
No	143	9.3%

[a] Primary or primary supplemental; [b] All types, or secondary supplemental; [c] Specialization, Master's degree, doctorate. [d] Regional Inter-managers Committee; [e] Source: 1,300 respondents. [f] Source: 1,544 respondents.

Table 2. Association between schooling, employment link and region of residence and awareness of the National Health Promotion Policy published in 2006.

Variable	Aware of the NHPP		p
	No	Yes	
Schooling			0.0001*
Primary[a]	1 (25.5%)	3 (75.0%)	
Secondary[b]	20 (19.6%)	82 (80.4%)	
Higher education	46 (11.7%)	347 (88.3%)	
Post-graduation[c]	72 (6.9%)	967 (93.1%)	
Never studied	4 (57.1%)	3 (42.9%)	
Region			0.0032**
North	11 (12.1%)	80 (87.9%)	
Northeast	16 (5.8%)	259 (94.2%)	
Center-West	25 (10.0%)	225 (90.0%)	
Southeast	45 (8.0%)	519 (92.0%)	
South	21 (17.5%)	99 (82.5%)	

[a] Primary or primary supplemental; [b] All types, or secondary supplemental; [c] Specialization, Master's degree, doctorate.
* Fisher's exact test. ** Chi-squared.

asked about any gap taking into account their own experience or work, 27.3% (n = 422) identified something that was lacking. Qualitative analysis of these answers indicated the need for a new drafting of the general objective to include aspects including: management and planning; SDH; intra-sectoral and intersectoral actions; equity; community action; development of personal skills; media and communication; and sustainability of actions. These inclusions indicate a more amplified view of health promotion and consequently one with a 'less restricted' agenda, as denominated by some leaders of the formulation of the 2006 NHPP[19].

The respondents also show concern for sustainability of the actions directly related to the guarantee of funding and reformulation in the models and practices of management, as exemplified by the following statements:

I think the present health promotion policy is still very vulnerable, and has very little funding for the investments that are still so necessary to be made for the health of the users of the SUS.

Changes in the processes of work in health, still focused on spontaneous demand.

The reach of the objectives of the NHPP is directly related to institutional commitments to public policies aiming to achieve them: Guaranteed, actual, funds, and responsibilities in their applicability.

Similarly, the evaluation of the specific objectives[10]was made by 1,162 people (75.1% total), and with the exception of the text "Amplify the processes of integration based on cooperation, solidarity...", always received a vote of more than 85% as being 'Essential or very important' for the NHPP (Table 3). In relation to what might be lacking, only 17% of respondents(n = 197) identified anything lacking in this item. Among these the following categories were highlighted: Accountability/transparency (*The objectives that are promoted need greater inspection and monitoring in the execution. It would be interesting to increase the number of government workers carrying out this work. And they should be duly qualified and remunerated*; Articulation of public policies (*Stimulation and articulation with the National Popular Health Education Policy and its dissemination among municipalities, states and the federal government*); Planning of health promotion actions (*To propose Plans of Action for execution of the NHPP*); autonomy and empowerment (*Perhaps the question of subjectivity and autonomy from a point of view of Collective Health*); Communication and media ("*Give more value to, and expand, initiatives for free access to the information available on the Internet, understanding that information is essential to Health Promotion.*); Intersectorality (*Contribute to preparation and implementation of integrated public policies that aim for improvement of quality of life in the planning of urban and rural spaces*); among others.

Analysis of the new specific objectives described in the 2014 NHPP[14] points to incorporation of the suggestions. Health promotion began to be considered as an element that is part of the

Table 3. Evaluation of the capacity of the specific objectives described in the 2006 Brazilian National Health Promotion Policy (NHPP) to respond to the present demand of the area, and opinions on what should be maintained.

Specific objective[a]	Assessment (n = 1162)		
	Essential/ Very important n (%)	Could be excluded n (%)	Would not include it / Disagree n (%)
"Incorporate and implement health promotion actions[b], with emphasis on basic healthcare"[c]	1129 (97.2%)	23 (2.0%)	09 (0.8%)
"Expand autonomy and co-responsibility of subjects and collectives..."	1106 (95.2%)	38 (3.2%)	18 (1.6%)
"Promote understanding of the widened conception of health ..."	1080 (92.9%)	70 (6.0%)	12 (1.0%)
"Contribute to increase of the System's capacity to resolve and provide solutions, guaranteeing quality ..."	1094 (94.2%)	53 (4.6%)	15 (1.3%)
"Stimulate innovative and socially inclusive alternatives..."	1028 (88.5%)	116 (10%)	18 (1.5%)
"Give value to, and optimize, the use of the public spaces for coexistence and production of health ..."	1048 (90.2%)	95 (8.2%)	19 (1.6%)
"Favor the preservation of the environment and the promotion of environments ...."	1034 (89.0%)	85 (7.3%)	43 (3.7%)
"Contribute to preparation and implementation of integrated public policies ..."	1032 (88.8%)	92 (7.9%)	38 (3.3%)
"Amplify the processes of integration based on cooperation, solidarity..."	964 (83.0%)	165 (14.2%)	33 (2.8%)
"Prevent the determinant and/or conditioning factors of illnesses and health problems."	1106 (95.2%)	33 (2.8%)	23 (2.0%)
"Stimulate the adoption of non-violent lifestyles and development..."	1017 (87.5%)	81 (7.0%)	64 (5.5%)
"Give value to and expand the cooperation of the Health sector with other areas of governments..."	1080 (92.9%)	67 (5.8%)	15 (1.3%)

[a] The full texts of the specific objections can be seen in the 2006 NHPP10. [b] Health promotion. [c] N = 1161.

actions throughout the network and not only in the area of Basic Healthcare. This expectation deposited in the potential of health promotion to contribute to reorienting the healthcare model, based on coordination of primary healthcare, has been explicit in Brazil since the first edition of the Family Health Program (FHP) in 1992[20],up to the present day with the celebration of 20 years of implementation of the FHP in Brazilian municipalities[21].

One of the objectives of the 2006 edition of the NHPP[10] dealt with expansion of the autonomy and co-responsibility of subjects, placing emphasis on the individual (Objective 2. Table 3). In the revised version[14] there is an objective that more directly refer to the action of the State (through its various sectors and policies) in the promotion of practices that seek to reduce inequalities and promote equity – Objective 2 of the 2014 NHPP[14] and maintenance of the focus on individuals as described in Objective 7 of the 2014 NHPP[14]. Campos, Barros and Castro[22], in considerations on the construction of the 2006 NHPP, already pointed to the complementarity of these aspects, that is to say, the need to expand and consolidate individual abilities for healthcare, associated with activity of the State promoting living conditions and legislation to reduce the vulnerability of the population at risk.

Some objectives presented in the 2006 version[10] had drafting that implied some difficulty in operation. Examples that can be cited are Objectives 3, 4 and 5 (Table 3). The widened concept of health is one of the central elements that orient the health promotion field. This was already present in the Ottawa Charter[23], where health is understood as a construction achieved on the basis of group aspects including biological, social, economic, political and other determining circumstances. It is perceived that the specific objective number 3, presented in the 2006 NHPP[10] (Table 3) has translated, in the 2014 NHPP[14], into other objectives whose focus deal with aspects such as urban mobility and human development (objective 3, NHPP 2014), a culture of peace (objective 4, NHPP 2014), lifestyles and consumption (objective 12, NHPP 2014) and articulation of national and international agenda (objective

13, NHPP2014)[14]. Another modification identified in the 2014 NHPP[14] is the translation of the objective that dealt with the system's capacity to resolve and provide solutions, into more concrete actions, able to be the subject of assessment and evaluation, such as recording of health promotion actions (objective 11, NHPP 2014)[14].

The purpose of public spaces was expanded in the 2014 NHPP. In the 2006 version[10], the focus was on public spaces for health production, while in the 2014 NHPP the focus is on human development and wellbeing (objective 5, NHPP 2014)[14]. The environmental question was already present in the 2006 NHPP[10], and was maintained in the 2014 version[14], but began to be seen from the point of view of human development (objective 5) and of the debate on ways of consumption and production (objective 12). The intra-sectoral and intersectoral focus of the policy was kept on specific objectives, but in the new drafting of the policy in 2014 there is more of a highlight on formulation of public policies and the need for an articulation with national and international levels (objective 13, 2014 NHPP). It was also found that some specific objectives of the version published in 2016 were included in other items of the revised version[14], such as values and principles or cross-sectional subjects, or received a new drafting.

Finally, it can be noted that this analysis points to the emergence of four new specific objectives. The themes dealt with by these were present in the 2006 NHPP, but it is considered that the drafting in the form of an objective can be interpreted as a greater visibility for these agendas in the 2014 version[14]. Considering the text of the 2014 NHPP, these objectives deal with the attribution of value to different areas of knowledge and of integrative and complementary practices (Objective 6), processes of training and permanent education (objective 8), strategies of social communication and media that favor health (objective 9) and, finally, an objective that is focused on production and dissemination of knowledge (objective 10)[14].

Of the total of participants, 1,103 (71.4%) answered the questions relating to assessment of the capacity of the guidelines described in the 2006 NHPP[10] to respond to the present demand of the area and positioning as to whether they should be maintained or suppressed. With the exception of the guideline "Promote changes in the organizational culture, with a view to adoption of horizontal management practices and establishment of intersectoral cooperation networks.", the guidelines in all cases obtained marks of more than 90% as Essential/Very important.

Of the respondents to this block 14.6% (n = 161) stated the absence of some point in the approach of the guidelines, based on consideration of their own experience/activity. The following are the lacunas that were identified, and some examples of statements relating to them: accountability/transparency (*Limitation of the activity of entrepreneurial groups in Health, such as pharmaceutical manufacturers and medical cooperatives.*); advocacy (*Two items not included which should be included in the guidelines: advocacy, and inter-professional education.*"); autonomy and empowerment; communication and media (*Communication in health cannot be an instrument for institutional use, as has been happening, but to promote horizontal circulation of knowledge and recognition of the Other, including all meanings – different professional categories, individuals, groups*); social participation and monitoring; sustainable development (*There is a lack of a guideline that clearly points to Strengthening of Polices and Actions for environmentally sustainable and socially fair development for a healthy life.*); SDH; popular education, and attribution of value to popular and traditional knowledge and integrative practices (*Encourage the creation of care spaces for integrative and popular health practices so as to attribute value to local knowledge.*); equity and respect for diversity (*Promote integral health for the black and indigenous populations, giving priority to reduction of ethnic-racial inequalities, combat of racism and discrimination in institutions and services.*); professional education, qualification and permanent education (*Promote permanent education in health and in the other areas that, in intersectoral terms, constitute health promotion, including discussion on concepts in the field of health promotion and strategies/actions/methodologies for practices that promote health. Education and professional training; development of competencies for the promotion of health.*); management and planning (*Ways of assessment and adoption of indicators that do not neglect the subjectivity of the processes that constitute health promotion.*); intersectorality; technological research and innovation (*Encourage research on health promotion, evaluating efficiency, efficacy, effectiveness and safety of the actions provided.*).

It can be considered that these points have been incorporated into the drafting of the guidelines. Exact affirmation on this process is not possible since the results of the FormSUS were analyzed jointly with the results of other studies carried out in the ambit of the NHPP revision process[11]. A simple comparison indicates some

changes as to the purpose of the guidelines in the NHPP and in its composition. In the 2006 NHPP[10]there are a total of six guidelines that refer to equity, intersectoral actions, social participation, horizontal management practices, research and publication and information[10]. The revised document published in 2014[14] has eight guidelines which are described in the policy as elements that are the grounds for the actions and their purpose. These eight guidelines deal with cooperation and intra-sectoral and intersectoral articulation; territorialized actions; democratic, participative and transparent management; governance in carrying out health promotion actions; stimulus for research, production and dissemination of experiences; training and permanent education; incorporation of health promotion actions into the healthcare model; and processes of management and planning[14].

As to assessment of the capacity of the specific actions described in the 2006 NHPP to meet the present demands of the area, respondents' positioning as to maintaining these items, with the exception of the action 'Promotion of sustainable development', the others obtained more than 90% assessment as essential or very important. Of those that stated the absence of some point in the specific actions, 18.4% (n = 198) identified: life-cycles (*Reduction of infant, early neonatal and maternal mortality*); communication and media (*Implant the health channel in health units, as an open network*); SDH (*Food security – it is important to have the minimum conditions for feeding oneself, so as afterward to think about a healthy diet.*); professional training and permanent education (*Include these public policies in the content of training of medical professionals* and *Training – continued education for health professionals and beyond the health sector*); prevention (*Prevention and control of excess weight in all the cycles of life*); etc.

The specific actions present in the 2006 NHPP[10] are now presented in the 2014 revised version[14] with the name of 'priority themes', the orientation being given that these should be analyzed in accordance with the local context [14]. New drafting is identified in seven items, with a more positive style and directed towards promotion and confronting of use of substances prejudicial to health. Comparison of the versions indicates exclusion of one item that was present in 2006, "Dissemination and implementation of the National Health Promotion Policy"[10]; and the inclusion, in 2014, of the item "Training and permanent education"[14].

The NHPP has an intersectoral managing committee in which, among other actions, the process of review of this policy was discussed[11]. One of the proposals of this committee was expressed as 11 operational directions, which were also inserted in the Form SUS questionnaire for assessment. These were named: vigilance, assessment and monitoring; intersectoral articulation; regulation and control; management and financing; social participation and control; healthy lifestyles in collective spaces; promotion of health in the healthcare network; education in health/self-care; qualification of the workforce; communication and media; and technological research and innovation. Of these, the majority obtained 90% or more answers in the field 'Essential / Very important' for the NHPP, with the exception of "Communication and media" (Table 4). Only 10.8% (n = 111) of the interviewees reported some aspect as absent in these items.

We can present some analytical categories and statements by respondents relating to this item: accountability/transparency (*Combat of corruption, especially in the ambit of the services, management and budgets and financing of the public policies of interest to health promotion*); articulation of public policies (*Transversal quality. ALL the Ministries should incorporate health promotion in the preparation of their policies, as well as – obviously – ALL the sectors of the Health Ministry, which is not always remembered.*); autonomy and empowerment (*Autonomy and empowerment of the various social groups grounded on the territorial health needs.*); communication and media (*I think the new policy needs to make the type of communication and media very clear, so that health promotion actions at municipal level are not restricted to events, marketing or merely 'media' actions.*); sustainable development (*For all the new directions, stimulus for practices that are sustainable or directed towards sustainable development should be mentioned/written in the NHPP.*"); professional training (*...inclusion, qualification and development of the training of the various graduations of the health professions.*); management and planning (*...a topic highlighting democratic and participative management of the health services ...*); strengthening of community action and social participation (*Inclusions of the citizen in the discussions on proposals for approaches and implementation in strategies for social awareness.*); and: sustainability of actions (*Decision on the financial resources allocated to execution of the actions in each sphere of government.*).

Finally, the authors identify limitations in this present study, such as the obtaining of data via web-based questionnaire, which could have influenced some of the respondents to desist. It

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Table 4. Assessment of the operational directions, proposed by the Managing Committee of the National Health Promotion Policy (NHPP) for the review process, as to their capacity to meet the present demand of the health promotion area.

Operational directions	Assessment (n = 1033)		
	Essential/ Very important n (%)	Could be excluded n (%)	Would not include/ Disagree n (%)
Vigilance, assessment and monitoring	997 (96.5%)	19 (1.8%)	17 (1.7%)
Intersectoral action	1001 (96.9%)	27 (2.6%)	5 (0.5%)
Regulation and control	935 (90.5%)	66 (6.4%)	32 (3.1%)
Management and financing	1004 (97.2%)	18 (1.7%)	11 (1.1%)
Social participation	992 (96.0%)	32 (3.1%)	09 (0.9%)
Healthy lifestyles in the collective spaces	963 (93.2%)	56 (5.4%)	14 (1.4%)
Promotion of health in the healthcare networks	997 (96.5%)	28 (2.7%)	08 (0.8%)
Education in health/self-care	984 (95.3%)	38 (3.7%)	11 (1.1%)
Qualification of the workforce	971 (94%)	45 (4.3%)	17 (1.7%)
Communication and media	921 (89.1%)	95 (9.2%)	17 (1.7%)
Technological research and innovation	946 (91.6)	75 (7.2%)	12 (1.2%)

can also be highlighted that the questions were directed on the basis of the topics present in the text of the NHPP, as Objectives (general, and specific), as guidelines and as specific actions; thus the focus was the policy itself, and evaluations on the actual field of health promotion in Brazil, itself, were to be made later. As positive aspects of this study, we can highlight – as well as the evaluations of the first edition of the NHPP: the capacity for capillarity of this instrument; the large number of people who had contact with the subject as a result of this study; and the greater familiarity of the target public with the subjects, and the concepts of health promotion.

Final considerations

The analysis of the contributions of the managers, employees, health council members and users of the SUS in this NHPP process review reaffirms the importance of carrying out this procedure of updating of this policy to achieve the optimum response to the present needs in the field. The greater focus on questions such as equity and intersectorality in the new NHPP appears to be a response to desires for changes in the policy.

This study has contributed to the knowledge construction in the field of health promotion policies, and this area would benefit from more studies[3]. It also points to a research agenda that would seek to understand how the 2014 NHPP[14] has been implemented in the states and municipalities, considering institutional elements, appropriateness of the subjects, principles and values to the local realities, and also in relation to the financial resources for the actions.

Collaborations

All the authors took part in the delineation of the study and paper, review of literature, collection and analyses of data, writing, revision and approval of the final version.

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