

## **Dilemmas in health promotion in Brazil: the National Policy under consideration.<sup>1</sup>**

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### **ABSTRACT**

Despite being a recurrent theme in day-to-day life, health promotion is a complex and multifaceted concept. The purpose of this article is to highlight some of the dilemmas and problematic aspects of institutional ideas about health promotion. It also emphasizes the difficulty of thinking about health promotion, without also considering how to eradicate the deep social iniquities of the Brazilian context. The article develops this line of thinking in depth by analysing the National Health Promotion Policy instituted in 2006, and demonstrates the relevance of deconstructing politically correct discourses and developing processes of reflection in our health-related practices.

**Key words:** health promotion, public health, National Health Promotion Policy, Social Psychology.

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<sup>1</sup> Some of the ideas developed in this paper were discussed during the post-doctorate internship at the Community Health Division, Faculty of Medicine, Memorial University of Newfoundland, St.John's, (NL), Canada, between 2004 and 2005. English revision of the text: David Anderson.

## **Introduction**

Although the conceptual development of expressions such as “health promotion” and “disease prevention” belongs only to the last decades, the ideas behind these concepts are not new. Since ancient times, medical philosophers have reflected on the necessity to promote health and, especially, to prevent diseases, through the observation of the relationships between health and certain social practices. In Ancient Greece, according to Rosen (1994, p.39), "in the ideal way of life, nutrition, bowel movements, exercise and rest were balanced." However, only the elite could follow this regimen, being traditionally part of an "aristocratic hygiene".

Examining the history of public health sheds light on how gradual and complex a task it has been worldwide, to increase the scope of public involvement in health promotion and disease prevention to the whole population. The concern for quality living conditions, as well as adequate health care, started with the early social medicine movement of the nineteenth century, and has continued throughout the years, with the development of public health.

Since the 1970s, after the Lalonde Report and the Alma Ata Conference on primary health care in Canada, and the First International Conference on Health Promotion held in Ottawa in 1986, the conceptual development of health promotion, worldwide, has become associated with a broader and more complex notion of the health-illness-care process, to include social and economic determinants of health (Souza & Groundy, 2004; Buss, 2003; Brazil, 2002).

However, the multiplicity of conceptions and the polysemic character of the term “health promotion” illustrate the impossibility of a univocal definition and highlight the complexity<sup>2</sup> of the subject, involving diverse and multifaceted symbolic nets (Buss, 2003; Czeresnia, 2003; Radley, 1994). In general terms, while disease prevention actions aim to avoid the proliferation of

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<sup>2</sup> Complexity, in accordance with Mariotti (2000, p.87-8), “is not a theoretical concept, but a fact of life [...] Even if we try, we will not be able to reduce this multi-dimensionality to simple explanations, rigid rules, simplified formulas or schematic ideas [...] This (concept) configures a new vision of the world that accepts and tries to understand the constant changes of the real and does not intend to deny contradictions, diversity, ambiguities and uncertainties, but implies learning to live with them”.

illnesses, health promotion is more concerned about the general well-being of people and communities, tending to focus on a positive conception of health (Czeresnia, 2003). The World Health Organization (WHO) defines health as “a resource which permits people to lead an individually, socially and economically productive life,” and understands health promotion as:

a social and political process, it not only embraces actions directed at strengthening the skills and capabilities of individuals, but also actions directed towards changing social, environmental and economic conditions so as to alleviate their impact on public and individual health. (WHO, 1998, p.1)

Thinking about health, within such a broad framework, as Czeresnia (2003, p.46) points out, “means dealing with something as broad as the notion of life itself”, involving both individual and macro-structural aspects, and the permanent interrelationship between these two dimensions.

The aim of this article is to draw attention to some of the quandaries and dilemmas behind local ideas and conceptions about health promotion, and the challenges implied, bearing in mind the profound social inequities of the Brazilian context. It carries out this reflection through the discursive analysis of the National Policy of Health Promotion, enacted through Decree no. 687 of March 30, 2006, which:

aims to promote quality of life and to reduce vulnerabilities and risks to health, related to its social determinants - ways of living, working conditions, dwelling, environment, education, leisure, culture, access to essential goods and services. (Brazil, 2006, p.19)<sup>3</sup>

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<sup>3</sup> I originally worked with the previous discussion document (Brazil, 2005a). However, since the National Policy, with some omissions and additions, was published in 2006, while this paper was being processed, the final public document was considered for further analysis.

## **The conceptual dilemmas of health promotion**

The difficulties to define health promotion stem from the problem of dealing with health itself. Besides the biomedical dimension, there are other aspects mediating what health and health care mean for each person, such as social, psychological, economic and spiritual aspects. However, the biggest difficulty resides in the fact that health is mainly a personal experience. The ways people perceive their health and how they care for it are as diverse as the many means they have to signify and deal with life in general (Radley, 1994). These means are mediated by subjectivation processes that depend on life histories and the complex web of interactions which are part of everyday life<sup>4</sup>.

Radley & Billig (1996) suggest a more dynamic view of health beliefs, beyond the sociological concept of social representations and the psychological concept of attitudes. The authors explain that these concepts tend to be reified and treated as static things, arguing that beliefs and discourses on health and illness would be better considered as accounts about these processes, as they might vary depending on specific social and relational contexts.

There are also ethical dilemmas involved when it is necessary to decide between initiatives limited to certain groups - characterized as 'groups of risk' - or generalized for the overall population. Moreover, it is not less problematic to define limits, in order to respect people's freedom of action. The above explains why some public health intervention practices have, sometimes, been considered as forms of social control (Radley, 1994), and why health promotion campaigns have been criticized for stigmatizing certain health problems, and for having the repressive and manipulative effect of generating fear (Lupton, 1999).

It is also observed that until rather recently, when speaking about health promotion, there was an immediate association with the adoption of healthy behaviors, centering the attention,

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<sup>4</sup> Hacking (1999) uses the term "matrix" to refer to the web of interrelationships present in every social phenomenon. It includes the institutional dynamics, the physical infrastructure, and values and ideologies influencing how we signify life and the world around us.

exclusively, on individuals. Even now there are articles and intervention practices prioritizing this trend, especially within the more traditional health psychology field.

The concern for the adoption of healthy behaviors tends to be based on the assertion that a significant amount of health problems are related to life style and the strategy resulting from this perspective is “health education.” Little attention is paid to the fact that there are many perspectives on education. Traditional approaches, such as information campaigns and lectures that aim to change behaviors tend to neglect what Freire (2003, p.22) rightly emphasizes: “to teach it is not to transfer knowledge, but to create the possibilities for its production or its construction.” For meeting Freire’s claim is important to acknowledge the psychosocial aspects of the process.

As Radley (1994) insists, the more there is this repetition of naïve and simplistic campaigns addressing linear cause-effect risks, the less the probability of people being affected by such messages. The simplified and homogenizing approaches, as well as the transmission or vertical imposition of what technicians and professionals consider “healthful,” are widespread in traditional health promotion and health education campaigns, and generally ensure that they are bound for failure (Briceño-León, 1996).

The considerations above stresses the importance of substituting the linear/vertical model for another one more predisposed to dialogical ways of working, considering the web of interdependencies into which health practices are inserted. Briceño-León (1996), inspired by Pablo Freire’s thinking, highlights that in every human action, more important than words alone, are what we express through our everyday *languaged* practices. He suggests to consider the effects of non-verbal communication and what is expressed through the unintentional “educative” dimension of everyday actions, insisting that education is not only what is expressed in educational programs, but through all means of health intervention practices. He also emphasizes that, in the dynamics of health education, there is not one who knows and another who knows nothing, but two knowing different things. Thus, he asserts that “ignorance is not a hole to be

filled, but a full to be transformed” (p.12). Therefore, lay knowledge and its universe of meanings must be considered and not simply rejected in service of a scientific or “true” knowledge.

In other words, the promotion of healthy living conditions must be an individual, as well as a social concern, taking into account even the steady increase of aging populations and the consequent growth of degenerative chronic illnesses. Medical cures for many chronic health problems do not exist; instead, the medical system relies on palliative interventions of soaring economic and social costs. Therefore, it is important to be cautious when health promotion is presented as a priority strategy of action in primary health care - as if it is possible to reach the utopia of a disease-free society. As Campos (1997) argues, such a strategy can be an excuse to reduce the investment in quality health services.

It has also been observed that arguments justifying the concern for health promotion vary a great deal. It is possible to find a range of positionings: from those with a humanist perspective, centered on the need to work with a broader conception of health, to those with more pragmatic arguments, that conceive of health promotion as a reaction to the medicalizing trend in society and its iatrogenic effects, or have an economic concern, focusing on the growing costs involved in modern medical technology.

Considering that implicit in any type of conception and argumentation process are assumptions about the individual-society relationship, it is relevant to pay attention to the complex web of meanings mediating the health-illness processes, as well as the intervention practices involved (Traverso-Yépez, 2001). For example, the image of individuals responsible for changing their life styles to preserve their health tends to be associated with the idea of a harmonic and class-conflict-free society, leaving aside socio-economical determinants influencing living condition and the health-illness process.

As observed by Rosen (1994), throughout history, the relationship between poor living conditions and poor health has been clearly expressed in epidemiological data in each country worldwide, as well as between developed and underdeveloped countries, although the

peculiarities of this relationship continue to be debated (Coburn, 2004, 2000). Wilkinson (1996) and Wilkinson & Marmot (2003) cite evidence that higher rates of morbidity and mortality are related to higher degrees of social inequities. Therefore, more important than material resources (in the case of a nation, we speak of gross national product or the GNP) seems to be less social inequities and the related social problems, as these have a significant impact on the wellbeing and health of the population.

### **Health promotion and social inequities in Brazil**

Without entering into the controversy that Wilkinson's (1996) and Wilkinson & Marmot's (2003) research has generated in the developed world between epidemiologists of divergent viewpoints, it is apt to state that the broad conception of health implicit in their work has served as the conceptual framework for new proposals in the area of health care. Thus, Brazil officially adhered to this more inclusive vision of health with the adoption of the Unified Health System (SUS) by the end of the 1980s. However, even today, a deep gap still exists between what is on paper and everyday intervention practices.

With regard to the implementation of the National Health Promotion Policy, the difficulties seem even more significant, considering socio-structural inequities, and the unfair power relations negatively affecting over one third of the Brazilian population.

Since the Ottawa Letter of 1986 and throughout the international conferences on health promotion, health has been considered an essential element for social and economic development, as has the necessity of working on the social, economic and environmental determinants influencing the overall health of the population (Brazil, 2002). This stance ensures that health promotion be "a basic priority of local, regional, national and international policies and programs" (Brazil, 2002, p.30).

The main challenge of this proposal stems from the fact that Brazil is one of the three countries in the world with the highest rate of social inequality, despite its being one of the ten

richest economies on the planet (IBGE, 2003). However, the problems generated by the high degree of social inequity, and the issue of the relatively small amount of attention these problems receive at all levels, are not being given enough consideration in official documents and in the literature on health promotion.

Therefore, besides studying the effects of social inequities, more attention must be given to their ideological-structural aspects (Coburn, 2004; 2000), and to the complex web of socioeconomic and political-ideological interdependencies involved. The increasing influence of neo-liberalism in a globalized world, for example, with its emphasis on individualism and competition, is in stark contrast with the ideological bases of the Welfare State, relying on governmental support and community solidarity (Coburn, 2004, 2000; Mehry, 1997). In countries like Brazil - that did not get even close to a Welfare State, but only adopted some of its principles within the scope of public services - the neo-liberal policies oriented to favor the market and big corporate interests are in permanent conflict with social policies, tending to make impossible the requirements of more progressive health policies (Paim & Almeida Son, 2000).

Moreover, ongoing health promotion initiatives, besides being based on differentiated conceptions, are very much restricted to specific spaces, people and moments, confirming the great limitations of a public health policy developed in the context of neo-liberal economic policies.

### **Analyzing the Brazilian National Health Promotion Policy**

Based on previous considerations, a possible contribution of Social Psychology is emphasized through the analysis of the National Health Promotion Policy. Like any health practice, health promotion involves a set of actions that aim to address specific necessities of the people (Brazil, 2005b). It also involves conceptions and world views stemming from diverse life experiences, expressing themselves as different beliefs and knowledges in the context of the rationalities and materialities of the health care system. Therefore, conceptions of and arguments



on health promotion practices do not only express positionings, but, being always relational, they also generate subjectivation processes and forms of action, involving psychosocial processes relevant to reflect upon.

The focus for this reflection is on the relational-responsive dimension of human life implicit in all social practices, influencing and influenced by the social and political world around us (Spink, 2004; Bakhtin & Voloshinov, 1992). The conception of (inter)action as a meaningful, relational activity stresses the constructed character of psychosocial processes, and the social constitution of subjectivity. As limited by contextual conditionings, psychosocial processes are generally non-reflective. Therefore, the reflective attention to the dynamic mediating actions and social practices allows one to go beyond automatic verbal and corporeal forms of communication, becoming more sensitive and aware of all forms of rationalities and materialities being produced. In other words, we become aware of the symbolic net of the varied perspectives mediating health actions, as well as health promotion.

It is easier to talk about this perspective, than to think about the complexity involved in everyday practices, because of the linear way we are socialized to think (Mariotti, 2000; Morin, s/d). The main difficulty of dealing with life as a process, in which a diversity of forces engage in continuous synergetic interaction, arises from the human need to rely on certainties and on fixed notions. This human limitation tends to lead to reductionist, and oversimplified explanations, and to be satisfied with simple cause-effect relationships.

Considering the above, any “reading” of the new Health Promotion Policy must engage in a great deal of reflection and self-reflection, to avoid the trend of reproducing the traditional symbolic networks within which we are conditioned. In such a critical reflection, academics and policy makers must question whether the discursive practices or forms of action implicit in the policy allow the necessary space for facilitating changes in everyday practices.

The National Policy of Health Promotion (Brazil, 2006) seems to be a result of international pressure, in addition to a growing awareness among some public health managers of

the limitations of a disease-centred health model. To study the policy, I have adopted a Foucauldian approach to discourse analysis (Willig, 2001), which was used by Sykes et al. (2004) in their study of the Health Promotion Programme 1996-2000 for the European Communities. The documentary analysis is presented in six stages: 1) identifying the discursive constructions dealing with the theme of health promotion and tracing how they are assembled in the text; 2) recognizing how the variety of discursive constructions fit within wider discourses, with special attention to the central ideas involved; 3) understanding the function that these wider discourses have with, special attention to the discursive context and the orientation for action implicit in the text; 4) apprehending the positionings that the persons involved occupy within the structure of rights and duties considered, as well as the way the text perceives and situates them in the world; 5) pointing out how the relationship between discursive constructions and positionings opens or closes possibilities of action, favoring certain types of practices, to the detriment of others; 6) exploring the relation between positionings and possible forms of subjectivation generated among the different social actors.

### **1) Discursive constructions**

Health Promotion is presented in the text of the Policy (Brazil, 2006) in different discursive constructions:

· **As a health production strategy:** health promotion is presented as tightly interwoven with other Unified Health System (SUS) policies and technologies, in that it opens the possibility to focus on the social determinants of health. It is specifically defined

as a possibility to focus on the social aspects determining the health-illness process, such as violence, unemployment, informal work, lack of basic sanitation, inadequate and/or lack of dwelling, difficult access to education, hunger, chaotic urbanization, poor quality of air and water (Brazil, 2006, p.14).

At the same time, it considers a more comprehensive vision of health. It emphasizes the social influence of choices and options on individuals' ways of living, instead of the fragmented and individualizing perspective that "positions citizens and communities as the only responsible for the events related to the health-illness process throughout life" (p.14). It also insists that "the intervention practices should broaden their scope to go beyond the walls of health centers and the health system, to work on the social conditions of living, as well" (p.14).

However, despite identifying the harmful effects of the meager living conditions in contemporary Brazil, there is a lack of discussion about the entrenchment and naturalization of inequities in the existing socio-economic system. This attitude of ignoring the high degree of social inequities does not only place serious restrictions on the possibility of implementing the principles and proposals of the new policy, but it tends to favor the institutionalization and reproduction of the inequalities which the SUS is meant to address.

To consider the social problems as "life styles" excludes the possibility of reflecting on their causes, the forms in which they appear, and the ways they are reproduced. Therefore, this sort of perception hinders options to design and implement adequate lines of action

• **Close relation with the concept of health monitoring and caretaking:** the Policy (Brazil, 2006) emphasizes the necessity of "an integrated movement in the construction of consensuses and synergies" (p.15), proposing that public policies "should be more favorable to health and life." It also emphasizes that public policies should stimulate "citizens agency," "social participation," "the exercise of citizenship," and "working in networks with organized civil society." The text also suggests that the participation of all social actors involved, including service users, social movements, health workers and management staff, should be achieved through democratic "shared management."

However, this invitation to democratic forms of living contradicts the existing hierarchical form of relationships in a stratified, vertically-oriented society like ours. On the other hand, as

Sen (2001) highlights, poverty is not only a lack of income, but tends to generate a condition that he calls “qualification poverty.” This term implies a chronic privation of action possibilities involving a lack of choices, resources, power and civil, cultural, economic, political, and social rights. It is this set of limitations that engenders the subjective experience of structural deficit expressed as social anomie, making difficult the participation and empowerment of a significant percentage of the population.

· **Transversal expression of the strategy:** the Policy (Brazil, 2006) also claims to favor the transversal expression of health promotion strategies, allowing

visibility to the factors which put in jeopardy the health of the population and to the existing differences between necessities, territories and cultures in the country, aiming at the creation of mechanisms to reduce the situations of social vulnerability, radically defending social equity, incorporating participation and social control in the management of the public policies (p.16).

This is supposed to be accomplished through the principle of “*integrality*,” a synonym for building comprehensive and integrated services at all levels of public health care. “Integrality” implies going “beyond the connection and tuning between the different strategies in the production of health, broadening listening spaces among workers and health services in the relation with the users, both at individual and/or collective levels [...]” The other principle considered in this discursive construction is “*intersectoriality*,” defined “as a joint endeavor of all the resources available at the different public sectors for thinking the complex question of health [... ]” (Brazil, 2006, p.16). However, this transversal endeavor is one of the most difficult to accomplish in everyday public services. Because of unequal power relations existing at all levels, public service workers, managers and people in general have severe difficulties with horizontal, dialogical communication. Communication is generally pervaded by a strong individualism,

impairing possibilities of working for the common social interest and “innovative solutions” (p.17), as the Policy suggests.

· **Strategy for enhancing the principles of the Unified Health System (SUS):** Health promotion is also considered a tool to enhance the principles of the SUS: integrality, equity, sanitary responsibility, mobilization and social participation, intersectoriality, information, education and communication. Nevertheless, there has been no reflection on the many difficulties and hindrances for the implementation of such principles throughout almost two decades of SUS. The Policy (Brazil, 2006) also highlights as “a challenge of health production” (p.18) to overcome dichotomies and work towards “making links between individual/collective, public/private, state/civil society, clinic/politics, sanitary sector/other sectors”. The aim is to resolve the excessive fragmentation pervading the health-illness intervention practices through the hegemony of the biomedical model.

· **Establishment of objectives:** Both the general and the specific objectives and lines of action, though expressed in different ways, repeat the same concern “of promoting the quality of life and reducing the vulnerabilities and health risks related to the social determinants of health,” insisting on a more comprehensive vision of health and the promotion of autonomy, co-responsibility and social participation, in order to fulfill the SUS principles. In this respect, there were significant changes and modifications from the original proposal (Brazil, 2005), in which four of the six objectives mixed the idea of health promotion with disease-prevention, as seen in its repeated references “to support actions of disease prevention and control of transmissible and non transmissible diseases and health problems” (p.19). In other words, the prevailing focus was disease and not health.

· **Implementation of strategies and lines of action:** The majority of implementing strategies and lines of action are oriented toward putting all responsibilities on federal, state and municipal health managers. There is also a special concern to train these professionals in order to guarantee the inclusion of health promotion and disease prevention at the primary health care level, and more specifically, in the Family Health Strategy. As has been mentioned, the difficulties of implementing operational aspects of these strategies in the context of an under-budgeted public primary health care service are not considered. Besides the poor living conditions of the great majority of public health users, another shortcoming left aside is the hegemony of the biomedical model centered on curing disease. As research shows, another difficulty to consider is that higher rates of morbidity and mortality among the population at the bottom of the social pyramid means higher demands for health services and primary health care. As a result, health care professionals are usually overwhelmed by curative demands from the population, which leaves little space or disposition for health promotion actions. (Traverso-Yépez et al., in prelo).

Therefore, it is worrisome, and not surprising at the same time, to observe that focal actions for biennium 2006-2007 are mainly centered on individual practices, such as: healthful eating habits, physical activities, smoking control and prevention, reduction of morbidity and mortality rates caused by alcohol and other drug abuse and consumption, reduction of morbidity and mortality caused by traffic accidents, prevention of violence and stimulation of a peace culture, and promotion of sustainable development. Although these are important actions, they would need to be specially designed to cope with the limitations of the corresponding social, economical and cultural context, which currently hamper the possibilities of success.

## **2) Types of discourses**

In this reading, the aim is to consider the different discursive constructions in the policy document, especially focusing on the types of arguments mediating them. The original proposal of the policy included “scientific” discourses, in which knowledge and scientific evidence

appeared as a pledge of action. There were also “economic” arguments, especially with regard to evaluation criteria. However, the only sort of discursive argument observed in the definitive version of the Policy is a:

- Political-prescriptive discourse, which means that in the majority of the document’s discursive constructions, there is a political-prescriptive emphasis. It seems to assume that the mere fact of its being enacted as a Policy ensures that it is already a norm of action, without considering or reflecting on the feasibility of its achievement in everyday intervention practices:

Health promotion is, therefore, presented as a mechanism for enhancing and implanting a transversal policy, integrated and intersectorial, to ensure an open dialogue among the diverse areas of the sanitary sector and the other sectors of the Government, private and non-governmental organizations, and the society, composing nets of commitment and co-responsibility with regard to the quality of life of the population, where all individuals are co-participants in the protection and care of life. (Brazil, 2006, p.18)

It is very ambitious to talk about a dialogue that includes the diverse areas of the sanitary sector, other sectors of the Government and the private sector. Although it is also appealing to speak of “networks of commitment and co-responsibilities,” these are hard to achieve in the ongoing context of profound individualism and competitive attitudes. Society is, unfortunately, treated in the document as a harmonic unity instead of how it actually is, fragmented by social classes and diverse economical interests.

### **3) Orientation for action**

The attention here turns to the function that specific types of discursive constructions would try to achieve, as well as to the implicit line of action in these constructions:

- As the discourses are constructed within this hierarchic-prescriptive character, health promotion, instead of a proposal-process, tends to be treated as something finished, unambiguous

and, especially, easy to accomplish. The ambiguity in the discourses, which implies divergent and sometimes irreconcilable ambitious ideas and attitudes, as well as the disregard for the web of interdependences involved, do not allow the delegation of responsibilities among the persons involved and the obligation to be accountable for their actions. The main leadership role in defining lines of action is given to top management staff at ministerial level, usually generously paid, and pay little attention to other social actors, such as the users of the SUS and public health professionals directly involved in health actions with the users.

#### **4) Positionings**

This stage of the analysis attends to the ways that the discursive constructions position the different social actors. Again, despite the inclusion of terms, such as “citizenship” and “active involvement,” the vagueness of the official discourses and, especially, the entrenched power dynamics - vertical and authoritarian - tend to treat the public (users, the community and the general population) as passive receivers of the services.

As also observed by Sykes et al. (2004), when the group or the collective level is emphasized in the Policy, it is seen as a homogeneous block, neglecting the socio-cultural differences within it, especially in contexts of economic privation. Thus, there is a generalizing thrust in the discourses about “the citizens” or “the population”:

in the articulation between health promotion and health monitoring there must be an integrated effort in the construction of consensus and synergies and in the execution of the governmental agenda [...], stimulating and supporting the agency of the citizens in its elaboration and implementation... (Brazil, 2006, p.15)

However, as already noted, there is a vertical slant, tending to grant the central and operative role regarding action to management staff. Activities to “support the technical cooperation” or to favor “training and mobilization of managers and health workers” are common. Thus, the great



majority of actions and activities that require the deployment of resources refer only to the public bureaucracy, especially managers at the federal, state and municipal level. Concrete proposals of action to reach the population or service users are rare or even absent.

In the text, there are also general references to forms of relationships whose occurrence is virtually impossible in everyday practices:

the work in nets with the organized civil society favors that the planning of health actions be related to the perceived necessities and experiences of the population in the diverse territories and, concomitantly, it guarantees the sustainability of the intervention processes on the determinants and conditioning of health. (Brazil, 2006, p.15)

Among others things, the lack of political will to generate these sorts of relations is not addressed, for to do so would involve radical changes in the existing power relations.

## **5) Practices**

Here it is considered relevant to be attentive to the sorts of practices that such discursive constructions make possible in the text (Brazil, 2006). It is obvious that some of the discourse recipients, whatever they are called – the “public,” “citizens” or “the population” - are treated as passive and conditioned to the prescriptions of managers, technicians and specialists. They are depicted as having little or no possibility to assume the responsibility for their health actions. On the other hand, technicians, managers and specialists, characterized as authorities, are positioned as qualified executives of the design and implementation of actions. However, the most worrisome concern is the great distance and virtual impossibility of dialogue between the elite managers and health specialists and the majority of the population at the bottom of the social pyramid, to whom these health promotion practices are mainly addressed.

## **6) Subjectivation processes**

With regard to the dynamics of dialogic inter-animation or mutual influences, the above mentioned positionings and practices enact possibilities of subjectivation processes on the involved actors. Thus, the instituted vertical relations position “public service users” as passive, and, in accordance with this conditioning, they tend to act this way. It generally does not help to speak of empowerment or of developing autonomy when these people have been conditioned to have neither voice nor initiative (Sykes et al., 2004).

As they are conceived as a homogeneous group, public service users generally fear showing any kind of autonomy, tending to remain passive. By the same token, the social power attributed to managers is internalized and the tendency among them is to feel superior, reinforcing their authoritarian relationship with those under their responsibility. On that ground, the analysis shows that discursive texts are not neutral, but loaded with intentions, value judgments and positionings that make possible certain types of social practices to the detriment of others. The power relations involved are consonant with the dynamics of social/institutional practices of vertical and authoritarian kind in which they participate.

What this vertical approach based on supposedly objective knowledge disregards is that well-being is always a joint and relational production process. Therefore, the concepts of care and health promotion must be defined in an inter-actional and dialogical way (Riikonen, 1999) to be effective. The authoritarianism and the focus on pathologies tend to deter the potential abilities of the users, while supporting the instituted power relations.

### **Points to continue the discussion**

The traditional epistemic positioning of modernity (we, scientists, “here,” and the social transformations and our subject/objects, “out there”) tends to generate intellectual constructions of “reality.” As highlighted by Santos (1995, p.19), this is a consequence not only of modern scientific rationality, but also of the fast pace and intensity of social changes:

If, on the one hand, it makes reality hyper-real, on the other hand, makes it trite and banal, a reality without capacity to surprise us or to get us involved. A reality like this, after all, easily becomes a theory, so easily that the trivial way for referring the subject under discussion, almost makes us believe that the theory is the reality itself with another name, in other words, it becomes a self-fulfilling theory.

Therefore, more emphasis on reflexivity, critical thinking and dialogical relations - fundamental values for the development of critical reflection - is earnestly needed in the Health Promotion Policy and, in general, in all our policies and health practices. Well-intended policies are not enough if they are unable to be realized because of the lack of political will and the unequal power distribution, or because of the institutionalized practices themselves, where the tendency is to act automatically, in a non reflective way.

Incorporating reflexivity into the world of social practices in which we participate is important within a critical social psychological approach. This sort of approach, as Domenech & Ibañez (1998) stress, should be understood as a disposition or special sensitivity for the elaboration of “generative” reflections. These sorts of reflections should question “the dominant premises of the culture and propitiate the reconsideration of everything which is presented as evident; generating, new alternatives of social action” (p. 21). Such reflections will also allow us to address the roots of existing rationalities and the materialities operating in the social field, and to develop a critical ontology of ourselves. In Foucauldian terms (1994, p.30):

this critical ontology does not have to be understood as a theory, nor as a doctrine, or as a body of steady knowledge to be increased. It must rather be conceived as an attitude, an ethos, a philosophical way of seeing life, where even self-criticism is at the same time, a historical analysis of the limits that are imposed, as well as the experimentation of possibilities to trespass those limits.

This sort of practice is part of a conception known as “self-care.” It implies a reflective control of possible bias conditioned by self-limitations and socio-structural conditionings, justifying the disposition to negotiate contradictions and conflicts in relationships (Morin, 2001; Mariotti, 2000; Csikszentmihaly, 1993). Caring, here, is an operating concept closely related to the concept of relational ethics, which involves, first of all, a self-critical stance on the ways in which we position ourselves in our different social practices. As a relational process, caring is something not to be considered as definitive and finished, but as a permanent *coming-to-be* and as a disposition or orientation for action.

What this perspective also suggests is that we must pull away from the excessive rationalisms and intellectualisms that have become so common. Technical language and scientific thought tend to be problematic in that they reproduce existing power relations. As suggested by Riikonen (1999, p.144), excessive intellectualism takes us away from the existential inspired moment of the interaction and dialogue. Somehow, it inhibits the possibilities of as citizen-users to engender joint practices of health promotion, considered by the author as “well-being-generating contexts, moments, experiences, and life projects”.

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Translated by David Anderson

Translation from **Interface - Comunicação, Saúde, Educação**, Botucatu, v.11, n.22, p.223-238, May/Aug. 2007.