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INSTITUTIONALIZATION OF HEALTH PROMOTION PROGRAMS: DEFINITIONS IN MUNICIPAL MANAGEMENT

INSTITUCIONALIZAÇÃO DE PROGRAMAS DE PROMOÇÃO DA SAÚDE: DEFINIÇÕES NA GESTÃO MUNICIPAL

INSTITUCIONALIZACIÓN DE PROGRAMAS DE PROMOCIÓN DE LA SALUD: DEFINICIONES EN LA GESTIÓN MUNICIPAL

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ABSTRACT

Objective: analyzing the definition and deployment of health promotion programs in municipal management. ***Method*****:** descriptive and exploratory study with a qualitative approach. Data were obtained through interviews with 24 managers responsible for defining the health promotion policy in three municipalities. The research project was approved by the Research Ethics Committee, under the protocol ETIC 0652.0.203.000-10. ***Results*****:** a conceptual and methodological plurality was revealed in the health promotion actions developed in programs with federal funding, by reproducing a downward programmatic institutionalization model. There is evidence of escape routes from this institutionalization in a set of practices performed at the local level that avoid policies' standards and emerge as inventions. ***Conclusion*****:** the challenge of strengthening autonomy at the local level in order to redefine health promotion practices prevails. ***Descriptors*****:** Health Promotion; Public Health Policies; Health Management.

RESUMO

Objetivo**:** analisar a definição e implantação de programas de promoção da saúde na gestão municipal. ***Método*****:** estudo descritivo-exploratório de natureza qualitativa. Os dados foram obtidos de entrevistas com 24 gestores responsáveis pela definição da política de promoção da saúde em três municípios. O projeto de pesquisa foi aprovado pelo Comitê de Ética em Pesquisa, sob o protocolo ETIC 0652.0.203.000-10. ***Resultados*****:** revelou-se uma pluralidade conceitual e metodológica nas ações de promoção da saúde desenvolvidas em programas com financiamento federal, reproduzindo um modelo de institucionalização programática descendente. Evidenciam-se rotas de fuga dessa institucionalização em um conjunto de práticas realizadas no nível local que escapam à normativa das políticas e se apresentam como invenções. ***Conclusão*****:** prevalece o desafio de fortalecer a autonomia do nível local na redefinição das práticas de promoção da saúde. ***Descritores*****:** Promoção da Saúde; Políticas Públicas de Saúde; Gestão em Saúde.

RESUMEN

Objetivo: analizar la definición e implantación de programas de promoción de la salud en la gestión municipal. ***Método***: estudio descriptivo y exploratorio de enfoque cualitativo. Los datos se obtuvieron mediante entrevistas a 24 gestores responsables de la definición de la política de promoción de la salud en tres municipios. El proyecto de investigación fue aprobado por el Comité de Ética en Investigación, bajo el protocolo ETIC 0652.0.203.000-10. ***Resultados***: se reveló una pluralidad conceptual y metodológica en las actividades de promoción de la salud desarrolladas en programas con financiación federal, mediante la reproducción de un modelo de institucionalización programática descendiente. Hay evidencias de rutas de escape de esta institucionalización en un conjunto de prácticas llevadas a cabo en el nivel local que escapan a las normas de las políticas y se presentan como invenciones. ***Conclusión***: prevalece el reto de fortalecer la autonomía del nivel local en la redefinición de las prácticas de promoción de la salud. ***Descriptores*****:** Promoción de la Salud; Políticas Públicas de Salud; Gestión de la Salud.

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INTRODUCTION

The Ottawa Charter, of 1986, highlights the significance of health promotion and the influence of social aspects on the health of individuals and the population, characterizing it as the "[...] community qualification process to work on improving its quality of life and health, including greater participation in controlling this process."[1:9]

The Ottawa Charter establishes five strategies for effectively deploying health promotion: healthy public policies, health-friendly environments, reorientation of health services, strengthening of community action, and development of personal skills[2], indicating that health promotion must influence the health system organization at the various regions in the world.

The Brazilian National Health System (SUS) establishes health promotion as a strategy to act on determinants of the health-illness process, such as violence, unemployment, underemployment, lack of sanitation, inadequate or no housing, difficult access to education, hunger, chaotic urbanization, air and water quality, as well as to enhance broader ways to intervene with health.[3] In order to put it into practice, investments have been made in Brazil, with federal support, which trigger the provision of actions in priority axes to meet the population's health demands and needs.[4]

The Brazilian National Policy on Health Promotion (PNPS), enacted in 2006, emerged as a proposal of cross-sectional policy, which operates by linking and interconnecting the various specialized technical areas, complexity levels, and specific health policies.

The PNPS highlights intersectoral actions as a strategy to cope with the problems concerning the environment, urbanization, food and nutrition security, unemployment, housing, legal and illegal drug use.[5] The guidelines defined in the PNPS include funding; encouragement to intersectoral actions; strengthening of social participation as key to achieve health promotion outcomes; promote changes in the organizational culture; encourage research and dissemination and information of the initiatives aimed at health promotion for health professionals and SUS managers and users.[3] At the same time, they point out the health promotion movement, by supporting political and managerial decision-making on health.[6]

The PNPS assumptions point out the expansion of interconnection procedures driven by cooperation, solidarity, and democratic management within the health field and those connecting it to the other fields of social and economic and policies.[3] Such assumptions establish as a responsibility of the municipal manager to implement the PNPS on local realities in line with the guidelines set at the national level, besides agreeing and allocating budget and financial resources to deploy the Health Promotion Policy.[3]

Health promotion regards the diversity of actions to preserve and enhance the potential of individuals and communities to choose healthy ways of living, grounded in comprehensive care and the construction of policies in favor of life by means of intersectoral connection.[4]

Within the same period when the PNPS was enacted, other policies focusing on the work that addresses individuals' habits or behaviors to favor healthier lifestyles were created. It is worth highlighting include the Brazilian National Policy on Integrative and Complementary Practices (PNPIC)[7]; the Healthy Gym Program[8], which encourages the creation of public spaces adequate to physical activity and leisure; the Brazilian National Policy on Food and Nutrition (PNAN)[9], encompassing the Healthy Weight Program, which aims to promote healthy eating practices; the Brazilian National Program to Promote Physical Activity "Agita Brazil"[10], which aims to increase population awareness about the benefits of physical activity by drawing attention to its importance as a predominant health protection factor.

Traditionally, the model to formulate and deploy policies in Brazil is characterized as top-down, i.e. decisions are made by authorities who have some control over the process and decide which policies will be deployed and the way how to deploy them.[11] Overall, these policies will be made public in the shape of normative, regulatory, programs regarding the scope, actions, goals, and evaluation means. This rationale is contradictory to the established thought aimed at health promotion, which requires a construction where various sectors participate, involving the civil society and public and private sectors.[2]

In Brazil, the key circumstance in political and institutional terms to trigger the construction of a health promotion policy was inducing, through funding, international organizations to include it in the Brazilian agenda.[12]

A study revealed that health promotion actions taken at the municipal level are restricted to the central axes defined in the

PNPS and they reproduce strategies in a vertical and centralized relationship.[6] Without denying the need for a State that induces, articulates, and aggregates structuring conditions for health promotion in the territory, the predominance of policies defined at the federal level entails standardizing the health care organization in the country, disregarding the peculiarities of each state and each municipality.

Opposite to the upward movement of appreciating local practices, the publication of federal programs contradicts the decentralization and appreciation of definitions at the local level. In this way, there is this question: Is it possible to build routes to escape from this process? That is, are there signs of overcoming the downward programmatic institutionalization in political definition and investment concerning health promotion?

OBJECTIVE

- Analyze the political perspective of health promotion and its definition in municipal management.

METHOD

Descriptive and exploratory study with a qualitative approach, anchored in the theoretical and methodological framework of dialectics.

Data were obtained through interviews with 24 managers responsible for defining the health promotion policy at the municipalities of Belo Horizonte, Betim, and Contagem, in Minas Gerais, Brazil. In Belo Horizonte, health care managers from the 9 city regions were included as subjects. In Contagem, 8 participants who provide technical reference within the sanitary districts were included. In Betim, 4 participants related to the municipal health coordination or the coordination of health promotion programs were interviewed. To present the results, the themes are exemplified with excerpts from participants' testimonies encoded by the letter "Mr" numbered from 1 to 24, when it comes to a manager's discourse; "My" numbered from 1 to 3, for the municipalities; and "N1" (municipal level) and "N2" (district level).

The interview was guided by a semi-structured script and recorded on audio. The material was transcribed and it underwent thematic content analysis. There were successive readings of interview transcripts to identify significant utterances, considering the research objectives. They were organized according to their themes. Then, they were empirically categorized by associating repeated themes.

Regarding ethical aspects, the authorization to conduct the research was asked through a letter to the health departments in each municipality-scenario. The project was approved by the Research Ethics Committee of the Federal University of Minas Gerais, under the Opinion ETIC 0652.0.203.000-10. Data collection was preceded by contact to professionals asking for their participation in the survey. An individual cover letter explaining the research project, as well as a free and informed consent term, was provided and data were collected only after this term was read and signed.

RESULTS

The results indicate that there are differences in the health promotion actions cited by participants. There is polysemy in the concept of health promotion. Conceptual and methodological plurality is revealed, now grounded in political guidelines having the same origin, then driven by various fields of knowledge and practice.

One example, highlighted by the study participants, is the inclusion of integrative and complementary practices (ICPs) in the health promotion model. These practices did not reveal, in the study, the health promotion principles. It is also clear that this finding in the allocation of traditional groups organized in public health (hypertension, diabetes mellitus, pregnant women, among others) as health promotion.

> *There are health practices aimed at gym in the town, Lian Gong, NASFs [Family Health Support Centers] actions, and today people also start talking of practices to prevent chronic diseases, which include smoking, NASF actions aimed at obesity, but there is a broader view that includes social determinants.* (Mr1.My1.N1)

> *We have educational groups, mainly with diabetes and hypertension, they work on the issue of changing habits.* (Mr24.My3.N2)

> *I observe, you know, during visits I make to health centers: when I talk to managers, the priority groups hypertension and diabetes and pregnant women, almost all health centers have them. But I notice they have been organized according to the demand.* (Mr3.My1.N2)

Investment on the component physical activity, a priority axis of the PNPS, is highlighted by the large-scale presence of healthy gyms in the municipalities. The

healthy gym (or 'city gym,' as it is called in one of the scenarios) is the main business card of health promotion for management in the three municipalities, followed by Lian Gong in two municipalities.

At the same time that the expansion of gyms and other bodily practices reveal the federal inducing movement required to reverse the health care model, by encouraging healthy living habits, it may signal a reduced space for freedom and creation of municipalities and districts to reinvent devices of their own.

In general, the health promotion practices frequently mentioned are related to the PNPIC, the Brazilian School Health Program (PSE), the Brazilian Family Health Support Centers (NASF), and the Brazilian 'Bolsa Família' Program (PBF).

> *City gym, Lian Gong, which constitute institutional projects towards health promotion and provide a heavier approach, in terms of being available, enabling access. The issues that also bring other determinants, such as diseases, the issue of food, it is up to the [primary health] center. So, there is an anti-smoking program; concerning nutrition, improved nutrition, obesity groups in partnership with NASFs aiming at this intervention type.* (Mr9.My1.N2)

> *Yeah, along with education, the program at school we provide in all municipal schools. Also [under this management], 'Bolsa Família,' health at school, these I am talking of are all mine.* (Mr4.My1.N2)

In respondents' speeches, intersectoral and interdisciplinary actions are mentioned as health promotion markers. According to them, the existence of programs, intersectoral and activities actions that take place on exchanges or partnerships having shared goals represent, per se, health promotion practices.

> *OK! And this, well, then you will see, in 'Bolsa Família' we have, we have a regional intersectoral center, this in all regions, consisting of education, social work, and health.* (Mr4.My1.N2)

> *We have some actions that derive from the NASF, but having a rather multidisciplinary view, several other professional categories, so there are some actions like those, provided by the NASF. (*Mr6. My1.N2)

In general, managers indicate as "good health promotion practices" those developed on priority programs with sectoral funding. Thus, most of the actions and practices is linked to political guidelines on the axes of the PNPS or of other federal policies and programs replicating the top-down model.

> [...] *there come the big programs from the national level that fall on us.* (Mr4.My1.N2)

> *It all come within the same [federal] program. Either specific [to the municipality] or not. All within the PSE...* (Mr6. My1.N2)

> *In fact, when this becomes a government policy, it ends up as something more successful... an example is the PSE. It is a project that has been put on the mayor's administration plan and he has demands concerning this program.* [...] *we have to sit down, we have to render accounts to someone... I think if they do not turn into a public policy, it is up to the heroic initiative of everyone who is at that space.* [...] *And there must be a definition even relying on institutional support, because it only says that a policy is a policy if there is money to make it happen.* (Mr8.My1.N2)

Although people acknowledge the actions taken at the local level, the emphasis on health promotion practices carried out in the municipalities concerns those linked to priority projects induced by the federal government, with a prevalence of downward programmatic institutionalization.

> *And, of course, each health center has its power level and it also does things, developing them according to creativity, according to... the department guidelines remain. It is compulsory.* (Mr4.My1.N2)

Municipal managers who are linked to the federal level and hold positions at the district management recognize the influence of national policies on the provision of practices. The recognition of reproducing the federal programs is noticed depending on the position held by the respondent.

> *The initiatives also focused on programs: the PSE. In the health promotion field it is funded by programs. We do not see a funding rationale, which is related to the subject and his needs, to provide the subject with funding. Today, we have funding for the PSE, to the gym, to the NASF.* (Mr8.My1.N2)

> *Because we have noticed there are differences in the organization of work processes according to the profile of each manager in each center.* (Mr3.My1.N2)

> [...] *we are always talking of the big programs coming from the national level that fall on us and everything else. And we have been asking for a program. Then, which is our role in it? It is time for us to start creating something to require such a policy by considering what we have instead of waiting this policy to emerge and do not come, which arrives here this or that way. And this practice is also not covered, and who else does scream for it, right? These are the weapons today. I think this is the big challenge.* (Mr4.My1.N2)

Everything seems to suggest there are escape routes from the downward

programmatic institutionalization. It became clear there is a set of practices carried out at the local level through actions such as choir, elderly dance, Shantala, workers' massage, environmental health actions, actions aimed at adolescents, among others.

> *There are actions taken in partnership with social work (elderly groups, youth groups); there is close contact to the staff of tutoring assistance and within the centers there is a partnership and a closer relationship with the CRAS [Brazilian Reference Center on Social Work], 'BH Cidadania.'* (Mr9.My1.N2)
>
> *So, there is a lot of things that are experiences introduced by the centers and I think they make a huge difference.* (Mr4.My1.N2)
>
> [...] *Lian Gong and the 'city gym,' as if they were the only actions, and they are not. I think the centers provide very nice health promotion activities.* [...] *Well, I think it has a very positive response, almost all, so to speak, the groups are always creating further groups and people provide a response that they have been improving in terms of their well-being. So, let us say, when we provide the obesity group, Shantala. We have such responses from users who experience improvement, their quality of life has improved.* (Mr10.My1.N2)

The findings can demonstrate that the successful practices taken as experiences developed at the initiative of local professionals "escape" from the policies' regulation and they constitute inventions.

> *Regardless of being a speech [therapist], nurse, at the local level I cannot see... Work at the far end flows, it escapes from the need for management. And I say that the federal level proposes public policies, guidelines, but the practice happens where we can even have lines, guidelines, but what takes action is the tip.* (Mr1.My1.N1)
>
> *Occasional actions take place at some centers. I know there is an intervention with adolescents; there is a group names as 'Luluzinha' at the school that works on sexuality during adolescence. If you go to the centers, you will find out other things I am not aware of and which are part of the specificity of each center in relation to the community.* (Mr9.My1.N2)
>
> *The health promotion groups were matrix groups. So, each team stopped doing things of its own...* [...] *Matrix groups are those of pregnant women, acupuncture, family planning, the elderly. And children with aids. But now, alone, we will become aware of some other health centers working on dance.* (Mr3.My1.N2)

The institutionalization of investment on healthy eating is revealed as an action axis of health promotion. In this regard, such practices are obesity control groups; eating and nutrition actions at schools and in community groups. These practices are almost exclusively attributed to the NASFs and occasionally to the PSE, focusing directed to obesity, overweight, and risk assessment. This finding contradicts the scope of eating issues defined by the PNPS.

> [...] *SISVAN [Brazilian Food Nutritional Surveillance System] regarding these issues on eating and healthy nutrition, which are also within this issue of health promotion.* (Mr21.My3.N1)
>
> *Through the Brazilian School Health Program, and we are doing a very interesting work at the school, where the nurse is the very key point, for some actions, such as measuring, weighing, body mass index, and measuring the blood pressure of all school children who participate in the Family Health Program. And, then, analyzing data and identifying which children are overweight, underweight, or show some change in blood pressure, as well as identifying them, referring them to some evaluation and follow-up to along with their primary health teams.* (Mr14.My2.N2)
>
> *And last week the aim was talking about the prevention of obesity. In fact, the actions were very cool! Did you see it in the news? I think it has drawn some attention from [health] teams.* (Mr3.My1.N2)

It is worth highlighting that the other axes of the PNPS – smoking prevention and control; reduced morbidity and mortality as a result of alcohol and other drug abuse; reduced morbidity and mortality due to traffic accidents; prevention of violence and promotion of a culture of peace; and promotion of sustainable development – emerge in an inexpressive way in respondents speech. The smoking cessation program was mentioned on a timely basis.

> [...] *health education they attend, you know, the groups, they participate in tobacco control groups, most of them are nurses who are leading these groups, you know, providing tobacco control.* (Mr23.My3.N1)

This finding may be explained by the fact these axes have not been prioritized on the political agenda of health promotion, although they represent relevant objects for the set of population's health needs.

> [...] *some centers have smoking, which is a nice action, then we realize there are centers participating, nursing is there, actively participating.* (Mr24.My3.N2)

DISCUSSION

The results demonstrate that the PNPS guidelines were deployed by managers in the municipalities under study, however, downward programmatic verticalization and institutionalization hinder the creation of "escape routes" at the local level. In general, there is an adaptation and implementation of preventive actions carried out at the local level to gain promotion features.

In this context, the worker executes actions established in the programs, consisting in a programmatic proposition that becomes a technological limitation, with work bureaucratization and consequences regarding the motivation of its players.[13] Thus, there seems to be little room for discussing other actions that might be within the scope of health promotion.

Regardless of the fact that the deployment of this policy takes place from a top-down or bottom-up perspective, physical activity, bodily practices, and healthy eating stand out concerning the provision of health promotion practices shown, above all, by the healthy/city gyms. The lack of regular physical exercise, seen as a primary and independent risk factor for many health problems, particularly cardiovascular and metabolic diseases[14], has become the focus of public policy actions.

The healthy/city gyms have emerged in face of this unfavorable situation concerning physical activity among the population and this fact encouraged international and national organizations to include physical activity in the global agenda. Based on the healthy cities proposal, which was created in 1978, in Toronto, Canada, some Brazilian municipalities have taken the initiative of developing programs to promote physical activity, focusing on an increased physical activity level among the population and improved knowledge on the benefits of this practice.[15]

Thus, the PNPS included the promotion of physical activity on the national agenda, and 'Portaria' 2,608, enacted on December 28, 2005, allocate resources to all states of the Federation for investment in local projects to encourage physical activity.[3] The main goal of the program is promoting physical activity, leisure, and healthy eating among the community.[15]

Given this context, increased physical activity and bodily practices may be explained by two simultaneous movements: political and cultural. In the first, the response by municipalities to the inducing policy is clear, particular through financial contribution[16], in order to deploy the Healthy Gym Program. The second movement depicts a cultural change to encourage physical activity in daily life.

Despite the evidence collected on the benefits of regular physical activity for health, some studies have pointed out low levels of this behavior among the population. Participation in these programs involves the very individuals' understanding about physical activity, health, body, and quality of life, as well as the principles that justify such actions both by the government and the private sector. Besides, the literature reveals that adherence to physical activity is influenced by factors such as: previous experience in sports and exercise; spousal and family support; medical advice; convenient site for exercise; gender; time availability; socioeconomic status; knowledge on exercise; and access to facilities and spaces suitable for such exercise.[15]

Thus, due to its expansion, the Healthy Gym Program has provided opportunities for physical activity at leisure times to other population strata that usually do not have many opportunities to do that, but there are other factors inherent to the subjects that may favor or not the practice of such activities.

Historically, the key circumstance in political and institutional terms to trigger the construction of a health promotion policy was inducing, through funding, international organizations to include it in the Brazilian agenda. It is also worth highlighting that approving the PNPS reveals that a large part of health policies are focused on the public sector. Even having a representative in the Brazilian National Agency of Supplementary Health (ANS), the focus of the PNPS lies on the federal, state, and municipal health levels, although some of the actions attributed to it aim at reaching non-governmental sectors.[12]

Verticalization of policies and programs emerges as a factor that induces to health promotion. Inducing may be identified as what activates local processes, especially the federal funding factor. It also allows the dissemination of concepts and the innovation of practices used as prevention. The health care model focused on the disease has a historically established force, which does not give in just because of good intent. Government decisions must be made and deployed through funding.[12] On the other hand, verticalization is emphasized by

respondents due to its normative nature. Even highlighting its mandatory nature, when deployed at the local levels, adherence to the policy and related programs takes place.

The analysis of results points out the reconfiguration and flexibility of top-down and bottom-up models, supported by other studies[17] showing that decision-making centralization and decentralization may be combined to provide interventions with greater effectiveness.

It is noteworthy that, in order to address the structural and complex issues related to a broader health approach, deploying policies may not take place instrumentally, disregarding peculiarities of the local context. Policies and actions depend on mobilization of social sectors and participation of the civil society, above all in contexts of poverty and inequity, in order to provide the intervention with effectiveness and bring rather comprehensive and sustainable changes in social, environmental, and political terms.[17]

The results allow indicating the need for a continued learning process of professionals and users on conceptual aspects of health promotion[18] and their relationship with daily life. In this regard, the benefits of health promotion must be analyzed as enhancers of quality of life, for workers and users.

It is concluded that there are advances in deploying the PNPS by inducing programs at the municipal level.

However, the challenge of strengthening autonomy at the municipal and local levels when redefining health promotion practices prevails, ensuring, to do this, their sustainability and innovation concerning the local capillarity and specificity.

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