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Health santé salud

## EVALUATION OF HEALTH PROMOTION EFFECTIVENESS IN BRAZIL

Proceedings from the 1<sup>st</sup> Brazilian Seminar on Health Promotion  
Effectiveness

May 10<sup>th</sup> to 13<sup>th</sup>, 2005. Rio de Janeiro, Brazil

- Historical overview of health promotion and health promotion evaluation in Brazil
- Methodological approaches to health promotion evaluation
- Institutionalising health promotion in Brazil



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May 10<sup>th</sup> to 13<sup>th</sup>, 2005. Rio de Janeiro, Brasil

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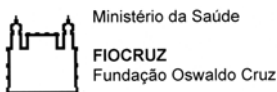


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## Health, development and equity

Marcia Westphal<sup>1,2</sup> and Nina Wallerstein<sup>1,3</sup>

We are in the seventh year of the twenty-first century, experiencing the results and consequences of globalization, such as, the continuous growth of global wealth, the social exclusion generated within market economies, and new societal and work dynamics marking this new phase of capitalism.

From whatever angle we look, the dynamics of reality and its guiding “ethos” may be seen as responsible for the paradox of unprecedented economic growth and major social and health disparities and inequalities.

Brazil, a country of continental proportions, shares this paradox along with other dynamics of a developing and dependent country. It is a country with great natural wealth, and major energy and raw material potential, each of which has not been properly exploited and used. Few segments of the population have been incorporated into the global economy and a large proportion are marginalized from the process of development and, more specifically, from the distribution of its wealth. Within its territory, there remain large islands of unequally distributed deprivation, destitution, and oppression, due to the longstanding economic – and not distributive – development model, recently imbued with neo-liberal elements.

Government efforts aimed at economic aspects, and not at human needs, have produced growing impoverishment accompanied by the inability of the overwhelming majority of the population to participate equitably in the production, management, and consumption of material and cultural goods and services. While it is not low in comparison to most countries in the world, Brazil’s Gross Domestic Product (GDP) does not present the same pace of growth as that of China or other countries of Latin America, such as, Chile and Argentina. This macro indicator of Brazil’s wealth also does not show a direct and consistent correlation with health indicators and living conditions of the population.

According to data from studies conducted on Brazil, this is not a poor country, but an unjust and unequal one. The comparison of per capita income of Brazil against other countries places it among the

richest one-third of countries in the world. However, the average percentage of families living in Brazil with up to half the monthly minimum wage (one of the indicators of poverty, i.e., around 75 dollars per capita a month for meeting basic needs), is much higher than in countries with income similar to that of Brazil. The poor population of Brazil represents 30% of the total population; however, in Chile and Argentina, the poor are 10% at most. These data demonstrate that the source of poverty is Brazil is in the poor distribution of existing resources. The average income of the richest 10% in the country is 28 times greater than the average income of the poorest 40%. In the United States, this proportion is five times; in Argentina, 10 times; and in Colombia, 15 times.

The distribution of poverty is also unequal among the country’s regions, as is the distribution of families living with up to half the monthly minimum wage, according to data from the national household survey (PNAD) of 2002. In many municipalities of the north region, the percentage of poor children and adolescents exceeds 90%. In the northeast region, especially in the semi-arid area, 75% of children and adolescents live in poverty. Meanwhile, in the south region, more specifically in Rio Grande do Sul, there are municipalities with less than 2% of poor children and adolescents. In this context, the distribution is even more unequal regarding poor black children (IBGE, PNAD, 2002).

Inequities in Brazil are also revealed by other indicators: persistence of poverty; concentration of income; low social mobility; high level of unemployment and under-employment; very significant school dropout rate; very high prevalence of adult illiteracy; and other unmet essential needs such as widespread chronic hunger; violation of basic political freedoms; and increasingly serious threats to the environment and sustainability of our economic and social life (IBGE PNAD 2004; FIPE/MTE 2003; Haddad & Graciano, 2003).

With regard to health, we see that there is no direct correlation between health status and access to health services, although actions of professionals committed to a

model of health care, which integrates social, economic, political, and cultural determinants, is very important. Today, approximately 70% of the population depends on the Unified Health System (SUS), whose principles are comprehensiveness and universality of health care for the population.

SUS has a major challenge ahead—to tackle the diseases of developed countries *as well as* infectious diseases still afflicting the country, especially the population of the north and northeast regions. The six main causes of death in the country are as follows: diseases of the circulatory system (31.8%), neoplasm (15.7%), external causes (14.2%), diseases of the respiratory system (11.4%), infectious and parasitic diseases (5.1%), and diseases originating in the perinatal period (3.5%). Other causes accounted for 18.3% of the total number of deaths each year (PNAD – IBGE, 2003).

Reducing infant mortality (33/000 in 2004) and violent deaths (14.2%) represents a major challenge; tackling them depends not only on medical consultations or preventive measures, but also on actions which engage the social, economic, political, and educational determinants of maintaining the lives of children born in this country. Malnutrition, which is unequally distributed by age, educational level, socioeconomic condition, and by region, remains a serious obstacle to the health and development of human capital. Drug use and AIDS are added to these problems, which, together, have become the biggest challenge to the maintenance of life and quality of life of populations (Marmot & Wilkinson, 2003).

Inequalities and inequities in access to essential basic services, which impact the quality of life and health of the population and affect environmental conditions are, according to Whitehead (2000), unfair, systematic, and relevant. However, they are also avoidable and unnecessary. SUS, in combination with health promotion strategies, has the potential to transform these inequities, since it presupposes actions on the social determinants of health.

In this special issue, considering the inequalities that characterize Brazilian reality, we are challenged to think to what

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extent health actions within the SUS context and integrated with a health promotion perspective, have been able to transform inequalities into “fair inequalities,” i.e., in equity. Social equities, between groups and individuals, are defined by Whitehead (2000) as inequalities which are preventable, unjust and unnecessary, which highlight the ethical and moral dimension of the concept. To act in the direction of equity, the system needs to give more to those who have less, not to end inequalities per se, but to give most people the chance for a dignified life.

The topic of evaluating and monitoring the effectiveness of health promotion policies has generated growing interest among policy formulators, managers, professionals, and other players involved in implementing health promotion actions, especially those aimed at social determinants of health.

Evaluation methodologies in health promotion have become indispensable for the success of interventions, in analyzing local processes and contexts for policy formation and implementation, for linking theory and practice, and for contributing to the production of knowledge in the field of health promotion.

In Brazil, health promotion has sought to establish itself as an interdisciplinary perspective, which prioritizes multi-sectoral cooperation and democratic and participatory dialogue with the various stakeholders involved in multiple actions of social change. Transcending the limits of the health sector, it turns to new designs and propositions for promoting quality of life, valuing the inherent ability of social agents to reflect critically on the context and the economic, social, cultural, and environmental determinants of health.

Innovative programs are developed in varied contexts and spaces. Expected results often revolve around the learning, autonomy, and ‘empowerment’ of the individuals involved; new forms of ‘governance’ and improvement in the organizational capacity of communities; and modernization and humanization of public services. On the other hand, more sustainable social changes presuppose comprehensive strategies involving intersectoral actions of community mobilization and participation, challenging the frames of reference traditionally used in the field of health evaluation.

The *First Brazilian Seminar on Health Promotion Effectiveness* renewed and updated the debate on the role of this field of knowledge and its practices for the improvement of the health system and quality of life in the country. The event intensified the partnership between national and international institutions and workgroups,

and helped put the topic of Health Promotion on the agenda of the Ministry of Health, which, in November 2006, institutionalized the National Health Promotion Policy and formed a Management Council for its implementation.

The articles presented here reveal the relevance of continuing the debate about Health Promotion in contexts marked by growing inequalities in living conditions and opportunities, which makes ‘equity’ the major challenge for effective change in the production of health at the national and global levels.

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Marcia Faria Westphal



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## Health promotion in Brazil

Antonio Ivo de Carvalho<sup>1</sup>, Marcia Faria Westphal<sup>2</sup> and Vera Lucia Góes Pereira Lima<sup>3</sup>

**Abstract:** Brazil, a Latin American country of continental proportions and contrasts, demographic inequalities, and social inequities, concomitantly faces the challenge of preventing and controlling infectious diseases, injuries, and non-communicable diseases. The loss of strength of the biomedical paradigm, the change in epidemiological profile, and the sociopolitical and cultural challenges of recent decades have fostered the emergence of new formulations about public health thinking and practice. Among them, are the paradigms of Brazilian Collective Health and Health Promotion. The former provides philosophical support for Brazil's Unified Health System (SUS). The aim of this article is to discuss the development of public health within the country's history, and to analyze and compare the theoretical assumptions of Health Promotion and Collective Health. We conclude that health promotion, based on the principles and values disseminated by the international Charters and concerned with social actors and social determinants of the health-disease process, has significant potential to promote the improvement of living and health conditions of the population. This frame of reference guided the formulation of the National Policy of Health Promotion within the Unified Health System, which was institutionalized by a ministerial decree. The importance and application of evaluating the effectiveness of health promotion processes and methodologies in Brazil have been guided by various frames of reference, which we clarify in this article through describing historical processes. (*Promotion & Education*, 2007, Supplement (1): pp 7-12)

**Key words:** Brazil, public health, health promotion

Resumo em português na página 33. Résumé en français à la page 37. Resumen en español en la página 41.

### Brazil and its socioeconomic and demographic characteristics

Brazil is the largest country in Latin America and the world's fifth largest in terms of land mass, occupying an area of 8,511,965 sq. km. It has a population of 169,799,000, three quarters of which live in urban areas. Up to the 1980s, the age structure of the population was characteristically young, but the aging index has shown a gradual aging in recent years. Life expectancy at birth is now 68.3 years and it is higher for women (72.3 years) than for men (64.5 years) (IBGE, 2000).

The country is divided into five geographical regions, 26 states, and a Federal District. There are demographic and development disparities and contrasts among the regions and states; despite that, its economy is the most diversified and has the most potential in South America. The intense economic growth experienced between the 1930s and 1990s was founded on a model of social exclusion, which generated marked social inequalities and created islands of wealth and/or pockets of poverty.

Traditional, bureaucratic, and corporate administrative structures, resistant to matrix systems and intersectoral actions, are an obstacle to the reduction of chronic poverty among the majority of the Brazilian population and to the improvement of its quality of life.

Infectious diseases which were once the biggest public health problem in the coun-

try are now reduced. Currently, diseases of the circulatory system are among the major causes of death and are responsible for 32.4% of general mortality, followed by external causes (14.9% of deaths) and neoplasm (14.0% of deaths). Infant mortality has fallen and studies have pointed out that this drop is not only associated with technological advances, but also and mainly with the increase in the gross domestic product (GDP) and with the policies of expansion of essential public services – basic sanitation, health, and education. (SIM/MS).

The loss of strength of the biomedical explanatory paradigm, changes in the epidemiological profile, and sociopolitical and cultural challenges of recent decades have fostered the emergence of new formulations about public health thinking and practice. Among them, are the paradigms of Collective Health in Brazil and Health Promotion in developed countries. Both of these theoretical and conceptual models influenced the development of the Brazilian Unified Health System (SUS) –the public health system established by the Federal Constitution of 1988 and regulated by laws 8080 and 8142 of 1990. SUS was thus conceived by public health specialists who affirmed the importance of social and economic factors as core determinants of the health-disease process.

Including ourselves in that group, we will revisit the history of public health in Brazil, relating it to the country's socioeco-

nomical and political development and the emergence of epidemic or endemic diseases that interfered with or were facilitated by this development.

### Overarching historical facts in the evolution of the health system, health education, and health promotion in Brazil

During the colonial period, from 1500 to 1822, Brazil was administered by Portugal. During that time and during the Brazilian Empire, the Brazilian State did not directly intervene in health matters, except in cases of emergencies, such as epidemics, and through educational centers where hygiene standards were taught among other educational activities.

By the end of the nineteenth century and beginning of the twentieth century, health policies were based on the economic and political interests of the country's dominant classes. With the abolition of slavery and with commercial and industrial development, groups of people migrated to the cities, which did not have the basic infrastructure necessary for survival. The need to expand foreign trade and open the borders to European workers, to replace the newly freed black slaves (1888), demanded quick solutions for the diseases that were ravaging the cities and beginning to threaten the workforce and the expansion of capitalist activities in cities and rural areas.

The first decade of the twentieth century was characterized by a radical shift in pub-

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lic health policies. The Pasteurian revolution, with the advent of microbiology, greatly increased scientific knowledge about infectious diseases and provided the conceptual basis for the first Brazilian health reform. Under the leadership of physician and scientist Oswaldo Cruz, public health actions were centralized and successful campaigns to control yellow fever, bubonic plague, and smallpox were launched, mobilizing available knowledge, as well as, significant human and material resources. The General Directorate of Public Health (federal body) and the Serum Therapy Institute of Manguinhos (now the Oswaldo Cruz Foundation) established themselves as the institutional model of what was then modern public health. At the same time, under the helm of the capital's Mayor Pereira Passos and inspired by urban reform implemented by Haussman in Paris at the end of the nineteenth century, new prosperity made it possible to change the face of cities. Central areas were renovated and sanitized – especially the city of Rio de Janeiro – the nation's capital at the beginning of the century. Additionally, liberal medicine served the health care needs of the urban middle class and the dominant sectors of society. Collective sanitation measures to identify and confine the sick to disinfecting stations through the so called “sanitary police” were also launched. Mandatory mass vaccination was initiated, meeting with fierce opposition from the population.

This form of intervention was reinforced by essentially traditional concepts of education that aimed to contain the population and eliminate ignorance, which, according to authorities, was an important determinant of diseases and plagues. The health authorities brought together control and policing activities.

As of 1920, the American medical/public health model began to have a decisive influence on the Brazilian health structure. Two distinguished Brazilians, Geraldo de Paula Souza and Borges Viera, who were students in the first course on public health at the John Hopkins School of Public Health in the United States, reorganized the Health Service of the State of São Paulo. During that time, the coercive power of the sanitary police was dramatically reduced, and health education was emphasized.

In 1930, there was a coup in the country, which resulted in seven years of dictatorship. During that time, labor legislation was implemented and Health Centers were eliminated and replaced by Pension Institutes, which, among other roles, were to provide health care to the workers of the different productive sectors of society—the only citizens with the right to health.

In the 1940s, with the end of the dictatorship, there was increased discussion of a new concept of the health-disease process based on its natural history. It was the era of development-oriented public health (*sanitarismo desenvolvimentista*), which coexisted with a populist political movement and allowed the creation of new concepts of health sector actions. The need to exploit raw materials during World War II helped move health actions toward the interior and inspired the creation of SESP – Special Public Health Service, funded by the Rockefeller Foundation to serve rural, poor, and neglected populations. This Service encouraged the population to recognize the social and economic obstacles to community development through new methodological resources for raising awareness (Mello, 1987).

In urban regions, there was access to technical assistance from the Social Security Institute, vertical health campaigns for controlling major epidemics, and supplemental medical assistance at Health Centers and Religious Hospitals aimed at incipient marginalized sectors that were concentrating in the periphery, forming a huge reserve army of labor. Health education, included as one of the health actions, was becoming the means, complement, and support for medical/public health actions, seeking to increase their efficiency. Education was seen as an individual process of changing behaviors with undesirable characteristics such as ignorance, lack of hygiene, and non-compliance with standards and directions based on culturally dominant values. At the time, conceptions and strategies were adopted that favored educational campaigns directed at specific problems, constituting the so-called “biologizing of health” –depoliticizing the social aspect, in the words of Cardoso de Mello— and later the “psychologizing of health.” The latter arose from the development of psychology, which recommended the adoption of disciplined routines aimed at good living habits, in a conservative perspective, translated into regulatory actions of sanitization and domestication. The structural and economic roots of health problems were not a part of the mental universe of health professionals of the time, much less a part of the actions developed by them (Mello, 1987; Oshiro, 1988).

From 1964 to 1985, during another period of dictatorship controlled by the military government, positive results emerged in terms of economic development, while a large share of the population remained marginalized. The detrimental side of these events was the worsening of social inequities and the subhuman living conditions of large sectors of society. The

public health situation was therefore characterized by a state of affairs in which “diseases of affluence” were added to the high prevalence of poverty-related diseases. In addition, the populations excluded from sharing the results of development lived with a curative, pro-privatization health care model based on a hospital-centered biomedical paradigm and guided by managerial and financial mechanisms that hindered rationalization initiatives. That system, with its inefficient curative and physician-centered practices did not meet health care, disease prevention, and health promotion needs. (Laurell, 1986, apud: Nunes, 1994, p 12; and Carvalho, 2005, p. 97)

Once the crisis of the social system in the 1970s was resolved with the end of the dictatorship, the process of redemocratization of the country began. Dissatisfied with the advances achieved with the changes from preventive movements and influenced by professionals who had engaged in actions related to problem-based learning, progressive health professional groups intensified the discussion in search of new paradigms to guide health and education programs. They sought to give a new dimension to the public policies of the health sector, focusing on the social and historical determinants of the health-disease process.

There were many contributions to the vitality of initiatives that affected the education, health education, and social research applied to health and education in Brazil at the time. They were: the political-pedagogical approach by Freire, methodological proposals for health education by Hortência de Holanda, and principles and procedures of participatory research by Carlos Brandão and others. Both Freire and Holanda proposed actions later characterized as personal and social ‘empowerment’ and skill development to transform living conditions, mobilizing the participation of the population and respecting the local context, as well as advocating a multi- and interdisciplinary approach. Such innovations would foster changes in the conceptions and procedures of Community Medicine, nurturing a transformative and emancipatory attitude and prevailing over the more conservative hygienic and moralistic view. These conceptions were gradually adopted not only by some health technicians who fiercely criticized hygienic and behavioral education, but also by popular health education movements that supported the public health movement in process of organization. (Freire, 1975; Hollanda, 1959; Brandão, 1988)

The public health movement, guided by the theoretical and conceptual model of

Collective Health that had been forming in the country since the 1940s, was articulated around Brazilian Health Reform, expanding the movement, which gradually grew in civil society. The theoretical model formulated by the leaders of the movement critically incorporated elements of international production, especially that of countries such as England, Cuba, Italy, and Canada, among others. In the process of theoretical-epistemological formulation, it sought to break with American functional sociology through the dialogue with English Social Medicine, French Structuralism, and Italian Political Sociology (Carvalho, 2005).

As a field of knowledge, Collective Health frames the study of the health-disease phenomenon in populations as a social process, investigating the production and distribution of diseases in society as a process of social production and reproduction. It analyzes social practices, seeking to understand how society identifies its health needs and problems, trying to explain them and providing elements for tackling them (Paim & Almeida, 1998).

As its object of intervention, Collective Health selects *“the health of the public, whether they are individuals, ethnic groups, generations, castes, social classes, populations.”* Through the historical-structural paradigm, it seeks to incorporate the “historical-social dimension into the epidemiological analysis and at the same time supply new categories of analysis” (Paim & Almeida, 1998 ; Arredondo, 1992; apud Carvalho, 2005).

Active since the mid-1970s, the Brazilian public health movement gradually garnered social support, enriched and systematized its collective health ideology, refined its technical criticism of the dominant assistance-oriented medical model, and consolidated the program of Brazilian Health Reform. In 1986, with the country’s redemocratization, the movement reached its peak with the Eighth National Health Conference, which was attended by more than 5,000 professionals, users, and managers, in a process of mobilization unprecedented in the area of health in the country. The final report of the conference—the result of proposals deriving from hundreds of regional and municipal conferences—served as the technical and political basis for the advanced text on health approved by the National Constitutional Assembly, which, two years later, created the Unified Health System in the country. Currently, the theoretical framework of Collective Health guides the activities of various Preventive and Social Medicine Departments at Brazilian Universities, assuming a relevant role in the political and ideological foundation of

ABRASCO (Brazilian Association of Collective Health).

The legal recognition of this frame of reference is in the Federal Constitution of 1988, in which health appears as a broad concept and universal citizen right, resulting from living and work conditions and inserted in the context of social policies in the form of a *“fundamental human right, and the State must provide the conditions required for its full exercise through social and economic policies and the establishment of conditions ensuring universal and equitable access to actions and services for its promotion, protection, and recovery”* (Brasil, 1988).

These policies must ensure, among other things, food, transportation, work, income, and leisure for all Brazilians. The inclusion of the social determinants of the health-disease process delimits the theoretical and practical field for Collective Health, differently from the movements that preceded it. (Berlinguer, 1988; Brasil, 1988; Westphal, 1992 Carvalho, 2005).

The constitutional text ensuring the right to health as a component of Social Security favored a broader approach, ensuring, in the context of health, actions not only aimed at health recovery but also disease prevention, health protection, and health promotion. As of the 1990s, the Unified Health System (SUS) became responsible for the health care of 70% of Brazilian inhabitants, who essentially depend on its services, and for regulating and inspecting the entire private system.

At the beginning of the 1990s, a new national Presidential imparted neo-liberal characteristics to his government and reinforced the biomedical model through actions of the Ministry of Health, preventing the integration of ministries that would tackle the social determinants of health. The concept and practice of health continued to be interpreted, especially by the planners and implementers of health policies, as preventive and curative medical interventions. The policy continued to be the art of integrating preventive and mass actions, with an emphasis on individual curative actions. (Westphal et al., 2004)

Ten years have gone by since the Eighth National Health Conference, and eight years since Health became a part of the Federal Constitution. We have attained the law but not the complete fulfillment of the law or its objectives (Brasil, 1988).

### Philosophy and practice of health promotion in Brazil

Since the mid-1980s, a number of events have taken place at the national level to contribute towards incorporating Health Promotion as a new philosophy and practice in health policies.

Broad discussion began on the previously mentioned Brazilian Health Reform in 1986, on the heels of the Eight National Health Conference, whose proposed concepts and objectives for Brazilian society were quite similar to those presented at the First global Conference on Health Promotion held in Ottawa, Canada, that same year. Both documents - the Ottawa Report and Charter – defined health not merely as the absence of disease, rather that it entailed attending to the basic needs of human beings within an environment that was favorable to their growth and development. Health professionals involved in the health reform movement were at the time busy implementing the Brazilian Health Reform, or, in more concrete terms, the Unified Health System (SUS), ideally understood as a public policy that was to involve various segments of society. (Westphal et al., 2004).

In practical terms, the efforts to implement SUS were initially limited to the struggle on the part of the health sector to cure disease and, more recently, to resolving issues regarding funding of health activities. Nevertheless, if the Reform failed to realize its initial aims, it did enable a series of changes. Substantial progress was made within the scope of SUS: the decentralization of health-related decision-making, and the development of a Municipalist Health Movement led by the Municipal Health Departments, thus enhancing participation and control by the population in health matters, and expanding health concepts and practices.

Another important event during this period was the Latin American Conference on Health Promotion, sponsored by the Pan-American Health Organization (PAHO), held in Bogotá, Colombia with participation of 550 representatives from 21 Latin American countries including Brazil. The purpose of the event was to discuss the significance of Health Promotion in Latin America and the principles, strategies and commitments necessary to improve health among the region’s population, seeking equity in health (Buss, 1997).

In 1995, the National Council of Municipal Health Departments (CONASEMS) met during the Congress of Municipal Health Secretaries of the Americas in Fortaleza, Ceará. The Charter of Fortaleza, prepared at the meeting’s end, publicly expressed the interest of Municipal Health Department representatives in the proposals of Health Promotion. It mentioned the Canadian experiences of Healthy Cities, drawing specific attention to the possibility of *“progressively transferring the emphasis the System has been placing on disease to the social production of quality of life, where the main actor will be the citizen in reference to his*

or her ecosystem” to advance the municipalization of health, based on an integrated, participatory and creative experience, towards the construction of “Healthy Cities” (Westphal et al., 2004).

From that point on, several proposals to implement the Healthy Cities Project began receiving support from the Pan American Health Organization and Canadian technicians, which were implemented in different states throughout the country: Paraná, São Paulo, Rio Grande do Sul, Minas Gerais, Alagoas and others, with support from important segments of society, particularly CONASEMS. Furthermore, the “I Brazilian Forum on Healthy Cities” was held in Ceará in August, 1998, and provided additional support to these initiatives. During this meeting a proposal was presented to launch the Brazilian Network of Healthy Cities (Westphal, Motta and Bogus, 1998).

An interstate and inter-sectorial group was formed with similar objectives in early 1998 at the USP Public Health School to promote studies, experimental programs and exchange of experiences among cities developing municipal projects. This group led to the formation of the Center for Studies, Research and Documentation on Healthy Cities (CEPEDOC).

In 1998, the Brazilian Ministry of Health underwent a structural reformulation, with Health Promotion activities being officially included in the structure for the first time, housed within the recently-established Secretariat for Health Policies, which had departments responsible for policy formulation, policy management and health policy evaluation. At this time, this new structure was responsible for preparing the Program – “Preparatory Assistance: The New Healthcare Model and Health Promotion” – which executed an international cooperation agreement between the Ministry of Health and the United Nations Development Program (UNDP), with assistance from the Brazilian Cooperation Agency (ABC) for the purpose of financing the same (Nilson & Westphal, 1998).

This caused great surprise and much resistance from health professionals, especially those most closely associated with the public health movement and collective health movement. They confused the new model of Health Promotion, based on principles of individual and collective participation in decision-making processes, the seeking of equity and inter-sectorial coordination to resolve the problem of broad social determinants of the disease-health process, with functionalist Health Promotion, an individual primary prevention orientation from the natural history of the disease-health process of Leavell & Clark or Behaviorist Health Promotion (Buss, 2003; Carvalho, 2005).

This inclusion within the Policies Secretariat had a positive impact on dissemination and clarification of health promotion proposals and coordinated actions, vis-à-vis other health programs and policies, and expanded horizons for its principles, values and strategies to be included in the formulation, implementation and evaluation of policies and programs. During this period, important bodies were under the Policies Secretariat, involved in negotiating health-related agreements between different levels of government: the Three-Party Inter-Management Commission, the National Health Council, the Council of State Health Secretaries and the National Council of Municipal Health Secretaries. The Secretariat also hosted venues for participation of professional and scientific associations, which provided a forum for clarifying the significance of health promotion and its potential for contributing to the implementation of SUS.

Two years later, after several experiences and discussions had been conducted in different places and times, for the first time a basic document was prepared that proposed the formation of a National Health Promotion Policy. This document warrants merit in that it reflects the entire process that was constructed and coordinated among the many stakeholders throughout the country in this last decade. (Brasil, 2002).

Another important event in the history of Health Promotion in Brazil took place in November 2002, when the III Latin American Conference on Health Promotion and Health Education was held in São Paulo. It was a joint initiative by the International Union for Health Promotion and Health Education, the Ministry of Health, the Pan-American Health Organization and the University of São Paulo. Over 1500 participants took part in the event, presenting 600 papers, recorded in the Annals of the event, the majority of participants being Brazilians. The large-scale participation in the event was evidence that Health Promotion had already formed critical mass within the country (Westphal et al., 2004).

January 2003 witnessed the inauguration of a new president in Brazil and the structure of the Ministry of Health was again reformulated. The new leadership, many of them from the Collective Health movement, demonstrated resistance to Health Promotion, but, as an international agreement had been signed to implement “A new model of healthcare within the scope of Health Promotion”, they resolved to integrate it as a healthcare philosophy, relocating it to the Executive Secretariat of the Ministry of Health.

## Consolidation of health promotion as the National Health Promotion Policy

The Brazilian group associated with Health Promotion, formed by university professors and program managers, continued to meet under the auspices of the Brazilian Collective Health Association (ABRASCO), the largest and most powerful professional association, responsible for studying and providing guidelines on health to the government.

Several workshops involving large numbers of participants preceded events such as the World Social Forum, the ABRASCO Congresses and others, and were also part of the program of these events. The workshops resulted in important contributions to the conceptual construction of the field and understanding of practices guided by health promotion strategies, in addition to the construction of a more solid and operationally feasible program base.

Participants of the ABRASCO Health Promotion Thematic Group (GT) were slowly able to re-affirm their concepts and values. In a report consolidating the results of discussions held in Fortaleza, in meetings prior to the Epidemiology Congress in 2004, a number of conceptual agreements were defined amongst the participants:

- “Health is quality of life, which results from the meeting of vital needs individually and collectively;
- Vital needs are not defined in rules but are socially established through inter-subjective pacts within economic, social and cultural contexts, historically defined and that crystallize into social contracts that define rights and obligations;
- beyond a social right is taking health as a fundamental right, therefore the object of an ethical imperative;
- health is the means and capacity to life with quality (not a regulatory goal).” (ABRASCO, 2004).

Health promotion, according to the report, “is a new paradigm reference that, returning to and informing the interdisciplinary and inter-sectorial agenda of Health Reform, inspires and drives social movements working towards changes in the field of health, on at least three planes of social determination of the health and disease process:

- the plane of healthcare, involving efforts to change the logic of assistance and management models, towards neutralizing the hegemony of medicating subjects and empowering their autonomy;
- the plane of social management of public policies, especially at the local level, involving inter-sectorial activities and programs, striving to avert policy fragmentation, motivating empowerment of individuals and groups, in addition to mobilizing and inte-

*grating governmental and non-governmental organizations;*  
 – *the plane of overall development of society involving social protection as a precedent and driving force of economics, combating the primacy of economic growth in detriment to equitable distribution of welfare within society; advocacy of health as a relevant component of the productive complex, in an advanced conception of social development and not as an insatiable consumer of public funds.*” (ABRASCO, 2004).

At the same event, the GT suggested that all learning institutions present consider it their responsibility to promote research and training in health promotion, both in academic institutions as well as health management organizations, to advance knowledge and practices in this discipline and its insertion within Brazilian reality. This same suggestion reappears later, permeating the interview of Carvalho, after having participated in the meeting of the National Health Policy Management Committee (Carvalho, 2006).

Concomitantly, the Ministry of Health continued with the theme due to pressures from the group of professors and professionals associated with the ABRASCO Health Promotion and Sustainable and Integrated Local Development GT; and it promoted a number of meetings focusing on health promotion within health care. In 2004, Health Promotion became part of the Health Protection Secretariat, due to ministerial changes, and also due to global and national calls regarding its contribution to Prevention and Control of Non-Transmissible Diseases and their risk factors, responsible for higher mortality rates in the country. Initially, the most accepted concept of health promotion amongst health professionals was more behaviorist in its content, focusing on controlling behavioral risks such as eating habits, use of tobacco, alcohol, drugs and sedentary lifestyles, without considering conditions that interfere in personal choices.

The in-depth discussions to define the National Health Promotion Policy, which included the holding of the Health Promotion Effectiveness Seminar in Rio de Janeiro in May, 2005, under the auspices of IUHPE – ORLA, Brazilian sub-region, and several partner organizations including ABRASCO, resulted in the drawing up of a new profile, approximating the conceptions of stakeholders from the Ministry of Health with the International Charters on Health Promotion and the concepts proposed by participants of the ABRASCO Health Promotion GT and DLIS.

On March 30, 2006, when the National Health Promotion Policy was published in

Ordinance 687 MS/GM, the current leadership of the Ministry of Health had already ratified its commitment to Health Promotion and had recognized that the principles and guidelines of Health Promotion and the Ministry were in agreement with each other.

In the abovementioned document, Health is “*the result of means of organizing production, labor and society within a certain historical context*”. It acknowledges that the sickness-disease process is associated with broader determinants and conditioning factors, which cannot be modified solely through biomedical means. This approach can “*favor the expansion of healthy options by individual and collective subjects within the territory they live and work*”.

The purpose of the National Health Promotion Policy was to make it clear that the intention of the government is to improve the quality of life of the population and to reduce health vulnerability and risks associated with the following determinants and conditioning factors: lifestyle, working conditions, housing environment, education, leisure, culture, and access to essential goods and services.

Health Promotion was considered “*a mechanism to strengthen and implement a cross-cutting, intersectorial and integrated policy that communicates with different areas in the health sector and other sectors of government, the private and non-governmental sectors, forming networks of commitment and co-responsibility regarding the quality of life of the population, where all participate in protecting and caring for life.*” It therefore assumes that the health sector, through health promotion activities, takes on responsibility for executing intersectorial activities, insofar as activities that expand the limited political, human and financial resources available to the health sector are necessary to address the social determinations of problems.

In order to achieve the policy’s objectives, according to the guidelines laid out in the document, we identified two frames of action that correspond to those recommended by the ABRASCO GT, mentioned previously, seeking to develop health promotion activities: healthcare and social policy management. The plan called “from society in general”, was not mentioned, demonstrating the difficulty of the health sector in assuming a protagonist role in defining government economic policies. The following were considered activities specific to health promotion: healthy eating habits, body practices and/or physical activity, prevention and control of smoking, reducing morbidity/mortality from substance abuse (alcohol and other drugs), reducing morbidity/mortality from traffic

accidents, prevention of violence and stimulating a culture of peace and promoting sustainable development.

The Ministry of Health formed a National Health Promotion Policy Management Committee to implement the policy, with representatives from the following bodies as members: all of the Secretariats of the Ministry of Health, the National Health Foundation, the Oswaldo Cruz Foundation, the National Cancer Institute and the National Supplementary Health Agency, with no members from outside the health sector. The Management Committee is responsible for coordination within the Ministry of Health for all health-producing procedures. During the two-year period from 2006-2007, priority activities are: the dissemination of the Policy and establishment of strategies to perform the specific activities mentioned earlier. The Committee is to interact with and integrate into the three levels of government so that the strategies proposed may be included in the Life Protection Pact and become intersectorial activities at the state and municipal levels, a very difficult task. Ongoing education programs for health professionals will be one of the priority strategies promoted by the Management Committee to facilitate implementation of the Policy.

## Conclusions

As we have already mentioned, health is a right guaranteed to Brazilian citizens in the 1988 Federal Constitution, which presents a broad concept in its chapter on health that transcends the absence of disease and suggests strategies to cure/recover, promote and protect health. Despite the legal explanation of the importance that the system plays in this trilogy of actions, health promotion continues to be addressed in a very incipient manner in Brazil, both within the health sector and outside of it and even in academic circles.

The history of Brazilian Public Health, presented herein, enables an understanding of some of the reasons behind the resistance in adopting health promotion as a guiding paradigm, action strategy and as principles guiding the processes of social health production, as defined in the Ottawa Charter and presented in the National Health Promotion Policy document of 2006.

Throughout society, there are in fact a number of different conceptions of health promotion, some behaviorist or associated with an individualist explanatory model of the natural history of the health-disease process, which are not connected to the concepts and principles assumed, for example, by participants of the ABRASCO DLIS or Health Promotion GT, that are contained in the Charters of International Con-

ferences on Health Promotion, or that are even coherent in terms of SUS principles.

It is essential that the National Health Promotion Policy be discussed and assessed, that those assessing make clear the theoretical references to be used in monitoring, analyzing and suggesting modifications in the practices to be studied.

With regards to assessment, those that introduced the policy comment that, to date, studies conducted to identify evidence of effectiveness of health promotion have been linked to behavior and habits of subjects, and therefore associated with the behaviorist concept of health promotion. The methodologies utilized for evaluating changes in behavior were epidemiological studies, demonstrating convincing associations between exposure and disease, and also observational prospective studies and even randomized clinical trials.

Therefore, the challenge remains to conduct studies and research to assess the results of the National Health Promotion Policy and the proposed activities in their full scope, based on concepts and principles established by SUS and also recommended in the Ottawa Charter, including: integrality, equity, co-responsibility, social mobilization and participation, intersectoriality, information, education, sustainability, and others. The challenge remains to monitor and evaluate programs, and further, to implement this Policy in a country of continental dimensions and so many deep social deficits. Evaluation strategies must be created to identify results despite the complexity of the new proposal and must use multiple action methods to verify the net effects of each of the methods and strategies used, in order to demonstrate that Health Promotion is effective in achieving the goals it has proposed. Today, there is emerging evidence that empowerment strategies (embodied within Health Promotion) improve health outcomes (Wallerstein, 2006).

Only in this manner will it be possible to collaborate in the formation of autonomous subjects capable of promoting changes in the status quo, through intervening in social determinants of the health-disease process.

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1. IBGE – Brazilian Institute of Geography and Statistics is the federal agency responsible for conducting, analyzing, and publishing population censuses. It also conducts other studies the federal government deems necessary for clarifying issues concerning the population.
2. SIM/MS is the Mortality Information System of the Ministry of Health. It is an imperfect data collection system, since the record of what happens in the health service is not directly sent to the Ministry, going first through IBGE. Despite the flaws identified, the SIM/MS data were used here based on the assumption that, although the results obtained represent a part of the whole, they convey the situation of the whole.

# Evaluation of health promotion effectiveness: a political debate and/or a technical exercise?

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**Abstract:** This article summarizes the points of view of professionals from different nationalities, working in diverse organizations and dealing with concepts and activities related to health promotion effectiveness evaluation. This collection of views came from a panel presentation and dialogue held during the First Brazilian Seminar on Effectiveness in Health Promotion. Four professionals working in evaluation and health promotion - two from the United States, one from French Canada and another representing an international professional organization - facilitated by one Brazilian and one Puerto Rican moderator, had an informal dialogue with the audience. Four questions about how these professionals perceive evaluation in health promotion were asked to initiate the dialogue. The panelists deliberated five aspects of health promotion evaluation, asking: "how", "how much", "what for", "with whom" and "why." Professionals working in developing countries (in this case, Brazil) and those dealing with indigenous communities (in developed countries) tended to put more emphasis on "what for?", "with whom?" and "why?" regarding initiatives to evaluate effectiveness of health promotion. Questions associated with "how?" and "how much?" were more often mentioned by professionals working for international or governmental agencies. A 90-minute dialogue among panelists with a clearly Brazilian bias, was not sufficient to produce conclusions on the predominant character of international evaluation efforts of effectiveness. Nevertheless, this debate framed the five aspects of evaluation into a value perspective. The questions, "what for?", "with whom?", "why?", "how?" and "how much?" are linked to a political or technical presumptions that could be orchestrated in evaluations of health promotion effectiveness. (*Promotion & Education*, 2007, Supplement (1): pp13-15)

**Key words:** evaluation, effectiveness, health promotion indicators

Resumo em português na página 33. Résumé en français à la page 37. Resumen en español en la página 41.

The views and opinions in this article are those of the authors and do not necessarily reflect the views of the Centers for Disease Control and Prevention and the Department of Health and Human Services of the United States.

The First Brazilian Seminar on Effectiveness in Health Promotion was held in the city of Rio de Janeiro, Brazil, in May 2005. This meeting represented the Brazilian response to the growing global movement to address the effectiveness of health promotion actions, which has been spurred and supported by governmental and private organizations and by the civil society (Akerman & Mendes, 2006; Ciências e Saúde Coletiva, 2004).

This global initiative has stimulated the introduction of evaluation components into health promotion projects and programs and the development of innovative assessment methodologies. Moreover, it has prompted theoretical and political debates on the theme of "effectiveness," discussing its capacity and power to influence decision-making processes and resource allocation in public and private healthcare management, as well as in the formulation of public policies at municipal, regional and national levels (Moises, 2006; Campos, 2004).

This article presents the points of view of professionals from different nationalities, working in diverse organizations and set-

tings dealing with concepts and activities related to health promotion effectiveness evaluation. These views were originally presented in a dialogue panel held during the First Brazilian Seminar on Effectiveness in Health Promotion. Four professionals working in evaluation and health promotion - two from the United States, one from French Canada and another representing an international professional organization - facilitated by one Brazilian and one Puerto Rican moderator, had an informal dialogue with the audience.

Four questions about how these professionals perceive evaluation in health promotion were asked to initiate the dialogue: (1) "what led you to become involved in evaluation?"; (2) "would a demonstration of the effectiveness of a health promotion project or program assure its implementation?"; (3) "are there other aspects that may influence the decision-making process which are not necessarily related to effectiveness of the programs to be implemented?"; "how would these aspects be considered in health promotion practice?"; and (4) "what do you expect from the global effort to evaluate effectiveness in health promotion?"

Each question was debated for 24 minutes - 12 minutes for the speakers and 12 minutes for audience's comments. The activity lasted for approximately 90 min-

utes. In the following sections, each participant answered the questions with different perspectives, demonstrating the range unique professional settings, social contexts, and/or personal experiences.

## What led you to become involved in evaluation?

One speaker put forward an interesting concept: we are always somehow involved with evaluation, either as "the evaluator" or "the evaluated".

Simply put, to be assessed means to be exposed to value judgments. According to one participant, "as a child I was evaluated well in terms of school achievement, but poorly assessed as to my behavior". Very often the use of these evaluative results may be ambiguous since "they recommended that I leave school due to my behavior, but later I was invited to come back for having good grades that helped my school compete with others".

The school achievement of this student enabled him to enter a Sociology Department, where he perceived other aspects of evaluation. In his first experience as an evaluator, he noticed there was not much connection between data collected in the field and the evaluation report produced, since the report was written by someone who did not gather data, and "these reports were (often) written before data collection!"

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In his first professional experience as an evaluator, he had the uncomfortable task of assessing colleagues in the health sector, although having no specific knowledge of this field. Recently, he was “assessed” by his peers, as he used to do in the beginning of his professional life, and received the unpleasant news that his request for funding for his research had been denied.

This brief account of a personal and professional experience of one speaker allows us to consider that the field of evaluation is characterized by value judgments, political will, and power relationships.

Two other speakers, one working for an international professional network and the other for federal agency, presented institutional experiences with the topic of evaluation. Both drew attention to the instrumental aspect of evaluation for advocacy purposes; one highlighted the use of evaluation as an advocacy tool for politicians and decision-makers to influence and leverage support for health promotion investments, whether through policy-making, infrastructure development or financial resource investments. Another speaker reported one experience of gathering and assessing data, which were important to demonstrate the need to expand the hours of counseling and testing service for suspected HIV-positive patients.

The fourth speaker stressed the influence of Paulo Freire in her life and her activities as an evaluator. She holds a broad view of effectiveness, and said that by working with young people and programs to prevent alcohol abuse, their focus is not on program effectiveness *per se* related to alcohol behaviors, but rather on strengthening the self and collective efficacy of the youth as subjects and as active players in society. She also expressed more interest in changing “indicators of community life,” rather than the effectiveness of programs and projects to change indicators on an individual level.

In addition, she values the experiences of participatory evaluation, in which the subjects who benefit from the programs are also evaluators of the programs. She is “very interested” in research questions that ask about the “possibilities of building authentic partnerships” and about how “power is negotiated in the evaluation process.”

### Would a demonstration of the effectiveness of a health promotion project or program assure its implementation?

In general, the participants do not think that effectiveness is the only criteria for assuring a program’s implementation.

There is a major current debate now

throughout the implementation and translation literature about the gap between what is considered an evidence-based program that may work in one community or setting, but has difficulty being transferred and disseminated to other cultures, places, and political contexts. This is true in the U.S., for example, where many programs are created in dominant culture settings (or even in a single cultural setting) with good effectiveness data. Yet, the same program may not work in a community that is different from the first (i.e. in a predominantly African-American, Latino, or Native American community).

One of the professionals thinks a participatory process that enables the program staff, community members and other stakeholders to incorporate the local political, social, cultural context is essential to assure widespread implementation.

In other words, some of the panel participants stated that they do not think we’ve been effective as public health practitioners and researchers when we just pull a “science-based program” off a shelf and implement it from the top without community input.

The panelists think we need to incorporate not only community people in the planning, but also ensure we, as “scientists,” are open to the “science that emerges from the community,” for example, the community and cultural perspectives, the indigenous theories, and other ideas that will assure that the program values are complementary to the setting, and the program has an opportunity to be adapted to local logistics and local insights. Only then can we hope for programs to be sustainable within local contexts.

### Are there other aspects that can influence health promotion implementation apart from a program’s effectiveness? How can these be considered?

The answers were similar to the question above. People stated that a community-based participatory research process (CBPR) in which you develop authentic partnerships, where decision-making and power is appropriately shared between public health professionals and communities, is needed to support health promotion implementation and sustainability.

There are excellent writings now about supporting collaborative partnerships within CBPR (among many others, Israel et al. (Eds), 2005 and Minkler and Wallerstein (Eds), 2003) for good case studies and explanations of the issues.

Some of these issues of course involve the role of stakeholders in the process:

- who has the power to make decisions;

- where decisions come from at different stages;
- whose voices are not heard (i.e. who in the community is participating and who is not participating);
- whose knowledge is being listened to (i.e. is it only the health promotion practitioners’ knowledge or is community knowledge being incorporated);
- who has control over the money;
- what kind of transparency and accountability is there to the community;
- what is the role of policy-makers in the health promotion implementation and in developing plans to sustain the program; and
- what indicators for success are being chosen and by whom.

Of course, each of these issues would require an entire discussion, but the bottom line is that the partnerships and collaborations between professionals and communities need to be looked at carefully.

Differences must be recognized and acknowledged. Community members, for example, might have different indicators of success than the health professionals, though with dialogue and negotiation, hopefully a comprehensive plan can be developed that includes the best ideas from all participants.

### What do you expect from the global initiative of evaluation of health promotion effectiveness?

The major expectations and benefits were to share experiences including case studies of different methodologies used for judging effectiveness and alternative research designs (other than the randomized clinical trial as the only gold standard) to assess indicators of success.

Panel participants stated they would also hope that we could support more work on indicators of empowerment, participation and community capacity outcomes so that we could look at these as important intermediate outcomes, other than just waiting for health status and health behavior changes as outcomes. Many of these empowerment and capacity outcomes are in fact intermediate system changes that are necessary to transform conditions that would lead to improved health status, behaviors and reduced disparities.

A vibrant discussion on models of evaluation of empowerment outcomes would be helpful in the literature, incorporating opportunities for people to debate each others’ indicators and categories. One discussion of this is found in a recent WHO review of the evidence of effectiveness of empowerment interventions (Wallerstein, 2006).

## A brief conclusion

Professionals working in developing countries and those dealing with indigenous communities tend to emphasize questions such as “what for?”, “with whom?” and “why?” regarding initiatives to evaluate effectiveness in health promotion. They are concerned with power relationships and the need to consider the importance of participatory approaches. Professionals working for international or governmental agencies are generally more pre-occupied with questions such as “how?” and “how much?”

Giving priority to the three questions (“what for?”, “with whom?” and “why?”) as compared with the other two (“how?” and “how much?”) would indicate a more political bias in evaluation for demanding that evaluators take a stand as to the purpose, direction, and participatory and inclusive nature of the evaluation efforts they take part in.

A 90-minute dialogue among panelists with a primarily Brazilian audience was not sufficient to produce concrete conclusions on the predominant character of international effectiveness evaluation efforts. Nevertheless, this debate framed the five aspects of evaluation into a value perspective. The questions, “what for?”, “with whom?”, “why?”, “how?” and “how much?” are linked to political or technical notions that could be included and harmonized in evaluations of health promotion effectiveness.

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# The complexity of the discussion on effectiveness and evidence in health promotion practices

Regina Bodstein<sup>1</sup>

**Abstract:** This article discusses an evaluation framework based on an understanding of the constitutive elements and multi-strategic characteristics of health promotion (HP) programs. Health promotion presents an ongoing challenge for traditional evaluation frameworks (Rootman et al., 2001; Potvin, 2006; Barnes et al., 2003) when it redefines its actions as empowerment, community participation, local development, health literacy and intersectorial activities for the purpose of reducing inequalities for individuals, organizations, and public policies (Kickbush, 1994). This challenge also applies to the discussion on effectiveness of HP practice; what is at stake is the knowledge about how health promotion actions generate changes and outcomes. In short, this article proposes to discuss this redefined HP perspective and identify its usefulness in terms of the debate on effectiveness and evidence of HP in Brazil. (*Promotion & Education*, 2007, Supplement (1): pp 16-20)

**Key words:** health programs, effectiveness, evidence, program evaluation

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In Brazil, the debate surrounding health promotion has developed from the perspective of re-politicizing health and health promotion within the field of social determinants, a concern which has been present in Latin American public health since the 1980s. This discussion brings to the fore a framework that conceptualizes health through actions which address determinants of health and quality of life aimed at multiple dimensions of local development: social, environmental, cultural and economic (Buss & Ramos, 2000).

Health promotion stimulates interdisciplinary dialogue, giving rise to the design of inter-sectorial policies and strategies aimed at improving the quality of life. Quality of life and health, in the case of countries marked by deep-rooted and persistent social inequality, raise the issue of health inequities, recognizing that differences are not only unnecessary and avoidable, but also unjust (Whitehead, 2000). The view that inequalities in health and illness, in lack of access to health care and medical services, are due to social factors (Rose, 1992; Kawachi, 2002) places HP as a radical and systemic struggle against social inequities (Ferreira & Buss, 2002; Carvalho et al., 2004). Practices based on the principles of participation, equality, intersectoriality, and empowerment are encouraged with the objective of promoting health in multiple settings: cities, districts, neighborhoods, hospitals, schools, workplaces; and of stimulating extensive debate and social participation.

Nowadays this perspective forms the basis of dialogue and commitments made between countries, and among the public sector, private sector and civil society. Health is presented as a fundamental public resource and a basic human right, with

criteria for good governmental and business practices (Kickbush, 2004). By redefining global and local development strategies, health promotion (HP) seeks to build a consensus agenda for public health in the 21<sup>st</sup> century. The challenge is to show the effectiveness of its proposals and actions, whether they are to redirect health services and practices or to design intersectorial actions and policies which mobilize institutional and non-institutional actors in local agendas for reducing inequalities (Buss & Ramos, 2000; Carvalho et al., 2004).

HP in Brazil has inspired intersectorial strategies and local actions aimed at improving the quality of life in various regions of the country. These have included the Rede de Cidades e Municípios Saudáveis (Network of Healthy Towns and Cities) in São Paulo, Campinas, Ceará, Pernambuco; Integrated and Sustainable Local Development (DLIS) in Manguinhos/Rio de Janeiro; Ambientes Saudáveis (Healthy Environments) in Curitiba; Rede de Escolas Promotoras de Saúde (Network of Health Promotion Schools) and Rede de Habitação Saudável (Network of Healthy Habitation) in Rio de Janeiro, to name but a few of many initiatives. From dialogues within these initiatives (ABRASCO, GT-PS),<sup>2</sup> one can clearly understand the importance of investing in evaluation and reflexive research on actions and practices, in order to disseminate successful methodologies and experiences (Bodstein et al., 2004).

The evaluation frameworks in the field of health promotion in Brazil have been driven by the concern not only with improving program performance, but also with promoting dialogue and learning based on a systematic reflection of experiences, classifying and redefining actions by means of conceptual and methodological

debate. The frameworks convey the concern with the effectiveness of initiatives and results, as well as the search for evidence that could guide decision-making (Carvalho et al., 2004).

The objective of this paper is to discuss an evaluation framework that is based on the understanding of HP concepts and initiatives vis-à-vis the theory and underlying mechanisms of HP actions. Working from this framework, it is possible to discuss the effectiveness of health promotion strategies. This article focuses particularly on an evaluation framework for Health Promotion programs which aim for social changes based on complex strategies, presenting great challenges in proving their effectiveness.

## Political dimension of programs and of evaluation processes

Programs are conducted within highly political contexts (Patton, 1978; Weiss, 1998; Shadish et al., 1991). They are embedded within complex decision-making processes that involve a range of actors in interdependent relations and networks, within which various institutional and non-institutional interests are at stake. The decision-making process includes the macro health sector, local decision-makers, various health professionals, and local social groups. Programs are thus immersed in contexts permeated by conflicting interests. Such complexity shapes programs and actions, defines and transforms objectives and activities throughout their implementation, and is responsible for the variety of effects, including expected and unexpected results (Weiss, 1998:46-70).

The DLIS program in Rio de Janeiro, for example, was conceived through identifying the principal stakeholders, stakeholder

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practices based on their interests, and local social networks. The conceptual framework of health promotion and the concept of Integrated and Sustainable Local Development (hereinafter referred to as DLIS, its Portuguese acronym) provided the underlying guidelines for the program that encompassed a set of inter-sector actions addressing determinants of health and quality of life through their social, environmental, cultural, and economic dimensions (Buss & Ramos, 2000) with intense community mobilization and participation. The DLIS was the establishment of a multi-sector coalition consisting largely of institutions located in the area to be benefited (Manguinhos), generating a commitment between academic sector (ENSP/FIOCRUZ) the Rio de Janeiro Municipal Government, and key State and municipal departments and major state-owned and private companies adjoining the Manguinhos Complex, aimed at integrated action to improve local quality of life. The evaluation experience in Manguinhos addresses the underlying mechanism that makes community involvement possible and the health promotion program works. The understanding of the context, the demands, and local priorities through a participatory approach was crucial to the process. The evaluation ended up prioritizing the dimensions of inter-sectorality, social networks of community participation, and involvement in program implementation. The evaluation of the DLIS program showed a marked difference between the interests of important organizations working for the local communities; and the existence of paternalistic practices and cronyism, creating vertical relations of dependence and subordination between the population and its leader vis-à-vis political parties, institutions, and the public sector in general (Bodstein et al., 2006).

In this sense, evaluation is understood as a policy evaluation, that is to say it's a reflexive system that engages decision-making, to the extent that it produces knowledge about the relevance of objectives, the coherence of different programmed activities and the relation between objectives and achieved results (Rootman et al., 2001; Potvin, 2001). It is up to the evaluator to formulate questions that identify essential elements and political dimensions of the intervention, in other words, organizations, subjects, hierarchies and functions, processes and activities, objectives and purposes vis-à-vis the context in which the program is placed.

Understanding the programs presupposes knowing the ideas, concepts and objectives underlying the intervention design. In the case of HP, the initiatives are often aimed at, in Nutbeam's classic defini-

tion, empowering people and communities to gain greater control over their health (Nutbeam, 1985). This includes, therefore, complex objectives and a set of strategies and practices for policy development, organizational change, community development, and educational or health literacy programs (Nutbeam, 2000; Kickbush, 2001).

A significant issue for the evaluation process and the search of effectiveness is the fact that the purposes and objectives are formulated in a generic and vague manner precisely in order to accommodate different interests and to allow political coalitions to sustain the implementation of programs (Weiss, 1998; Chen & Rossi, 1992). In this sense, it is necessary to distinguish between officially formulated objectives and those that will in fact be implemented (Mazmanian & Sabatier, 1989). With a high number of interests involved and with various decision makers, the objectives and purposes are outlined and modified in tandem with the development of the activities and the contexts, sometimes radically altering the original nature of the program's aim (Chen, 1990).

Program objectives, both multiple and variable throughout time, need to be problematized in view of the specific political context in which they are located. The effects or accomplished results often have little or nothing to do with the official objectives at the program's conception or implementation. New technical-social spaces and meanings are created and re-created as a result of the reflections produced by the interventions, even generating unexpected results. The programs must be understood as organizational systems that mobilize human, technical and social resources that make actions and services available. The raw materials for organizations are hierarchical positions, norms and regulations, but also have distinct and sometimes conflicting interests. Programs involve actors and strategies to optimize gains and minimize losses in a trade-off process (Potvin et al., 2006) that represents a temporary consensus among diverse interests, shaping the program's course and performance. Programs can be, and often are, politically effective – generating political and electoral dividends – without having any social impact or effectiveness, that is to say, without achieving the expected results.

The evaluation of inter-sectorial actions in DLIS clearly illustrated that coalitions are easy to form under a vague and noble goal. Conversely, operative goals, involving the details of resource allocations or value trade-offs, only highlight differences among coalitions and enhance the conflicts between them and their agendas. It further illustrated that the short life of inter-sectorial dialogue

in the DLIS case was explained by the highly politicized setting – as expected in an antipoverty program (Weiss, 1998; Shadish, 1991). Finally, it showed that inter-sectoriality was undermined by institutional fragmentation and administrative discontinuity. It also showed that the negotiation of an agenda with common objectives, in the DLIS case, merely consisted of the juxtaposition of previously drafted sector-specific goals. Negotiation of other issues and priorities, reflecting agreement on inter-sectorial actions adapted to local issues, did not actually occur.

### Mechanisms and theory in the evaluation of HP programs

A crucial evaluation task is to understand the manner in which the program aims to achieve the intended changes (Weiss, 1998). Therefore, a relatively recent tendency in the creation of evaluation frameworks and in the discussion about effectiveness has been the construction of models that link implemented strategies with achieved results (expected or unexpected, beneficial or detrimental) in light of the contexts in which the programs are located. The structuring of programs is carried out through putting ideas and concepts into practice to bring about changes, in such a way those programs should be understood as theories in action.

Much more than the mere application of methods and investigative techniques, evaluation presupposes approaches that take into account not only the political context that determines a large part of the action development, but also a discussion about how the programs intend to achieve the results and outcomes. This concern is dealt with in the respective literature as theory-driven evaluation (Shadish et al 1991; Rossi et al 1999; Chen, 1990, Weiss, 1998). As Shadish et al highlight (1991) there can be no theory-free program design, so evaluation often provides partial probes of theoretical ideas. It's impossible for a program to exist without a theoretical base. Evaluation is, to a certain extent, a test of the theory's validity.

By trying to establish a theoretical base of interventions, one forms a perspective to produce knowledge about the processes that actually explain the program's changes and outcomes. These changes may occur at a micro level, in other words, changes in people's beliefs and attitudes, fundamental for the discussion about risk behaviors in relation to health; or changes at the level of public policies and social determinants. Important for the debate is the distinction between process and summative evaluation to the extent that it's useful to question and learn from the relationship between

processes, results and outcomes (Patton, 1981). Process evaluation is crucial to comprehending the context, the ideas and principles that implicitly or explicitly underlies the program.

In addition to the concern with program results and outcomes, there is also a need to forming a rich description, holistic understanding of programs that involve theories and the structure of “organized services, materials, or activities that are directly delivered to the clients or subjects” (Chen, 1990: 198). Theory-driven evaluation shows that apart from the program description, in terms of content, setting, participants and implementing organizations, what matters is understanding the theory that is implicitly or explicitly present and responsible for the possible results and effectiveness of the actions. That is to say, theory-driven evaluation stresses that programs involve causal or explicative theories as core social science theories (Chen, 1990). What is at stake is a perspective not only for evaluating outcomes and effectiveness, but also an approach that explains how programs work.

Even if the evaluation process is concerned more with program improvement – which would seem important in light of the multi-strategic dimensions and plasticity of health promotion programs in which various strategies of participation, mobilization and empowerment are tested – it is of equal importance to question the adequacy and relevance of these concepts and strategies in relation to the expected results of health promotion actions.

Evaluating the effectiveness of health promotion proposals presupposes analyzing the principles and objectives of interventions vis-à-vis mechanisms and processes focused on changes in socio-cultural determinants and quality of life for individuals and communities, i.e., initiatives and programs that are complex by definition, namely multi-focal, interdisciplinary, and inter-sectorial, and that are only sustained and justified through a reflexive process between decision-makers and actors/subjects. The issue is to identify why and how the interventions “work” and to generate changes and effects that can benefit health and quality of life in the short, medium, and long term.

Understanding theories that sustain and justify health program activities is useful, because from these theories, we can explain the changes and also go beyond inputs and outputs, to a better understanding of the relationship between processes and outcomes. Furthermore, lessons that have been learned about interventions have resulted far more from understanding the underlying theory than comprehending the programs *per se* (Pawson & Tilley, 1997).

Therefore, an important aspect of evaluative research originates from questioning the adequacy of the theory in relation to the intended outcomes and changes. The inclusion and discussion of social determinants for health seem to lead to more qualitative approaches to understand the socio-cultural processes that affect program outcomes. As maintained by Pawson and Tilley (1997), programs only enjoy successful outcomes when they introduce appropriate ideas and opportunities and/or resources (mechanisms) to groups within adequate socio-cultural conditions (context).

Implementation of HP programs, –with DLIS characteristics and politicized settings, depend largely on expanding decision making space through a dynamic that is capable of mobilizing and valuing the existing social organizations that are active in the area (Sullivan et al., 2004). Thus, empowerment and work with cultural mediators are crucial mechanisms for a program aimed at expanding the exercise of citizenship and the public space against a background of growing violence. Identification of the role of these mediators and the local networks of sociability and socio-recreational and cultural activities undoubtedly constituted one of the key factors for dialogue and participation by the community in the program, to the extent that they provided clear examples of the potential for change in local living conditions.

Literature about evaluation in health promotion has shown the importance of charting a wide-ranging system to explain the changes and to discuss both effectiveness and evidence (McQueen, 2001; Tang et al., 2003; Potvin, 2001, 2005; Hills & Carroll, 2005). HP programs face challenges that vary in accordance with the concepts and strategies involved, whether they are to redirect services, care and practices, or to promote people’s and communities’ empowerment and autonomy and to deal with inequalities and quality of life. This search for conceptual references and underlying factors of contexts and determinants, in other words, about social policies, cultural practices and standards that affect HP programs and strategies, has received growing attention in discussions and the respective literature.

Carvalho and colleagues (2004) began a discussion of health promotion evaluation in Brazil, from the point of view of Pawson’s “realist” evaluation. In their perspective, “[...] the so-called realist evaluation fundamentally targets the mechanisms sustaining programs with greater complexity in their respective contexts [...] mobilizing various theoretical frameworks beginning, for example, with a theory of social exclusion that justifies the intervention, moving

on to theories of social mobilization and organizational theories [...]” (Carvalho et al., 2004: 526). The authors looked for a new understanding of “evidence”, examining the possibility of creating useful knowledge for decision-makers and identifying the underlying mechanisms and theories to deal with inequalities and quality of life. When they maintain that what is in question is a broad view of health and of social determinants, they state that multi-focal strategies and inter sectorial actions only become intelligible by means of a more far-reaching evaluation framework.

Crucial mechanisms for effective and sustainable social changes especially entail the involvement, mobilization, participation, and empowerment of actors and subjects. Unveiling the mechanisms for mobilization by communities, groups, and individuals in the dialogue on aspects of health and improvement in quality of life in well-defined contexts contributes to understanding the proposals’ effectiveness (Bodstein et al., 2004; Peres et al., 2005). Educational practices that are participatory and reflexive at the personal, organizational, professional, and public-policy levels provide the structure for health promotion proposals and constitute a promising pathway for evaluating the impact and outcomes of the actions.

Another example comes from the view that “[...] if interventions are to change individual risk behaviors, they may also need to bring about changes in the social contexts that influence why and how people behave in certain ways” (Davey and Seale apud Shaw and Crompton, 2003:194). That is to say, even individual behaviors are explained in the broader context of social conditions and determinants. Community capacity, community development and/or social capital also feature implicitly and explicitly in the health promotion literature, referring to a set of resources and shared values that bestow the sense of identity on a given community (Hawkins & Catalano, 1992; Jackson et al., 2003; Moody et al., 2003). This also relates to protective factors that help certain communities and groups comprehend and react to adverse social conditions. Social capital is seen in terms of shared common values that reinforce senses of cohesion, belonging and shelter.

Bourdieu (1986) shows that social capital is related to a set of current or potential resources that form a durable network of more or less institutionalized relations in terms of belonging to a group. Coleman’s (1993) classic work on this concept refers to it as an aspect of the social structure that facilitates certain actions by individuals placed within these structures, in other

words, which facilitate the acquisition of certain ends and advantages that would not otherwise be possible. Putnam (1993) identifies social capital as certain features of social organizations that conform to a network of norms based on trust and that enable greater efficiency by means of coordinated and collaborative actions.

The concept of social capital creates a theoretical base and an underlying explanation for health promotion programs and actions, postulating that organizations, behaviors, attitudes and habits are socially constructed products. Changes that they undergo therefore imply the active cooperation and participation of the social agents involved (Shaw & Crompton, 2003; Minkler & Wallerstein, 2003). This goes beyond the attribution of individual responsibility for risky behaviors, to emphasize the need to explain the social determinants and roots both of individual habits and of collective values and behavior. In other words, it does not locate the problem in individual behavior, but rather in structural conditions and social processes.

## Conclusion

The complex nature of health promotion (HP) interventions has led to the expansion of traditional evaluative approaches and models, thereby challenging the search for evidence and effectiveness. An innovative evaluative perspective on evidence in complex social and politicized interventions has been discussed based on the contribution from both theory-driven and realist evaluation, drawing on systematic reviews and lessons learned from evaluative research.

This perspective appears quite promising for discussing effectiveness and evidence in the field of HP since it proposes to investigate factors at work in interventions, i.e., the social and political context which structure elements in any intervention. Despite the complexity of decision-making processes and the political environment surrounding social programs (especially those focused on fighting social inequalities), this approach seeks to identify the mechanisms operating in specific contexts which account for the changes and effects observed in the interventions.

There is a need to question the initial generic objectives and to identify structural elements that determine interventions in health promotion, including the setting, the target population, stakeholder relationships and interests, discontinuous activities, and mechanisms for addressing conflicts and stalemates. Specifying the context, which largely explains the particular configuration of each program, has been well-highlighted in the literature. In evaluation, programs are analyzed through understanding the actors

involved in decision-making processes, their interests and reasoning, in light of the political context in which programs and evaluations take place. Contexts are especially analyzed critically, in that they do not only refer to the spatial, geographic or institutional location of the programs, but rather to the institutional relationships of norms, values and specific roles that shape programs and actions.

The importance of choosing aspects to be evaluated and the limits of that choice has been discussed. If the purpose of the evaluation is to only judge the effectiveness of a program, it runs the risk of judging only what went well and what went wrong, without reaching any understanding of the processes and relations that made certain outcomes possible. When the evaluations' purpose also includes the changes and outcomes caused by the presence of participatory practices, inter-sectorial actions and the formation of community coalitions across a range of levels and settings, another evaluation framework is needed. Literature on evaluation of health promotion has been seeking to show the importance of charting an extensive system in order to explain changes and discuss effectiveness. Health promotion evaluation should emphasize the processes and theories that are responsible for changes and outcomes, processes that are, in turn, congruent with the ideas and assumptions of HP programs. Such programs face particular challenges, be they to redirect services, care and practices; or to promote the empowerment and participation of individuals and communities: in short, challenges to improve quality of life and reduce social inequalities.

The growing demand by managers, evaluators, and professionals to assess effectiveness of health promotion initiatives and programs thus raises the challenge of systematizing the theories and mechanisms that sustain innovative practices and programs in this field. Evaluation of effectiveness, from the perspective defended here, focuses on the relationships between theory and practice and between conceptualization and results, emphasizing the importance of unveiling theoretical models that directly or indirectly impact the practices and explain the results.

Evaluating the effectiveness of health promotion proposals presupposes analyzing changes in socio-cultural determinants and quality of life for individuals and communities, i.e., initiatives and programs that are complex by definition, namely multi-focal, interdisciplinary, and inter-sectorial, and that are only sustained and justified through a reflexive process between decision-makers and actors/subjects. The issue

is to identify why and how the interventions "work" and to generate changes and outcomes that can benefit health and quality of life in the short, medium, and long term.

By understanding the processes and mechanisms for involvement and active participation by stakeholders, health promotion actions lead to new knowledge and practices. Thus, to a great extent, the outcomes of participatory and/or inter-sectorial and/or interdisciplinary actions are linked to strategies for building new practices (behaviors, habits, and knowledge) based on processes that respect subjects' autonomy and the diverse social and cultural patterns that define and shape their habits and practices.

A promising path to apply the rules of scientific evidence to correlate interventions and observable effects would be to apply systematic and realistic reviews, and uncover the theories and mechanisms that explain adherence, participation, and reflexivity by subjects and actors involved in the reorientation of comprehensive interdisciplinary health promotion practices and inter-sectorial initiatives for social development and better quality of life (UIPES, 2000). The emphasis on qualitative methods and case studies for understanding the meanings that explain behaviors and attitudes is another promising approach. The complexity of these processes and contexts needs to be taken into account in designing evaluation and in the discussion of effectiveness and evidence in health promotion programs and actions.

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i. In 2003, the Brazilian Association of Collective Health (ABRASCO), with the support of the Brazilian National School of Public Health (ENSP-FIOCRUZ), created a Working Group on Health Promotion to promote dialogue and exchange of experiences among various professionals and researchers in Brazil involved in HP theoretical discussion and practices. The Working Group has met annually since then and has served as an important forum for the discussion and in-depth enhancement of Health Promotion within the Unified National Health System (SUS) in Brazil.

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# Analyzing the outcomes of health promotion practices

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**Abstract:** This article focuses on health promotion (HP) outcomes, illustrated through evaluation of case studies and identification of strategies which have contributed to their success and sustainability. Evaluation research and practice in three distinct sceneries are discussed: (i) institutional and governmental agencies; (ii) communities in the “*Manguinhos Complex*” and Nova Iguaçu Municipality, and (iii) building of potentially healthy municipality networks.

The *effectiveness of a social program in a health promotion perspective* was based in the “School for Parents” program, undertaken by the First Court of Childhood and Youth of Rio de Janeiro, between 2001 and 2004. The analysis was grounded in the monitoring of 48 parents in charge of children under 18, who were victims of abuse, violence or negligence, and social exclusion, most of all. The study’s objectives were: illustrating the evidence of effectiveness of health promotion, discussing the concept of HP effectiveness under macro unfavorable conditions, and identifying strategies that foster sustainability of results. Institutional resources included a multi-professional staff, multidisciplinary approaches, participatory workshops, family case management, partnership with public and private institutions, and volunteer and civil society sponsorship of the families. Evaluation was based on social impact indicators, and psychosocial and contextual determinants. Evaluation methods included program monitoring and quantitative-qualitative methods, through a longitudinal evaluation of 3 years, including one year post program. The evaluation showed highly favorable results concerning “family integration,” “quality of family relations” and “human rights mobilization.” Unsatisfactory results such as “lack of access to formal employment” are likely related to structural factors and the need for new public policies in areas such as education, professional training, housing, and access to formal employment.

The *training process of social actors in environmental management and housing*, supported by the Public Health Technology Development Project of the Oswaldo Cruz Foundation, was employed as a tool of environmental education and healthy housing. The purpose of this study was to construct an integrated and participatory model of environment management. The methodology included training, research and evaluation of participants, from 21 to 50 years of age, who participated in building Thematic *Learning Books* and *Community Guides* about water quality monitoring. Participants’ evaluations emphasized the training process, encouraging them to become multiplier agents of environmental education in their communities and to continue learning how to bring together sectors for problems solving.

The *Potentially Healthy Districts’ Network (RMPS)* aimed at increasing knowledge and building capacity to develop actions which originate from each of the local units, based on their characteristics and practices. Developed by the Preventive and Social Department of Campinas State University with PAHO/WHO and the Society Special Research Institute (IPES), RMPS’s mission was to cooperate in the construction of healthy public policies in a participatory and articulated way through different municipal representatives. The network offered tools to municipal administrations to develop integrated projects that brought together government, managers, technicians, academy and organizations for the construction of public policies aimed at health promotion and quality of life. The methodology is based in the construction of knowledge and action networks by social actors, stimulating trans-sectorial and inter-district actions. The outcome evaluation is based on case studies, focus groups, oral stories, documents and image analyses. (*Promotion & Education*, 2007, Supplement (1): pp 21-26)

**Key words:** health promotion, effectiveness, macro structural conditions, Family Health Program (PSF), healthy housing, integrated participatory management

Resumo em português na página 34 Résumé en français à la page 38. Resumen en español en la página 42.

## Clélia Parreira

The debate within health promotion (HP) points to the need for an in-depth discussion on effectiveness. Being a new area involving multiple fields of knowledge, HP requires new and different evaluation procedures, approaches and indicators concerning policies and practices. Distinct ways to understand evaluation processes and outcomes therefore are critical.

The following studies, beyond their individual contributions, express aspects that characterize new evaluation approaches and practices within HP. The first one, a government-run program for parents and relatives responsible for child victims of abandonment, neglect or violence, utilizes multiple processes and methods in order to achieve a better understanding of individual, social and political outcomes.

The second one, focusing on empowerment of social players, environmental management and housing, emphasizes community participatory evaluation methodologies and intersectorial actions. These methodologies are thought to be most effective for analyzing environmental education proposals, as they demand the development of critical thinking, actions and tools for intervening in the environment.

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The third one presents a methodological approach for evaluating municipality networks which required the creation of new monitoring tools to consider their complex operating dynamics.

### Effectiveness of a social program from a health promotion perspective

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This section discusses the outcomes of the School for Parents Program (SPP), which consists of three projects: (1) the School for Parents (SP); (2) the Solidarity Family Project; and (3) Parents at Work, which were run by the former first Court of Childhood and Youth of Rio de Janeiro. Monitoring and evaluation of the case study lasted three years from 2001 to 2004.

The program was created in 1998 by Judge Siro Darlan de Oliveira and was designed to replace punishment with social and educational support for parents, as well as to search for family integration and alternative income generation opportunities feasible for the families. Attached to the Family Guidance Service (FGS), one of the sectors of the First Court, SPP was addressed to parents (or relatives) of children and adolescents who were victims of abandonment, neglect or violence. It provided support to more than 500 families, through 15 groups of School for Parents, up to 2004.

The present analysis involves families from the 8<sup>th</sup> and 9<sup>th</sup> Schools for Parents' groups, whose predominant structure was uniparental, directed by women (60% and 57%, respectively). Participants came from various Municipal District regions, and some of them were or had been street dwellers (5% at the 8<sup>th</sup> SP and 3.6% at the 9<sup>th</sup> SP). They didn't have a geographical community reference, thus the program was developed inside the First Court. Consequently, the evaluation paid special attention to institutional and programmatic conditions, which were defined as psychosocial or institutional determinants, evaluated through semi structured interviews with the coordinators and institutional staff.

### The School for Parents Program (SPP)

The School for Parents project, the first SPP segment, included 9 information and self-reflection workshops (30 hours in total) focusing on personal sensibilities, education, health, employment, art, culture, citizenship and recreation. Its objectives were the development of self esteem, self confi-

dence and self expression, and knowledge of citizenship's rights and duties (Pereira Lima et al., 2002). Beyond the group experiences, FGS professionals provided support to each family, according to goals defined in common.

The Solidarity Family Project, the second SPP segment, with 12 months duration, focused on consolidating the previously reached progress (construction / rescue of self esteem, strengthening ties between parents and children) through workshops to develop personal work abilities, including skills for income generation. Psychosocial support was offered through personal, family and group support, home visiting and orientation on searching the public services network. Considering the need for financial assistance to support family social inclusion, the program coordination engaged society's more favored sectors to obtain sponsors for one or more families, equivalent to a minimum wage salary per month, during the 12 months. The objective was to make it feasible for participants to achieve autonomy and competence for taking care of their lives appropriately, with sustainability and without legal interventions.

The *Parents at Work* project (3<sup>rd</sup> segment – optional) was dedicated to strengthening the participants' survival and self-sustenance, through their adherence to social and citizenship values; creation of employment and income generation opportunities through partnerships; and identification of external offers, which supported the parents' own initiatives (Pereira Lima et al., 2002).

### Evidence of effectiveness

The analysis of health promotion effectiveness, based at the School for Parents Program, drew upon Nutbeam's model (1999) and was adapted to the Brazilian social reality, considering the heterogeneity and social exclusion of significant population groups (UIPES/ORLA-BRASIL, 2004). The evaluation was also based on: documents of the international conferences of HP between 1986 and 2000 (Brasil/MS, 2001); the "Analysis of the Implementation of an Intervention" (Denis & Champagne, 1997); and the "Discourse Analysis of Collective Subjects" (Lefèvre et al., 2000).

In the exploratory and developmental phase of the evaluation design, the IUHPE researchers, acting as external evaluators, closely followed the 8<sup>th</sup> School for Parents for 3 months, through observation, recordings and analysis grounded in the following dimensions: objectives, content, methodology, parents' participation and coordination.

This phase allowed the IUHPE/LARO/Brazil and the First Court staffs to build up a

monitoring routine, as well as multiple quantitative-qualitative evaluation processes integrated into the projects (Pereira Lima et al., 2002). The 8<sup>th</sup> and 9<sup>th</sup> Schools for Parents were then selected for longitudinal monitoring for three years, totaling 48 participants (33 of which concluded the program).

Monitoring and recordings on a weekly and fortnightly basis were targeted to assess transparency, identification of barriers, advances, corrections and proposals, and incorporation of parents' and staff suggestions arising from the workshops and the participatory evaluation meetings.

Quantitative evaluation was accomplished through defining and assessing Social Impact Indicators, at the end of each of the three segments. Further assessment of "real life" conditions was carried out, 12 months after the end of the program.

Between November 2001 and July 2002 (during the program implementation), there was consistent progress (60% to 100%, positive answers) for the following variables: "search for health care," "completion of immunization calendar," "enrollment of children in schools," "possession of personal documents," "registration of children's birth certificates" and "family housing." "Accessibility to formal employment" was the most unfavorable indicator (24% of positive responses). In general, outcomes in the successive stages, involving actions in the individual, social and political spheres reaffirmed the program's success.

Qualitative evaluation was conducted during the implementation of the program and one year after its end, with the same periodicity (per semester), and included meetings with both groups of participants. It also incorporated partial evaluations at the end of each workshop. The participants were stimulated to express their feelings and perceptions by responding to the following questions:

1. How is your family relationship today?  
Are your children living with you?
2. Are you able to participate in your family maintenance? In what way? If not, why?
3. Are you feeling more capable to find public services?
4. Are you involved in some community association or organization?

People's responses were carefully registered, classified into categories, and analyzed, using a methodology of Discourse of the Collective Subject (Lefèvre et al., 2000). The qualitative evaluation confirmed participants' increased feelings of self esteem and self confidence and a higher ability for searching for their own rights and their children's. The improvement of the family relationship and maintenance of chil-

Table 1.

Impact indicators	8th SP Nov/2003 %	9th SP Nov/2003 %
Not committing nor relapsing into the transgression*	82.0	100.0
Reintegration of children sheltered in institutions into their families	100.0	100.0
Possession of personal documents	91.0	75.0
Possession of children's birth certificate	100.0	100.0
Search for health care	100.0	87.5
Completion of the immunization calendar	100.0	87.5
Children not living on the streets	91.0	75.0
Enrollment of children under 18 in schools	82.0	75.0
Capacity to generate income	64.0	75.0
Housing for the family	82.0	75.0
Access to formal employment	27.0	25.0

\*Transgression that has motivated the accusation – abandonment, negligence or violence.

dren living with their families were also stressed. The difficulties related to income generation are more accentuated when related to formal employment opportunities, due to systemic and macro structural problems. Contextual local conditions, such as violence, were pointed out to justify their weak participation in community movements.

Twelve months after the end of the program, the coordination staff held a participants' meeting (8<sup>th</sup> and 9<sup>th</sup> SP), in order to collect new quantitative and qualitative data, aiming at showing evidence of the sustainability of positive results. Table 1 presents the results expressed in percentiles, found in November 2003 (real life conditions), for a total number of 19 participants (11 from the 8<sup>th</sup> SP and 8 from the 9<sup>th</sup>), equivalent to 57% of the total number of participants who accomplished the program in 2002.

Follow up procedures presented limitations related to the maintenance of subjects. In this program there was a special difficulty due to the fact that families involved had not a geographical community reference and some of them had moved from their former houses, beyond other possible impediments.

While the results show high maintenance of program effect for the parents who attended the meeting (57% of total), it is likely that the parents who did not attend the meeting were less successful. It would be important for future evaluations to attempt to find the non-attendees, in order to provide a more comprehensive understanding of which families tended to be successful and which families had greater difficulty. Nevertheless, considering life difficulties faced by those groups, living under the persistence of macro structural adverse conditions beyond their own control, any sustainable progress related to their quality of life was understood as a demonstration of the program success.

In conclusion, the multiple and inte-

grated evaluation strongly contributed to the program's visibility, starting from the identification of facilitating and obstructive factors, followed by continuous corrections and revisions, allowing for the reformulation of intervention strategies.

The outcomes of the successive phases involving HP actions on the individual, social and political levels demonstrate evidence of program success, through the educational process, which stressed self confidence and self determination, closer affective relations in the family and among partners, exchange of experiences, consciousness of citizen's rights and duties, and achievement of greater autonomy and competence (Pereira Lima et al., 2004).

However, consistent and sustainable outcomes under adverse macro-structural conditions require the implementation of far-reaching healthy public policies concomitant with changes in health determinants led by the communities, as a consequence of their empowerment. Such policies should achieve effective social inclusion and equity, through the implementation of actions that would strongly benefit community development, popular housing needs, creation of an educational model based on inclusion and quality. Policies for training and employment, and rules which favor the integration of informal work into the social security system should be stressed.

This study opens a discussion on how to define "the success of a program" under adverse situations. How can we characterize a program's effectiveness, considering tough conditions? What would be the *elasticity* of the concept? What effectiveness level might be searched for? How do we define "evidence" when macro context is adverse, so that any advances in the quality of life became significant and relevant? The key question is: *Are there always real possibilities for people to control the social determinants of health? Or to what extent are the social and economic determinants within the control of individuals for people?*

## Empowering social players: environmental management and housing

Simone Cynamon Cohen

Débora Cynamon Kligerman

The City of Rio de Janeiro has been making an effort to reorganize the health care system in order to overcome a predominantly curative model characterized by low problem-solving capacity, ineffective cost-benefit ratio, and difficulties in using a comprehensive approach to address approaching health issues.

It is within this context of building a new health system practice that the Family Health Strategy was introduced, aiming at incorporating concepts such as health promotion, interdisciplinary work, and community participation with responsibility, in order to contribute to improving the quality of the health system. The health promotion movement proposes several areas of action and, among them, the creation of healthy environments and settings.

The present study shows the results of research carried out with the support of the *Technologic Development Project on Public Health / Oswaldo Cruz Foundation (PDTSP-water/FIOCRUZ)*. Using environmental education and healthy housing strategies as its main tools, the project designed guidelines to create an integrated participatory environment management model, oriented to environmental sanitation, housing and health within the watersheds of *Canal do Cunha/ Faria Timbó* (Manguinhos Complex, RJ) and *Bota River* (Nova Iguaçu-Rio de Janeiro).

A teaching-investigation-action-evaluation methodology was used so that a continuous information process could establish a permanent exchange of technical and scientific knowledge with popular knowledge; the evaluation of conditions and stages attained; as well as production of pedagogical materials. For the latter, booklets on water issues and a *Community Guide for Monitoring Water Quality* were produced with community participation.

The production of the booklets involved discussions with the population during workshops, on the following subjects: water quality; waste and health; housing and health; sanitation and health, and river revitalization. The *Community Guide for Monitoring Water Quality* was developed from the knowledge acquired by these social players during the classes.

The release of these products is expected to contribute to the empowerment of monitors and/or community "multipliers," with goals of family health promotion, sustainable management of hydro resources, participatory and integrated management of the river basins, and social empowerment.

The project is developed in two river basins. One, in Nova Iguaçu municipality, and the other in Manguinhos neighborhood, in Rio de Janeiro.

In Nova Iguaçu municipality, the project consisted of two training programs containing two modules each: one of them related to Environmental Management and the other concerning Healthy Houses. The classes were organized in the format of 48 workshops. In the module on *Environmental Management* the following themes were developed: Rivers Revitalization; Pollution and Water Quality; Sanitation and Health; Residues and Health, and Guided Visits in Nova Iguaçu Municipality. Other contents were developed in the module of *Healthy House*, such as: Concept of Healthy House; Factors of Risks inside the House; Space Representation; Planning of Healthy Spaces and Guided Visits (community, schools, etc.). The training program was accomplished for 4 groups, in two weekly classes, for three months (from July to September and from October to December, 2004). Thirty students were enrolled in each group, totaling one hundred and twenty students. Among those, about one hundred and ten were certified.

In Manguinhos neighborhood the same design (programs and modules) was developed. Twenty four workshops were completed and its contents were the same described above. The training program was completed by two groups of 50 students each, one class per week, for six months (from July to September and from October to December of 2005). In each group of fifty students, about forty one students were certified.

There was a difference between the two programs in the rivers' basins, concerning the students' profile. In Botas River's Basin the majority of students came from the Municipality Secretariat, and in Faria Timbó River's Basin students drawn from the Association of Residents and from representatives of NGOs who acted in the area. All of them lived in the surroundings, 51,2% of the participants being women. Data about participants' school level are synthesized in Table 2.

According to the students, the most prominent aspects of the training process were: empowering, program contents (88.2%) and learning how different sectors need to

work together for solving problems (11,7%). River revitalization (33%), solid waste (21%), water quality (18%), housing (13%) and sanitation (10%) were named as subjects they would like to study in depth. Environmental awareness, technology-based sanitation, river revitalization, selective waste collection, group-dynamics and alternative housing technology were stated as actions to be developed.

Course participants declared their interest in taking part of environmental education projects in their communities, acting as "multiplying agents." The group emphasized the importance of both information and technical visits: the former being instrumental as a tool for the required change, and the latter as a means of translating theory into actions. Training replication with communities' residents associations was recognized as a necessary and important action.

The construction of didactic material based in the project experience was one of its important outcomes. Didactic materials for the classes were produced, as well as 6 thematic booklets built with the participation of students, to be used by the municipal schools: 'Management of Watercourses Resources'; 'Importance of the Water'; 'Sanitation and Health'; 'Residues and Health'; 'Water Analysis and Healthy House'.

A Guide ('Everybody can understand what healthy water is') was produced for the community monitoring of the water quality. This material was amended with form cards so that the community could, by its own, verify and follow the river basin water quality.

- Other outcomes were:
- elaboration of Maps and drawings of Botas and Faria Timbó River Basins;
  - photographic and historical reports on the rivers basins;
  - report of the 2 river basins' quality of water, as well as the indication of its classification according to the Resolution of the *Environmental National Commission - CONAMA 357/2005*;
  - the organization of the groups 'Protectors and Friends of Faria Timbó River' and a 'Sub-Committee of Faria Timbó River / Channel of Cunha's hydrographic basins'.

The project qualitative evaluation demonstrated that the potential basis of an Integrated Environmental Management should start with environment awareness. It initiates with each single person in its "micro-habitat" where family health actually takes roots, contributing to the establishment of a healthy environment and citizenship strengthening through information and practice, in order to facilitate the implementation of policies, diffusion of concepts

and individual actions, as well as the responsibility for the habitat.

Clearly, the workshop process had an important positive effect. The next level of evaluation, however, would require follow-up to assess how many participants became real multiplying agents; what skills and knowledge did they use to what extent the booklets and the Community Guide were used; how many people did they reach; what actions did they engage in, or effectively promote; and ultimately, if an integrated environmental management model was consummated, benefiting quality of life.

### Methodology for evaluating networks of healthy municipalities: an experience towards building of public policies

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Social networks are important spaces for forming and developing social capital, for they allow connections among people (Milani, 2004); identifying common aims; promoting partnerships and creativity arising from a mutual recognition, cooperation and reciprocity; and increasing people's ability to comprehend and participate in public policy development. Networks allow the possibility to operationalize HP strategies aiming at the collaboration to build a healthier city.

The starting point for a social network, the communication among people (Capra et al., 1996) depends on established connections, and it becomes fundamental to define channels and spaces for transmission; exchange and multiplication of common aims; action methodologies for solving difficulties and success stories of people who live in certain territories, as well as publishing achieved results (Sperandio, Correa, Rangel, 2004). In Brazil, there are several networks with different objectives and methodologies, but data concerning their quantity and functioning are unknown. There is no information about social and political transformations which a network could provide within a specific territory.

One of the most recent social networks in Brazil is the Potentially Healthy Municipalities Network - RMPS (*Rede de Municípios Potencialmente Saudáveis*), a project based on knowledge exchange and practice arising from each participating locality, in respect to its characteristics and aims. Its mission is to collaborate to develop healthy public policies in a participatory, articulated way, through its different representatives. Municipality participation is dependent on

Table 2. School education level (%)

	Botas River Basin (Nova Iguaçu)	Faria Timbó River Basin (Manguinhos)
First degree	5.49	34.1
Secondary school	39.56	60.9
Third degree	54.9	4.8

the signature of a Commitment Statement by the mayor. The network has the technical support of the Pan-American Health Organization (PAHO/WHO), the Campinas State University – UNICAMP (Medical Science School/ Preventive and Social Medicine Department), and the Special Research for Society Institute (IPES: *Instituto de Pesquisas Especiais para a Sociedade*), and of 27 member Municipalities.

Created in 2003, with signatures covering a region of two million inhabitants, the RMPS has held 30 conferences and five seminars, written four publications recording collaborators' knowledge and actions of participating Municipalities, and provided exchanges with two international missions (Equator and Japan).

Its aims are: 1) to make feasible, enhance and monitor PAHO strategies for Healthy Municipalities, by means of building public policies, participation of all sectors, and creation of sustainable initiatives; 2) to support municipalities' administrations to develop a single, integrated governmental project; and 3) to support managers, technicians, academic personnel, organizations and society to build HP public policies and improve quality of life.

The strategy of creating knowledge-practice webs has been adopted by stakeholders, motivating inter-and trans-sectorial actions; strengthening transformative participation and search for autonomy of the different stakeholders; building practices which affirm local values and wishes of the participants; and publishing successful experiences of the municipalities within and outside the Network (Sperandio, 2004).

The Network's working methodology includes project monitoring, organizing committees in cities, identifying local network multiplication agents, establishing priorities and selecting themes. The feedback to municipalities has given rise to new reflections, project designs and public policy formulation.

The RMPS presents three characteristics:

1. A transversal approach, integrating specific issues from each locality into a common framework;
2. An activating *node* represented by the university, which holds and feeds the network, in order to take advantage of each municipality's potentialities and necessities, and to engage in common treatment of aggregated problems as well as solutions found in different municipalities, so that each experience supplies the others.
3. Absence of a hierarchical, formally organized structure, giving it a special and self-sustainable dynamic. The mayors' election and consequent replacement

between 2004/2005 was an interesting test to the network, which has become stronger, since most of the common proposals of the Network were incorporated within municipal administration and managers, in spite of political change.

The core dynamic of the *integrated participation management* is its flexibility. Without formal structure or commitments, plans develop with shared strategies in order to meet the needs of managers, technicians and societies within the municipalities which take part in the RMPS. In the process of developing diversity, it is the proposal of a *healthy municipality* as a common milestone that is encouraged.

In March, 2005 the event "*Building Healthy Sustainable Development*" was held with the attendance of mayors and coordinators. Such an event aimed at presenting the network principles and backing them up with knowledge concerning Brazilian successful experiences and HP strategies. Its targets were to stimulate reflection of how a guiding plan of potentially healthy municipalities could create spaces for public policies which meet the population needs. It also proposed to gather information to establish a schedule of events and activities, highlighting the following priorities:

1. **Environment** – solid waste and water quality;
2. **Popular Participation;**
3. **Safety** – prevention and health promotion approaches through intersectorial actions aimed at the root causes of the problems;
4. **Health** – "Family Health Program;"
5. **Income and Job generation.**

The existence of the RMPS generated the proposal to monitor changes within each municipality. The monitoring aims to understand how local dynamics work towards healthy public policies, and how to establish the social and managerial conditions which favor the creation and implementation of policies as milestones to healthy municipalities.

As a consequence of how RMPS has functioned, the monitoring and evaluation process opens a space for participation of the different stakeholders at two levels: within municipalities, where it is possible to identify and integrate activities which take place within the network through a matrix; and in the collective space of the network, where integration of the regional policies is examined, starting from a discussion on local successes and difficulties within the Network.

A matrix offers the possibility of monitoring the policies which emerge within municipalities, including the internal processes of local dynamics, as well as the

participatory integrated management system and over. Therefore, the dynamic of RMPS facilitates knowledge of new policy directions, and recognizes the management elements which allow for its generation and sustainability.

In order to characterize HP as the Network's main axis based in the integrated management methodology of public policies, criteria are needed for concepts such as intersectoriality, transversal perspective, integrality, partnership, which might be contemplated and developed by managers. Evaluation methods include procedures such as: analysis of interviews' and documents' content produced inside the Network, under a historical perspective; focus groups for qualitative evaluation; case studies, and outcomes' analysis. It foresees visits to municipalities randomly chosen, so researchers and coordinators might be able to observe public policies implemented through the Network experience.<sup>1</sup>

The construction of an Observatory involving people who live in different municipalities, and researchers from the University and NGOs, in order to monitor the Network's integrated public policies is proposed. This is due to the complexity of RMPS, which involves different realities, territories and people. The observatory should collect the production of each Municipality and would advance in its analysis, respecting dialogue practices, interactions, strategies and actions that search for the improvement of quality of life under the HP perspectives.

Considering that the project implementation is under development, there are not accurate final outcomes. Nevertheless, some intermediate results are:

- Definition of shared strategies among managers, technicians and societies within municipalities which take part in the RMPS;
- Definition of needs and priorities through the participation of mayors and coordinators to establish a schedule of events and activities;
- Construction by the potentially healthy municipalities of a guiding plan to generate public policies able to meet the population needs;
- Decision to monitor changes within each municipality, aiming at the understanding of local dynamic work towards the construction of healthy public policies;
- Definition of strategies to establish social and managerial conditions for the implementation of policies.

## Final considerations

Efficacy and effectiveness are concepts that are used to analyze HP interventions outcomes. Evidence of efficacy is an appropriate expression related to the experi-

mental sciences paradigm. Its adequacy, when applied to HP outcomes, is often questioned, considering the fact that the epistemological basis which supports HP is not the experimental sciences but the social and behavioral sciences. Parallel to this controversy is the understanding of the complexity of HP actions, which need to be monitored and evaluated. WHO recommends “adopting an approach with multiple actors, sceneries and management levels, and to use all quantitative and qualitative existent methodologies” (WHO, 1998; McQueen & Anderson, 2004, p 11).

Monitoring and multiple quantitative-qualitative evaluation methods in all phases of HP programs and projects, including analysis of “real life” conditions, are essential for transparency, adjustments and improvement of practices. They allow researchers to detect difficulties; review strategies, facilitate progress, and refine outcomes assessment and analysis.

The analysis concerning the effectiveness of local interventions under adverse macro structural conditions beyond individual control, in programs that search for social inclusion, citizens' rights, respect for deprived groups, shows the value of any progress related with his/her life itself, as a demonstration of effectiveness, considering the persistence of social environment difficulties, as was shown in the School for Parents Program.

The example concerning stakeholders empowering processes and the participatory integrated management highlights the significant role of continuous exchange of technical, scientific and popular knowledge, and points to strategies that strongly contribute to success, such as the creation of participatory educational tools based on local experience, and knowledge development. It also recommends the incorporation of HP practices and community commitment to the actions developed by the Family Health Program (PSF – Ministry of Health). Sustainability is a relevant condition to show intervention effectiveness.

The organization of Healthy Municipalities' networks favors the diversity and choice of collective planned strategies, as well as participants' commitment to meet the needs of stakeholders, and to create opportunities for the development of public policies related to population needs.

The evaluation of policy outcomes related to Health Promotion strategies has been a challenge for researchers and policy-makers, managers, professionals, and all those involved in this subject. Health promotion requires new evaluation methods and monitoring systems for continuously searching for effectiveness, knowledge development, and improved social conditions.

1. This program had the collaboration of Prof. Dr. Nelson Filice de Barros, Department of Preventive and Social Medicine, State University of Campinas (UNICAMP), São Paulo.

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## Theory and practice in the context of health promotion program evaluation

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**Abstract:** Evaluation of health promotion (HP) actions is a major challenge, generating inquiries and reflections that can contribute on the effectiveness of the actions themselves. With the aim on fostering exchange on monitoring and evaluation experiences related to the implementation of healthy settings, the 1st Brazilian Seminar on Health Promotion Effectiveness was launched in 2005. The program included round table and workshops known as Working Groups (WG) in Brazil. The criteria used to constitute the workshops focused settings as spaces of circulation and living as an intrinsic connection to lifestyles and conditions, as well as to social and/or environmental risk factors associated with groups living in these settings day after day. Focusing on evaluation as an activity that generates knowledge, this article highlights and stimulates the discussion about some major issues arising from the theoretical-methodological approach and the discussions developed in the workshops. The debates carried out during the Seminar illustrated the different perceptions and views of the social players involved in implementation and evaluation of HP practices, disclosing a multiplicity of meanings. It became clear that procedures are needed to document a future maturation of concepts and methods, in combination with further in-depth theoretical discussion. (*Promotion & Education*, 2007, Supplement (1): pp 27-30)

**Key words:** effectiveness, evaluation, health promotion, monitoring

Resumo em português na página 34. Résumé en français à la page 38. Resumen en español en la página 42.

Institutionalizing health promotion actions (HP) and their evaluation is a major challenge, generating inquiries and reflections that change the context of the actions themselves. These reflections generate a learning space that can establish new relations among people, knowledge and broader health practices (Pedrosa, J.I.S., 2004).

The program of the 1<sup>st</sup> Brazilian Seminar on Health Promotion Effectiveness included workshops, also known as Work Groups (WG) in Brazil, which aimed to foster an exchange of evaluation experiences related to the implementation of healthy settings.

In organizing the workshops, settings were viewed as spaces of circulation and living, with an intrinsic connection to lifestyles and conditions, as well as to social and/or environmental risk factors associated with groups living in these settings day after day. Workshop coordinators presented pre-chosen experiences to provide a conceptual and methodological framework for a particular setting. By exchanging experiences with other participants, they encouraged debates on the barriers and successes of different evaluation models and designs utilized.

Focusing on evaluation as an activity that generates knowledge, this article highlights and stimulates the discussion about some major issues arising from the theo-

retical-methodological approach and the discussions developed in the workshops. These discussions, grounded in the guiding concepts of the HP area in each setting, pointed to critical elements and perspectives experienced by participants from the diverse groups.

### Workshop 1: Health promotion in primary health care

Key health promotion features in Brazil related to Primary Health Care have included advocacy for egalitarian and universal principles underlying SUS (Brazil's Unified Health System), and a critique of the biomedical model. The dialogue between both HP and health care stakeholders has taken place at all levels of the health care system, leading to building a new health care model, starting from the restructuring of the primary health care (PHC).

The experiences and innovations in PHC and in the Family Health Program and the Community Health Agents Program (FHP/CHAP) are particularly important as they address social determinants in the health-disease process; and include strategies such as intersectorial actions, community participation, strengthening of population/health care links, empowerment, and the increase of community control. However, the effectiveness of community-based

HP programs and actions has been hardly explored, in spite of indications that point to successful experiences.

Under these conditions, the workshop proposed a debate on evidence and/or indicators of HP actions in order to evaluate whether the program works, or to provide input to change the primary health care and/or health care model. The experiences people reported underscored common problems involved in implementing public policies inspired by programs whose practices are often difficult to evaluate, which has threatened their sustainability. Such insufficiency in traditional evaluation and financing models becomes even more of a challenge, when applied to health care based in the perspective of HP. Researchers often lack adequate criteria and indicators connected with the HP paradigm. The group also placed great emphasis on the need to overcome "spontaneous" trends, like specific campaigns; and to overcome false dichotomies, such as health versus disease, quantitative versus qualitative approaches, or research versus provision of health services.

Specifically, with the latter false dichotomy, the participants proposed strengthening the alliances between researchers and health care professionals, who, notwithstanding the fact that they have disagreements related to their specific

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objectives, need to provide visibility to their initiatives as well. Visibility of the HP paradigm involves establishing fundamental legitimacy and sustainability to the actions. For this alliance, participants underlined the need to systematically share information, knowledge, and experiences; to stimulate virtual and supportive networks; as well as to promote mutual communication and learning flow between research and health services. In addition, they suggested the organization of other meetings to present and discuss successful “paradigmatic cases”, or even the unsuccessful ones.

Finally, the group addressed autonomy and self-evaluation, emphasizing the adaptation and development of better evaluation indicators. Another proposal involved the advocacy of professional credentialing, and the carrying out of workshops on assessment indicators and quality of data.

### Workshop 2: Environment and healthy housing

Habitat as the setting involves housing, dwellings, or other built structures within surrounding environments. This definition implies the need to articulate public policies on housing, health, environment and urban infrastructure, in order to confront the challenges of consolidating interventions that address the determinants of health in the built space. (Cohen, 2004)

A program designed to encourage the building of healthy habitats, joining both healthy housing initiatives (HH) and environmental primary care (EPC) (the basic care of ecosystem’s health, can be considered a tool for optimizing outcomes in a gradual process to improve people’s quality of life. These programs tend to be effective only through the elaboration of healthy public policies which require intersectoral and interdisciplinary actions, as well as new relationships to social institutions. This model is actualized by initiatives within specific territories, which are connected to institutions and accountability, and have a comprehensive view of the environment in which individuals and their families are living. It requires the translation of concepts, such as “integral health care” and “healthy housing,” into practices, as well as exchanges of technical-scientific and popular knowledge.

Sanchez (1997) states that the solution to environmental and sanitary problems rests in local management because citizens, in a direct way, or through the local government and/or organizations, are aware of their problems and needs. They can examine these needs in accordance with their technical, financial, political and institutional contexts, and can detect and find possible

solutions. Thus, social mobilization has been a great challenge to environmental projects, requiring a social approach imbued with criteria and indicators from Environment Primary Care (EPC), and Health Promotion, so that a higher level of participation, involvement and commitment from the players engaged in the project can be achieved.

In this workshop, the debate on governmental and non-governmental actions in Rio de Janeiro slums contributed to the systematic analysis of parameters and criteria of effectiveness, with regard to the environment and HP. In particular, the debate focused on parameters related to the following objectives: strengthening of individual /collective rights and public freedom; development of community capacity towards action; implementation of primary and preventive actions over elements of the social environment; intersectoral actions which integrate the different governmental agendas; and consolidation of participation as a tenet of this work.

Within Brazil, there are several types of human settlements and habitats with different levels of precarious health and housing conditions, which could be specifically discussed. These include: “cortiços” (poor houses like a “beehive”), precarious building lots in peripheral zones, and occupation under bridges, people living in the streets, and apartment blocks for the poor in a state of degradation, among others. Thus, the discussions carried out by the group did not exhaust the full parameters, indicators and criteria for HP effectiveness applied to human settlement typologies in all localities of the country. Nevertheless, it contributed to an initial systematization of such elements, especially in exchanging ideas and dialogue among several public sectors, such as health, health promotion, housing, urban development, and environment. The latter may be the greatest achievement of the WG 2 discussions.

### Workshop 3: Health Promoting Schools

The initiative Health Promoting Schools (HPS) (OPAS/ OMS, 1996) proposes a concept of school both as an efficient system for providing education and as a human community concerned with health for all its members: teachers, students, staff, and all the people involved in these relationships. The Health Promoting School is expressed as a joint commitment and capability of the school, health services, and community to provide adequate conditions for the development of students’ physical and intellectual potential, for HP attitudes and practices, and for building healthier settings.

This conception served as the ground

for debates in WG 3 which addressed the education role within the HP process. It was assumed by the group that the HP main objective does not lie just in health education, but in the overarching political-pedagogical approach, whose design ought to contain commitment to social change and the adoption of educational principles oriented to people’s (“subject”) emancipation, so that the development of critical and reflexive thought leads to citizens’ empowerment (FREIRE, 1996).

Social change, considered as a HP target for the improvement of health and living conditions, is achieved through concerted actions involving the whole society. The group debated this interdisciplinary and intersectoral character of the HPS process within the context of its potentialities and its challenges, i.e. the difficulties regarding intercommunication and linkages faced by both health and education sectors in the development of integrated actions. The group discussed the need to design strategies that might improve the relations between both sectors, and also among others, for the consolidation of proposals.

In addition, the debate included revisiting how HPS have been implemented, with strategies usually without prior knowledge of the actual needs and interests of stakeholders accountable for their operation; and embedded within infrastructural, financial and political conditions. The debate fostered the development of a minimal set of guidelines for evaluation: 1) evaluation should start from program inception, with clear formulation of objectives and diagnosis jointly undertaken by professionals and the community; 2) evaluation should contain a complexity of components and strategies to define indicators, incorporating dimensions concerning context, process, and outcomes; 3) introduction of “actions assessment,” considering the process and potential reformulations as the program is developed; and 4) creation of conditions to support different social actors’ involvement and participation in decisions as to what should be evaluated as well as in the assessment process itself.

The participants were animated by the discussion on the compatibility of objectives proposed by the HPS initiative with those feasible in their own realities. They suggested continuing to discuss and study this issue, including developing a frame of reference with guidelines that might foster the institutionalization of assessment in this field.

### Workshop 4: Healthy workplaces

Health Promotion in Workplaces (HPWP) or Healthy Enterprises (HE) requires taking into consideration the world of labor with its economic, socio-political

and cultural dimensions, as well as the level of organization and functioning of contemporary global capitalism, which critical effects can be seen in social fragility, expressed in feelings such as instability and distress, with repercussions in workers' biological and psychological integrity (Luz, 2004). The changes that have affected labor for the last 20 years, markedly the precariousness of work conditions, the informal workforce of labor relations and structural unemployment are reflected in the epidemiological profile of the country (Augusto, 2005)

The debates in WG 4 characterized the HPWP or HE approach as a field to be consolidated within the scope of the Worker Health Program in the Ministry of Health, which reveals the challenges related to linking HP with the Ministry of Labor. Taking as a reference the national informal workforce average, (60% of total workers) (IBGE, 2004); and considering that informal employment is generally found in small and micro businesses (98% of total enterprises in the country) (Pastore, 2005), the participants stressed the need to build strategic actions targeting effective initiatives addressing better health conditions and quality of life for this significant portion of unprotected workers living on reduced benefits. Under-scored strategies included building social networks capable of integrating small businesses, with particular emphasis on the so called "S System" (Social Service of Industry - National Industrial Training Service - SSI/SENAI; Social Service of Commerce - National Service for Commercial Training - SSC/SENAC), which has large coverage and infiltration into multiple settings.

As far as the formal work sector is concerned, the interest and development of HP and quality of life initiatives have been increasing and surpassing the legal requirements related to safety and health in the workplace. The group considered, however, the need to broaden individualistic intervention approaches, dealing with behavioral and lifestyle changes, in order to combine these activities with those involving work conditions and organizational designs.

This approach requires that existing barriers to the democratization of labor relations be overcome, through the redesign of policy management. Worker participation should be facilitated in the design of programs, and in the reflection on what should be evaluated, joining together the different segments and sectors of businesses (Breucker e Schöer, 1999).

To redesign policy management, what is needed is a diagnosis of each business enterprise, and a labor force profile. Both aspects contribute to the role of policies and programs to address diversified, complex and changeable problems and needs

of the labor force in each setting, considering the multiple relations involving living contexts, health and work.

In order to overcome traditional productivity- and competitiveness-related categories for defining indicators, WG 4 discussed new combinations of factors, such as motivation and worker satisfaction in the job; labor relations; policies oriented to professional valuation; new ethical-political dimensions, which take into consideration the worker's subjectivity; and values like solidarity and common well-being in labor relations.

### Workshop 5: Healthy Cities and Communities

Evaluation of healthy cities is a recent issue within the current debates on the assessment of HP actions and strategies (WHO 1998, WHO 2001, Akerman et al. 2002). This evaluation perspective requires a reflection on meanings and definitions. After all, what does a healthy municipality mean? How can such a complex field, with multiple determinants, be evaluated? Assuming these questions as a starting point, WG 5 participants debated theoretical and methodological assumptions that guide the "healthy cities and communities movement" (HC & C), in particular its fundamental pillars or strategies included the five actions fields of Health Promotion.

As a special challenge, "healthy cities" broadens the discussion of evaluation capacity related to ongoing processes, and discussions on their effectiveness. The group debated the pertinence of searching for an identity in the existing HP evaluation methodologies, in order to compare available data and information, and consolidate the knowledge produced by different experiences in both national and international arenas.

Developing evaluation skills must be considered a core objective of the healthy community and municipality movements, processes and networks. The focus must be pedagogical, placing greater interest in the development of a local evaluation culture that involves "promoters and beneficiary populations" in a permanent and systematic learning exercise. It pre-supposes the adoption of a participatory methodology which is necessarily a formative process; the combination of quantitative and qualitative indicators; and the use of multiple methods. This combination is capable of establishing new analytic categories, addressing integrated and articulated processes of local action, all of which are multidimensional and complex from a theoretical-methodological formulation.

The interdisciplinary approach, considered to be one of the core pillars of HC & M

initiatives, must be present in the evaluation, so that new understandings of what tenets guide the movement, (with its emphasis on health and urbanism) can be discussed. Moreover, different disciplines generating new approaches and analytic categories capable of comprehending the integral lived process should also be considered. It is important to consider evaluation from the very inception of the intervention, adding concepts of sustainability and future to analyze outcomes. The evaluation process is a crucial strategy of the intervention itself, as it fosters empowerment through production of knowledge about local actions, strengthening stakeholders, and contributing to broad understandings of the integrated actions.

As for evaluation guidebooks and tools (i.e., OPAS/ OMS, 1999), the group examined the risks of promoting a certain "ontologization" of tools, providing them with their own power, when it is the action about social reality that is the core element of both the intervention and its evaluation. The collective construction of "issues for debate" among stakeholders is a core premise, since diverse views and perspectives about social reality change depending on the place they live in, and the degree of government capacity and identified demands of the local area, whether a community or city. Evaluative questions have strategic value, once the starting points and issues to be investigated, systematized, monitored, and evaluated are shared by all.

### Conclusion

The debates carried out during the Seminar illustrated the different perceptions and views of the social players involved in implementation and evaluation of HP practices, disclosing a multiplicity of meanings. It became clear that procedures are needed to document a future maturation of concepts and methods, in combination with a more in-depth theoretical discussion. Nevertheless, stimulated by the theoretical-practical challenges presented through the initiatives in different settings, the participants proposed a continuous exchange of experiences. This article, therefore, is the first fruit of the collective construction of the workshop participants as well as an invitation to new reflections and encounters for discussing the theme of health promotion evaluation.

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## Saúde, desenvolvimento e equidade

Marcia Faria Westphal<sup>1,2</sup> e Nina Wallerstein<sup>1,3</sup>

Estamos no sétimo ano do século XXI, vivenciando os resultados e as consequências da globalização, isto é, o contínuo processo de crescimento da riqueza mundial, a exclusão social gerada no contexto da economia de mercado e a nova dinâmica social e do trabalho que marca esta nova fase do capitalismo.

Seja qual for o ângulo pelo qual se examinem as situações características do período atual, a dinâmica da realidade e seu "ethos" orientador podem ser vistos como responsáveis por um paradoxo expresso por crescimento econômico sem precedentes e grandes disparidades e desigualdades sociais e de condições de saúde.

O Brasil, um país de proporções continentais, compartilha deste paradoxo acrescido de outras questões específicas de sua dinâmica de país em desenvolvimento e dependente. É um país com grande riqueza natural e um grande potencial energético e de matéria prima, que não tem sido corretamente explorado e aproveitado. Poucos segmentos da população foram incorporados à economia global e grande proporção está marginalizada do processo de desenvolvimento e mais especificamente da distribuição da riqueza. No seu território, permanecem grandes ilhas de privações, destituição e opressão distribuídas desigualmente, na direção inversa das condições econômicas e sociais das famílias, em função do modelo de desenvolvimento economicista que há muitos anos vem sendo adotado, acrescido recentemente de elementos neoliberais.

Os esforços governamentais, voltados para o econômico e não para as necessidades humanas, tem resultado em um empobrecimento crescente, acompanhado da incapacidade da esmagadora maioria da população de participar de forma equitativa da produção, gestão e consumo de bens e serviços materiais e culturais. O Produto Interno Bruto (PIB) do Brasil, embora não seja baixo em comparação com a maioria dos países do mundo, não apresenta a mesma velocidade de crescimento que o da China e outros países da América Latina como o Chile e a Argentina. Também esse macro-indicador da riqueza da sociedade

brasileira, não apresenta uma correlação direta e constante com os indicadores de saúde e as condições de vida das populações.

Conforme dados de estudos realizados sobre a situação do Brasil, este não é um país pobre, mas um país injusto e desigual. A comparação da renda per capita do Brasil com a de outros países, o coloca entre o terço mais rico dos países do mundo. No entanto, a média de famílias que vivem no Brasil com até meio salário mínimo (um dos indicadores de pobreza, ou seja, em torno de 75 dólares per capita mês para o atendimento de suas necessidades básicas), é muito maior do que a dos países com renda similar à brasileira. A população pobre do Brasil representa 30% da população total; no entanto em outros países do continente, como Chile e Argentina, os pobres representam no máximo 10% da população. Esses dados demonstram que a origem da pobreza do Brasil está na má distribuição dos recursos existentes. A renda média dos 10% mais ricos do país é 28 vezes maior do que a renda média dos 40% mais pobres. Nos Estados Unidos a proporção é de 5 vezes, na Argentina 10 vezes e na Colômbia, 15 vezes.

A distribuição da pobreza é também desigual entre regiões do país, a exemplo da distribuição das famílias que vivem com até meio salário mínimo, segundo dados da pesquisa nacional por amostra de domicílios (PNAD) de 2002. Em muitos municípios da região norte o percentual de crianças e adolescentes pobres é superior a 90%. Na região nordeste, particularmente no semi-árido 75% das crianças e adolescentes vivem em situação de pobreza. Enquanto na região Sul, mais especificamente no Rio Grande do Sul há municípios com menos de 2% de crianças e adolescentes pobres. Neste contexto a distribuição é ainda mais desigual considerando a crianças negras pobres. (IBGE, 2000)

A expressão das iniquidades no Brasil se revela também em outros indicadores: persistência da pobreza, concentração da renda, baixa mobilidade social, alto nível de desemprego e subemprego, uma evasão escolar bastante significativa, prevalência

muito alta de analfabetismo na idade adulta e outras necessidades essenciais não satisfeitas tais como fome crônica disseminada, violação de liberdades políticas elementares, ameaças cada vez mais graves ao meio ambiente e a sustentabilidade de nossa vida econômica e social. (IBGE PNAD 2004; FIPE/TEM 2003; Haddad & Graciano, 2003.)

Em relação à saúde, vemos que não existe correlação direta entre os níveis de saúde e o acesso a serviços de saúde, embora seja muito importante a ação dos profissionais comprometidos com um modelo de atenção correspondente a um conceito de saúde ampliado que procura também influir nos determinantes sociais, econômicos, políticos e culturais. Hoje aproximadamente 70% da população é dependente do Sistema Único de Saúde (SUS) que tem como princípios a integralidade e universalidade da atenção à população.

O SUS tem um grande desafio pela frente - dar conta de doenças de países desenvolvidos e, também, de doenças infecciosas que ainda assolam o país especialmente a população do norte e nordeste. As seis principais causas de morte no país são: doenças do aparelho circulatório (31,8%), neoplasias (15,7%), causas externas (14,2%), doenças do aparelho respiratório (11,4%), doenças infecciosas e parasitárias (5,1%) e doenças originadas no período pré-natal (3,5%). Outras causas responderam por 18,3% do total de óbitos a cada ano. (PNAD - IBGE, 2003)

A redução da mortalidade infantil (33/000 em 2004) e das mortes violentas (14,2%) são grandes desafios, cujo enfrentamento depende não somente de consultas médicas ou de medidas preventivas, mas também de ações sobre os determinantes sociais, econômicos, políticos e educacionais da manutenção da vida das crianças que nascem neste país. A desnutrição, com uma distribuição desigual por idade, condição de escolaridade, condição socioeconômica e por região, continua sendo um obstáculo sério a saúde e ao desenvolvimento do capital humano. O uso de drogas e a AIDS se associam a esses problemas que em conjunto vem se tornando

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o maior desafio à manutenção da vida e da qualidade de vida das populações (Marmot & Wilkinson, 2003).

As desigualdades e as iniquidades no acesso a serviços básicos essenciais, que impactam a qualidade de vida e saúde da população e têm efeitos sobre as condições ambientais, são, segundo Whitehead (2000), injustas, sistemáticas e relevantes. Porém são também evitáveis e desnecessárias. O SUS, aliado às estratégias de Promoção da Saúde, têm potencial para transformar estas iniquidades, uma vez que pressupõe ações sobre os determinantes sociais da Saúde.

Neste número especial, considerando as desigualdades que caracterizam a realidade brasileira, nos desafiamos a pensar sobre o quanto as ações de saúde, delineadas dentro do contexto do SUS, na perspectiva da Promoção da Saúde, tem sido capazes de transformar as desigualdades em “*desigualdades justas*”, isto é em equidade. Equidade social, entre grupos e indivíduos, são definidas por Whitehead (2000) como iniquidades preveníveis, injustas e desnecessárias, as quais ressaltam a dimensão ética e moral do conceito. Para caminhar na direção da equidade, o sistema necessita dar mais para os que tem menos, não para exterminar as desigualdades, mas para possibilitar à maioria da população a oportunidade de ter uma vida digna.

A temática da avaliação e do monitoramento da efetividade de políticas de promoção da saúde tem gerado um crescente interesse entre formuladores, gestores, profissionais e demais atores envolvidos na implementação de ações, particularmente aquelas voltadas para os determinantes sociais em saúde.

Metodologias de avaliação em promoção da saúde vêm se tornando indispensáveis para o sucesso das intervenções, na análise de processos locais e contextos para a formulação e implementação de políticas, fundamental na articulação entre teoria e prática, concorrendo para a produção de conhecimento no campo da Promoção da Saúde.

No Brasil, a Promoção da Saúde tem buscado consolidar-se através de uma visão interdisciplinar, que prioriza a cooperação multisectorial e o diálogo democrático e participativo com a diversidade de atores e sujeitos envolvidos nas múltiplas ações de mudança social. Ultrapassando os marcos do setor saúde, volta-se para novos desenhos e propostas de promoção da qualidade de vida, valorizando a capacidade inerente aos agentes sociais de refletirem criticamente sobre o contexto e os determinantes econômicos, sociais, culturais e ambientais em saúde.

Programas inovadores são desenvolvidos nos mais diversos contextos e espaços. Resultados esperados freqüentemente giram em torno do aprendizado, autonomia e ‘empoderamento’ dos sujeitos envolvidos, das novas formas de ‘governança’ e melhoria na capacidade organizativa das comunidades, como também na modernização e humanização de serviços públicos. Por outro lado, mudanças sociais mais sustentáveis pressupõem estratégias abrangentes, envolvendo ações intersetoriais, de mobilização e participação comunitária, desafiando os referenciais tradicionalmente utilizados no campo da avaliação em saúde.

O I Seminário Brasileiro de Efetividade da Promoção da Saúde(,) revelou e atualizou o debate sobre o papel deste campo de saberes e práticas para a melhoria do sistema de saúde e da qualidade de vida no país. O evento intensificou a parceria entre as instituições e grupos de trabalho nacionais e internacionais, contribuindo para pautar o tema da Promoção da Saúde no Ministério da Saúde que, em novembro de 2006, institucionalizou a Política Nacional de Promoção da Saúde e formou um Conselho Gestor para sua implementação.

Os artigos aqui apresentados revelam a pertinência e relevância da continuidade do debate sobre a Promoção da Saúde em contextos marcados por crescentes desigualdades nas condições e oportunidades de vida, o que faz da ‘equidade’ o grande desafio para mudanças mais efetivas na produção da saúde nos níveis nacional e global.

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### Promoção da saúde no Brasil

A. Ivo de Carvalho, M. F. Westphal e V. L. G. Pereira Lima, p. 7

O Brasil, país da América Latina de dimensões continentais, pleno de contrastes, desigualdades demográficas e iniquidades sociais, enfrenta, concomitantemente, o desafio de prevenir, controlar as doenças infecciosas, os agravos e as doenças não transmissíveis. O esgotamento do paradigma biomédico, a mudança do perfil epidemiológico e os desafios sociopolíticos e culturais das últimas décadas têm ensejado o aparecimento de novas formulações sobre o pensar e o fazer sanitários. Entre estas merecem relevância os paradigmas da Saúde Coletiva no Brasil e a Promoção da Saúde, sendo o primeiro aquele que dá sustentação filosófica ao Sistema Único de Saúde (SUS). O objetivo deste artigo foi o de retomar os aspectos da história do país, focalizando nesta o desenvolvimento da Saúde Pública. Foram analisados os pressupostos teóricos da Promoção da Saúde e comparados com os da Saúde Coletiva. Concluímos que a Promoção da Saúde, baseada nos princípios e valores disseminados pelas Cartas Internacionais e preocupada com os sujeitos e a determinação social do processo saúde-doença, tem importante potencial para promover a melhoria nas condições de vida e saúde da população. Este referencial orientou a formulação da Política Nacional na sua recente inserção no Sistema Único de Saúde, institucionalizada através de portaria ministerial. A importância da avaliação da efetividade da Promoção de Saúde no Brasil e os processos e metodologias que têm sido utilizadas para sua implementação têm se orientado por vários referenciais, que clarificamos neste artigo ao descrever o processo histórico vivido.

### Avaliação da efetividade em promoção da saúde: um debate político e/ou um exercício técnico?

M. Akerman et al., p. 13

Este artigo apresenta pontos de vista de profissionais de diferentes nacionalidades, que trabalham em tipos diferentes de organizações, relacionadas com concepções e atividades em avaliação da efetividade da promoção da saúde. Quatro perguntas, sobre como os profissionais percebem avaliação no campo da promoção da saúde, serviram para iniciar o diálogo:

(1) “o que fez você se envolver com avaliação?”; (2) “demonstrar a efetividade de algum projeto ou programa de promoção da saúde garante a sua implementação?”; (3) “há outros aspectos que podem influenciar a tomada de decisão, não necessariamente relacionados com a efetividade dos programas a serem implementados?”, “como fazer para que estes aspectos, também sejam levados em conta na implementação de práticas em promoção da saúde?” (4) “o que vocês esperam do esforço global de avaliação da efetividade em promoção da saúde?”. Cinco aspectos da avaliação em promoção da saúde permearam o

debate. Um diálogo de, apenas, 90 minutos, entre um número restrito de pessoas, com um viés nitidamente brasileiro, parece ser insuficiente para produzir evidências sobre qual caráter predomina em iniciativas internacionais de avaliação da efetividade. Entretanto, este debate abre perspectivas sobre de que maneira os cinco aspectos de avaliação levantados - “pra quê”, “com quem” e “por quê” “como” e “quanto” como vinculadas a um viés político ou técnico, poderiam ser harmonizadas, conjuntamente, em qualquer processo de avaliação da efetividade da promoção da saúde.

### Complexidade da discussão sobre evidências e efetividade das intervenções em promoção da saúde

R. Bodstein, p. 16

O artigo discute uma perspectiva avaliativa que parte da compreensão dos elementos constitutivos dos programas e da característica multi-estratégica das ações de promoção em saúde (PS). As práticas de PS constituem um desafio aos enfoques avaliativos mais tradicionais (Rootman et al., 2001; Potvin, 2006; Barnes et al., 2003), quando redefine ações e propõe empoderamento, participação comunitária e desenvolvimento local, educação em saúde e ações intersetoriais, voltadas para as desigualdades tanto no nível individual, como no organizacional e no plano das políticas públicas (Kickbush, 1994). Esse desafio se coloca igualmente na discussão sobre a efetividade no campo da PS, na medida em que o que está em jogo é o conhecimento sobre como ações de promoção da saúde geram mudanças e resultados. Pretende-se, resumidamente, discutir essa perspectiva, apontando sua utilidade para o debate sobre efetividade e evidências da PS no Brasil.

## Análise de resultados de práticas de promoção da saúde

V. L. G. Pereira Lima et al., p. 21

O foco deste artigo são os resultados das práticas de Promoção da Saúde evidenciados por meio de avaliação, identificando-se estratégias que contribuem para resultados exitosos e sustentáveis. Foram discutidos projetos e pesquisa desenvolvidos em cenários e âmbitos distintos: (i) institucional governamental; (ii) comunitário no Complexo de Manguinhos e Município de Nova Iguaçu; e (iii) construção de Rede de Municípios Potencialmente Saudáveis.

A discussão sobre a Efetividade de programa social na perspectiva da promoção da saúde teve como referência o Programa “Escola de Pais” da 1ª Vara da Infância e Juventude do Rio de Janeiro, entre os anos de 2001 e 2004. Baseou-se no monitoramento de 48 pais ou responsáveis por crianças e adolescentes vítimas de abandono, violência ou negligência, em geral excluídas socialmente. Objetivou a análise da evidência da efetividade do programa de promoção da saúde, discussão conceitual sobre efetividade, e a identificação de estratégias para a sustentabilidade de resultados exitosos. Os recursos metodológicos empregados contaram com equipe multiprofissional, enfoque multidisciplinar, oficinas participativas, acompanhamento profissional das famílias, parcerias com instituições públicas e privadas, e recursos do apadrinhamento das famílias pela sociedade civil. A avaliação baseou-se na definição de indicadores de impacto social, e de determinantes psicossociais e contextuais. Utilizou o monitoramento do programa e empregou métodos quanti-qualitativos, em acompanhamento longitudinal por 3 anos, incluindo um ano após o término do programa. Observaram-se, nas sucessivas avaliações, mudanças significativas quanto à “integração familiar”, “qualidade das relações familiares”, e “exercício dos direitos de cidadania”. A resposta menos favorável - o “acesso ao emprego formal”, relaciona-se a fatores macroestruturais adversos e à necessidade de implementação de políticas públicas saudáveis nas áreas da educação, capacitação profissional, acesso à moradia, acesso ao emprego formal..

O processo de capacitação de atores sociais na gestão ambiental e habitação, apoiado pelo Projeto de Desenvolvimento Tecnológico em Saúde Pública da Fundação Oswaldo Cruz, utilizou como principais ferramentas a educação ambiental e habitação saudável, objetivando a construção de modelo de gestão ambiental integrada e participativa. A metodologia abrangeu capacitação, investigação e avaliação, envolvendo 160 pessoas entre 21 e 50 anos, que participaram da construção de Cartilhas Temáticas e Guias Comunitários de Monitoramento da Qualidade da Água. Na avaliação dos participantes os aspectos mais relevantes foram: o processo de capacitação que os qualificou como multiplicadores em educação ambiental comunitários e o aprendizado sobre articulação entre setores para a resolução dos problemas.

A Rede de Municípios Potencialmente Saudáveis visa o entrelaçamento de saberes e práticas originadas de cada localidade participante, respeitando características próprias e anseios. Sua missão é colaborar na construção das políticas públicas saudáveis de forma participativa e articulada por meio dos diferentes representantes municipais. Desenvolvido pelo Departamento de Medicina Preventiva e Social (Universidade Estadual de Campinas), com o apoio da Organização Pan-Americana de Saúde (OPAS/OMS) e do Instituto de Pesquisas Especiais para a Sociedade (IPES), objetiva instrumentalizar a administração municipal para o desenvolvimento de plano de governo único e integrado, subsidiando gestores, técnicos, acadêmicos, organizações e sociedade para a construção de políticas públicas em que promoção da saúde e qualidade de vida constituam o eixo principal. A metodologia baseia-se na construção de teias de saberes e práticas pelos atores sociais, incentivando ações trans-setoriais e intermunicipais. A avaliação dos resultados se faz mediante estudo de caso, grupos focais, relatos orais e análise de documentos e imagens.

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## Teoria e prática no contexto da avaliação de programas de promoção da saúde

M. F. Lobato Tavares et al., p. 27

Para o avanço das ações de promoção da saúde (PS), um importante desafio que se coloca são os questionamentos e reflexões a cerca da efetividade destas. Com tal objetivo foi realizado no Rio de Janeiro em 2005, o I Seminário de Efetividade em Promoção da Saúde que promoveu um intercâmbio de experiências quanto ao monitoramento e avaliação relacionadas à implementação de ambientes saudáveis. A programação deste evento possibilitou a participação em mesas-redondas e Grupos de Trabalho (GT). O critério utilizado para a constituição destes GTs foi o de focar os cenários da Promoção da Saúde como espaços de circulação e de vivências intrinsecamente vinculados com os estilos de vida e condições sociais, assim como aos fatores sociais e/ou ambientais de risco relacionado aos grupos que ali vivem.

Tendo o enfoque na avaliação como uma atividade geradora de conhecimento em Promoção da Saúde, o artigo em questão joga o foco de luz e procura estimular a discussão sobre a abordagem teórico-metodológica que emergiu fruto das discussões nos GTs. Tal debate ilustrou a gama de percepções dos diferentes atores sociais envolvidos na implementação e avaliação das práticas de PS, revelando sua multiplicidade de significados. Torna-se, então, evidente a necessidade de procedimentos que documentem e consolidem conceitos e métodos relacionados ao aprofundamento das discussões sobre efetividade em Promoção da Saúde.

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## Santé, développement et équité

Marcia Westphal<sup>1,2</sup> et Nina Wallerstein<sup>1,3</sup>

Nous voici dans la septième année du vingt-et-unième siècle, témoins des résultats et conséquences de la mondialisation, à savoir la croissance continue des richesses mondiales, l'exclusion sociale générée au sein des économies de marché, et de nouvelles dynamiques de travail et de société qui marquent cette nouvelle phase du capitalisme.

Quelle que soit la perspective que l'on ait, on voit bien que la dynamique de la réalité et les ethos qui la guident sont responsables du paradoxe d'une croissance économique sans précédents côtoyant des disparités et des inégalités sociales et sanitaires majeures.

Le Brésil est un pays aux dimensions d'un continent qui partage ce même paradoxe parallèlement à une autre dynamique : celle d'un pays dépendant en voie de développement. Ce pays possède une grande richesse naturelle, ainsi qu'un énorme potentiel en termes d'énergie et de matières premières qui n'ont pas encore été proprement exploitées et utilisées. Peu de segments de la population ont pris part à l'économie mondiale et une large proportion reste en marge du processus de développement et, de façon plus spécifique, de la distribution de ses richesses. Sur son territoire, de larges zones subsistent où les manques, le dénuement et l'oppression sont répartis de façon inégale, en raison du modèle de développement économique – et non distributif – pratiqué de longue date et récemment imprégné de néo-libéralisme.

Les efforts gouvernementaux dirigés vers les aspects économiques, plutôt que vers les besoins humains, ont produit un accroissement de la pauvreté qui s'est accompagné de l'incapacité de la majorité écrasante de la population à participer équitablement à la production, la gestion, et la consommation des biens et services matériels et culturels. Bien qu'il ne soit pas faible comparativement à la plupart des pays du monde, le produit intérieur brut (PIB) du Brésil ne présente pas le même rythme de croissance que celui de la Chine ou d'autres pays d'Amérique latine, comme le Chili et l'Argentine. Cet indicateur de la

croissance du Brésil n'indique pas non plus de corrélation directe et significative avec les indicateurs de santé et les conditions de vie de la population.

D'après les résultats d'études menées au Brésil, il ne s'agit pas d'un pays pauvre, mais d'un pays inégal et inéquitable. La comparaison de son revenu per capita avec celui d'autres pays place le Brésil parmi les tiers des pays les plus riches du monde. Cependant, le pourcentage de familles brésiliennes vivant avec moins de la moitié du salaire mensuel minimum (l'un des indicateurs de la pauvreté, soit environ 75 dollars par personne, par mois, pour répondre aux besoins élémentaires) est bien plus élevé que dans les pays au revenu similaire. La population pauvre du Brésil représente 30 % de la population totale ; alors qu'au Chili et en Argentine, les pauvres représentent tout au plus 10 %. Ces chiffres indiquent que la pauvreté au Brésil résulte de la mauvaise distribution des ressources existantes. Le revenu moyen des 10 % les plus riches du pays est 28 fois plus élevé que le revenu moyen des 40 % les plus pauvres. Aux États-Unis, cette proportion est de cinq fois ; en Argentine, de 10 fois ; et en Colombie, de 15 fois.

La distribution de la pauvreté est tout aussi inégale entre les diverses régions du pays, comme l'est la distribution des familles vivant avec moins de la moitié du salaire mensuel minimum ; c'est ce qu'indiquent les chiffres de l'enquête nationale de 2002 auprès des ménages (PNAD). Dans de nombreuses municipalités du nord, le pourcentage des enfants et des adolescents en situation de pauvreté dépasse les 90 %. Dans la région au nord-est, en particulier dans la zone semi-aride, 75 % des enfants et des adolescents vivent dans la pauvreté. Dans le même temps, au sud, et plus particulièrement dans la région du Rio Grande do Sul, certaines municipalités n'ont que 2 % d'enfants et d'adolescents pauvres. Dans ce contexte, la répartition des biens et des richesses est encore plus inégale en ce qui concerne les enfants noirs en situation de pauvreté. (IBGE, PNAD, 2002)

Les inégalités au Brésil sont également révélées par d'autres indicateurs : la per-

sistance de la pauvreté ; la concentration des biens et des ressources ; la faible mobilité sociale ; le niveau élevé de chômage et de sous-emploi ; le taux très significatif d'abandon scolaire ; la prévalence très élevée d'analphabétisme chez l'adulte ; et d'autres manques par rapport aux besoins vitaux comme la faim chronique largement répandue ; la violation des libertés politiques élémentaires ; et des menaces de plus en plus sérieuses qui pèsent sur l'environnement et la durabilité de la vie économique et sociale. (IBGE PNAD 2004 ; FIPE/MTE 2003 ; Haddad & Graciano, 2003.)

En ce qui concerne la santé, on observe qu'il n'y a pas de corrélation directe entre l'état de santé et l'accès aux services de santé, bien que l'action des professionnels, engagés pour un modèle de soins qui intègre les déterminants sociaux, économiques, politiques et culturels, soit très importante. Aujourd'hui, environ 70 % de la population dépend du Système de Santé Unifié (SUS), dont les principes sont la globalité et l'universalité des soins de santé pour la population.

Le SUS a un défi majeur à relever – lutter contre les maladies des pays développés ainsi que contre les maladies infectieuses qui continuent à affecter le pays, en particulier la population des régions nord et nord-est. Les six principales causes de décès dans le pays sont les suivantes : maladies du système circulatoire (31,8 %), néoplasme (15,7 %), causes externes (14,2 %), maladies du système respiratoire (11,4 %), maladies infectieuses et parasitaires (5,1 %), et maladies contractées dans la période périnatale (3,5 %). Les autres causes comptent pour 18,3 % du nombre total de décès chaque année. (PNAD – IBGE, 2003)

Réduire la mortalité infantile (33‰ en 2004) et les morts violentes (14,2 %) constitue un défi majeur ; lutter contre elles ne dépend pas seulement de consultations médicales ou de mesures préventives, mais aussi d'actions engageant les déterminants sociaux, économiques, politiques, et éducatifs pour maintenir la vie des enfants nés dans ce pays. La malnutrition, qui est inéga-

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lement répartie selon l'âge, le niveau d'études, les conditions socio-économiques, et les régions, reste un sérieux obstacle à la santé et au développement du capital humain. L'usage de drogue et le SIDA s'ajoutent à ces problèmes qui, mis ensemble, sont devenus le plus grand défi au maintien de la vie et de la qualité de vie des populations (Marmot & Wilkinson, 2003).

Les inégalités d'accès aux services essentiels, qui ont un impact sur la qualité de vie et de santé de la population et affectent les conditions environnementales sont, au dire de Whitehead (2000) injustes, systématiques et forcément importantes. Elles sont par ailleurs évitables et parfaitement inutiles. Le SUS, combiné à des stratégies de promotion de la santé, a le potentiel de transformer ces inégalités et injustices, puisqu'il présuppose des actions sur les déterminants sociaux de la santé.

Dans ce numéro spécial, nous examinons dans quelle mesure, compte tenu des inégalités qui caractérisent la réalité brésilienne, les actions de santé menées au sein du contexte du SUS, et intégrées dans une perspective de promotion de la santé, ont pu transformer les inégalités en « *inégalités justes*, » c'est-à-dire en équité. Les justifications sociales, entre groupes et individus, sont définies par Whitehead (2000) comme des inégalités évitables, injustes et inutiles, ce qui éclaire la dimension éthique et morale du concept. Pour agir dans le sens de l'équité, le système doit donner plus à ceux qui ont moins, non pour mettre un terme aux inégalités en elles-mêmes, mais pour donner à la plupart des gens la chance de vivre dignement.

La question de l'évaluation et du contrôle de l'efficacité des politiques promotrices de santé a suscité un intérêt croissant chez les concepteurs de politiques, les gestionnaires, les professionnels, et d'autres acteurs impliqués dans la mise en œuvre des interventions en promotion de la santé, en particulier celles qui visent les déterminants sociaux de la santé.

Les méthodes d'évaluation en promotion de la santé sont devenues indispensables au succès des interventions, en analysant les processus et les contextes locaux pour l'élaboration et la mise en œuvre de politiques, pour lier la théorie et la pratique, et pour contribuer à l'accroissement des connaissances, des savoirs et des savoir faire dans le domaine de la promotion de la santé.

Au Brésil, la promotion de la santé a cherché à s'établir dans une perspective interdisciplinaire, accordant la priorité à la collaboration multisectorielle et au dialogue démocratique et participatif avec les différentes parties prenantes impliquées dans les actions multiples du changement social.

Transcendant les limites du secteur de la santé, elle se tourne vers de nouvelles conceptions et propositions pour promouvoir la qualité de vie, en valorisant la capacité inhérente aux agents sociaux de réfléchir de façon critique au contexte, ainsi qu'aux déterminants économiques, sociaux, culturels, et environnementaux de la santé.

Des programmes novateurs sont développés en divers contextes et endroits. Les résultats escomptés tournent souvent autour de l'apprentissage, de l'autonomie, et de l'*empowerment* des individus impliqués ; autour de nouvelles formes de 'gouvernance' et de l'amélioration des capacités des communautés pour s'organiser ; autour enfin de la modernisation et de l'humanisation des services publics. D'un autre côté, des changements sociaux durables présupposent des stratégies globales impliquant des actions intersectorielles de mobilisation et de participation communautaire, mettant au défi les cadres de référence traditionnellement utilisés dans le domaine de l'évaluation en santé.

Le premier Séminaire brésilien sur l'Effacité de la Promotion de la Santé a révélé et mis à jour le débat sur le rôle de ce champ de connaissances et de ses pratiques dans l'amélioration du système de santé et de la qualité de vie dans le pays. Cet événement a intensifié le partenariat entre institutions et groupes de travail nationaux et internationaux, et a contribué à inscrire la promotion de la santé à l'ordre du jour du Ministère de la Santé. En novembre 2006, celui-ci a institutionnalisé la Politique nationale de Promotion de la Santé, et formé un Conseil de Gestion pour sa mise en œuvre.

Les articles présentés ici révèlent l'importance de poursuivre le débat sur la promotion de la santé dans des contextes marqués par les inégalités croissantes dans les conditions de vie et les opportunités des personnes et des groupes sociaux, ce qui fait de l'équité l'objectif majeur à atteindre pour un changement efficace dans la production de la santé à l'échelle nationale et mondiale.

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### La promotion de la santé au Brésil

A. I. de Carvalho, M. F. Westphal et V. L. G. Pereira Lima, p. 7

Le Brésil, un pays latino-américain aux dimensions à l'échelle d'un continent, pétri de contrastes, d'inégalités démographiques et d'injustice sociale, est en même temps confronté à la nécessité de prévenir et de lutter contre les maladies infectieuses, les accidents et traumatismes, et les maladies chroniques. L'affaiblissement du paradigme biomédical, le changement du profil épidémiologique, ainsi que les difficultés sociopolitiques et culturelles de ces dernières décennies ont alimenté l'émergence de nouveaux discours sur les concepts et les pratiques de santé publique. Parmi eux, figurent les paradigmes de la Santé collective et de la Promotion de la Santé du Brésil. Le premier apporte un cadre philosophique au Système Unique de Santé (SUS) brésilien. Cet article a pour objet d'examiner le développement de la santé publique à l'intérieur du cadre historique du pays, puis d'analyser et de comparer les hypothèses théoriques de la Promotion de la Santé et de la Santé collective. Les auteurs en arrivent à la conclusion que la Promotion de la Santé, basée sur les principes et les valeurs diffusées par les Chartes internationales, et concernée par les acteurs sociaux et les déterminants sociaux du processus santé-maladie, dispose d'un potentiel considérable pour promouvoir l'amélioration des conditions de vie et de santé de la population. Ce cadre de référence a permis de formuler les termes de la Politique nationale de Promotion de la Santé au sein du Système Unique de Santé, institutionnalisée par un décret ministériel. Divers cadres de référence soutiennent l'importance et la réalisation de l'évaluation de l'efficacité des processus et des méthodologies de Promotion de la Santé au Brésil. Ils sont détaillés dans l'article en décrivant les processus historiques.

### Évaluation de l'efficacité en promotion de la santé : débat politique et/ou exercice technique ?

M. Akerman et al., p. 13

Cet article résume les points de vue de professionnels de différentes nationalités travaillant dans diverses organisations, sur des concepts et activités liés à l'évaluation de l'efficacité de la promotion de la santé. Ce recueil de points de vue provient d'une présentation réalisée sous forme de panel et de dialogue dans le cadre du premier Séminaire brésilien sur l'Efficacité de la Promotion de la Santé. Quatre professionnels travaillant dans le domaine de l'évaluation et de la promotion de la santé – deux des Etats-Unis, un du Canada francophone, et un autre représentant une organisation professionnelle internationale, ont dialogué de façon informelle avec le public, aidés par un modérateur brésilien et un autre portoricain. Quatre questions sur la façon dont ces professionnels percevaient l'évaluation en promotion de la santé ont été posées pour ouvrir le débat. Les panélistes ont délibéré sur cinq aspects de l'évaluation, à savoir les « comment », « combien », « dans quel but », « avec qui » et « pourquoi » ? Les professionnels travaillant dans des pays en voie de développement (dans ce cas, le Brésil) et ceux s'occupant de communautés autochtones (dans des pays développés) ont eu davantage tendance à insister sur les questions « dans quel but ? », « avec qui ? » et « pourquoi ? » en ce qui concerne les initiatives pour évaluer l'efficacité de la promotion de la santé. Les questions associées aux « comment ? » et « combien ? » ont été plus souvent mentionnées par les professionnels travaillant pour des organismes gouvernementaux ou internationaux. Ce dialogue de 90 minutes entre les panélistes, avec un parti pris brésilien assez fort, n'a pas été suffisant pour produire des conclusions sur le caractère prédominant des efforts internationaux d'évaluation de l'efficacité. Cependant, ce débat a permis de placer les cinq aspects de l'évaluation dans une perspective positive. Les questions « dans quel but ? », « avec qui ? », « pourquoi ? », « comment ? » et « combien ? » sont liées à des présomptions politiques ou techniques qui pourraient être orchestrées dans des évaluations de l'efficacité de la promotion de la santé.

### La complexité du débat sur l'efficacité et les données probantes dans les pratiques en promotion de la santé

R. Bodstein, p. 16

Cet article examine un cadre d'évaluation qui se fonde sur la compréhension des éléments et des caractéristiques multi stratégiques qui constituent les programmes de promotion de la santé (PS). La promotion de la santé présente constamment un défi quand on utilise des cadres traditionnels d'évaluation (Rootman et al., 2001 ; Potvin, 2006 ; Barnes et al., 2003) en particulier lorsqu'elle tente de définir ses actions en termes d'*empowerment*, de participation communautaire, de développement local, de niveau de connaissances en santé et d'activités intersectorielles destinées à réduire les inégalités pour les individus, les organisations, et les politiques publiques (Kickbush, 1994). Cette difficulté s'applique aussi aux débats sur l'efficacité des pratiques en PS. Tout l'enjeu ici est de savoir comment les actions promotrices de santé produisent des changements et des résultats. En bref, cet article propose d'examiner cette perspective redéfinie de la PS, et d'identifier son utilité pour les débats sur l'efficacité et les données probantes de la PS au Brésil.

## Analyser les résultats des pratiques en promotion de la santé

V. L. G. Pereira Lima et le Groupe Consultatif de l'UIPES/ORLA, p. 21

Cet article se concentre sur les résultats de la promotion de la santé (PS), illustrés à travers l'évaluation d'études de cas et l'identification des stratégies qui ont contribué à leur réussite et à leur durabilité. La recherche en évaluation et les pratiques dans trois contextes différents ont été examinées : (i) agences institutionnelles et gouvernementales, (ii) communautés dans le « Complexe Manginhos » et la Municipalité de Nova Iguaçu, et (iii) développement de réseaux de municipalités potentiellement en santé.

L'efficacité d'un programme social dans une perspective de promotion de la santé s'est construite à partir du programme « l'École pour les Parents », entrepris entre 2001 et 2004 par la Première Cour de l'Enfance et de la Jeunesse de Rio de Janeiro. L'analyse a reposé sur le suivi de 48 parents ayant la charge d'enfants de moins de 18 ans, victimes d'abus, de violence ou de négligence, et d'exclusion sociale, pour la plupart. Les objectifs de cette étude étaient : d'illustrer les preuves de l'efficacité de la promotion de la santé, de discuter du concept d'efficacité de la promotion de la santé dans des conditions on ne peut plus défavorables, et d'identifier les stratégies qui vont favoriser la pérennité des résultats. Les ressources institutionnelles comprenaient un personnel multi professionnel, des approches multidisciplinaires, des ateliers participatifs, la gestion de cas familiaux, des partenariats avec des institutions publiques et privées et le soutien aux familles en faisant appel au volontariat et à la société civile. L'évaluation a été basée sur les indicateurs d'impact social, et sur les déterminants psychosociaux et contextuels. Les méthodes d'évaluation incluaient le suivi du programme et des méthodes quantitatives et qualitatives, à travers une évaluation longitudinale sur trois années, y compris une année successive au programme. L'évaluation a montré des résultats très favorables concernant « l'intégration familiale », la « qualité des relations familiales » et la « mobilisation pour les droits humains ». Des résultats insatisfaisants comme le « manque d'accès à un emploi reconnu » sont visiblement liés aux facteurs structurels et à la nécessité de nouvelles politiques publiques dans des domaines tels que l'éducation, la formation professionnelle, le logement, et l'accès à un emploi reconnu.

Le processus de formation des acteurs sociaux dans la gestion de l'environnement et le logement, soutenu par le Projet de Développement technologique pour la Santé publique de la Fondation Oswaldo Cruz, a été utilisé comme outil pour l'éducation à l'environnement et le logement favorable à la santé. Le but de cette étude était de construire un modèle intégré et participatif de gestion de l'environnement. La méthodologie incluait la formation, la recherche et l'évaluation des participants, âgés de 21 à 50 ans, qui ont pris part à l'élaboration de Manuels thématiques et de Guides communautaires sur le contrôle de la qualité de l'eau. Les évaluations des participants ont mis en avant le processus de formation, les encourageant à devenir des agents multiplicateurs de l'éducation pour l'environnement au sein de leurs communautés et de continuer à apprendre comment réunir les différents secteurs de façon à résoudre les problèmes.

Le Réseau des Districts potentiellement en Santé (RMPS) vise à accroître les connaissances et à développer les capacités pour mettre en place des actions issues de chacune des unités locales, basées sur leurs caractéristiques et sur leurs pratiques propres. Développé par le Département de Médecine sociale et préventive de l'Université d'Etat de Campinas, avec l'OPS/OMS et l'Institut de Recherche et d'Etudes sociales (IPES), la mission du RMPS est de collaborer à la construction de politiques publiques favorables à la santé d'une manière participative et articulée, par le biais de différentes représentations municipales. Le réseau propose des outils aux administrations municipales pour développer des projets intégrés qui rassemblent à la fois le gouvernement, les gestionnaires, les techniciens, les universitaires, les organisations et la société, pour la construction de politiques publiques visant la promotion de la santé et la qualité de vie. La méthodologie se fonde sur la construction, par les acteurs sociaux, de réseaux d'actions et de connaissances qui stimulent les actions intersectorielles entre les districts. L'évaluation de l'impact est basée sur des études de cas, des groupes de discussion, des histoires orales et des analyses de textes et d'images.

## Théorie et pratique dans le contexte de l'évaluation des programmes de promotion de la santé

M. F. Lobato Tavares et al., p. 27

L'évaluation des actions de promotion de la santé (PS) est un défi majeur qui génère des enquêtes et des réflexions susceptibles de contribuer à l'efficacité des actions elles-mêmes. C'est afin d'encourager les échanges sur les expériences de contrôle et d'évaluation liées à la mise en place de lieux de vie en santé, que le 1er Séminaire sur l'Efficacité de la Promotion de la Santé a été organisé en 2005. Son programme comprenait une table ronde et des ateliers connus au Brésil sous le nom de Groupes de Travail (GT). Les critères utilisés pour la constitution des ateliers ont mis en avant les lieux de vie comme des espaces de circulation et de vie intrinsèquement connectés aux modes et aux conditions de vie, ainsi qu'aux facteurs de risques sociaux et/ou environnementaux associés aux groupes vivant quotidiennement dans ces milieux.

Axé sur l'évaluation en tant qu'activité génératrice de connaissances, cet article met en lumière et stimule la discussion sur certains points majeurs soulevés par l'approche théorico-méthodologique et par les discussions développées au sein des ateliers.

Les débats qui ont eu lieu au cours du Séminaire ont illustré les différentes perceptions et visions des acteurs sociaux impliqués dans la mise en œuvre et l'évaluation des pratiques de PS, révélant une multiplicité de significations. Il est apparu de façon évidente que des procédures étaient nécessaires pour décrire une maturation future des concepts et des méthodes, de même qu'un approfondissement de la discussion théorique.

## Salud, desarrollo y equidad

Marcia Faria Westphal<sup>1,2</sup> y Nina Wallerstein<sup>1,3</sup>

Estamos ya en el séptimo año del siglo XXI, experimentamos los resultados y las consecuencias de la globalización, a saber, el crecimiento continuo de la riqueza mundial, la exclusión social generada en el seno de las economías de mercado y las nuevas dinámicas de la sociedad y del ámbito laboral que marcan esta nueva fase del capitalismo.

Se mire por donde se mire, la dinámica de la realidad y de la ética que guía la globalización puede considerarse responsable de la paradoja de este crecimiento económico sin precedentes junto a enormes desigualdades y disparidades en el ámbito social y de la salud.

Brasil, un país de proporciones continentales, comparte esta paradoja con otras dinámicas propias de un país en desarrollo y dependiente. Es un país con grandes riquezas naturales y con un enorme potencial energético y en materias primas, que no han sido explotados ni utilizados debidamente. Pocos segmentos de la población han sido incorporados a la economía mundial y una gran parte de ella ha sido marginada del proceso de desarrollo, y más concretamente, de la distribución de la riqueza del país. En el seno de su territorio, sigue habiendo extensas bolsas de pobreza, miseria y opresión debido al modelo de desarrollo economicista –y no distributivo– que ha sido imbuído de elementos neoliberales.

Las iniciativas del gobierno que priman los aspectos económicos y no las necesidades humanas, han desembocado en un aumento continuado de la pobreza acompañado de la incapacidad por parte de una abrumadora mayoría de la población de participar de manera equitativa en la producción, gestión y el consumo de los bienes y servicios materiales y culturales. El Producto Interior Bruto (PIB) de Brasil, si bien no es bajo comparado con la mayor parte de los países del mundo, no evidencia el mismo ritmo de crecimiento que el de China o el de otros países de América Latina, como Chile o Argentina. Este macroindicador económico de la riqueza de Brasil tampoco muestra una correlación directa y coherente con los indicadores de salud y con las condiciones de vida de la población.

Si nos atenemos a los datos que aportan los estudios llevados a cabo en Brasil, no estamos ante un país pobre, sino injusto y desigual. La comparación de la renta per cápita de Brasil con la de otros países lo sitúa en el tercio de países más ricos del mundo. No obstante, el porcentaje promedio de familias que viven en Brasil con menos de la mitad del salario mínimo mensual (uno de los indicadores de la pobreza, es decir, unos 75 dólares per cápita al mes para la satisfacción de las necesidades básicas) es mucho más elevado que en otros países con una renta similar. La población pobre de Brasil representa el 30% del total de la población; no obstante, en Chile y Argentina, los pobres alcanzan como mucho el 10%. Estos datos demuestran que el origen de la pobreza en Brasil es la mala distribución de los recursos existentes. La renta media del 10% más rico del país es 28 veces superior a la renta media del 40% más pobre. En los Estados Unidos, la proporción es de 5 veces; en Argentina, 10 veces; y en Colombia, 15.

La distribución de la pobreza en las diferentes regiones del país también es desigual, como lo es la distribución de familias que viven con menos del salario mínimo mensual, según los datos de la encuesta doméstica nacional (PNAD) de 2002. En muchos municipios de la región septentrional, el porcentaje de niños y adolescentes pobres supera el 90%. En la región nororiental, especialmente en la zona semiárida, el 75% de los niños y adolescentes viven en la pobreza. Mientras tanto, en la región meridional, concretamente en Rio Grande do Sul, hay municipios cuyo porcentaje de niños y adolescentes pobres no llega al 2%. En este contexto, la distribución es todavía más desigual en relación con los niños negros. (IBGE, PNAD, 2002).

Las injusticias existentes en Brasil se revelan también en otros indicadores: persistencia de la pobreza, concentración de los ingresos, baja movilidad social, elevado nivel de desempleo y de subempleo; tasa de abandono escolar muy importante; prevalencia muy elevada de analfabetismo entre los adultos y otras necesidades básicas no satisfechas que provocan la existencia de hambre crónica ampliamente

extendida, violación de las libertades políticas fundamentales y amenazas cada vez más graves al medio ambiente y a la sostenibilidad de nuestra vida económica y social (IBGE PNAD 2004; FITE/MTE 2003; Haddad & Graciano, 2003).

En materia de salud, vemos que no existe una relación directa entre situación de salud y acceso a los servicios sanitarios, aunque son importantes las acciones de profesionales comprometidos con un modelo de atención de salud que integra los determinantes sociales, económicos, políticos y culturales. En la actualidad, cerca del 70% de la población depende del Sistema Unificado de Salud (SUS), cuyos principios son la integralidad y la universalidad de la atención sanitaria de la población.

El SUS tiene ante sí un reto de primer orden: hacer frente a las enfermedades de los países en desarrollo además de luchar contra las enfermedades infecciosas que siguen afectando al país, especialmente a la población de las regiones septentrional y nororiental. Las seis principales causas de muerte del país son: enfermedades cardiovasculares (31,8%), neoplasias (15,7%), causas externas (14,2%), enfermedades del sistema respiratorio (11,4%), enfermedades infecciosas y parasitarias (5,1%) y enfermedades derivadas del periodo perinatal (3,5%). Otras causas representan el 18,3% del número total de fallecimientos al año (PNAD-IBGE, 2003).

Reducir la mortalidad infantil (33/000 en 2004) y las muertes violentas (14,2%) representa un gran reto; para poder abordar ambos aspectos se precisan no sólo consultorías médicas o medidas preventivas, sino también acciones que incidan en los determinantes sociales, económicos, políticos y educativos, que mantienen las vidas de los niños nacidos en este país. La desnutrición, distribuida de manera desigual en función de la edad, el nivel educativo, la situación socioeconómica y la región, sigue siendo un obstáculo importante para la salud y el desarrollo del capital humano. Se añaden a estos problemas el consumo de droga y el SIDA, que se han convertido en el mayor problema para el mantenimiento de la vida y de la calidad de vida de la población (Marmot & Wilkinson, 2003).

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Las desigualdades y las injusticias en el acceso a los servicios básicos esenciales, que inciden en la calidad de vida y en la salud de la población y afectan a las condiciones medioambientales son, en opinión de Whitehead (2000), injustificadas, sistemáticas y considerables. Por otra parte, también son evitables e innecesarias. El SUS, combinado con estrategias de promoción de la salud, tiene potencial para transformar estas desigualdades puesto que prevé acciones que inciden en los determinantes de la salud.

En este número especial, teniendo en cuenta las desigualdades que caracterizan la realidad de Brasil, se nos invita a evaluar hasta qué punto las medidas sanitarias en el contexto del SUS e integradas en una perspectiva de promoción de la salud, han logrado transformar las desigualdades en “desigualdades más justas”, es decir, en equidad. Según la definición de Whitehead (2000) la “equidad social entre grupos e individuos” consiste en desigualdades que pueden evitarse, que son injustas y superfluas, lo cual destaca la dimensión ética y moral del concepto. Para obrar con miras a la equidad, el sistema tiene que dar más a los que tienen menos, no para poner fin a las desigualdades per se, sino para ofrecer a la mayoría la posibilidad de llevar una vida digna.

El tema de la evaluación y el seguimiento de la efectividad de las políticas de promoción de la salud ha suscitado un interés creciente entre los responsables de formular las políticas, los gestores de las mismas, los profesionales y otros actores implicados en la implementación de acciones de promoción de la salud, especialmente aquellas dirigidas a los determinantes sociales de la salud.

En la promoción de la salud, los métodos de evaluación se han hecho indispensables para el éxito de las intervenciones, puesto que analizan los procesos y contextos locales necesarios para la formulación y aplicación de las políticas, vinculan la teoría y la práctica y contribuyen a generar conocimientos en esta materia.

En Brasil, la promoción de la salud ha intentado establecerse como perspectiva interdisciplinaria que prioriza la cooperación de los diversos sectores de la sociedad y el diálogo democrático y participativo con los diversos grupos interesados y afectados que llevan a cabo acciones múltiples de cambio social. Al trascender los límites del sector sanitario, busca nuevos diseños y propuestas para la promoción de la calidad de vida, valorando la habilidad intrínseca de los agentes sociales de reflexionar de manera crítica sobre el contexto y sobre los determinantes económicos, sociales, culturales y medioambientales de la salud.

Se están desarrollando programas innovadores en diversos contextos y espacios. A menudo, los resultados que se pretende alcanzar giran en torno al aprendizaje, la autonomía y la potenciación de las personas implicadas; en torno a nuevas formas de gobernanza y a la mejora de las capacidades organizativas de las comunidades; a la modernización y humanización de los servicios públicos. Por otro lado, si se pretende lograr cambios sociales sostenibles, ello presupone la existencia de estrategias integrales que impliquen acciones intersectoriales de movilización y participación de las comunidades que cuestionen los marcos de referencia utilizados tradicionalmente en el campo de la evaluación de la salud

El *Primer Seminario Brasileño sobre la Efectividad de la Promoción de la Salud* reveló y actualizó el debate existente en torno al papel de este campo de conocimientos y de sus prácticas en la mejora del sistema de salud y de la calidad de vida del país. El acontecimiento intensificó la colaboración entre instituciones nacionales e internacionales y grupos de trabajo, y ayudó a colocar el tema de la Promoción de la Salud en la agenda del Ministerio de Salud, que, en Noviembre de 2006, institucionalizó la Política Nacional de Promoción de la Salud y estableció una Junta Gestora para su aplicación.

Los artículos que integran el presente número señalan la importancia de continuar el debate en torno a la promoción de la salud en contextos marcados por una desigualdad cada vez mayor en las condiciones de vida y en las oportunidades, que hace que la «justicia» sea el reto prioritario si queremos lograr cambios efectivos en el ámbito de la salud a nivel nacional y mundial.

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### La promoción de la salud en Brasil

A. Ivo de Carvalho, M. F. Westphal y V. L. G. Pereira Lima, p. 7

Brasil, un país latinoamericano de proporciones continentales y grandes contrastes, desigualdades demográficas y sociales, se enfrenta además al desafío de prevenir y controlar las enfermedades infecciosas, las lesiones y las enfermedades no transmisibles. La pérdida de fuerza del paradigma biomédico, el cambio del perfil epidemiológico y los problemas sociopolíticos y culturales de las últimas décadas han favorecido el nacimiento de nuevas formulaciones sobre la teoría y la práctica de la salud pública. Entre ellas, están los paradigmas de la Salud Pública y de la Promoción de la Salud en Brasil. Los primeros aportan apoyo ideológico al Sistema Unificado de Salud de Brasil. La finalidad de este artículo es hablar del desarrollo de la salud pública dentro de la historia del país y analizar y comparar los presupuestos teóricos de la Promoción de la Salud y de la Salud Pública. Concluimos que la Promoción de la Salud, basada en los principios y valores divulgados por las Cartas Internacionales y centrada principalmente en los actores y determinantes sociales del proceso salud-enfermedad, tiene un potencial significativo para promover la mejora de la vida y de las condiciones de salud de la población. Este marco de referencia orientó la formulación de la Política Nacional de Promoción de la Salud dentro del Sistema Unificado de Salud, que fue institucionalizado por decreto ministerial. La importancia y la aplicación de la evaluación de la efectividad de los procesos y métodos de promoción de la salud en Brasil han sido orientadas por diversos marcos de referencia, que exponemos en este artículo, describiendo sus procesos históricos.

### La evaluación de la efectividad en la promoción de la salud: ¿debate político y/o ejercicio técnico?

M. Akerman et al., p. 13

El artículo expone los puntos de vista de profesionales de diversa nacionalidad, que trabajan en organizaciones distintas y tratan con conceptos y actividades relacionados con la evaluación de la efectividad de la promoción de la salud. Dichas opiniones quedaron expresadas en una mesa redonda organizada con ocasión del Primer Seminario Brasileño sobre la Efectividad de la Promoción de la Salud. En la mesa redonda participaron cuatro profesionales que trabajaban en evaluación y promoción de la salud –dos de los Estados Unidos, uno de Québec y otro representante de una organización internacional– junto con dos moderadores, uno de ellos brasileño y otro puertorriqueño, que coordinaron el diálogo con el público. Para iniciar el diálogo se plantearon cinco preguntas sobre cómo percibían estos profesionales la cuestión de la evaluación en el ámbito de la promoción de la salud. Los cinco aspectos de la evaluación (“cómo”, “cuánto”, “para qué”, “con quién” y “por qué”) son los que se plantearon en dicha mesa redonda con relación a la promoción de la salud. Los profesionales que trabajaban en países en vías de desarrollo (en este caso concreto, en Brasil) y los que tenían trato con comunidades indígenas (en países desarrollados) hacían más hincapié en “¿para qué?”, “¿con quién?” y “¿por qué?” respecto de las iniciativas dirigidas a evaluar la efectividad de la promoción de la salud. Los profesionales que trabajaban para agencias internacionales o gubernamentales mencionaban más las preguntas que tenían que ver con el “¿cómo?” y el “¿cuánto?”. Un diálogo de 90 minutos entre los participantes de la mesa redonda, con mucho peso de la perspectiva brasileña, no fue suficiente para aportar evidencia sobre los rasgos predominantes de las iniciativas de evaluación de la efectividad a nivel internacional. No obstante, este debate situó a los cinco aspectos de la evaluación bajo una perspectiva de valores. Las preguntas “¿para qué?”, “¿con quién?”, “¿por qué?”, “¿cómo?” y “¿cuánto?” están vinculadas a un sesgo político o técnico que podrían equilibrarse en las evaluaciones de la efectividad de la promoción de la salud.

### La complejidad del debate sobre la efectividad y la evidencia de las prácticas de la promoción de la salud

R. Bodstein, p. 16

El artículo trata de un marco de evaluación basado en una idea determinada acerca de los elementos constitutivos y de las características de los programas de promoción de la salud (PS) que utilizan estrategias múltiples. La promoción de la salud representa un desafío permanente para los marcos de evaluación tradicionales (Rootman et al., 2001; Potvin, 2006; Barnes et al., 2003) en el momento en el que redefine sus acciones entre las que incluye el empoderamiento, la participación comunitaria, el desarrollo local, la alfabetización en materia de salud y actividades sectoriales cuyo fin es la reducción de las desigualdades y cuyos destinatarios son las personas, las organizaciones y las políticas públicas (Kickbush, 1994). Este desafío es igualmente aplicable al debate sobre la efectividad de la práctica de la PS; lo que está en juego son los conocimientos acerca de cómo las acciones de promoción de la salud generan cambios y resultados. En resumen, el artículo propone debatir esta nueva definición de la PS y la perspectiva que conlleva e identificar su utilidad en el debate sobre la efectividad y la evidencia de la PS en Brasil.

## Analizar los resultados de las prácticas de la promoción de la salud

V. L. G. Pereira Lima et al., p. 21

El artículo trata de los resultados de la promoción de la salud, ilustrándolo con la evaluación de casos prácticos y la identificación de las estrategias que han contribuido al éxito y a la sostenibilidad. Se aborda la evaluación tanto de la teoría como de la práctica en tres escenarios diferentes: (i) agencias institucionales y gubernamentales; (ii) comunidades del “Complejo Manguinhos” y del Municipio de Nova Iguaçu, y (iii) construcción de redes de municipios potencialmente saludables.

La “efectividad de un programa social desde la perspectiva de la promoción de la salud” se basaba en el programa “Escuelas para Padres”, emprendido por el Primer Juzgado Especial para Niños y Jóvenes de Río de Janeiro, entre 2001 y 2004. El análisis realizó en base al seguimiento de 48 padres que tenían a su cargo niños menores de 18 años, víctimas de abusos, violencia o negligencia, y casi todos ellos, también de exclusión social. Los objetivos del estudio eran: ilustrar con ejemplos la efectividad de la promoción de la salud, debatir el concepto de efectividad de la promoción de la salud en macrocondiciones desfavorables y definir estrategias que favorecieran la sostenibilidad de los resultados. Los recursos institucionales empleados fueron: plantilla de profesionales de diversos ámbitos, enfoques multidisciplinarios, talleres participativos, gestión de casos familiares, colaboración con instituciones públicas y privadas, patrocinio de las familias por parte de voluntarios y de la sociedad civil. La evaluación se realizó a partir de indicadores del impacto social y de los determinantes psicosociales y contextuales. Los métodos de evaluación incluyeron la supervisión del programa y métodos cuantitativos y cualitativos, a lo largo de 3 años, entre ellos el año posterior a la finalización del programa. La evaluación mostró resultados muy favorables en cuanto a “integración familiar”, “calidad de las relaciones familiares” y “movilización a favor de los derechos humanos”. Los resultados insatisfactorios, como la “falta de acceso al empleo formal” están posiblemente relacionados con factores estructurales y con la necesidad de llevar a cabo nuevas políticas públicas en áreas como la enseñanza, la formación profesional, la vivienda y el acceso al empleo formal.

El “proceso de formación de actores sociales en gestión medioambiental y vivienda”, apoyado por el Programa de Desarrollo e Innovación Tecnológica de la Fundación Oswaldo Cruz, fue utilizado como herramienta para la educación medioambiental y en favor de una vivienda saludable. La finalidad del estudio era construir un modelo integrado y participativo de gestión medioambiental. Dentro de la metodología se contemplaba, la formación profesional, la investigación y la evaluación de los participantes, de edades comprendidas entre los 21 y los 50 años, que participaron en la elaboración de Libros de Aprendizaje Temático y de Guías comunitarias sobre la vigilancia de la calidad del agua. Las evaluaciones de los participantes subrayaron el proceso de formación y les alentaron a convertirse en agentes multiplicadores de la educación medioambiental en el seno de sus comunidades y a continuar aprendiendo cómo reunir a los diferentes sectores para la solución de los problemas.

La Red de Municipios Potencialmente Saludables (RMPS) pretende aumentar los conocimientos y capacitar a las personas para que desarrollen acciones que se originen en cada una de las unidades locales, en función de sus características y de sus prácticas. La misión de la RMPS, desarrollada por el Departamento Social y de Prevención de la Universidad del Estado de Campinas junto con la OPS/OMS y el IPES (Promoción del desarrollo sostenible), es colaborar en la elaboración de políticas públicas saludables de forma participativa y articulada a través de diversos representantes municipales. La red ofrece herramientas a las administraciones municipales para desarrollar proyectos integrados que reúnan a gobierno, directivos, técnicos, académicos, organizaciones y sociedad para la construcción de políticas públicas destinadas a promover la salud y la calidad de vida. La metodología se basa en la elaboración de conocimientos y el establecimiento de redes de acción por parte de los actores sociales que estimulen las acciones que impliquen a unos y otros sectores y a diversos municipios. Para evaluar los resultados se han utilizado estudios de casos prácticos, sesiones de grupo, declaraciones, documentos y análisis de imágenes.

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## Teoría y práctica en el contexto de la evaluación de los programas de promoción de la salud

M. F. Lobato Tavares, p. 27

La evaluación de las acciones de promoción de la salud es un desafío de primer orden, que suscita interrogantes y reflexiones cuyo contenido puede contribuir a la efectividad de las propias acciones. Con el fin de promover el intercambio de experiencias de seguimiento y evaluación en relación con la implementación de entornos saludables, se organizó el Primer Seminario Brasileño sobre Efectividad de la Promoción de la Salud en 2005. El programa incluía mesas redondas y talleres denominados grupos de trabajo en Brasil. Los criterios utilizados para organizar los talleres se centraron en los entornos, en tanto que espacios de tránsito y de vida intrínsecamente vinculados a los estilos y condiciones de vida, así como en los factores de riesgo sociales y medioambientales asociados a los grupos que viven en dichos entornos día tras día.

Este artículo trata sobre la evaluación en tanto que actividad que genera conocimientos, y subraya y estimula el debate en torno a algunas de las principales cuestiones que surgen del enfoque teórico-metodológico y de las discusiones que tuvieron lugar en los talleres.

Todo lo que se habló en el transcurso del Seminario ilustró las diversas percepciones y puntos de vista de los actores sociales implicados en la aplicación y en la evaluación de las prácticas de la promoción de la salud, que desvelaron la multiplicidad de significados que encierran. Quedó claro que se precisan procedimientos para documentar la maduración de conceptos y métodos, sin olvidar la necesidad de profundizar en el debate teórico.

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These structures are currently being developed

The IUHPE is a Global Professional Association devoted to contributing to greater equity in health through health promotion and health education. Founded in 1951, the IUHPE works in close cooperation with major inter-governmental and non-governmental organisations to influence and facilitate the development of health promotion strategies and projects.

The journal is one of the IUHPE's main communication tools and it aims to:

1. provide an international and interdisciplinary forum for the dissemination and exchange of health promotion, health education and public health theory, research findings, practice and reviews in a range of settings and specific populations;
2. publish articles which ensure wide geographical coverage and are of general interest to an international readership;
3. encourage and support authors from low- and middle-income countries, as well as, non-English speakers to publish through the Health Promotion Journals Equity Project (HPJEP);
4. remain committed to equitable access in publication, in terms of language and type of contribution. The journal's content spans wider than a traditional academic journal to reflect the daily practical success stories and challenges of practitioners in the field in terms of their lessons learned from interventions, and their experiences in terms of areas like advocacy, networking and partnership.
5. provide a fair, supportive and high quality peer review process;
6. ensure a multi-lingual print dissemination tool for information on IUHPE projects, events and other relevant communications for members of the network.

L'UIPES est une Association professionnelle mondiale dont la mission est de contribuer à la réduction des inégalités de santé à travers la promotion de la santé et l'éducation pour la santé. Fondée en 1951, l'UIPES travaille en étroite collaboration avec de nombreux Organismes intergouvernementaux et non gouvernementaux pour influencer et développer des stratégies et projets de promotion de la santé partout dans le monde.

La revue a pour but de :

1. Fournir un forum international et interdisciplinaire pour diffuser et échanger des théories de promotion de la santé, d'éducation pour la santé et de santé publique, des résultats de recherches, des pratiques et des évaluations, dans différents environnements, et auprès de populations spécifiques ;
2. Publier des articles qui garantissent une large couverture géographique et présentent un intérêt d'ordre général pour un lectorat international ;
3. Encourager et soutenir les auteurs de pays à faible et moyen revenu, de même que les non anglophones, afin qu'ils puissent publier en bénéficiant du Projet Équité des Publications de Promotion de la Santé (HPJEP) ;
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5. Garantir un processus de révision des articles qui soit juste et de grande qualité, et qui soutienne les auteurs ;
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La UIPES es una Asociación profesional mundial dedicada a la consecución de la equidad en materia de salud a través de la promoción de la salud y la educación para la salud. Fundada en 1951, la UIPES trabaja en estrecha cooperación con importantes organizaciones intergubernamentales y no gubernamentales para influenciar y facilitar el desarrollo de estrategias y proyectos de promoción de la salud.

La revista aspira a:

1. Ofrecer un foro internacional e interdisciplinario para la divulgación e intercambio de la teoría, los descubrimientos de la investigación, la práctica y la crítica de la promoción de la salud, de la educación para la salud y de la salud pública, en diversidad de entornos y de poblaciones concretas;
2. Publicar artículos que garanticen la diversidad geográfica y que sean de interés general para una red de lectores de ámbito internacional;
3. Promocionar y prestar apoyo a los autores procedentes de países de rentas medias y bajas, así como a los de habla no inglesa, para que puedan publicar, gracias al Proyecto de Equidad en las Revistas de Promoción de la Salud (HPJEP, en sus siglas en inglés);
4. Mantener su compromiso de trabajar por una mayor igualdad de oportunidades a la hora de publicar respecto de los diferentes idiomas y tipos de textos. El contenido de Promotion & Education es mucho más amplio que el de una revista académica tradicional en aras a reflejar los éxitos cosechados y los problemas surgidos en la práctica cotidiana de los profesionales de nuestro campo, es decir, las lecciones aprendidas a partir de las intervenciones realizadas y sus experiencias en el campo de la abogacía, el trabajo en red y los partenariados.
5. Ofrecer un proceso de revisión por iguales que sea equitativo, constructivo y de elevada calidad;
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