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National Health Promotion Policy (PNPS): chapters of a journey still under construction

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Abstract *Health is a fundamental human right, according to the global commitment to the Universal Declaration of Human Rights. Health is a public good socially produced by and within social networks and disputes among subjects that seek to place certain interests and needs on the agenda of public policies. Health Promotion, as a set of strategies and forms of producing health, both individual and collective, aiming to meet the social needs of health and to assure better quality of life of the population, emerges intrinsically marked by tensions inherent to the defense of the right to health. The present article intends to detail a certain pathway of Health Promotion at SUS, telling the history of its affirmation as a National Policy and the possibilities that were produced therein to amplify the completeness of healthcare. The authors, totally involved in the preparation, implementation, and revision of the National Health Promotion Policy (PNPS), classified the journey into three chapters: (1) 1998/2004 – Embryo of a PNPS; (2) 2005/2013 – Birth, growth, and development of a PNPS; (3) 2013-2015 – Revision, expansion and dissemination of the PNPS. In addition to the narrative of a history, the cycle analysis of a policy, or balance of advancements, there is an attempt to restore contexts, texts, speeches, and tensions in the PNPS trajectory. The next chapters are still ongoing, and announce paths and possibilities on how to ensure that a Policy is kept alive.*

Key words *Health promotion, National health promotion policy, Public policy, Policy analysis*

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Introduction

Health is a fundamental human right inscribed in the founding letter of the WHO, in 1948, following the worldwide commitment to the Universal Declaration of Human Rights[1]. At the same time, health becomes a public good, an effect produced socially by and within networks and disputes of subjects that seek to place certain interests and needs on the agenda of public policies[2].

Health Promotion, as a set of strategies and forms of producing health, within the individual and collective realms, aiming to meet the social needs of health and to ensure improvement of the population's quality of life, emerges intrinsically marked by its own tensions in defense of the right to health[3,4].

In Brazil, the fight for the right to health is immanent to the fight for democracy and for the constitutional guarantee of human rights[5,6]. The Unified Healthcare System (SUS) is an effect of a series of social and political forces in defense of health as a public good, and at the same time, it is the form with which the Brazilian State has organized itself in order to put into practice the health policies in the country[7].

As SUS adopts an expanded understanding of health, aiming to overcome the hegemonic perspective of health as absence of disease, focusing on the analysis of the effects of the social, cultural, economic, and bioecologic conditioners[7], and simultaneously the joint intersectoral actions with society to reduce vulnerability and health risks, it commits to Health Promotion[8].

Health Promotion, a constitutional commitment of SUS[9], is linked to the concept expressed in the Ottawa Charter. It is a document in which 35 countries ratified as health-promoting actions those that aim at *"reducing inequities in health, guaranteeing opportunity to all citizens to make the choices most favorable to health, and to be, therefore, players in the process of production of health and improvement of quality of life"*[10].

The present article intends to detail a certain pathway of Health Promotion at SUS, telling the history of its affirmation as a National Policy and the possibilities that were produced therein to amplify the completeness of healthcare[5].

In this sense, the authors, totally involved in the formulation, implementation, and review of the National Health Promotion Policy (PNPS), classified the journey into three chapters: (1) 1998/2004 – Embryo of a PNPS; (2) 2005/2013 – Birth, growth and development of a PNPS; (3) 2013-2015 – Revision, expansion and dissemination of the PNPS.

During the first period, the attempt is to restore the initial formulation and institutionalization process of the PNPS, the players involved, and the main strategies developed. In the second period, the changes in the institutional arrangement are presented and the structuring actions of the PNPS are analyzed, as well as an assessment based on the primary axes of PNPS's Agenda. In the third, the changes conducted in the policy, based on the new agendas and challenges for the PNPS are discussed.

Besides the narrative of a history, cycle analysis of a policy, or assessment of the advancements, the article tries to restore contexts, texts, discourses, and tensions in the PNPS trajectory.

Information was searched in ordinances of the federal government, documents and institutional publications of the Ministry of Health, consultations of the Ministry of Health website, books and scientific articles related to the theme of Health Promotion Policy and its priorities.

At the end, we announced that PNPS is still an ongoing work, indicating a few pathways and possibilities as to how to keep a policy alive, bringing in the contribution of Stephen Ball, a British researcher interested in the analysis of policy cycles.

"First chapter": 1998/2004 – Embryo of a PNPS

If in the text of the Federal Constitution dated 1988 and the Organic Health Law, Health Promotion was enunciated, it took longer for it to gain institutional status at the Ministry of Health (MS)[7].

It was in 1998/1999 that the MS, by means of the Secretariat of Health Policies, in cooperation with the United Nations Development Program (UNDP), formalized the project "Health Promotion, a new model of care". It aimed to prepare the National Health Promotion Policy (PNPS), which would disseminate another way of thinking of public policies and in fomenting the construction of partnerships outside the health sector, thus expanding the discussion on the social determinants of health[11,12].

The first movements in this period invested in placing Promotion on debate in Brazil, spreading its principles with the publication of the translation of the Charters for Health Promotion, and raising, classifying, and making visible experiences that already existed in the country, with the launching of the publication *Revista Promoção da Saúde*, which had seven issues published until 2002[12].

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At that time, several national and international initiatives associated with the reduction of the main causes of morbidity and mortality were already in the health political agenda. Within this context, documents and projects were prepared under the framework of Health Promotion at SUS, especially in the areas of healthy eating, physical activity, violence in traffic, and health promotion in schools, cities, and healthy communities, as well as integrated and sustainable local development.

The cities movement was one of the main strategies to report and operationalization of health promotion principles and strategy in this period. The First Meeting of Healthy Cities was held in Sobral, state of Ceará, in 1998, and the Sobral Declaration was launched. The Declaration recommends "the initiative to negotiate a Brazilian network of healthy cities involving the National Council of Municipal Health Departments (CONASEMS)".

CONASEMS organized the First Health Promotion at SUS Workshop, together with the Ministry of Health, in Brasília, on May 17, 2000. Besides the debate on Healthy Cities, Primary Care and Health Promotion, a proposal was formally put forwarded for Healthy Industry. This effort resulted from a partnership between SESI and Ministry of Health, and mediated by the Pan-American Health Organization (PAHO), and intended to grant a "Quality Seal" to companies that would comply with the proposal.

The period is also marked by the highlight reached by Brazil in the preparation of the International Treaty for Tobacco Control, developed within the realm of WHO, which culminated with the approval of the Framework Convention by the 56th World Health Assembly, in 2003[8,12].

Several efforts were made to formalize a National Health Promotion Policy (PNPS) by the then Secretariat of Healthcare Policies of the Ministry of Health, which materialized in the "Document for Discussion", published in 2002, which was announced with the following purpose:

This document is inserted into this dialogical process of theory/practice, reflect/act for the construction of a National Health Promotion Policy that might expand our capacity for management, care, and partnerships, based on an ethical commitment in defense of life[13] .

The dialogical process mentioned, however, did not surpass the boundaries of the relation among the Ministry of Health, Pan-American Health Organization (PAHO), and a few members of the academy, but contributed towards the analysis of the health situation in Brazil, in order to systematize good practices in Health Promotion at SUS[13]. It basically advanced in outlining seven "strategies" for boosting the Policy, which are shown on Chart 1.

Nevertheless, between 1999 and 2003, a series of difficulties was seen in articulating the tensions between the biomedical paradigm and the healthcare promoter, the different theoretical-conceptual ideas of the promotional field and management of Health Promotion within the Ministry of Health, whose change of leadership seven times produced a significant lack of continuity[14]. Such difficulties in composition implied fragmentation of the project operation, while at the same time, delaying the forming of pacts and implementation of a PNPS[11].

Chart 1. Strategies to foster a national health promotion policy.

Intersectoral management of the resources in approaching the problems and potentialities in health, expanding partnerships and sharing solutions in the construction of healthy public policies.
Capacity of regulation of the states and cities as to the factors of health protection and promotion.
Reinforce the processes of community participation in diagnosis of the health problems and their solutions, stressing the preparation and consolidation of social and protective networks.
Promotion of healthy habits and lifestyles, with emphasis on the encouraging healthy eating habits, physical activity, safe behaviors, and fighting smoking.
Promotion of safe and sustainable venues, with emphasis on work with community schools.
Reinforcement of the reorientation of the practices of the services within the positive concept of health, comprehensive care and quality, having promotion as a cross-sectional focus of the policies, programs, projects, and actions, with priority given to primary care and the Family Health Program.
Reorientation as to care in the perspective of respect to autonomy, culture, in an interaction of care/being cared for, teaching/learning, open to the incorporation of other practices and rationalities.

Between 2003 and 2004, it was up to the Executive Secretariat of the Ministry of Health to manage the process of health promotion, by mapping of the main ongoing initiatives and experiences in the country, organizing workshops for debate and preparation of the PNPS together with the teaching and research institutions and healthcare managers. Moreover, the first Policy Writing Group was formed, comprising representatives of the Ministry of Health, PAHO, National Council of Municipal Health Departments (CONASEMS) and municipal managers of successful health promotion experiences[11,15].

At the end of 2004, with the changes in management in the Ministry of Health, the PNPS was moved to the General Coordination of Non-communicable Diseases (CGDANT), based at the Health Surveillance Secretariat (SVS).

From this initial period of institutionalization of Health Promotion, regarding accelerations and decelerations if the preparation of the Policy, there was a significant exchange with teaching and research institutions dedicated to the theme, expanding the debate with state and municipal healthcare authorities, and especially, the radical defense of "cast-iron" principles of Health Promotion at SUS: autonomy, equity, integrality, intersectoriality, co-management in work process of and social participation.

"Second chapter": 2005-2013 – Birth, growth, and development of a PNPS

The General Coordination of Non-communicable Diseases (CGDANT) of the Health Surveillance Secretariat (SVS) took on the coordination of the process in 2005. It established in 2005 a technical area with the responsibility of setting up a National Health Promotion Policy (PNPS) based on the theoretical mark of the previous period, but with the concern of producing Health Promotion interventions in the realm of the three levels of government.

Therefore, an initial version of the PNPS was produced and submitted to the evaluation of a Health Surveillance Work Group (GTVS), with a tripartite character, composed of representatives of the Ministry of Health, CONASEMS, and National Council of Health Authorities (CONASS).

Still in 2005, the Health Promotion Policy Management Committee (CGPNPS) was established; it was coordinated by CGDANT and had representatives of several departments and agencies of the Ministry of Health. In 2007, the CGPNPS had its composition expanded, with the insertion of representation from CONASS and CONASEMS. Since then, it has maintained it regular operation, also counting on the participation of the Brazilian Association of Collective Health – ABRASCO[16,17]. Among its many attributions, we point out: coordinating and implementing the PNPS; encouraging the states and cities to prepare Health Promotion Plans; negotiating and integrating Health Promotion actions at SUS; monitoring and assessing the implementation of PNPS.

In 2006, the MS, CONASS and CONASEMS approved the National Health Promotion Policy, conceived with the perspective of operating transversally, producing a network of coresponsibility for the improvement of quality of life, recognizing the importance of the social conditioners and determinants of health in the disease-health process, contributing to change in the care model of SUS, and incorporating health promotion[10]. A National Health Promotion Agenda was added to the PNPS for the 2007/2008 period[18]. In the next years, health promotion was included in the Agenda of Commitments to Health, in the Defense of SUS, Defense of Life, and Management Pacts, and was included in the strategic agenda of the MS and in the subsequent National Health Plans[10,18].

1. Structuring actions for the institutionalization of PNPS in the federal scope

In 2006, important steps were taken for the institucionalization of the PNPS at SUS, such as its approval at CIT, the creation of a specific budget programming for Health Promotion in the Plurianual Plan, and its insertion into the National Healthcare Plan[10].

Between 2008 and 2011, the PNPS was included in the interfederative agenda by means of the Pact for Life. The indicators related to reducing the prevalence of sedentarism and smoking in the capital cities were monitored, as well as the implementation of groups on violence prevention and health promotion[10]. As of 2011, in the Public Action Organization Contract (COAP), provided by Decree 7508/11, which regulates the Organic Health Law, health promotion indicators were also included, such as notification of domestic, sexual and/or other types of violence, implementation of the Health Academy Program, among others.

Between 2008 and 2010, the following items were inserted in health promotion actions monitoring: financial funding for health promotion projects or programs, such as the promotion of physical activity and healthy eating habits, smoking prevention, implementation of centers for the prevention of violence, surbveillance and

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prevention of injuries and deaths in road accidents. In 2011, these actions were also inserted in the National Health Plan (2011-2015) and in the Strategic Planning of the Ministry of Health (2011-2015), emphasizing the Plan for Confronting Chronic Non-communicable Diseases, the implementation of the Health Academy Plan, the expansion of the Health at School Program and the Life in Traffic Program[19-22].

As from 2005, the Ministry of Health has financed the states of the federation with the objective of inducing actions in health promotion programs, initially supporting the capital cities and the Federal District. Between 2006 and 2010, approximately 171 million *reals* were transferred to the State Health Departments and to 1,500 Municipal Health Departments of all regions of the country, which comprise the National Health Promotion Network. These transfers occurred due to a pact at CIT, by means of public notices or administrative rulings, and cities submitting projects that were evaluated and selected, considering budget availability. With these resources, the public administrators developed health promotion projects, focused mainly on actions of promoting physical activity, violence prevention and a culture of peace, and reducing morbidity and mortality rates due to road accidents. Between 2008 and 2010, some programs were also financed for the other priorities of the PNPS[10,23].

As of 2011, new modalities were defined for transferring funds, seeking sustainable, continuous and universal actions. In the case of promotion of physical activity and practices, it was defined by implementing the *Health Academy Program*[21], with financial resources from the *Piso Variável em Vigilância e Promoção da Saúde* (PVPVS) [Variable Rate Floor in Surveillance and Health Promotion] and the *Piso de Atenção Básica Variável* (PAB variável) [Variable Rate Floor for Primary Care] of the Healthcare Secretariat-[21]for the construction of the program hubs and the expenses of their activities. Programs similar to the Health Academy Plan were also supported.

New modalities were also defined for financing of the Health at School Program (PSE), as from 2008. With the expansion of the criteria for joining the program, the PSE went from 1.9 million benefited individuals, in 2008, to 18.7 million in 2013, with the enrolment of 4,864 cities. In 2014, the PSE received R$ 71 million.

Regarding the programs to reduce morbidity and mortality in roads, funds were transfered as from 2006, initially to 16 capital cities, and later progressively to other capitals and cities with populations of more than one million inhabitants. In 2010, the *Projeto Vida no Trânsito* (PVT)[22,23][Life in Roads Project] was created, advancing in the intersectoral partnerships. Thus, between 2006 and 2015, roughly R$ 50 million were given to the cities. In 2013, the PVT was inserted in the Variable Rate Floor in Surveillance and Health Promotion (PVPVS), providing more sustainability to the theme and reaffirming the commitments of SUS in an interfederative manner[21].

The *Rede Nacional de Prevenção das Violências e Promoção da Saúde* [National Network of Violence Prevention and Health Promotion] was created in more than 1000 cities, according to the National Policy on Reducing Morbidity and Mortality due to Accidents and Violence. It aims at comprehensive care to and protection of persons and their families in violent situations. Between 2006 and 2012, about 1300 cities received funds for prevention actions against violence and accidents, and for a culture of peace[23].

In 2011, the National Plan for Confronting Chronic Non-communicable Diseases from 2011 to 2022 was launched, establishing administrative commitments, prioritizing actions and investments necessary to face and deter the chronic non-communicable diseases (CNCD) and their risk factors[15,23].

2. Assessment of the PNPS Agenda priority themes

We chose to assess based on the priority themes of the PNPS, revised in 2014, which ended up serving as an inducer for strengthening promotion actions in all levels of SUS. The inclusion of these themes considered the magnitude of the situation of morbidity and mortality, transcendence, intersectoral action, and effectiveness of health promotion practices in response to the priority axes, as per the three government levels responsible for public management, as shown on Chart 2.

Chart 2. Priority themes of the PNPS.

Permanent training and education
Healthy and appropriate eating habits
Body practices and physical activity
Fighting use of tobacco and its products
Fighting alcohol abuse
Promotion of safe and sustainable mobility
Promotion of a culture of peace and human rights
Promotion of sustainable development

Considering the theme *Permanent training and education* along ten years of the PNPS, there were innumerable training processes, including seminars, debates, technical meetings, training on diverse topics, aiming to broaden understanding of the theme of health promotion at SUS, with the participation of SUS professionals and managers from states and cities, and representatives of teaching and research institutions. The strategy of conducting in-person courses for the qualification of SUS workforce proved insufficient and distance training courses were organized. These courses fulfilled their role of offering contents that can provide support for the qualification of managers and healthcare professionals on the topic of health promotion. Additionally, many items were made available, such as books, publication of articles in journals, websites and educational material[24,25], to prepare healthcare professionals. Moreover, for social communication process, it conveyed information to the population, such as the *Guia Alimentar para a População Brasileira* [Food Guide for the Brazilian Population], produced as of 2011 and launched in 2014, in a process with ample social participation[26].

Healthy and appropriate eating is one of the determinants and conditioners of health and a right inherent to all people. The guarantee of Food and Nutritional Security requires a set of public policies, among which the PNPS and the National Policy on Food and Nutrition (PNAN) paly crucial roles. Numerous efforts were made for health promotion and Food and Nutritional Security (SAN) at SUS, as well as several intersectoral negotiations. Among these, we highlight: a) actions relative to healthy eating, production of care and the regional care networks (RAS, acronym in Portuguese); b) the systematic follow-up of health conditions of individuals benefited by the *Programa Bolsa Família* (PBF), carried out by the Primar Care teams throughout the country; c) the set of actions developed within the scope of the Health at School Program (PSE), in a partnership of the AB teams with education professionals; d) the strategic actions to increase fruit and vegetable consumption, reducing salt intake, involving negotiation and pacts made with the food production sector, represented by the *Associação Brasileira das Indústrias de Alimentação* (ABIA) [Brazilian Food Industry Association], to reduce sodium content in processed foods in a gradual and voluntary manner, and by means of two-year targets. The Ministry of Health was in charge of monitoring the results of the first two commitment terms, which show a reduction in the mean sodium content in all categories analyzed, achieving goals agreed on of 80 to 99% [27]; e) the publication of the guidelines for organizing prevention and treatment of overweight and obesity as priority line of care of the Network for Care of Individuals with Chronic Diseases[28,29]; f) the Food Guide for the Brazilian Population that brought new paradigms on the need for understanding eating habits within the context of the food system and in a consistent manner with the current stage of the nutritional transition[26,29].

Within the context of the PNPS, the theme *body practice/physical activity* had its impulse as of 2005, and among its actions we point out: a) organizing surveillance of risk factors and protection against chronic diseases, which made it possible to monitor the indicators of physical activity by means of population surveys, such as the S*istema de Vigilância de Fatores de Risco and Proteção para DCNT* (VIGITEL) [System of Risk Factor Surveillance and Protection for CNCDs], starting in 2006; *Pesquisa Nacional de Saúde do Escolar* (PeNSE)[30][National Survey on Students´ Health], first edition in 2009; health supplement of PNAD (2008), which enabled ongoing monitoring of physical activity indicators, as well as inducing actions that promote health; b) communication actions to celebrate specific world days highlighting physical activity and health, which takes place in the first week of April, every year; c) financing of physical activity projects in about 1,500 cities, between 2005 and 2010; d) evaluations of the existing physical activity programs in several cities, including Recife, Curitiba, Belo Horizonte, Aracaju, and Vitória. In Latin America the program was evaluated by means of the Useful Guide for Physical Activity Evaluation Project (GUIA), which counts on national and international partnerships[31-33]. As a result of the evaluations and considering the evidence accumulated, the MS decided to implement the Health Academy Plan in 2011. The Plan is a model of national health promotion intervention, aiming to contribute towards equity in access to actions focused on the production of care and healthy lifestyles in qualified venues. This is primary care equipment, with body practices and physical activity as a central axis of its actions, but it also includes other health promotion actions within its scope, such as healthy eating, violence prevention, prevention of smoking, alcohol, and drugs, and others[20].

The theme *facing the use of tobacco and its products* gives priority to one of the four main

risk factors for the development of the four major chronic non-communicable diseases in Brazil[34]. In 2006, Brazil ratified the *Convenção-Quadro sobre Controle do Uso do Tabaco* (CQCT) [Framework Convetion on Tobacco Control] and the *Comissão Nacional de Implementação da Convenção-Quadro para Controle do Tabaco* (CONICQ) [National Comission to Implement the Framework Convetion on Tobacco Control] was established. This Commission has an interministry character and is the governmental forum responsible for implementing the measures of CQCT in the country; it is composed of 18 areas of the government, and is presided by the Minister of Health.

In 2011, in the Plan of Strategic Actions to Confronting Chronic Non-communicable Diseases: 2011 – 2022, the goal to reduce the prevalence of smoking by 30% was included. Various actions were conducted to face smoking in the country, which has been considered a successful task by different global organizations, such as WHO, the Bloomberg Foundation and PAHO. The Ministry of Health has been awarded prizes for its performance[34,35]. Prohibition of smoking advertisement and the introduction of warning messages on cigarette packs took place in the 1990s, and has been enhanced in recent years. In December 2011, the Federal Law number 12,546 was approved, prohibiting the act of smoking in collective facilities, increasing taxes on cigarettes by 85%, and defining a minimum price for the sale of cigarettes, to avoid sale of cigarette-theft racket. The Law also determined the increase in space of warnings against cigarettes, which is 100% on one of the frontal surfaces and one of the lateral surfaces of the packs, and increased to more than 30% the other frontal surface, as of 2016. Regulation of this Law occurred in 2014, extending the prohibition of smoking to facilities partially closed by a wall, divider, ceiling, or even a canopy, and defining the state and municipal health surveillance agencies as responsible for supervision and for applying penalties for the infringement.

Another important measure was the expansion of treatment of smokers at the SUS units, including access to medications and follow-up[23].

These measures seek to protect the current and future generations from the devastating consequences generated by consumption of and exposure to tobacco smoke. The positive results obtained by Brazil in confronting smoking serve as a stimulus for the country to continue investing in public health promotion policies and in smoking prevention. The effects of the measures adopted can already be seen: data from the National Household Sample Survey (PNAD) – 2008, showed that, among individuals aged 18 years or older, the prevalence of smoking was 18.2%, and dropped to 14.7% in 2013, as reported in the National Health Survey, or a decline of approximately 20% in five years[19,34].

Based on evidence that regulatory measures can be effective in facing the rise in deaths and injuries in road accidents, the Ministry of Health has progressively been taking action regarding the theme *fight against the abusive use of alcohol and promotion of safe and sustainable mobility,* in negotiations. Furthermore the Ministry acts on *advocacy* of approval of laws that restrict the consumption of alcoholic beverages by drivers and that strengthen the role of traffic agents in applying measures that favor life protection and prevention of road accidents related to alcohol and driving.

Additionally, we highlight the increased control and supervision in the supply of alcoholic drinks to minors aged less than 18 years. We also point out the *Projeto Vida no Trânsito* (PVT) [Life in Traffic Project] that has an ample partnership involving local, national, and international organizations to prepare integrated and intersectoral plans of action for traffic safety, seeking to reduce this status of morbidity and mortality. Implemented in five Brazilian capital cities (Belo Horizonte, Curitiba, Teresina, Palmas, and Campo Grande), in 2010, it was expanded in 2012 to all capitals and cities with more than one million inhabitants. The PVT used information obtained from the analyses made by the Local Data Commissions, which guide the integrated and intersectoral interventions in the territories at greatest need[22]. Assessments already conducted of the PVT in five cities, a pilot project, pointed out the high percentage of reaching the performance targets of both programs; increased supervision of driving speed; increased number of blitzes to check alcohol use, with an increase in the number of tests and reduction of the percentage of positive tests; reduction in mortality rates per 100 thousand inhabitants in Palmas, Teresina, Belo Horizonte, and decreased ratio per 10 thousand vehicles in five capitals; a tendency towards reduction of the risks of death in the capitals of greatest magnitude than in their respective states[22].

As to the *Promotion of a culture of peace and human rights*, the intersectoral actions of violence prevention were undertaken through some

legal framemarks, such as: Plan of Action to Fight Violence Against the Elderly (2005); National Policy to Fight Against Traffic of People (2006); Law Maria da Penha (2006); National Policy on Comprehhensive Healthcare to Black Population (2009); Nacional Policy on Comprehhensive Care for Lesbian, Gay, Bisexual, Travestite and Transexual Individuals – LGBT (2008), Policy on Comprehensive Care to Woman Health, Care Line for Children, Adolescents and their Families in Violent Situation (2010), among others. Among the actions in the territory, we highlight the National Network of Violence Prevention and Health Promotion, made up of a capillary network that increases identification and notification of violence in the territory, acting in an integrated fashion with the intersectoral actions within the care network and that of victims of violence[36].

On the theme *Promotion of sustainable development* various partnerships were established with the Ministries of Environment, Integration, Cities, Chief of Staff, State and Municipal Health Departments in order to conduct the Sustainable Development Plans in some areas, such as the Turistic Region in Mid-North (Piauí, Maranhão and Ceará); Regional Sustainable Develompent Plan of Xingu, among others. We further mention the establishment of the Technical Health Chamber to Support the National Policy on Regional Development (2012), Technical Health Group and Environmental Licencing (2009), and the development of the Sustainable Cities Program - Brazil + 20 – all public policies geared towards urban environmental management.

"Third Chapter" - 2013-2015 – Revision, expansion, and dissemination of the PNPS

Over the last decade, there have been several changes in the national and international scenario pointing towards new agendas and challenges in the field of Health Promotion, such as intersectoral programs coordinated by the Civil Staff of the Presidency of the Republic - for example, the Program to Fight Poverty, Family Grant, and others. In addition, the international agendas, including the United Nations High Level Meeting on Non-communicable Disease Prevention and Control (2011), World Conference on Social Determinants of Health (2011), Rio +20 (2012), 8th Global Conference on Health Promotion – *Health in all Policies* (Finland, 2013), among others, which updated and revised the agenda of promotion and demanded the improvement and updating of the Policy. In face of this new context, the Ministry of Health opted for an ample and participatory revision of the PNPS[37].

The PNPS revision was set off by the Ministry of Health and coordinated by the Health Surveillance Secretariat, by means of the Department of Surveillance of Non-communicable Diseases and Health Promotion, established in 2013, and the CGPNPS, in partnership with the PAHO and the Thematic Group Health Promotion of ABRASCO. The revision was performed in an ample, democratic, and participatory manner with the involvement of managers, workers, counselors, representatives of social and professional movements from Higher Education Institutions, besides representatives of organizations outside the healthcare sector and committed to health promotion actions in five Brazilian regions. As SUS for a, the PNPS was discussed and established by the Working Group Health Surveillance, Working Group Care and Management, and was approved by the Tripartite Intermanagers Commission (CIT) and by the National Health Council (CNS)[37].

The PNPS revised in 2013/2014 points towards the need for liaison with other public policies in order to strengthen it, with the imperative of social and grass-roots movement participation, since it is impossible for the health sector to fight alone against the determinants and conditioners that influence health, recognizing, in first place, that the promotion and prevention actions need to be carried out – always – negotiating with other public policies, along with other levels of government and with the organized civil society in order to obtain success.

This period is also marked by the recognition of the need to potentiate the capacity of disseminating the elements of the PNPS along with the players of SUS and the society as a whole, expanding the dialogue channels. In this sense, a strategy of advertisement and social communication was created and dedicated to integrate and promote the primary guidelines of the PNPS.

This material, prepared in partnership bewteen the coordination of the PNPS, the Institutional Advertisement and Promotion Department and the Communication Services of the Ministry of Health, was entitled *Da Saúde se Cuida Todos os Dias* [Taking care of health everyday] (http://promocaodasaude.saude.gov.br/promocaodasaude) and used the integrated strategy of advertising and media, social communication, public relations, events and promotion, strategic partnerships and the challenge of a new digital po-

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sition in the worldwide network, so that the MS might assume the role of inducer of information on health promotion.

For the development of this strategy, the essence of the mark developed was based on health promotion as the great landmark of the fight for the universalization of the healthcare system and for the implementation of public policies in defense of life, making health an irrevocable social right.

The PNPS came to bring changes in the modes of organizing, planning, conducting, analyzing and assessing the work in healthcare. It brings along with it, in its essence, the need to establish a relation with the other public policies already conquered by the population.

"Taking care of health everyday" seeks to develop strategies of communication and social mobilization, negotiating specific intersectoral actions in the following axes: a) encouraging healthy eating habits; b) encouraging alcohol consumption reduction; c) encouraging physical activity; d) smoking control; and) encouraging road safety; f) encouraging a culture of peace; g) encouraging a healthy environment; h) encouraging vaginal delivery.

The great innovation, besides the integrated strategies that seek to articulate publicity and social communication based on a common axis (take care of health everyday), strongly committed to the fundamental principles of the PNPS, was the inclusion of the incentive for vaginal delivery as a "new axis" of the PNPS or an annex to the promotion policy.

Such a decision is based on the observation that Brazil was going through a serious public healthcare problem related to maternal care. In 2013, 84% of deliveries performed by the private healthcare network were Caesarian sections. An alarming number that place the country in the position of world leader in surgical deliveries, since the recommendation of the WHO is 15%. Even though, the WHO recognizes that the efforts should be concentrated on guaranteeing that the C-sections be done in cases where they are necessary, instead of seeking to attain a specific rate of Caesarian sections[38].

One of the most efficient ways of combating these indexes is providing information and encouraging vaginal delivery. In this regard, SUS offers the *Rede Cegonha* [Stork Network] accompaniment during the gestation, delivery, and postpartum, and the ANS and the Ministry of Health have now proposed a change in the model of birth assistance in the area of private healthcare as well, giving value to vaginal delivery and expanding measures of obstetric regulations.

To change this picture, it is necessary to produce ample social mobilization and to empower women, in addition to the measures related to the changes needed in the model of obstetric care, valuing the insertion of nurses in maternal care, the financing model, and in the regulations of obstetric care.

From that one could understand the pertinence of producing a broader range of interventions proposed in the PNPS. It is a technical and political decision assuming the PNPS should not be restricted to the intervention on the consecrated risk factors for the CNCD. Thus, since it already seeks to face other important determinants and diseases, such as the various forms of violence and alcohol and other drug abuse, it should be open and include different health problems – based on the population needs – that require early interventions, surveillance, empowerment of the population for self-care, production of health consciousness, personal and collective commitment of all citizens (users, target/risk groups or not, workers, researchers, managers, etc) to face these challenges.

Next chapters: power of a job that is still open

The PNPS presented diverse advancements and important challenges. The agenda of priorities for 2006 to 2007 was fulfilled, but new actions were also inserted, which were not in the original text. Noteworthy here is the articulation between the PNPS and the Plan to Fight CNCD, enhancing actions, priorities and results.

We point out the importance of the Managing Committee of the PNPS in the coordination of the intra- and intersectoral health promotion actions, working continuously and supported during this period, and this enabled integration of the processes.

The insertion of health promotion programs in the budget programming was very important; finances destined to the cities and states for physical activity projects and body practices; expressive advancements in surveillance of morbidity and mortality and of risk factors, as well as protection from the CNCD; and advancements in the evaluation of the projects, in partnerships, in human resources training, and in social mobilization. The field of promotion is still under construction, and we have yet a long journey ahead,

but the effective initial steps for its institutionalization and strengthening have been taken.

There still is the challenge of advancing in the intersectoral action aiming to negotiate actions for specific audiences, such as promoting health in the work environment, in the community, to develop projects designed to improve urban mobility, including disabled individuals and the elderly. In addition to the intersectoral actions needed in reference to urban planning, with evident impact on the levels of physical activity of the population, enabling access to safe and healthy venues for the low-income population. These actions are the responsibility of various sectors, in all levels of government, including the Ministry of Cities and the Ministry of Transport, among others.

The revision process of the PNPS enlarged the scope of consultation for the Brazilian regions and brought a diversity of expectations and priorities. The need to adjust to a national policy overshadows singularities. One must follow on with successive approximations between the whole and the parts. Try to make it so that local/territorial/municipal/regional/state aspects have their colors represented in a national policy is a legitimate aspiration. To this end, a Public Policy must be under constant revision. And this reflexive and evaluation process should be continuously conducted in a shared fashion - "evaluate those who prepare, evaluate those who do, evaluate those who use it"[39].

We would like to call attention to the fact that in 2015, at the launching of the campaign "Taking care of health everyday" to report the principles and actions of the PNPS, the topic "encouraging vaginal delivery" was included, which was not in the official declaration of launching of the PNPS, in November of 2014.

Stephen Ball, cited by Rezende and Baptista[40], recognizes that there are disputes all the time in the production of policies: there is constant preparation/production of new texts. Thus, there is production of texts in all contexts to draft a policy. And the force of the law is not enough as a deterrent or limit for social clamors and ethical-political imperatives to manifest *a posteriore* regarding any formal publication of a Policy.

The law cannot be a dead letter without life that pulses within it. There needs to be sensitivity, since a policy undergoes multiple crossings of texts, discourses, disputes, actions, and effects[40]. And in this sense, for a policy to remain alive, it needs to be seen, not as something absolute and definitive, but as a device of an *essentially strategic nature...of a rational and combined intervention of the relations of forces...the device is always inscribed in some power game, while at the same time, always linked to the limits of knowledge...*[41].

Collaborations

DC Malta, OL Morais Neto, MMA Silva, D Rocha, AM Castro, AAC Reis and M Akerman participated equally in all stages of preparation of the article.

References

1. Dallari SG. O Direito à Saúde. *Rev Saude Publica* 1988; 22(1):57-63.
2. Akerman M, Righi LB, Pasche DF, Trufelli D, Lopes PR. Saúde e Desenvolvimento: Que Conexões? In: Campos GWS, Bonfim JRA, Minayo MCS, Akerman M, Júnior MD, Carvalho YM, organizadores. *Tratado de Saúde Coletiva*. São Paulo: Hucitec; 2006. p. 123-147.
3. World Health Organization (WHO). *The Ottawa Charter for Health Promotion*. Geneva: WHO; 1986.
4. Buss PM. Uma introdução ao conceito de promoção da saúde. In: Czeresina D, Freitas CM, organizadores. *Promoção da saúde: conceitos, reflexões, tendências*. Rio de Janeiro: Fiocruz; 2003. p. 15-38.
5. Pasche DF, Hennington, EA. Promoção da Saúde e o Sistema Único de Saúde In: Castro A, Malo M. *SUS: ressignificando a promoção da saúde*. São Paulo: Hucitec; 2006. p. 19-40.
6. Escorel S. *Reviravolta na Saúde, origem e articulação do movimento sanitário*. Rio de Janeiro: Fiocruz; 1999.
7. Vasconcelos CM, Pasche DF O Sistema Único de Saúde. In: Campos GWS, Bonfim JRA, Minayo MCS, Akerman M, Júnior MD, Carvalho YM, organizadores. *Tratado de Saúde Coletiva*. São Paulo: Hucitec; 2006. p. 531-562.
8. Malta DC, Silva MMA, Albuquerque GM, Lima CM, Cavalcante T, Jaime PC, Silva Júnior JB. A implementação das prioridades da Política Nacional de Promoção da Saúde, um balanço, 2006-2014. *Cien Saude Colet* 2014; 19(11):4301-4311.
9. Brasil. Constituição (1988). Constituição da República Federativa do Brasil: promulgada em 5 de outubro de 1988. 39ª ed. São Paulo: Saraiva; 2006.
10. Malta DC, Castro AM. Avanços e resultados na implementação da Política Nacional de Promoção da Saúde. *Boletim Técnico do SENAC* 2009; 35:63-71.
11. Castro AM. A institucionalização da Promoção da Saúde no Sistema Único de Saúde. Boletim da Sub-região Brasil UIPES/ORLA Ano VII (10), setembro/2005. [acessado 2016 jan 30]. Disponível em: http://openlink.br.inter.net/vllima.orla/boletim10.htm
12. Buss PM, Carvalho AI. Desenvolvimento da Promoção da Saúde no Brasil últimos vinte anos (1988-2008). *Cien Saude Colet* 2009; 14(6):2305-2316.
13. Brasil. Ministério da Saúde (MS). Secretaria de Políticas da Saúde. Política Nacional de Promoção da Saúde. *Documento para Discussão*. Brasília: MS; 2002.
14. Campos GWS, Barros RB, Castro AM. Avaliação da Política Nacional de Promoção da Saúde. *Cien Saude Colet* 2004; 9(3):745-749.
15. Brasil. Ministério da Saúde (MS). Secretaria de Vigilância em Saúde. *A Vigilância, o Controle e a Prevenção das Doenças Crônicas Não Transmissíveis. DCNT no Contexto do Sistema Único de Saúde Brasileiro. Situação e Desafios*. Brasília: MS; 2005.
16. Brasil. Ministério da Saúde (MS). Portaria do Gabinete do Ministro nº 1.409, de 13 de junho de 2007. Institui Comitê Gestor da Política Nacional de Promoção da Saúde. *Diário Oficial da União* 2007; 14 jun.
17. Brasil. Ministério da Saúde (MS). Portaria 1.571, de 19 de julho de 2012. Altera a Portaria nº 1.409/GM/MS, de 13 de junho de 2007, que institui Comitê Gestor da Política Nacional de Promoção da Saúde. *Diário Oficial da União* 2012; 14 jun.
18. Brasil. Ministério da Saúde (MS). Secretaria de Vigilância em Saúde. Política Nacional de Promoção da Saúde. Portaria nº 687 MS/GM, de 30 de março de 2006. Aprova a Política de Promoção da Saúde. *Diário Oficial da União* 2006; 31 mar.
19. Szwarcwald CL, Malta DC, Pereira CA, Vieira MLFP, Conde WL, Souza Júnior PRB, Damacena GN, Azevedo LO, Silva GA, Theme Filha MM, Lopes CS, Romero DE, Almeida WS, Monteiro CA. Pesquisa Nacional de Saúde no Brasil: concepção e metodologia de aplicação. *Cien Saude Colet* 2014; 19(2):333-342.
20. Brasil. Portaria nº 719, de 7 de abril de 2011. Institui o Programa Academia da Saúde no âmbito do Sistema Único de Saúde. *Diário Oficial da União* 2011; 8 abr.
21. Brasil. Ministério da Saúde (MS). Portaria 2.684, de 14 de novembro de 2013. Redefine as regras e os critérios referentes aos incentivos financeiros de investimento para construção de polos e de custeio no âmbito do Programa Academia da Saúde e os critérios de similaridade entre Programas em desenvolvimento no Distrito Federal ou no Município e o Programa Academia da Saúde. *Diário Oficial da União* 2013; 15 nov.
22. Morais Neto OL, Silva MMA, Lima CM, Malta DC, Silva Júnior JB. Grupo Técnico de Parceiros do Projeto Vida no Trânsito. Projeto Vida no Trânsito: avaliação das ações em cinco capitais brasileiras, 2011-2012. *Epidemiol. Serv. Saúde* 2013; 22(3):373-382.
23. Malta DC, Silva Júnior JB. O plano de ações estratégicas para o enfrentamento das doenças crônicas não transmissíveis no Brasil e a definição das metas globais para o enfrentamento dessas doenças até 2025: uma revisão. *Epidemiol. Serv. de Saúde* 2013; 22(1):151-164.
24. Castro AM, Sperandio AMG, Gosch CS, Rocha DG, Cruz DKA, Malta DC, Albuqyerque GM, Zancan L, Westphal M, Neto OLM, Durán PRF, de Sá RF, Mendes R, Moysés ST, Marcondes W, organizadores. *Curso de extensão para gestores do SUS.Adriana Miranda de Castro em promoção da saúde*. Brasília: CEAD/FUB; 2010.
25. Ministério da Saúde (MS). Biblioteca Virtual em Saúde. Doenças Crônicas não Transmissíveis. [acessado 2016 jan 30]. Disponível em: http://bvsms.saude.gov.br/bvs/doencas_cronicas/inf_est_politicas.php
26. Brasil. Ministério da Saúde (MS). Guia Alimentar para a População Brasileira, consulta pública nº 04. [acessado 2016 jan 30]. Disponível em: http://www.foodpolitics.com/wp-content/uploads/Brazils-Dietary-Guidelines_2014.pdf
27. Brasil. Termo de Compromisso nº 034/2011. Termo de Compromisso que firmam entre si a União, por intermédio do Ministério da Saúde, e a Associação Brasileira das Indústrias de Alimentação (ABIA), a Associação Brasileira das Indústrias de Massas Alimentícias (ABIMA), a Associação Brasileira da Indústria de Trigo (ABITRIGO) e a Associação Brasileira de Panificação e Confeitaria (ABIP), com a finalidade de estabelecer metas nacionais para a redução do teor de sódio em alimentos processados no Brasil. *Diário Oficial da União* 2011; 26 dez.

28. Malta DC, Dimech CPN, Mora L, Silva Junior JB. Balanço do primeiro ano da implantação do Plano de Ações Estratégicas para o enfrentamento das Doenças Crônicas Não Transmissíveis no Brasil, 2011 a 2022. *Epidemiol. Serv. Saúde* 2013; 22(1):171-178.
29. Jaime PC, Silva ACF, Lima AMC, Bortolini GA. Ações de alimentação e nutrição na atenção básica: a experiência de organização no Governo Brasileiro. *Rev. Nutr*. 2011; 24(6):809-824.
30. Instituto Brasileiro de Geografia e Estatística (IBGE). *Pesquisa Nacional de Saúde do Escolar: 2012. Coordenação de População e indicadores sociais*. Rio de Janeiro: IBGE; 2013.
31. Hallal PC, Knuth AG, Cruz DKA, Mendes MI, Malta DC. Prática de atividade física em adolescentes brasileiros. *Cien Saude Colet* 2010; 15(Supl. 2):3035-3042.
32. Pratt M, Brownson RC, Ramos LR, Malta DC, Hallal P, Reis RS, Parra DC, Simões EJ. Project GUIA: A model for understanding and promoting physical activity in Brazil and Latin America. *Journal Phys. Activ. & Health* 2010; 7(Supl.):S131-S134.
33. Parra DC, McKenzie TL, Ribeiro IC, Ferreira Hino AA, Dreisinger M, Coniglio K, Munk M, Brownson RC, Pratt M, Hoehner CM, Simões EJ. Assessing physical activity in public spaces in Brazil using systematic observation methods. *Am J Public Health* 2010; 100(8):1420-1426.
34. Malta DC, Iser BPM, Sá NNB, Yokota RTC, Moura L, Claro RM, Luz MGC, Bernal RIT. Tendências temporais no consumo de tabaco nas capitais brasileiras, segundo dados do VIGITEL, 2006 a 2011. *Cad Saude Publica* 2013; 29(4):812-822.
35. Brasil. Ministério da Saúde (MS). Secretaria de Vigilância em Saúde. *Plano de ações estratégicas para enfrentamento das doenças crônicas não transmissíveis (DCNT) no Brasil 2011-2022*. Brasília: MS; 2011.
36. Brasil. Ministério da Saúde (MS). Secretaria de Vigilância em Saúde. Departamento de Doenças e Agravos não Transmissíveis e promoção da Saúde. *Viva: Vigilância de Violências e Acidentes, 2009, 2010 e 2011*. Brasília: MS; 2013.
37. Rocha DG, Alexandre VP, Marcelo VC, Rezende R, Nogueira JD, Franco de Sá R. Processo de revisão da Política Nacional de Promoção da Saúde: múltiplos movimentos simultâneos. *Cien Saude Colet* 2014; 19(11):4313-4322.
38. Martins CSH, organizador. *Projeto diretrizes*. Rio de Janeiro: Federação Brasileira das Sociedades de Ginecologia e Obstetrícia; 2002.
39. Merhy EE. *Projeto de Pesquisa Observatório Microvetorial de Políticas Públicas em Saúde e Educação em Saúde*. Brasília: CNPq, MS; 2014.
40. Rezende M, Baptista TWF. A Análise da Política proposta por Ball. In: Mattos RA, Baptista TWF. *Caminhos para análise das políticas de saúde*. Rio de Janeiro: UERJ; 2011. p.173-180.
41. Agamben G. *O Amigo e o Que é Dispositivo*. Argos: Chapecó; 2015.

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