Rev Saúde Pública 2014;48(1):76-85

Original Articles

DOI:10.1590/S0034-8910.2014048004596

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Health promotion: challenges revealed in successful practices

ABSTRACT

OBJECTIVE: To examine successful practices of health promotion in health, education, culture, welfare and sport, leisure, identifying the elements of success and challenges in the field.

METHODS: A qualitative study with data obtained from in-depth analysis that included participant observation, interviews with managers, coordinators, professionals and participants from 29 practices reported as successful for promoting health in six municipalities of the metropolitan region of Belo Horizonte, MG, Southeastern Brazil, in 2011. The variables of the study were concept, dimension, dissemination and ease of access, identified in practices guided by content analysis.

RESULTS: The results indicate a conceptual and methodological uncertainty about health promotion as evidenced by conflicting objects and contradictory purposes. The practices differ in size, coverage and ease of access, determined by inter-sector coordination and political and financial investment.

CONCLUSIONS: We identified challenges to health promotion focusing on vulnerable populations, limits to financing and intersectoral partnerships.

DESCRIPTORS: Health Promotion. Health Public Policy. Health Education. Social Assistance. Motor Activity. Culture. Qualitative Research.

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Received: 10/15/2012
Approved: 9/26/2013

Article available from: www.scielo.br/rsp

INTRODUCTION

There has been evident concern, over the last few decades, concerning changes in the lifestyle habits of the Brazilian population so as to reduce vulnerability to disease, chronic disability and early death. The population's health is the result of the way in which the society in which they find themselves is organized. Biomedical tools are not capable of changing determinants of this process.[2,14,a]

With the evolution of health care practices and the health care model that guides the services provided, the definition of the term health care has undergone some alterations, adapting it to the historical, political and social context in which a specific population finds itself. The concept used is better accepted and is a wider concept of health care, as the result of a set of social, economic, political and cultural factors requiring the State to take responsibility for a health care policy that is integrated with other social and economic policies that guarantee its effectiveness.[2]

Promotion of health as a dimension of health care policy has been part of ideological discourse since the 1970s, gaining form and expression in the 1986 I International Conference on Promoting Health, in Canada.[13] In 1998, the World Health Organization (WHO) defined programs, policies and activities based on the principles of holistic inter-sectorialism, empowerment, social participation, equality, multi-strategic actions and sustainability as characteristics of health promotion.[20]

The health promotion movement aims to overcome the gaps in the biomedical model, articulating the whole of society in order to improve quality of life for individuals and the collective. However, one challenge lies in overcoming the traditional, hegemonic model in constructing a health paradigm that considers daily events of individuals and collectives in their ways of life, as well as singular and subjective expressions in determining health and illness.[14]

The National Health Promotion Policy was published in 2006, leading to the development of various practices in all spheres of government. In the municipal area, it was the management's responsibility to implement National Policy directives in accordance with other directives defined at a national level and depending on the local situation.

This process is filled with challenges[4-6,12,16,19,b] and evidence of success in the field of promoting health may guide how this success can be repeated in other contexts. Linked to this is the need to show advances and challenges in promoting health in other areas of social policies, beyond the health care sector.

This study aimed to identify advances and challenges in promoting health in successful practices promoting health in the areas of health care, education, social care, culture and sport and leisure.

METHODS

Qualitative study using dialectic as a reference. By synthesizing the qualitative question, the Marxist dialectic embraces not only the system of relationships that construct the subjects mode of knowing the exterior, but also social representations, which constitute the experience of objective relationships by those involved, who attribute meaning to them.[10]

The study's methodological approach includes mapping experiences of promoting health in the areas of health, education, culture, social care and sport and leisure in six municipalities in the Metropolitan Region of Belo Horizonte, MG, in 2011. The six municipalities were: Baldim, Belo Horizonte, Contagem, Igarapé, Nova Lima and Santa Luzia, MG, Southeastern Brazil, representing different population groups, from < 10,000 inhabitants to municipalities with populations of > 500,000.

Interviews were conducted with managers from the areas in question in the municipalities, indicating 29 successful practices. Practices were deemed successful if they had a positive impact on the quality of life of the population according to managers in that area, or in related sectors. The observations were made when interviews were conducted with coordinators, professionals and participants in the practices.

The practices were classified according to their potential to promote health care for their innovatory, reforming or transforming character. All of the indicated practices showed some degree of advance as regards their conception, processes or the relationships mobilized in their development. Thus, they were taken as successful on the whole, even though some aspects faced challenges in fully meeting the premise and principles of health promotion.

The data underwent content analysis, searching for manifest and latent meanings in the empirical material.[1] The technique was operationalized by exhaustive and repeated readings of the empirical material with the aiming of learning the key ideas. This enabled the study's empirical categories to be established.

[a] Ministério da Saúde. Portaria n° 687 de 30 de março de 2006. Aprova a política nacional de promoção da saúde. *Diario Oficial Uniao*. 30 mar 2006.

[b] World Health Organization. Health promotion evaluation: recommendations to policymakers. Copenhagen: European Working Group on Health Promotion Evaluation; 1998.

Analysis of the practices was oriented by the discussion for their potential to promote health in the categories of conception, dimension (large or small scale provision), dissemination (concentrated or capillary distribution) and access opportunities (universal or focused). These categories were paired with the practices' links to governmental projects and programs, enabling an analysis of financing and intersectorial coordination.

The results were organized in a matrix showing common elements within the practices which enabled them to be characterized as successful, as well as aspects which denoted challenges in promoting health in the different socio-political sectors.

The research respected Ministry of Health Resolution 196/96 and was approved by the Research Ethics Committee of the *Universidade Federal de Minas Gerais* (ETIC 0456.0.203.000-09). Subjects were informed of the aims and objectives of the study and signed a consent form.

RESULTS

A variety of practices were deemed successful and effective in promoting health. There were diversified practices, with a focus on social determinants and broad access, as well as others in which the provision was small scale, with a focus on preventing health problems and risks. Practices were identified which were provided in centralized social spaces in the municipalities, aimed at vulnerable groups with segmented access, as well as others with a coverage considered capillary as there were access opportunities in different areas of the municipalities (Table).

Successful practices in the health care sector were related to physical activities, exercise, educational groups and treatment workshops. Physical activities taking place in public areas of municipalities 1 and 2, with large scale provision and access in all regions of the municipality, stood out in this sector.

Practices in the education sector included family workshops, discussion of gender and sexual diversity, provision of a balanced diet, clinical, pedagogical and home appointments for children and adolescents in situations of social risk or domestic violence or exposed to child labor. Two aspects of practices in this sector attracted attention: one composed of practices essentially focusing on vulnerable children and teens, marked by small scale provision; the other composed of practices predominantly providing healthy eating, with widespread and capillary access, albeit restricted to pupils in public schools in the municipalities. Amplifying provision and providing universal access to practices were revealed as challenges to promoting health.

In the area of culture, initiatives were identified which were based on health promoting principles, although those involved were not always aware of the practices' potential to promote health and quality of life. Within this area, one of the practices mentioned stood out for its holistic view, stimulating participants to value their sense of belonging and cultural roots, as well as focusing on the collective and resuscitating community values. However, challenges emerged early on, in financing cultural activities.

Similarly, it was verified that in the sport and leisure sector, practices were occasional interventions, sometimes being small scale and little disseminated, sometimes because of the characteristics of the event and, therefore, with a limited capacity to consolidate themselves in the day-to-day life of the public, an indispensable element in sustainability within the field of promoting health.

A variety of foci, objectives and aims associated with promoting health were observed in the social care practices. Large scale practices were developed, although focusing on vulnerable groups, aimed at interventions concerning violence and food or housing insecurity.

From the managers' perspectives, it was not possible to identify positive aspects of health and quality of life understood to be the object, aim and investment in the practices. This shows conceptual inaccuracy with regards promoting health in different sectors of social policies.

The managers mentioned health promotion in terms of activities preventing diseases, indicating conceptual confusion when discussing the premises of the topic. Promoting health as a new way of interpreting health care needs and actions was present in the managers' discourse, although they did not discuss the topic from a contextual, broad or collective perspective. Managers from the education, social care, culture and sport and leisure departments considered that the responsibility for initiatives to promote health should lie in the health sector.

The managers recognized that health promotion is a strategic field in improving the population's quality of life, indicating practices which valued local aspects, focus on social determinants as experiences of success in health promotion:

> "Another action which also takes place in the territory is an action promoting the production of healthy food, through community vegetable gardens, vegetable gardens in the yards, in the schools. Not only vegetable gardens, but a whole discussion about the possibilities of families prepared to produce healthy food anywhere" (Social care manager, Municipality 2)

Table. Characterization of successful health promotion practices. Metropolitan Region of Belo Horizonte, MG, 2011.

Practices	Characterization	Elements of success	Challenges
P1SM1	Oriental exercise in public spaces of the city with predominant involvement of the elderly population. About 300 beneficiaries in different locations of the city.	Capillarity, low cost to implement.	Focus on the use of drugs and physical and psychological symptoms.
P2SM1	Talks and educational groups working cognitive perception, emotion and diet, involving different age groups. Organized in groups of approximately 10 patients with chronic diseases, varied occurrence in local health units of the municipality.	Federal financing	Biomedical design and few mechanisms for intersectorial coordination and monitoring and evaluation.
P3SM1	Physical activity and aerobic and anaerobic exercises for young people and adults in 48 gyms around the city	Capillarity and recognition of the population, federal funding.	No monitoring or evaluation mechanisms.
P4SM2	Physical activity in 26 public spaces in the city with aerobic and anaerobic exercises with audience predominantly comprised of seniors.	Based on the healthy city perspective; capillarity, universal access and recognition by the population.	Little evidence of intersectorial cooperation or monitoring or evaluation mechanisms.
P5SM3	Complementary and integrative practices such as acupuncture, auriculotherapy, homeopathy, herbal medicine, tai chi chuan, and others, performed in two centers in the city serving a population of approximately 3,500 individuals/year.	Diversity of activities, capillarity; municipal investment.	Scarce financing.
P6SM3	Therapeutic workshops in music, theater and crafts favoring psychosocial rehabilitation of those with mental health problems in a Reference Center for Social Assistance.	Potential for sustainability through income generation; has personal initiative to reintegrate socially.	No government financing; small scale.
P7SM4	Complementary and integrative practices, such as homeopathy, acupuncture, yoga, dance therapy and others in a core municipality serving a population of approximately 200 individuals/year.	Municipal investment.	No potential for autonomy or accountability.
P1EM1	Monthly workshops to integrate families and schools in Social Care Centers for approximately 6,000 recipients of the *Bolsa Família* and *Família-Escola* Programs.	Municipal financing.	Restricted to a specific population group.
P2EM1	Workshops in all municipal schools covering topics such as sexual and gender diversity, citizenship and health aspects along with overall comprehensive development.	Capillarity and federal financing	No evidence of intersectorial cooperation or monitoring or evaluation mechanisms.
P3EM2	Workshops covering gender and sexual diversity inclusion in 14 in the municipality's high schools.	Training of peer educators could attain capillarity.	Small scale.
P4EM4	Providing balanced meal in 23 municipal schools.	Federal financing and municipal support; large scale.	Few intersectorial cooperation or monitoring or evaluation mechanisms.
P5EM5	Clinical and pedagogical appointments promoting inclusive education though caring for children with special needs in a municipal center.	Municipal initiative and investment, together with federal financing.	Biomedical conception; few intersectorial cooperation or monitoring or evaluation mechanisms.
P6EM6	Home visits to clear up doubts and help children with homework. Especially those who are socially vulnerable.	Based on personal initiative of a teacher in the municipality.	Restricted to a specific group.
P1ASM1	Games workshops and theatre working on healthy eating with primary school children in 54 schools in different areas of the city, especially those which are more vulnerable.	Municipal policy guarantees development of this practice.	Limited to groups deemed vulnerable.

Continue

Continuation

P2ASM1	Monthly meetings of groups of 15 to discuss issues related to family organization and structure for recipients of *Bolsa Família* Program.	Priority investment area for social policies.	Little evidence of intersectorial cooperation or monitoring or evaluation mechanisms.
P3ASM2	Providing low cost balanced meat to families with food insecurity. Serving around 600 people 5 days a week.	Federal financing.	Assistance limited to a specific group. No mechanisms to stimulate autonomy or social participation were observed.
P4ASM2	Community vegetable gardens involving 21 units in the municipality including schools, churches and health care services.	High capillarity. Federal financing.	No evidence of monitoring or evaluation mechanisms.
P5ASM2	Meetings with 64 families resettled due to the *Aceleração do Crescimento* Program.	Priority investment area for social policies.	Limited amplitude.
P6ASM2	Action of 30 women living in vulnerable regions, identifying risk situations and intervening with individuals and communities, reducing situations of violence especially aimed at young people.	Municipal investment regarding political induction.	Restricted to a specific, vulnerable group of the population.
P7ASM2	Transport for 120 special needs children in wheelchairs to health care and education services.	Municipal investment.	Restricted to a specific, vulnerable group of the population.
P8ASM2	Educational workshops covering topics related to ageing and integration in a municipal center for the elderly.	Priority investment area for social policies.	Small scale and no evidence of monitoring or evaluation mechanisms.
P9ASM4	Physical activity and crafts, singing workshops and leisure afternoons with bingo and dancing for the elderly population in a municipal center for the elderly.	Capillarity and municipal investment.	Scarce financing.
P10ASM6	Activities of dance and music from different cultures, with approximately 160 children and adolescents in situations of vulnerability caused by child labor.	Priority investment area for social policies.	Small scale and no evidence of intersectorial cooperation mechanisms.
P1LM2	Sports and competition in three sports courts for municipal school age children, in particular those with social risk.	Municipal investment.	No evidence of intersectorial cooperation or monitoring or evaluation mechanisms.
P2LM2	Sports competition between public and private schools in the city with about 3,500 participants in activities that take place annually.	Social mobilization and municipal investment.	Little evidence of intersectorial cooperation or monitoring or evaluation mechanisms.
P3LM4	Physical activities and arts and music workshops with children and adolescents at social risk.	Municipal investment.	Scarce financing.
P4LM4	Work activities developed through physical activity in the workplace of a company.	Municipal investment.	Based on the biomedical concept; restricted to a specific group.
P1CM4	Physical activities, and talks with information on pregnancy and baby care for groups of six pregnant women in a highly vulnerable area of the municipality.	Based on an NGO initiative	No government financing; small scale.
P2CM6	Annual event for socializing with traditional recipes of the county and with the participation of approximately 1,500 people.	Social mobilization, enhancement of autonomy and sense of belonging; municipal investment and supporting local culture.	Scarce financing.

P: Health promotion practice; M1: Belo Horizonte; M2: Contagem; M3: Santa Luzia; M4: Nova Lima; M5: Baldim; M6: Igarapé Codes which show participants' links: S: health; E: education; C: culture; A: social care; L: sport and leisure, ordered by municipality from M1 to M6.

> "All of our teams struggle to give value to cultural identity. So, in the cultural centers, they are anchored in cultural identity, enrichment of the person, that community until they come out of the zone of weakness, of illness and start to value themselves as human beings, as someone who has a trajectory to construct as a subject, in relationships". (Cultural Manager, Municipality 1)

The majority of practices developed in the municipalities work primarily with physical activity and healthy eating, present in the National Health Promotion Policy. There are few initiatives in areas such as preventing violence and promoting culture and peace and acting on social determinants. Nor were any successful practices mentioned that incentivized reducing smoking, alcohol or drug use.

Managers and coordinators recognized the need to widen provision of health promoting activities regarding the dimension and dissemination of the practices. They revealed that investment in, and expansion of, determined practices, especially those linked with federal programs containing specific financing, constituted a priority area.

> "These programs which I mentioned before- P3SM1, P1SM1, P2EM1 – are all supportive. So resources are guaranteed to make them happen. In addition, we have financing from the ministry of health. And now, this year, they are going to finance a national health promotion policy". (Health Care Manager Municipality 1)

> "[...] Social Care is a policy which has consolidated itself. There are federal resources...". (Social Care Manager Municipality 1)

> "In terms of financing, what we have is more related to Federal and State government programs. In the municipality, there is nothing specifically aimed at promoting health". (Health Care Manager Municipality 6)

> "All of the programs I mentioned have government resources. That is the biggest support we have". (Social Care Manager Municipality 6)

The health care sector showed itself to be the most "independent" with regards government programs, with the majority of large scale successful practices maintained almost exclusively through municipal investment. The practices indicated in the cultural and sport and leisure sector, with limited provision, did not have a specific line of finance, indicating the scarcity of resources to be invested in health promotion practices.

Successful practices had in common a link with federal government programs, such as the *Bolsa Família* grant program, the accelerated growth – *Aceleração do Crescimento* – program, health in schools – *Saúde na Escola* – program, national citizenship and safety program – *Nacional de Segurança com Cidadania* – program and the national food and nutrition security – *Programa Nacional de Segurança Alimentar e Nutricional* – program.

The social care area stood out for the diversity and number of practices, which were in priority investment areas for social policies, such as income, diet, housing and eliminating child labor, which seemed to be an element of the "success" from the interviewees' perspectives.

Despite the amplitude and access to the practices developed in the social care and education areas – the foci were shown to be an element which marked challenges for promoting health. Actions were aimed at specific groups through criteria of segmenting risk such as low income, locations in violent areas of the municipality. This finding was more apparent in larger municipalities, with investment in practices preventing violence and developing strategies to encourage culture and peace.

Intersectorial coordination seemed to represent a dilemma for health promotion. The interviewees reinforced the recognition of partnerships and links to make advances in the field but, at the same time, revealed that inter-sectoriality is restricted to "requirements" in federal programs and policies.

> "I see that, all of a sudden, we need to be more coordinated, although the client is the same. But, unfortunately, we aren't yet". (Sport Manager Municipality 3)

> "We hear the word inter-sectoriality a lot, but inert-sectorial actions are still very fragmented. There is no action that is effective, that is effectively intersectorial". (Health Care Manager Municipality 2)

> "It is very complicated/each sector has their talks, their annual conferences, sometimes this is a requirement of some state or national systems. So they manage separately, each looks after their own. Nothing is horizontal, that doesn't work in a city where you need to oblige everybody to sing from the same hymn sheet". (Cultural Manager Municipality 6)

Links between social care, health care and education were observed, principally in practices which involved monitoring fulfilment of conditions to claim cash transfer benefits. The interviewees reinforced the recognition of partnerships and links to make advances in the field but, at the same time, revealed that intersectoriality is restricted to "requirements" in federal programs and policies.

DISCUSSION

Analysis of the data showed conceptual inaccuracy surrounding health promotion, which reinforces the findings of other studies on the same topic.[15,18] These studies, which claim that the incipience of incorporating health promotion practices into health care services is due to the term being used inappropriately by health care professionals, who confuse it with prevention practices and health education

Despite this inaccuracy, analysis of the findings show the incorporation of health promotion topics into different sectors, be that through the behavioral aspect, which directs changes in life style and habits related to physical activity and diet, among others, or from the socio-environmental perspective, including topics such as diversity, equality, citizenship and guaranteeing social rights.

Practices indicated to be successful by municipal managers in this study revealed the potential for promoting health in the socio-environmental aspect, with actions which tend to minimize ills resulting from social vulnerability, using the territory as the main guiding axis. Thus, poverty and social inequalities, recognized social determinants of health, are objects of intervention. They guide health promotion in the municipalities where they take place, confirming what was said in the National Health Promotion Policy regarding collective actions to improve the population's health conditions and well-being.[3,7]

The plurality of concepts which permeate health promotion place it in permanent dispute. This field was delineated by tension between amplitude and extent; access opportunities and focus; investments and intersectoriality.

Broadening health promotion was identified as a factor of success for health promotion in the practices analyzed, allowing a large number of individuals to have access to large scale provision. It is also noteworthy how the provision is extended, especially regarding initiatives in priority areas of national policies. This datum confirms what has been seen in other studies, which indicate investment and amplification of programs and practices aimed at situations characterized as challenges to the population's health and quality of life.[9] The results of this study are in agreement with those of other authors, who highlight the prioritization of incentivizing exercise, physical activity, access to healthy food, promoting culture and peace and preventing violence, housing and health education.[6,9]

The challenge of constructing a capillary model of developing actions, in contrast to the centralized model concentrating on a reduced number of practices within the municipalities, remains. If nucleation rationalizes costs, it can, on the other hand, hamper the creation of links and access, focusing the opportunity on the "same" individuals circulating in those spaces.

Access opportunities constitute a challenging element in health promotion, given the focus identified in a significant number of practices. We observed that the foci of policies, programs and practices on the topic, with interventions for vulnerable groups in contexts of risk, such as poverty and violence.

The focus indicates a duality between vulnerability and the possibility of access to cultural and social goods. Public policies – those with which the successful activities of this study are linked – aim to respond to demands, principally those of marginalized segments of society, deemed to be vulnerable. Thus, poor socioeconomic conditions, defined as low per capita income and food and housing insecurity create unequal conditions between the different population groups, producing differences in their living conditions.[11] The focus of the practices becomes a means of trying to reduce inequalities in the distribution of goods in society highlights the facets of biopower.[14] They show little potential for promoting structural or significant change which enables social justice to be guaranteed through universal and equal access to citizens' constitutional rights. From another perspective, it indicates the large scale investment in universal access practices to promote quality of life and the opportunity to enjoy goods and services which ensure social rights.

The nature of the programs with which these practices are linked affect intersectorial links and financing as elements of success. The majority of practices analyzed include financial investments from the federal government to subsidize the cost of the activities, which guarantees more solid structures regarding the organization and maintenance of the activities.

This can be considered a positive aspect, as it indicates the incorporation of health promotion in the government agenda introducing efficient practices for improving the population's life and health. However, reproducing the vertical models developed through the guarantees of federal programs represents a challenge for management in overcoming the trend of making all of the health care programs in the country uniform, without taking into consideration the peculiarities of states and municipalities.[17]

Introducing and financing from national policies contribute to overcoming the challenge of insufficient resources for health promotion, which limits the effectiveness and sustainability of the practices.[6] This was more evident in practices subsidized by the municipalities, suggesting the successful side of being linked to federal investment programs.

Likewise, scarcity of resources in the cultural and sport and leisure sector was a recurrent note in the analysis, due to the marginal position it occupies in most of the municipalities or not understanding the relationship of social rights to culture, sport and leisure with health promotion. It is from this that the lack of resources for the practices related to this topic stem.

The most modern approach to health promotion, which covers determinants distant from the health-disease process and includes leisure and culture, still needs to be understood. By recognizing this amplitude, it is hoped that managers and professionals related to culture, sport and leisure increase investment in consolidating these practices, breaking away from the secondary character identified in this study.

Intersectoriality was a constant dilemma in health promotion. Even when it was recognized that these links are strategic in responding effectively to complex problems which impact on individual and collective well-being, inter-sectoriality remains restricted to the field of intentions in the context of the practices analyzed. Partnerships are limited, with fragile agreements regarding referrals and sharing some material and human resources. Such factors become a challenge to the sustainability of the practices due to specific, short-term and structural issues.

Advances need to be made in the consistency of intersectorial practices. Ultimately, this concerns the production of well-structured programs with shared objectives, planning and management, as well as with their own budgets.[8,c]

There are some limitations to this study regarding the methodology used: practices analyzed were those mentioned by the managers, which may have been affected by political influence or interest in being more visible in the municipality. This method was chosen for its coherence with the understanding of health promotion as not being exempt from different interests which permeate the field of politics and health care practices.

There are tensions within the field of health care, with diversity and contradictions concerning the conception and performance in practical and structural elements. It is necessary to increase discussion of health promotion with managers, professionals and civil society, increasing the possibilities of effective and more universal interventions to improve the population's quality of life.

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This study was supported by the *Conselho Nacional de Desenvolvimento Científico e Tecnológico* (CNPq – Process 479809/2009-7) and the *Fundação de Amparo à Pesquisa do Estado de Minas Gerais* (FAPEMG – Process APQ 01319-10). The authors declare that there are no conflicts of interest.