

The Councils of Municipal Health Secretariats and the National Tobacco Control Policy: a necessary approach

Erica Cavalcanti¹ (Orcid: 0000-0001-8380-241X) (cavalcantir.eric@gmail.com)

Lucas Manoel da Silva Cabral² (Orcid: 0000-0001-6144-8050) (admlucascabral@gmail.com)

Vera Lúcia Gomes Borges¹ (Orcid: 0000-0003-4822-4110) (vborges@inca.gov.br)

Maria Raquel Fernandes Silva¹ (Orcid: 0000-0003-3392-4827) (mraquel@inca.gov.br)

¹ Instituto Nacional de Câncer. Rio de Janeiro-RJ, Brazil.

² Instituto de Medicina Social, Universidade do Estado do Rio de Janeiro. Rio de Janeiro-RJ, Brazil.

Abstract: Tobacco-related diseases burden the entire public health system, at the three levels of governance: municipal, state and federal. The insertion of the theme of tobacco control in state and municipal Health Secretariats is historic, being present since the initial debates on the health, social, economic and environmental damage that smoking causes to the Brazilian population as a cycle of diseases, poverty and deaths precocious. This article aims to present the importance of articulating the National Tobacco Control Policy with the Councils of Municipal Health Secretariats, given the role that these instances play in the Unified Health System and the contributions that they can add to the Tobacco Control Policy in Brazil, with its constant challenges to advance in the reduction of deaths and illnesses caused by tobacco products.

► **Keywords:** COSEMS. PNCT. Smoking.

Received on: 06/03/2023

Approved on: 18/05/2023

Revised on: 23/06/2023

DOI: <http://dx.doi.org/10.1590/S0103-7331202333SP102.en>

Editor in charge: Jane Russo

Reviewers: Renata Ferreira dos Santos and Vinicius Azevedo Machado

Introduction

Tobacco is the second most consumed drug among young people in the world and in Brazil, and this finding is probably linked to the way in which its consumption is inserted in society. The facilitation in obtaining the product, the low price, promotion and advertising (despite the prohibitive legislation in force), which associate the product with images of beauty, success, freedom, power and other attributes, desired above all by young people, end up creating a positive image of smoking behavior, encouraging around 90% of users to start smoking by the age of 19. Today, there is still the challenge of new tobacco products circulating in our society, such as electronic cigarettes (WHO, 2019).

Thus, it is clear that tobacco control is a phenomenon that involves issues that are not limited to the individual user. It must be admitted that it is a problem resulting from a whole social, political, economic context that historically encourages people to start smoking and at the same time makes it difficult for those who have already started to quit. It requires, therefore, the approach of a larger context.

All these aspects reinforce the logic implemented at the beginning of the tobacco control policy in Brazil, starting in the 1980s, composed of prevention programs, treatment for cessation, in addition to legal, economic, and communication regulations, among others, evaluated as successful. Undoubtedly, this brought in essence the articulation of various governmental and non-governmental segments, elements considered fundamental, given that tackling this serious health problem must involve society as a whole (CAMPOS, 2015; CAMPOS *et al.*, 2021).

The inclusion of the theme of tobacco control in state and municipal Health Secretariats is historic, going back to the early debates on the health, social, economic and environmental damage that smoking causes to the Brazilian population, such as a cycle of diseases, poverty and early deaths. Tobacco-related diseases burden the entire public health system at the three governance levels: municipal, state and federal.

In the field of health, it is essential that programs are well structured to meet expectations of awareness and motivation for positive behavior changes. This occurs because these programs have direct contact with the population and have a significant power of influence over the community. Therefore, it is important that they are adequately guided by the other instances in order to achieve the necessary changes.

The Instituto Nacional de Câncer [National Cancer Institute], since the 1980s, articulates and develops tobacco control actions in a transversal and intersectoral way with state and municipal Health Secretariats, governmental and non-governmental organizations, and universities throughout the national territory. These actions are guided by the logic of SUS, by INCA, in a decentralized way in the 26 states and Federative Unit, through the Network of State Coordinators of the National Tobacco Control Program. Managers and technicians are oriented, trained and qualified, with the specific methodology of this program, to carry out preventive, legislative, economic and political actions in their states, multiplying knowledge in their local network (BERTONI; SZKLO, 2021).

Thus, when the technical visits to the states of Tocantins, Goiás, Paraíba, Rio de Janeiro and Paraná began, within the scope of the pilot project "Aprimoramento da Política Nacional de Tabaco: 2020-2022 [Improvement of the National Tobacco Policy: 2020-2022]", aiming to strengthen and expand the actions of the National Tobacco Control Policy (PNCT), it was considered strategic to include the COSEMS of the respective states in these visits, seeking to rescue and align the participation of this important representative, technical and political body in the PNCT.

This article aims to present the importance of articulating the National Tobacco Control Policy with the Councils of Municipal Health Secretariats, given the role that these instances play in the Unified Health System (SUS) and the contributions that they can add to the Tobacco Control Policy in Brazil, with its constant challenges to advance in the reduction of deaths and illnesses caused by tobacco products.¹

CONASS, CONASEMS, COSEMS, Collaborative Network (regional support) and INCA: construction of an articulated network

Next, we initially present a historical redemption of the representation councils, both state and municipal, with greater emphasis on the latter. Finally, we analyze the COSEMS as important actors for the strengthening of the PNCT.

The Representative Councils of Health Secretaries *CONASS*

Established in February 1982, CONASS was born out of the need for state Health secretaries to join forces to increase their representation and negotiating power with

the federal government in defining public health policies in Brazil. The set of state health secretariats and the Federal District (DF) thus became more active in the health reform process, in a context of political openness and redemocratization of the country (CONASS, 2011).

Despite having been created in the early 1980s, Noronha (2001) and Lima and Machado (2014) state that it was created throughout the 1990s, fighting for stable resources for the SUS and for expanding the system's management process. of Brazilian health, that this council established itself as a representative entity of managers.

According to its statute, CONASS is a private, non-profit entity governed by the principles that govern public law, bringing together the State Secretaries of Health and their legal substitutes, as official managers of the Health Secretariats of the states and from the FD. With headquarters and jurisdiction in Brasilia, it must provide technical advice to the State and Federal District Health Secretariats on matters related to the management of the health system; vocalize to society the technical and political positions of the health secretariats of the states and the DF, in addition to promoting training and scientific research for the improvement of the SUS (CONASS, 2017).

CONASEMS

CONASEMS is the entity that represents the municipalities – at the national level – in the instances of the SUS, being an important political actor in the process of construction and agreement on health policies in our country. Its origin, like that of CONASS, also predates the SUS and can be defined from the annual meetings held by the entity from 1984 onwards. In 1988, these meetings began to be organized in the form of a congress and, in the same year, in the city of Olinda-PE, its first board of directors was elected (CONASEMS, 2008).

The Charts of its meetings and congresses reflect the political position of municipal managers in the different moments of the SUS, are named after the municipality where the events take place and are available for consultation on the institution's website. We highlight here the “Chart from Rio de Janeiro”, the result of the XII National Meeting of Municipal Health Secretaries, held in July 1996, whose theme was “Municipalization: path to a new model for quality of life”, organized in partnership between CONASEMS and COSEMS RJ.

As for the governing bodies and administration of the entity, its statute defines: general assembly, National Council of State Representatives (CONARES), National Executive Board and Fiscal Council. Its activities include meetings, seminars, congresses, studies, research, provision of services, training and permanent and continuing education of personnel, information, participation in public and private collegiate bodies, technical support, and inter-institutional cooperation, with governmental and non-governmental bodies and entities working in the health area or in related areas, whether or not for profit, nationally and internationally.

COSEMS

Also in the CONASEMS statute, mention is made of the COSEMS, which are recognized as entities that represent municipal entities, at the state level, to deal with matters related to health, provided that they are institutionally linked to CONASEMS, in the way their statutes provide. Thus, it is correct to state that in each federative unit of Brazil there are state representations of municipal Health secretaries.

For Lima (2013), the representation councils of municipal health managers are important spaces for political articulation and learning for the Health Secretariats, especially those of smaller size, with worse administrative conditions.

The first norm to mention the COSEMS was the Basic Operational Norm (NOB/92), whose text, in the chapter that deals with the financing of hospital activities, delegates powers to COSEMS, even if to authorize, together with the State Health Council, the distribution of authorizations for hospital admissions. The Basic Operational Norm of 1993 (NOB/93), although it does not substantially define COSEMS attributions, makes clear its competence as the representative body of the municipal Health Secretaries in the composition of the Bipartite Intermanagers Committees (CIB).

This fact is confirmed by Levcovitz, Lima and Machado (2001), when they state that the CIB guarantees the participation of the representation of the municipalities so that, together with the state, they make decisions of an allocative, distributive and operational nature of the set of health services, thus becoming a “double management” negotiation.

As for NOB/96, Silva (2014) argues that it expressly mentions the COSEMS as representatives of the municipal Health secretaries in the respective CIBs.

The 2002 Health Care Operational Norm (NOAS/2002) also confirms the importance of COSEMS, by requiring the signature of the president of the body in the Term of Commitment of the Pact of Indicators of Primary Care, together with the State Health Secretary.

For Levcovitz, Lima and Machado (2001), the basic operating norms of the 1990s consolidated spaces for intermanagers negotiations (CIT and CIB) as forums for the operationalization of national policies, programs and projects, as these instances create rules and instruments necessary for relationships between the government levels for the organization and functioning of the health system. In this sense, considering COSEMS as a member of the CIB, we can understand that its importance is now recognized within the scope of SUS management.

Despite its existence declared in several SUS regulations, only with the enactment of Law n. 12466, of August 24, 2011, COSEMS were legally institutionalized. The aforementioned law adds two articles (14-A and 14-B) to Law 8080, of September 19, 1990, to provide for the intermanagers committees of the SUS, CONASS, CONASEMS and their respective compositions.

CONASEMS / COSEMS Collaborative Network: regional support

Before approaching aspects inherent to the practices of institutional support in processes involving the agenda of municipal managers, regarding the regionalization of health, it is worth mentioning the legal-political environment occupied by these actors. In the case of Brazil, it is a triune federative space where federal, state and municipal managers coexist, or at least seek to coexist, guided by a decentralized organization, whose intergovernmental relations can be competitive or cooperative, where conflict and negotiation are constant, particularly with regard to the effectiveness and implementation of public policies.

In this context, federalism can be defined as the territorial distribution of power that is found in more than one government level, involving a set of political institutions that form the combination of two principles: self-government and shared government. It advocates the simultaneous existence of the Union (central power) and non-centralization (or decentralized government), promoting the unification of multiple identities, thus admitting a wide spectrum for the exercise of power by national and subnational governments (ALMEIDA, 2001, LIMA *et al.*, 2010; LIMA, 2012).

The Federal Constitution of 1988 designed a decentralized federation, redefining competences and attributions of the three levels, regarding the development and implementation of social policies, as is explained in Art 23/CF-88, of the common competences of the Union, States and Municipalities, items II and XII, and in Article 24/CF-88 item XII, of concurrent competences. This fact leads some authors to consider that this federative arrangement is responsible, in part, for the low effectiveness of the actions, as the responsibilities are not clear and delimited; in some cases, the government entity does not have the financial or structural capacity to fulfill its function (BRASIL, 1988).

The management of health systems in Brazil is a challenging task and, despite the expansion of the offer of services, it is far from the needs imposed by the construction of a continuous network of comprehensive care, which are essential to qualify and guide the stages of care and, consequently, optimize the use of SUS resources and consolidate its legitimacy with users (MERHY *et al.*, 2003; SANTOS, 2007).

There are many challenges for the consolidation of a decentralized and regionalized SUS in the daily management, in which the task of meeting health demands linked to the needs of the population is a constant of the themes discussed by SUS managers. Thus, it becomes necessary to stimulate and invest in intergovernmental agendas, considering the social, economic and political differences and diversity in each space-region of the country.

In view of the above, the role of institutional support is highlighted, which is configured as a way to encourage participatory management, understood as a valuable instrument for building changes in management modes and health practices, contributing to make care more efficient/effective and motivating for work teams (BRASIL, 2009).

It should be noted that institutional support in health is presented as a device for reorienting the model of care and management by several authors, in which the supporter uses problematization to evaluate the practices of both managers and workers, aligning with the policies of Permanent Education and Humanization (CECIM, 2005; CECÍLIO, 2009; SANTOS, 2007; PAIXÃO; TAVARES, 2014).

With regard to institutional support aimed at the processes and management models of organizations, it makes it possible to offer specialized care, technical and pedagogical support for teams and professionals in charge of caring for health

problems, functioning as a device to support and strengthen the capacity of government over the health system at the state and municipal levels (CAMPOS; DOMITTI, 2007; BRASIL, 2012).

Support has a managerial function that brings a reformulation of the traditional way of coordinating, planning, carrying out supervision and evaluations in health, with a view to the supporter promoting and monitoring processes of change in organizations, articulating concepts and technologies arising from institutional analysis and management, promoting ruptures in management models based on authoritarian intervention, helping in the analysis of the institution and in the search for new ways of operating and producing in organizations (BRASIL, 2009; CAMPOS, 2003). The proposal of institutional support stands out as a process of reorientation of vertical management practices of health services, using, for this purpose, the exercise of horizontal dialogue guided by co-responsibility in the management of proposals for the qualification of health work (PAIXÃO; TAVARES, 2014).

Support as praxis is characterized beyond a technology or a tool, being a dialectical method that can also be used in the co-management of established interprofessional relationships (matrix support), in the clinical relationship (shared between professionals and users) and in community or public health education projects. However, it is the methodological application of institutional support to management and matrix support to care teams that have stood out with greater appreciation in the SUS (PEREIRA; CAMPOS, 2014).

In this context, institutional support actions should encourage the development of collective spaces, expanding processes of dialogue, reflection and analysis of care and management practices, favoring the production of consensus between management teams, workers and users, allowing the construction of new practices and a process of collective co-responsibility aimed at promoting institutional changes.

Thus, the institutional supporter stands out as a subject capable of promoting the organization of management and work processes, in the construction of collective spaces, in which the groups analyze, define and elaborate intervention projects. The agenda of this strategic actor involves a triple task – activating collectives, connecting networks and including the multiplicity of perspectives and practices, interests and desires for the production of common objectives, in the implementation of health policies (CAMPOS, 2006).

It should be noted that the supporter has the role of activating and using devices capable of promoting the analysis of work processes, seeking ways to produce knowledge, in the environment of management and services. To this end, it makes use of workshops, training activities, agenda matrixing, among others (BARROS, 2011).

In this way, institutional support articulates strategic actors, enabling a permanent critical analysis of the work process and management practices, to ensure care and the expansion/renewal of technologies involved in care, strengthening practices that expand aspects inherent to the implementation of care networks, aiming to encourage and monitor processes of change in organizations (GARCIA, 2016; MERHY, 2003).

Notably, the support proposal brings aspects related to the monitoring, conduction and evaluation of health actions in a shared way with the participation of health teams, managers, to build dialogues with users, enabling the (de) construction and (re)construction of processes. It aims to arise ways to reorient the health care model, aiming to improve the care and managerial response capacity of the services.

One of the ways to carry out these processes has been worked on by the National Councils of Municipal Health Secretariats (CONASEMS) and by the Councils of Municipal Health Secretariats (COSEMS) (PINHEIRO *et al.*, 2014, p. 56).

Based on the ideas of Campos (2006), Cosems RJ built a support model for municipal health managers, both for management in their own municipalities and to strengthen the inter-federative relationships that are imposed in the space of regional governance. Support is thus also a strategy for instrumentalizing the municipal manager, contributing to the qualification of his performance in spaces of bipartite interlocution.

According to the authors, regional support is a co-management strategy in municipalities with similar socio-sanitary situations, which takes place in spaces of regional agreement – currently, the CIRs, which are collective management spaces, to broaden the discussion on the public health needs of each municipality to a regional level, where its solutions can be understood and sought as common goals for the entirety of the municipalities involved and other federated entities, using advantages inherent to them and advances acquired individually (PINHEIRO *et al.*, 2014). Therefore, the working mechanisms of this regional support strategy stand out, which include the monitoring and instrumentalization of the municipal

manager, the creation of tools that allow the quantification, comparison and projection of positive results for the health of the region and the existence of one or more agents that promote and mediate the support strategy.

In this perspective, the supporter needs to identify the health needs for which solutions need to be devised through articulated actions, the population-service interaction at the regional level, the development of the mapping of management conditions and the health situation of the population, among others, thus contributing to finding adequate conditions for intervention in facing a considerable set of health problems.

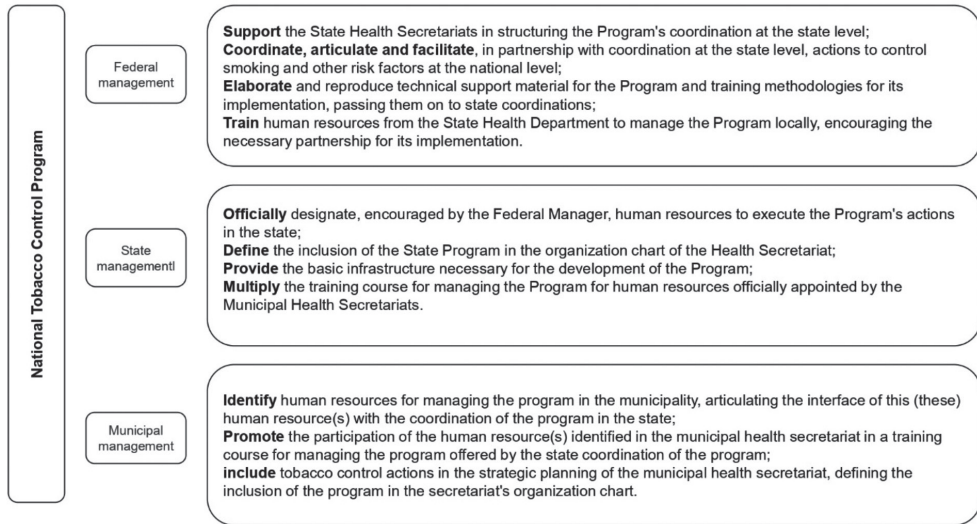
The supporter penetrates this space of dispute, seeking to create meeting spaces that favor dialogue and agreement between management and workers, between workers and between them and users – both focusing on the organization of work processes and on the production of care itself. In this sense, the supporter's work is not configured as a purely technical practice nor dependent exclusively on the professional core, but rather as a relational practice, triggering relational technologies, in an intensely micropolitical production (BRASIL, 2021).

PNCT State Coordinators Network

The size of Brazil and the regional differences involving socioeconomic and cultural angles require, for tobacco control, strategies for the decentralization of actions following the logic of the SUS. A decisive step in this realization was the strengthening of a geopolitical base, through which a network of managerial centers is articulated in state, regional and municipal Health secretariats, for the expansion of actions in an equitable manner throughout the country.

Acting through decentralized management within the scope of the SUS allows the creation of an information network and the implementation of actions for the control of smoking and other risk factors, with attributions of competences distributed by the administrations at different levels. Some of its responsibilities are shown below, in Figure 1.

Figure 1. Responsibility of the three entities of the federation within the scope of the National Tobacco Control Program



Source: The authors.

The Network of State Tobacco Control Coordinators was built decades ago and is still maintained by the National Cancer Institute in the 26 states and the Federal District. It aims to disseminate the PNCT throughout the national territory, structured around prevention, legislative, economic, political and tobacco control actions, so that there was, at the time, guidance and leveling of knowledge and coordinated execution of actions, due to the advance of tobacco-related diseases in the country.

Each Brazilian state has a coordinator, and many manage to structure a technical team to carry out the actions recommended by the PNCT, respecting the regional characteristics and the autonomy they receive from the hierarchical chain of the State Health Secretariat. To be able to implement the PNCT throughout the region and under the logic of the SUS model, the tobacco coordinator will report to the technical references of the municipalities for tobacco control, enabling, qualifying and training these focal points so that all actions are expanded in their territory.

This methodology and the guidelines proposed throughout Brazil resulted in a reduction in the prevalence of smoking, which occurred dramatically in the

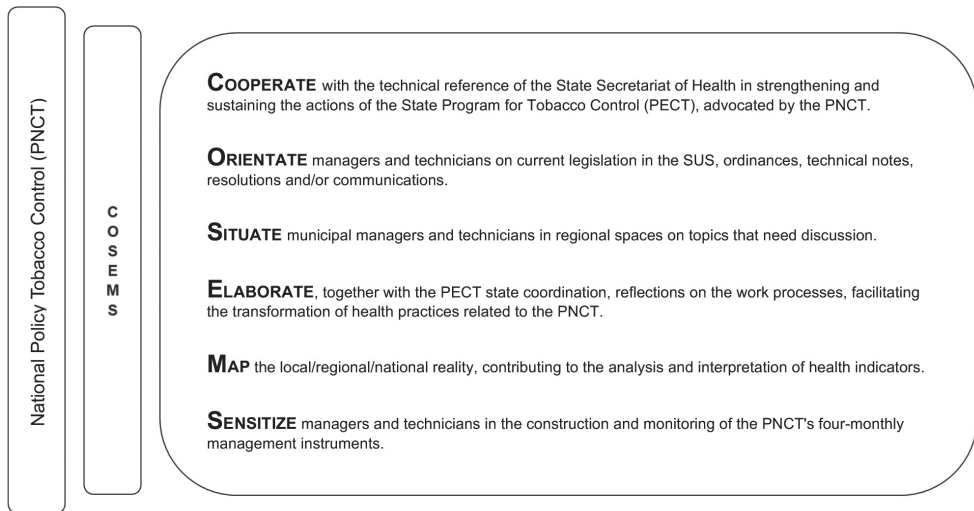
period from 1989 to 2019 – from 38% to 12%. The advances in specific laws such as protection of environmental tobacco pollution, protection of the health of family farmers who plant tobacco, taxation, prevention, cessation, among others contributed to this scenario (IBGE, 2019).

However, today there are numerous challenges, such as electronic cigarettes (DEFs), marketing strategies and media dissemination of new tobacco products on social networks, the price of the commercialized product, taxes on tobacco products, the easy accessibility and vulnerability of children and adolescents to these products, in addition to the great interference of representatives of the tobacco industry in the Public Health Policy on Tobacco Control.

All the facts mentioned above show that the involvement of the representative bodies of the municipal and state Health secretaries is fundamental, demanding to preserve and safeguard the achievements of the PNCT, as it is also necessary to reinvigorate, debate and advance proposals and collective actions of interest to the health of the population.

It is also necessary to measure the expenses that the Health Secretariats have with treatment and hospitalization for diseases that could be avoided, such as those related to tobacco, as well as safeguarding health managers, who have the challenge of balancing the resources of public accounts that are always overloaded to take advantage of other SUS priorities. Therefore, based on the COSEMS acronym (Figure 2), we created proposals for actions that could be developed by regional supporters in SUS governance bodies, such as the Regional Intermanagers Committee (CIR), CIR Technical Chamber; Working Groups on Primary Care, Planning and others, with the aim of strengthening the PNCT and ensuring its sustainability at the local level (city and health regions):

Figure 2. Proposal for articulating the actions developed by the Councils of Municipal Health Secretaries (COSEMS) and the National Tobacco Control Program (PNCT)



Source: The authors.

Final remarks

Based on visits to the COSEMS in the states selected to participate in the pilot project, it was possible to build this fundamental interface to join forces, potentialities and outline strategies for coordinated actions to face the new challenges that confront the National Tobacco Control Policy.

In this sense, the approximation and partnership between the representative bodies of SUS managers would add value to both organizations, with municipal and state managers qualified on tobacco-related topics, being able to establish and execute coordinated actions in an agile and specific way, protecting the health of the population. This articulation favors possible needs for agreements in the Regional (CIR), State (CIB) and Federal (CIT) Intermanager Committees, instances that, once implemented, will significantly strengthen the policy aimed at controlling the product, meeting its main objective, which is to reduce illnesses and deaths caused by tobacco consumption.²

References

- ALMEIDA, M. H. T. Federalismo, democracia e governo no Brasil: ideias, hipóteses e evidências. *Revista Brasileira de Informação Bibliográfica em Ciências Sociais*. São Paulo, n. 51, p. 13-34, 2001.
- BARROS, M. E. B.; GUEDES, R. C.; ROZA, M. M. R. O apoio institucional como método de análise-intervenção no âmbito das políticas públicas de saúde: a experiências em um hospital geral. *Ciência & Saúde Coletiva*, v. 16, n. 12, p. 4.803-4.814, 2011.
- BERTONI, N.; SZKLO, A. S. Dispositivos eletrônicos para fumar nas capitais brasileiras: prevalência, perfil de uso e implicações para a Política Nacional de Controle do Tabaco. *Cadernos de Saúde Pública*, v. 37, n. 7, e00261920, 2021.
- BRASIL. Ministério da Saúde. *Guia da Estratégia Apoiador COSEMSCONASEMS*. Brasília: Ministério da Saúde, 2021.
- BRASIL. Ministério da Saúde. *Programa Nacional de Controle do Tabagismo e Outros Fatores de Risco de Câncer*, 2ª ed. Rio de Janeiro: INCa, 2003.
- BRASIL. Ministério da Saúde. Secretaria de Atenção à Saúde. *Plano de Qualificação das Maternidades e Redes Perinatais no Nordeste e Amazônia Legal*. Brasília: Ministério da Saúde, 2009.
- BRASIL. Norma Operacional da Assistência à Saúde – NOAS-SUS 01/2002/. *Portaria 373*, de 27 de fevereiro de 2002.
- BRASIL. Portaria n. 4.279, de 30 de dezembro de 2010. Estabelece diretrizes para a organização da Rede de Atenção à Saúde no âmbito do Sistema Único de Saúde (SUS). *Diário Oficial da União*, 3 dez. 2011.
- BRASIL. Senado Federal. *Constituição Federal, de 05 de outubro de 1988*. Brasília-DF, 1988.
- CAMPOS, G. W. S. Clínica e Saúde Coletiva compartilhadas: teoria Paideia e reformulação ampliada do trabalho em saúde. In: CAMPOS, G. W. S. et al. (org.). *Trabalho em Saúde Coletiva*. Rio de Janeiro: Fiocruz, 2006. p. 53-92.
- CAMPOS, G. W. S. *Saúde Paideia*. São Paulo: Hucitec, 2003.
- CAMPOS, G. W. S.; DOMITTI, A. C. Apoio matricial e equipe de referência: uma metodologia para gestão do trabalho interdisciplinar em saúde. *Cadernos de Saúde Pública*, v. 23, n. 2, 2007.
- CAMPOS, P. C. M.; BARBOSA, D. V. S.; GOMIDE, M. O Programa Nacional de Controle do Tabagismo no município do Rio de Janeiro: ligações que promovem oportunidades. *Cadernos Saúde Coletiva*, v. 29, n. 3, 2021.
- CAMPOS, P. C. M.; GOMIDE, M. O Programa Nacional de Controle do Tabagismo (PNCT) na perspectiva social: a análise de redes, capital e apoio social. *Cad saúde coletiva*, v. 23, n. 4, ou. 2015.

- CARVALHO, A. L. B. *et al.* A gestão do SUS e as práticas de monitoramento e avaliação: possibilidades e desafios para a construção de uma agenda estratégica. *Ciência & Saúde Coletiva*, v. 17, n. 4, p. 901-911, 2012.
- CECÍLIO, L. C. O. As necessidades de saúde como conceito estruturante na luta pela integralidade e equidade na atenção em saúde. In: PINHEIRO, R.; MATTOS, R. A. (orgs.). *Os sentidos da integralidade na atenção e no cuidado à saúde*. Rio de Janeiro: IMS/UERJ/Abrasco, 2009. p. 117-130.
- CECIM, R. B. Educação permanente: desafio ambicioso e necessário. *Interface Comunic. Saúde e Educ.*, v. 9, n. 16, p. 161-177, 2005.
- CONASS. *Estatuto*. Available at: <https://www.conass.org.br/wpcontent/uploads/2016/04/ESTATUTO-CONASS-2017-Assembleia-de29.11.2017.pdf>. Accessed on: 4 June 2021.
- GARCIA, J. R. As relações entre apoio institucional e democratização institucional: um método para o trabalho do apoiador da Política Nacional de Humanização. *Saude & Transf. Soc*, Florianópolis, v. 6, n. 1, p. 1-12, 2016.
- INSTITUTO BRASILEIRO DE GEOGRAFIA E ESTATÍSTICA. *Pesquisa nacional de saúde, 2019: ciclos de vida*: Brasil. Rio de Janeiro: IBGE, 2021.
- LEVCOVITZ, E.; LIMA, L.D. de; MACHADO, C. V. Política de saúde nos anos 90: relações intergovernamentais e o papel das Normas Operacionais Básicas. *Ciênc. saúde coletiva*, v. 6, n. 2, p. 269-291, 2001.
- LIMA, L. D. A Coordenação federativa do sistema público de saúde no Brasil. In: FUNDAÇÃO OSWALDO CRUZ. *A saúde no Brasil em 2030 - prospecção estratégica do sistema de saúde brasileiro: organização e gestão do sistema de saúde*. Rio de Janeiro: Fiocruz/Ipea/Ministério da Saúde/Secretaria de Assuntos Estratégicos da Presidência da República, 2013. Vol. 3. p. 73-139.
- LIMA, L. D. *et al.* O pacto federativo brasileiro e o papel do gestor estadual no SUS. In: UGÁ, M. A *et al.* *A gestão do SUS no âmbito estadual: o caso do Rio de Janeiro*. Rio de Janeiro: Editora Fiocruz, 2010.
- LIMA, L. D. *et al.* Regionalização e acesso à saúde nos estados brasileiros: condicionantes históricos e político-institucionais. *Cien Saude Colet.*, v. 17, n. 11, p. 2881-2892, 2012.
- LIMA, L. D. Federalismo, descentralização e regionalização na política de saúde do Brasil. In: ASENSI, F. D.; PINHEIRO, R. (orgs.). *Direito Sanitário*. Rio de Janeiro: Editora Elsevier, 2012. p. 131-161.
- MERHY, E. E. *et al.* *O trabalho em saúde: olhando e experienciando o SUS no cotidiano*. São Paulo: Hucitec, 2003.
- NORONHA, J. C.; SOARES, L. T. A política de saúde no Brasil nos anos 90. *Cien Saude Colet.*, v. 6, n. 2, p. 445-450, 2001.

PAIXÃO, L.; TAVARES, M. F. L. A construção do projeto “Apoio de Rede” como estratégia institucional. *Interface* (Botucatu), v. 18, supl. 1, p. 845-858, 2014.

PEREIRA, N.C.; CAMPOS, G W. S. O apoio institucional no Sistema Único de Saúde (SUS): os dilemas da integração interfederativa e da cogestão. *Interface - Comunicação, Saúde, Educação*, v. 18, supl. 1, 2014.

PINHEIRO, R. *et al.* Apoio regional no estado do Rio de Janeiro, Brasil: um relato de experiência. *Interface - Comunicação, Saúde, Educação*, v. 18, supl. 1, p. 1125-1133, 2014.

SANTOS, L.; ANDRADE, L. O. M. *SUS: o espaço da gestão inovada e dos consensos interfederativos - aspectos jurídicos, administrativos e financeiros*. Campinas: Instituto de Direito Sanitário Aplicado, 2007.

SILVA, M. L. O COSEMS RJ: origem, identidade e seu papel na defesa das Secretarias Municipais de Saúde. In: PINHEIRO, R. *et al.* (org.). *Apoiadores Regionais: uma experiência brasileira*. Rio de Janeiro: CEPESC: IMS/UERJ: COSEMS/RJ: OPAS, 2014.p. 21-30.

WORLD HEALTH ORGANIZATION (WHO). *Tobacco*. Geneve: WHO, 2019. Available at: <https://www.who.int/news-room/fact-sheets/detail/tobacco>. Accessed on: 25 Sept. 2022.

Notes

¹ This study was carried out by the Divisão de Controle do Tabagismo [Division of Tobacco Control – DITAB], of the Coordenação de Prevenção e Vigilância [Coordination of Prevention and Surveillance], Instituto Nacional de Câncer [National Cancer Institute], with the support of the International Union Against Tuberculosis and Lung Disease (The Union), Bloomberg Philanthropies and the Centro de Estudos e Pesquisa em Saúde Coletiva (Center for Studies, Research and Technological Development in Collective Health - Cepesc) of the Universidade do Estado do Rio de Janeiro (Rio de Janeiro State University - UERJ).

² E. Cavalcanti: study conception, data analysis, text elaboration, revision and approval of the final version of the manuscript. L. M. da S. Cabral and V. L. G. Borges: study conception and planning, data analysis, text elaboration, revision and approval of the final version of the manuscript. M. R. F. Silva: data collection, analysis and interpretation, revision and approval of the final version of the article.

Resumo

Os Conselhos de Secretarias Municipais de Saúde e a Política Nacional de Controle do Tabaco: uma aproximação necessária

As doenças relacionadas ao tabaco sobrecarregam todo o sistema público de saúde, nos três níveis de governança: municipal, estadual e federal. A inserção do tema do controle de tabaco nas Secretarias de Saúde estaduais e municipais é histórica, estando presente desde os debates iniciais sobre os danos sanitários, sociais, econômicos e ambientais que o tabagismo gera à população brasileira como um ciclo de doenças, pobreza e mortes precoces. Este artigo tem como proposta apresentar a importância da articulação da Política Nacional de Controle do Tabaco com os Conselhos de Secretarias Municipais de Saúde, dado o papel que essas instâncias desempenham no Sistema Único de Saúde e as contribuições que poderão somar à Política de Controle de Tabaco no Brasil, com seus constantes desafios para avançar na redução de mortes e adoecimentos causados pelos produtos de tabaco.

► **Palavras-chave:** COSEMS. PNCT Tabagismo.

