MINISTRY OF HEALTH OF BRAZIL

# National Health Promotion Policy (PNPS)

Annex I of the Consolidation Ordinance No. 2, dated September 28, 2017, which consolidates the norms on the national health policies of SUS

Brasília DF 2019

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Secretariat of Health Surveillance
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# Abstract

# Presentation

Based on the constitutional definitions, on the legislations that regulate the Unified Health System (SUS, *Sistema Único de Saúde*), on the deliberations made in national health conferences, and on the National Health Plan (2004-2007), SUS National Health Promotion Policy was approved in 2006, in the Three-Party Interagency Commission, with the purpose of confronting challenges in health production and continuously qualifying sanitary practices and the health system.

Its institutionalization in SUS started in 2005 with the creation of the Policy Managment Committee, through Ordinance MS/GM No. 1.190, dated July 14, 2005, which should, among other assignments, consolidate the proposal of the National Health Promotion Policy, define its conduction in different secretariats in the Ministry of Health, and coordinate and integrate health promotion actions within the scope of the SUS. Initially, the Committee only comprised entities and bodies linked to the Ministry of Health. Subsequently, through Ordinance MS No. 1.409, dated June 13, 2007, the National Council of State Health Departments (Conass, *Conselho Nacional de Secretários de Saúde*), and the National Council of Municipal Health Departments (Conasems, *Conselho Nacional de Secretarias Municipais de Saúde*) became part of the referred joint board; and the Brazilian Association of Public Health (Abrasco, *Associação Brasileira de Saúde Coletiva*) became part of the Committee, as per MS Ordinance No. 1.571, dated July 19, 2012.

The National Health Promotion Policy (PNPS, *Política Nacional de Promoção da Saúde*) was created through Ordinance MS/GM No. 687, dated March 30, 2006, and redefined by Ordinance No. 2.446, dated November 11, 2014. The Ordinance No. 2.446/2014 was revoked by the Consolidation Ordinance No. 2, dated September 28, 2017, which consolidates the norms on the national health policies of the Unified Health System (SUS). The PNPS ratified the commitment of the Brazilian Government to increase and qualify health promotion actions in SUS services and management; since then it was included in the SUS managers' strategic agenda and in the subsequent National Health Plans, thus broadening the possibilities of the existing public policies.

In compliance with its duties involving the coordination and establishment of public policies to ensure the integrity of health care, the Ministry of Health (MS, *Ministério da Saúde*) has been assuming new demands and new commitments, both internationally and domestically.

The domestic and international context indicated new challenges and commitments that have motivated the enhancement and updating of the PNPS. Its revision process – started by the Ministry of Health and coordinated by the Secretariat of Health Surveillance as of 2013 through the Policy Management Committee, and in partnership with the Pan-American Health Organization (PAHO) and the Health Promotion Thematic Group of the Brazilian Association of Public Health (Abrasco) – took place in an far-reaching, democratic and participative manner, and involved managers, workers, counselors, representatives of social movements, and professionals in higher education institutions, in addition to the participation or representatives of institutions outside of the Health sector from

the five regions of Brazil, who are committed with health promotion actions. Within the scope of SUS, the PNPS was presented and adjusted in the Health Surveillance, Health Care, and Management Work Groups, as well as in the Three-Party Interagency Commission (CIT, *Comissão Intergestores Tripartite*) and in the National Health Council (CNS, *Conselho Nacional de Saúde*).

The foundation of this new version of the referred policy is the SUS itself, which includes in its base a broadened concept of health, the theoretical reference of health promotion, and the results of its practices since its creation.

The revised PNPS indicates the need for coordination with other public policies to reinforce it, with the imperative participation of social and popular movements, as it is impossible for the Sanitary sector to be held solely responsible for fighting health determinants and constraints.

Therefore, the goals, principles, values, guidelines, cross-cutting themes, operational strategies, responsibilities, and priority topics that have been reformulated and updated for this Brazilian Government's policy are intended to improve conditions and ways of life, as well as to affirm the right to life and health, dialoguing with the reflections of the movements within the scope of health promotion.

# Introduction

Health promotion has been discussed since the Brazilian re-democratization process, in which the 8th National Health Conference became a major milestone in the struggle for the universalization of the health system and for the implementation of public policies to protect life, thus rendering health an irrevocable social right, such as the other rights to citizenship and human rights.

Within this context, the 1988 Federal Constitution created SUS and ensured not only universal access by citizens to health services and actions, but also integrity of assistance with equality and wide social participation, and without prejudices or privileges of any nature, thus rendering it capable of responding for health promotion, prevention, protection and recovery, according to people's needs.

In Organic Health Law (Law No. 8.080, dated September 19, 1990), the SUS incorporated the broadened concept of health resulting from ways of life, organization and production within a particular historical, social, and cultural context, in an attempt to overcome the conception of health as absence of diseases, focused on biological aspects.

To operate the health policy, including that of health promotion, it is necessary to consolidate practices focused on individuals and groups, from a perspective of multidisciplinary work, integrated work, and networking, so as to consider the health-related needs of the population in a coordinated action between the several actors, and in a particular region.

To organize all health services and actions, the SUS political and institutional design includes a network, referred to as Health Care Network, which is regionalized and hierarchized with different technological densities formed by health care points. Complementarily, the PNPS needs to coordinate its actions with the other networks, such as that of social protection, of which health forms an integral part, with assistance and social security. The Policy also considers that the other sectors and institutions are crucial for the production of health and its protection.

From this perspective, and based on the letters of international conferences, health promotion is a set of strategies and manners to produce health, both individually and collectively, which is characterized by intersectoral and intrasectoral collaboration and coordination, and by the creation of the Health Care Network, in an attempt to coordinate in conjunction with the other social protection network with broad participation and social control. Therefore, it recognizes other existing policies and technologies with the purpose of promoting equality and quality of life, with a reduction in the health risks and vulnerabilities that arise from social, economic, political, cultural, and environmental determinants.

Within the scope of health care and protection, integrity in health promotion becomes a health production strategy that respects specificities and potentialities in the preparation of life and therapeutic projects, and in the organization of health work, through the qualified hearing of workers and users, so as to transfer attention from the strict perspective of illness to the understanding their stories and life conditions.

Thus, health promotion must consider the autonomy and singularity of the individuals, groups and regions, because the manners in which they select their ways of life, organize their choices, and create possibilities to meet their needs depend not only on community and individual freedom or will, but are also conditioned and determined by the social, economic, political and cultural contexts in which they live.

The health-illness process arises from multiple and complex aspects, and it is up to the Health sector to make them more and more visible. Accordingly, from the perspective of health promotion, the intersectoral coordination must encourage and push the other sectors to consider, in the construction of their specific policies, the health-related vulnerability factors and conditions, risks and potentialities that affect the life of the population, thus holding all sectors responsible and ensuring the inclusion of health in the agendas of all public policies.

It is therefore proposed that health interventions widen their scope, taking as subject matter health issues and needs, as well as their determinants and constraints, so that the organization of care and protection will jointly involve the actions and services that operate on health and illness, with a view beyond the walls of the health units and the health system, thus affecting life conditions and creating more healthy choices.

Health requires the active participation of all individuals in the analysis and formulation of actions that aim at its promotion. So, the approach of health promotion points to the development of public policies and to the production and dissemination of health practices and knowledge in a shared and participative manner.

In this sense, the PNPS – in its process of implementation in the several of SUS's management spheres and in the interaction with the Sanitary sector and the other public policy sectors and the society – is here to encourage the manner in which health work is organized, planned, conducted, analyzed and assessed.

It is relevant to highlight that, by proposing changes to health work with the purpose of promoting health and quality of life, the PNPS complies with the Adelaide Declaration (2010) and the Declaration of Helsinki on Health in All Policies (2013). These documents emphasize that it is much easier to achieve the goals set by the government when all sectors incorporate health and wellbeing as central components in the development of policies. This occurs because the foundations of health and wellbeing are outside of the Health sector, and formed on a social and economic basis. These documents express the need for the establishment of a new social contract among all sectors to enhance human development, sustainability and equality, as well as to improve health conditions.

The PNPS includes in its core the need to establish a relationship with the other public policies achieved by the population, including those in the Health sector, such as: the National Primary Health Care Policy (Pnab, *Política Nacional de Atenção Básica*), the National Food and Nutrition Policy (Pnan, *Política Nacional de Alimentação e Nutrição*), the National Popular Health Education Policy (Pnep-SUS, *Política Nacional de Educação Popular em Saúde*), the National Humanization Policy (HumanizaSUS, *Política Nacional de Humanização*), the National Strategic and Participative Management Policy

(ParticipaSUS, *Política Nacional de Gestão Estratégica e Participativa*), the National Policy on Integrative and Complementary Practices (PNPIC, *Política Nacional de Práticas Integrativas e Complementares*), the National Policy on the Reduction of Morbidity and Mortality from Accidents and Violence, the National Emergency Care Policy, and the National Policies on Comprehensive Health for Specific Populations, such as the black and the LGBTQ population.

Since the institutionalization of the PNPS in 2006, several facts have drawn new scenarios, thus interfering with the discussion on health promotion. It is relevant to highlight the social agendas coordinated by the Executive Office of the Presidency of the Republic; the United Nations Conference on Sustainable Development – Rio +20; the Global Strategy on Diet, Physical Activity and Health; the 8th International Conference on Health Promotion, with the Declaration of Helsinki with the topic Health in All Policies; the Brazil Without Misery Plan (*Plano Brasil Sem Miséria*); the Decade of Action for Road Safety – 2011 to 2020; and the World Economic Forum, with a discussion on the challenge of fighting noncommunicable chronic diseases.

There were also changes on the legislation, including the publishing of the Decree No. 7.508, dated 2011, which regulated the Organic Health Law (Law No. 8.080/1990), which provides for the inter-federative coordination, with emphasis on the equality among health areas; and the publishing of Complementary Law No. 141, dated 2012, which regulated Constitutional Amendment No. 29 and set forth the sharing and transfer of resources in health, in addition to the standards of inspection, assessment and control of the expenses incurred with health in the three government spheres.

The re-elaboration of the PNPS is appropriate, as it establishes a dialog with the new domestic and international milestones, it ensures the SUS principles and guidelines, and recognizes the constant need for qualifying and updating the actions and services provided by SUS managers and workers, revising the role played by the Health sector in the coordination and induction of other public policies.

A need arose for identifying how health promotion in SUS was being operated in the regions to subsequently revise how the PNPS, as a public policy, mobilized the actors in search of its practical establishment. The importance of including new inductive elements for its achievement became evident, such as the explanation of values, the definition of cross-cutting theme and operational axes, and the adaptation and updating of the priority topics of the policy.

All aspirations made evident in the PNPS will be fully established to the extent that managers, workers and users in the Health sector and other sectors accept the invitation to become actively involved in the collective construction of the common good to reduce inequalities and promote basic human rights.

# Values and principles

Values and principles consist of the basic expressions of all practices and actions in the health promotion field of activity.

The PNPS:

a) recognizes the subjectivity of people and groups in the process of care and protection to defend health and life;

b) considers solidarity, happiness, ethics, respect to diversity, humanization, co-responsibility, justice, and social inclusion, as the basic values in the process of its establishment;

c) adopts as principles: equality, social participation, autonomy, empowerment, intrasectors, sustainability, integrity and regional characteristics.

Each one of these values and principles identified in the PNPS is defined in articles 3 and 4 of the attached ordinance.

# Goals

## General Goal

To promote equality and improvement in the conditions and ways of life, enhancing the potentiality of individual and collective health, and reducing vulnerabilities and health risks arising from social, economic, political, cultural, and environmental determinants.

## Specific Goals

I. To encourage the health promotion as a part of the integrity of protection in the Health Care Network, coordinated with other social protection networks.

II. To contribute to the adoption of social and health practices focused on equality, participation and social control, with the purpose of reducing systematic, unfair and avoidable inequalities, respecting differences in social class, gender, sexual orientation, gender identification, between generations, ethnical and racial, cultural, regional, and those related to people with disabilities and special needs.

III. To enable human mobility and accessibility; safe, healthy and sustainable development.

IV. To create a culture of peace among communities, regions and cities.

V. To support the development of social production spaces and healthy environments that enable human development and good living.

VI. To value traditional and popular knowledge and integrative and complementary practices.

VII. To foster empowerment and the capacity to make decisions, as well as the autonomy of individuals and groups through the development of personal skills and competencies in life and health promotion and protection.

VIII. To create specific educational, professional education and qualification processes in health promotion, in accordance with the principles and values stated in this Policy for workers, managers and citizens.

IX. To set forth media and social communication strategies aimed at reinforcing health promotion principles and actions, and defending healthy public policies.

X. To encourage the research, production and dissemination of innovative knowledge and strategies within the scope of health promotion.

XI. To provide means for the inclusion and qualification of the recording of health promotion activities, and of equality in information and inquiry systems, thus allowing the analysis, monitoring, assessment and financing of the actions.

XII. To encourage discussions on consumption and production methods that are in conflict of interest with health promotion principles and values, and which increase vulnerabilities and health risks.

XIII. To contribute to the coordination of intersectoral and intrasectoral public policies with domestic and international agendas.

# Guidelines

The following are PNPS guidelines, which are understood to be lines that form the basis of the actions and explain their purposes:

I. Encouragement to intrasectoral and intersectoral cooperation and coordination to improve activity on health determinants and constraints.

II. Stimulation to the planning of regional health promotion actions based on the recognition of local contexts and the respect to diversities, with the purpose of enabling the construction of social production spaces, health environments, and the search for equality, guarantee of human rights and social justice.

III. Incentive to democratic, participative and transparent management to reinforce the participation, social control and co-responsibilities of individuals, groups, institutions and of the governmental and civil society spheres.

IV. Broadening of governance in the development of health promotion actions that are sustainable in the political, social, cultural, economic and environmental dimensions.

V. Encouragement to research, production and diffusion of experiences, knowledge and evidence that support the decision-making process, autonomy, collective empowerment, and the shared construction of health promotion actions.

VI. Support to permanent qualification and education in health promotion to increase the commitment and critical and reflective capacity of health managers and workers, as well as the encouragement to the enhancement of individual and collective skills to reinforce sustainable human development.

VII. Incorporation of health promotion interventions in the health care model, especially in the daily routine of basic health care services through intersectoral actions.

VIII. Organization of the management and planning processes of the several intersectoral actions, as a means to reinforce and foster the implementation of the PNPS in the Health Care Network (RAS, *Rede de Atenção à Saúde*), in a cross-cutting and integral manner, establishing commitments and co-responsibilities to reduce vulnerability and health risks associated with social determinants.

# Cross-cutting themes

Cross-cutting themes are references for the formulation of health promotion agendas and for the adoption of strategies and priority topics, operating in consonance with the SUS and the PNPS principles and values.

I. **Social Health Determinants (DSS, *Determinantes Sociais da Saúde*), equality and respect to diversity:**

This means to identify differences in life conditions and opportunities, seeking to allocate resources and efforts to reduce unfair and avoidable inequalities through a dialog between technical and popular knowledge.

II. **Sustainable development:**

This refers to providing visibility to the consumption and production methods associated with the priority topic, by mapping possibilities to intervene in those that are harmful to health, adapting technologies and potentialities according to local specificities, without compromising future needs.

III. **Protection and health production:**

This represents the incorporation of the topic in the logic of networks that enable humanized protection practices that are based on local needs, in such a manner that the reinforce community action, participation and social control, and which foster recognition and dialog between the several forms of knowledge (popular, traditional and scientific), building practices based on the integrity of protection and health. It also means to link the topic to a broadened health conception, taking into consideration the role and organization of the different sectors and actors that, in an integrated and articulated manner, through common goals, act in health promotion.

IV. **Healthy environments and regions:**

This means to associate the priority topic with the group's and people's life and work regions and environments, identifying opportunities to include health promotion in the developed actions and activities, in a participative and dialogue manner.

V. **Life at work:**

This consists of inter-associating the priority topic with formal and non-formal work and with the different sectors of the economy (primary, secondary and tertiary), considering both urban and rural spaces, and identifying opportunities to operate in the logic of health promotion for actions and activities developed in the different places, and in a participative and dialogue manner.

VI. **Culture of peace and human rights:**

This consists of creating opportunities of interaction, solidarity, respect to life and reinforcement of bonds, developing social technologies that enable the mediation of conflicts in situations of social tension, ensuring basic freedom and human rights, reducing violence and building peace culture and solidarity practices.

# Operational axes

Operational axes are strategies to perform health promotion actions, respecting the PNPS values, principles, goals and guidelines.

**I. Regionalization:**

Regionalization is a SUS guideline and a structuring axis, which purpose is to give guidance to the decentralization of health services and actions, and to organize the Health Care Network. The regionalization process takes into consideration the coverage of health areas and their coordination with the social equipment existing in the regions. It also complies with inter-federative agreements, the definition of parameters of scale and access, and the performance of actions that identify regional singularities for the development of policies, programs and interventions, widening health promotion actions and contributing to reinforce regional identities.

**II. Intrasectoral and intersectoral coordination and cooperation:**

The sharing of common plans, objectives, resources and goals between the different sectors and different areas in the same sector.

**III. Health Care Network:**

The cross-cutting of promotion in the Health Care Network, enabling humanized care practices based on local needs and on the integrity of protection, in coordination with every health production equipment in the region, such as basic care, priority networks, and health surveillance, among others. The coordination of the Health Care Network with the other social protection networks, linking the topic to a broadened health conception, taking into consideration the role and organization of the different sectors and actors that, in an integrated and articulated manner through common goals, act in health promotion.

**IV. Participation and social control:**

An increase in the participation and inclusion of individuals in the preparation of public policies and in the relevant decisions that affect the life of individuals and the community, and their contexts.

**V. Management:**

The prioritization of processes of democratic and participative regulation and control, planning, monitoring, assessment, financing, and communication.

**VI. Education and qualification:**

The encouragement to the permanent attitude of learning sustained by problem, dialog, freedom, emancipation and critical pedagogical processes.

**VII. Surveillance, monitoring and assessment:**

The use of multiple approaches in the generation and analysis of information on the health condition of individuals and population groups to subsidize decisions and interventions, as well as to implement public policies on health and quality of life.

**VIII. Production and dissemination of knowledge and information:**

The encouragement to a reflective and solving attitude towards issues, needs and potentialities of co-management groups, by broadly sharing and disclosing results to the groups.

**IX. Media and social communication:**

The use of several formal and popular communication expressions to favor listening and vocalization of the different groups involved, contemplating information on the planning, performance, results, impacts, efficiency, efficacy, effectiveness and benefits of the actions.

# Competencies that are common to all management spheres in the Health sector

The following activities are competencies that are common to all spheres in the Health sector:

I. To disclose the PNPS, reinforcing its values and principles.

II. To establish partnerships, promoting intersectoral and intrasectoral coordination.

III. To contribute to the reorganization of the health care model based on the PNPS values, principles and guidelines.

IV. To foster rules and regulations for a safe, healthy and sustainable development in environments, communities, cities and regions.

V. To reinforce participation and social control, as well as the scope of democratic and participative management, as mechanisms to implement the PNPS.

VI. To build mechanisms to identify potentialities and vulnerabilities to subsidize the reinforcement of the team.

VII. To define priorities, goals, strategies and objectives in the scope of the joint boards, and establish interagencies to implement health promotion programs, plans, projects and actions.

VIII. To establish instruments and management, planning, monitoring and assessment instruments and indicators.

IX. To allocate budgetary and financial resources to implement the PNPS.

X. To encourage the exchange of experiences and the development of studies that intend to enhance and disseminate technologies and knowledge focused on health promotion.

XI. To develop organizational strategies and mechanisms to qualify and value the health-related workforce, stimulating permanent education and qualification processes focused on the establishment of the PNPS.

XII. To stimulate health promotion initiatives and actions, as well as to produce data and disclose information.

XIII. To include health promotion in Health Plans and in Annual Health Agenda, in compliance with the SUS planning and management instruments, to implement the PNPS taking into consideration local and regional specificities.

XIV. To coordinate the insertion of actions focused on health promotion in the SUS information systems, among other systems.

XV. To enable partnerships with international bodies, governmental and non-governmental organizations, including the private sector and the civil society, to reinforce health promotion in the country.

# Competencies of the Ministry of Health

The following activities are competencies of the Ministry of Health:

I. To foster coordination with states and cities to support the establishment and implementation of the PNPS.

II. To agree upon priority topics and the financing of the PNPS in the Three-Party Interagency Commission (CIT).

III. To support the implementation of the PNPS, taking into consideration the epidemiological profile and health needs.

IV. To enable mechanisms to co-finance health promotion plans, projects and programs.

V. To include health promotion actions in Multi-Annual and National Health Plans.

VI. To present health promotion strategies, programs, plans and projects in the National Health Council.

VII. To institutionalize and maintain in operation the PNPS Committee in compliance with its principles and guidelines.

VIII. To provide institutional support to state and city health departments, including the Federal District, to establish, implement and consolidate the PNPS.

IX. To support and prepare disclosure materials to socialize health promotion information and actions.

X. To encourage, monitor and assess health promotion processes, programs, projects and actions.

# Competencies of State Health Departments

The following activities are competencies of the State Health Department:

I. To foster coordination with the cities to support the establishment and implementation of the PNPS.

II. To agree upon the strategies, guidelines, goals, priority topics and financing of the PNPS establishment and implementation in the Two-Party Interagency Commissions (CIB, *Comissões Intergestores Bipartite*), Regional Interagency Commissions (CIR, *Comissões Intergestores Regionais*) and in the Federal District Management Joint Board (CGSES/DF, *Colegiado de Gestão do Distrito Federal*).

III. To establish and implement the PNPS in the Health Care Network, within the scope of their region, respecting its guidelines and promoting adaptations to local and regional specificities.

IV. To present health promotion strategies, programs, plans and projects in the State Health Council.

V. To include health promotion actions in Multi-Annual and State Health Plans.

VI. To allocate budgetary and financial resources to establish and implement the PNPS.

VII. To provide institutional support to Municipal Departments and health areas in the process of establishing, implementing and consolidating the PNPS.

VIII. To monitor and assess health promotion programs, projects and actions within the state and district scope.

IX. To support and prepare disclosure materials with the purpose of socializing information and disclosing health promotion, programs, plans, projects and actions.

X. To foster cooperation, create spaces for discussions and exchange of experiences and knowledge on health promotion.

XI. To support and execute programs, plans, projects and actions associated with health promotion, taking into consideration the epidemiological profile and needs of their region.

# Competencies of Municipal Health Departments

The following activities are competencies of the Municipal Health Department:

I. To foster intrasectoral and intersectoral coordination to support the establishment and implementation of the PNPS within the scope of their competency.

II. To establish and implement the PNPS within the scope of their region, respecting local and regional specificities.

III. To agree upon the strategies, guidelines, goals, priority topics and financing of the PNPS establishment and implementation in the Two-Party Interagency Commissions (CIB, *Comissões Intergestores Bipartite*), Regional Interagency Commissions (CIR, *Comissões Intergestores Regionais*) and in the Federal District Management Joint Board (CGSES/DF, *Colegiado de Gestão do Distrito Federal*).

IV. To present health promotion strategies, programs, plans and projects in the Municipal Health Council.

V. To include health promotion actions in Multi-Annual and Municipal Health Plans.

VI. To allocate budgetary and financial resources to perform health promotion actions.

VII. To provide institutional support to the managers and workers in the process of establishing, implementing and consolidating the PNPS.

VIII. To promote and conduct the permanent education of workers in the local health system in order to develop health promotion actions.

IX. To identify and create channels for the participation in the decision-making process for the development and sustainability of health promotion actions.

X. To foster participation and social control and reinforce community health promotion actions in the regions.

XI. To identify, coordinate and support the exchange of experiences and knowledge on health promotion actions.

XII. To participate in the process of monitoring and assessing health promotion programs, plans, projects and actions.

XIII. To prepare educational materials with the purpose of socializing information and disclosing health promotion, programs, plans, projects and actions.

XIV. To support and execute in a privileged manner programs, plans, projects and actions directly associated with health promotion, taking into consideration the epidemiological profile and needs of their region.

The competencies of the Federal District Health Department are the same as those assigned to the State and Municipal Health Departments as already described.

# Financing

Policies, programs and actions that provide for health promotion components are financed by means of the SUS financing blocks. The financing of the PNPS priority topics and their operational plans are the subject matter of a prior agreement in the Three-Party Interagency Commission (CIT).

# Priority topics

In permanent dialog with other policies, with other governmental and non-governmental sectors, including the private sector and the civil society, and especially with the sanitary specificities, the PNPS indicates the topics identified as priorities and evidenced by the health promotion actions that have been performed since 2006 and inserted in the first version of the PNPS, as well as by the rules and regulations in effect in the federal sphere, by the national (National Health Plan, inter-federative agreements, and the MS strategic planning) and international agreements signed by the Brazilian government.

**I. Permanent education and qualification:**

To mobilize, sensitize and provide training to Health managers and workers, as well as those in other sectors, for the development of health promotion education actions, with the purpose of including them in permanent education spaces.

**II. Proper and healthy diet:**

To perform actions associated with proper and healthy diet for purposes of health promotion and food and nutritional safety, contributing to poverty mitigation actions and goals, social inclusion, and the guarantee of the human right to proper and healthy diet.

**III. Body practices and physical activities:**

To provide body practice and physical activity actions, counseling and disclosure, encouraging the improvement of the condition of public spaces, taking into consideration the local culture and including plays, games, and popular dance, among other practices.

**IV. Fighting the use of tobacco and its by products:**

To perform, coordinate and mobilize actions to reduce and control the use of tobacco, including educational, legislative, economic, environmental, cultural and social actions.

**V. Fighting the abusive use of alcohol and other drugs:**

To perform, coordinate and mobilize actions to reduce the abusive consumption of alcohol and other drugs, with the co-responsibility and autonomy of the population, including educational, legislative, economic, environmental, cultural and social actions.

**VI. Providing safe mobility:**

To attempt to advance in intersectoral and intrasectoral coordination, involving the region's health surveillance, basic care and urgency and emergency networks in the production of care and in the reduction of traffic-related morbidity and mortality. To direct integrated and intersectoral actions in the regions, including actions involving health, education, traffic, inspection, environment and in the other sectors involved, in addition to the society, with the purpose of defining an integrated plan, partnerships, assignments, responsibilities and the specificities of each sector to foster safe

mobility. To advance in the performance of educational, legislative, economic, environmental, cultural and social actions based on qualified information and on an integrated plan, in order to ensure safe traffic, the reduction of morbidity and mortality, and peace in traffic.

**VII. To create a culture of peace and human rights:**

To perform, coordinate and mobilize actions that encourage interaction, solidarity, respect to life and the reinforcement of bonds. To develop social technologies that enable the mediation of conflicts, the respect to diversity and gender and differences in sexual orientation, between generations, ethnical and racial, cultural, regional differences, as well as those related to people with disabilities and special needs, ensuring human rights and basic freedoms. To foster the coordination of the Health Care Network with the other social protection networks, producing information that is qualified and capable of generating individual and collective interventions, thus contributing for the reduction of violence and the culture of peace.

**VIII. Promotion of sustainable development:**

To perform, mobilize and coordinate governmental and non-governmental actions, including the private sector and the civil society, in the different scenarios (cities/municipalities, field, forest, waters, districts, regions, communities, homes, schools, churches and companies, among others), allowing for the interaction between health, the environment, and sustainable development in the social production of health, in coordination with the other priority plans.

# Consolidation Ordinance No. 2, dated september 28, 2017

Consolidation of the norms about the national health policies of the Unified Health System

## ANNEX I

### NATIONAL HEALTH PROMOTION POLICY (PNPS) (SOURCE: ORDINANCE MS/GM No. 2.446/2014)

**Article 1** The National Policy for the Promotion of Health (PNPS) is established. (Source: Ordinance MS/GM No. 2.446/2014, Art. 1)

### CHAPTER 1

**Article 2** The PNPS includes in its base the broadened concept of health and the theoretical reference of health promotion as a set of strategies and manners to produce health, both individually and collectively, which is characterized by intersectoral and intrasectoral collaboration and coordination, and by the creation of the Health Care Network (RAS, *Rede de Atenção à Saúde*), in an attempt to coordinate its actions with the other social protection network with broad participation and social control. (Source: Ordinance MS/GM No. 2.446/2014, Art. 2)

**Article 3** The following are basic values in the process of establishing PNPS: (Source: Ordinance MS/GM No. 2.446/2014, Art. 3)

**I –** solidarity, understood as the reasons that lead individuals and groups to nurture solicitude towards others, in moments of disagreements or difficulties, building a common vision and goals, supporting the resolution of differences, contributing to improve the lives of people, and to form networks and partnerships; (Source: Ordinance MS/GM No. 2.446/2014, Art. 3, I)

**II –** happiness, as self-perception of satisfaction, built in relationships between individuals and groups, which contributes to the capacity of deciding on how to enjoy life and how to become a participating actor in the construction of common interventions and projects to overcome individual and collective difficulties from the recognition of potentialities; (Source: Ordinance MS/GM No. 2.446/2014, Art. 3, II)

**III –** ethics, which presupposes conducts, actions and interventions sustained by the valuing and protection of life, considering that they are the basis of common good with dignity and solidarity; (Source: Ordinance MS/GM No. 2.446/2014, Art. 3, III)

**IV** – respect to diversity, which recognizes, respects and explains the differences between individuals and groups, encompassing ethnical, age, capacity, gender, sexual orientation, regional and geographic area differences, among other types of differences that influence or interfere with health conditions and determinations; (Source: Ordinance MS/GM No. 2.446/2014, Art. 3, IV)

**V** – humanization, as an element for the evolution of mankind, through interaction with others and the environment, with the valuing and enhancement of aptitudes that provide better and more human conditions, building practices based on the integrity of protection and health; (Source: Ordinance MS/GM No. 2.446/2014, Art. 3, V)

**VI** – co-responsibility, as shared responsibilities between people or groups, in which two or more people share obligations and/or commitments; (Source: Ordinance MS/GM No. 2.446/2014, Art. 3, VI)

**VII** – social justice, as a need for achieving an equal sharing of social goods, provided that human rights are respected, in such a manner that the most disadvantaged social classes rely on opportunities of development; and (Source: Ordinance MS/GM No. 2.446/2014, Art. 3, VII)

**VIII** – social inclusion, which presupposes actions that ensure access to the benefits of life in society to all people, in an equal and participative manner, with the purpose of reducing inequalities. (Source: Ordinance MS/GM No. 2.446/2014, Art. 3, VIII)

**Article 4** The PNPS adopts the following as principles: (Source: Ordinance MS/GM No. 2.446/2014, Art. 4)

**I** – equality, when based on health promotion practices and actions, in the equal distribution of opportunities, considering the specificities of individuals and groups; (Source: Ordinance MS/GM No. 2.446/2014, Art. 4, I)

**II** – social participation when interventions consider the vision of different actors, groups and classes in the identification of problems and the solution of needs, acting as co-responsible individuals in the process of planning, performing and assessing actions; (Source: Ordinance MS/GM No. 2.446/2014, Art. 4, II)

**III** – autonomy, which refers to the identification of potentialities and the development of capacities, thus enabling conscious choices of individuals and communities regarding their actions and paths; (Source: Ordinance MS/GM No. 2.446/2014, Art. 4, III)

**IV** – empowerment, which refers to the intervention process that encourages individuals and groups to obtain control over decisions and choices of ways of life, which is appropriate to its social, economic, and cultural conditions; (Source: Ordinance MS/GM No. 2.446/2014, Art. 4, IV)

**V** – intersectoral characteristics, which refer to the process of coordinating the knowledge, potentialities and experiences of individuals, groups and sectors in the construction of shared interventions, establishing bonds, co-responsibility and co-management for common goals; (Source: Ordinance MS/GM No. 2.446/2014, Art. 4, V)

**VI** – intrasectoral characteristics, which refer to the permanent exercise of defragmentation of the actions and services offered by a sector, with the purpose of building and coordinating cooperative and resolutive networks; (Source: Ordinance MS/GM No. 2.446/2014, Art. 4, VI)

**VII** – sustainability, which refers to the need for the permanence and continuity of actions and interventions, taking into account the political, economic, social, cultural and environmental dimensions; (Source: Ordinance MS/GM No. 2.446/2014, Art. 4, VII)

**VIII** – integrity, when interventions are based on the recognition of the complexity, potentiality and singularity of individuals, groups and classes, building coordinated and integrated work processes; and(Source: Ordinance MS/GM No. 2.446/2014, Art. 4, VIII)

**IX** – regional characteristics, which refers to the activity that takes into consideration the singularities and specificities of the different regions in the planning and development of intrasectoral and intersectoral with an impact on the health situation, constraints and determinants equality inserted in them. (Source: Ordinance MS/GM No. 2.446/2014, Art. 4, IX)

**Article 5** The following are the PNPS guidelines: (Source: Ordinance MS/GM No. 2.446/2014, Art. 5)

**I** – encouragement to intrasectoral and intersectoral cooperation and coordination to increase activity on health determinants and constraints; (Source: Ordinance MS/GM No. 2.446/2014, Art. 5, I)

**II** – stimulation to the planning of regional health promotion actions based on the recognition of local contexts and the respect to diversities, with the purpose of enabling the construction of social production spaces, health environments, and the search for equality, guarantee of human rights and social justice; (Source: Ordinance MS/GM No. 2.446/2014, Art. 5, II)

**III** – incentive to democratic, participative and transparent management to reinforce the participation, social control and co-responsibilities of individuals, groups, institutions and of the governmental and civil society spheres; (Source: Ordinance MS/GM No. 2.446/2014, Art. 5, III)

**IV** – broadening of governance in the development of health promotion actions that are sustainable in the political, social, cultural, economic and environmental dimensions; (Source: Ordinance MS/GM No. 2.446/2014, Art. 5, IV)

**V** – encouragement to research, production and diffusion of experiences, knowledge and evidence that support the decision-making process, autonomy, collective empowerment, and the shared construction of health promotion actions; (Source: Ordinance MS/GM No. 2.446/2014, Art. 5, V)

**VI –** support to permanent qualification and education in health promotion to increase the commitment and critical and reflective capacity of health managers and workers, as well as the encouragement to the enhancement of individual and collective skills to reinforce sustainable human development; (Source: Ordinance MS/GM No. 2.446/2014, Art. 5, VI)

**VII –** incorporation of health promotion interventions in the health care model, especially in the daily routine of basic health care services through intersectoral actions; and (Source: Ordinance MS/GM No. 2.446/2014, Art. 5, VII)

**VIII –** organization of the management and planning processes of the several intersectoral actions, as a means to reinforce and foster the implementation of the PNPS in the RAS (*Rede de Atenção à Saúde*), in a cross-cutting and integrated manner, establishing commitments and co-responsibilities to reduce vulnerability and health risks associated with social determinants. (Source: Ordinance MS/GM No. 2.446/2014, Art. 5, VIII)

**Article 6** The general purpose of the PNPS is to promote equality and improvement in the conditions and ways of life, enhance the potentiality of individual and collective health, and reducing vulnerabilities and health risks arising from social, economic, political, cultural, and environmental determinants. (Source: Ordinance MS/GM No. 2.446/2014, Art. 6)

**Article 7** The following are the PNPS specific goals: (Source: Ordinance MS/GM No. 2.446/2014, Art. 7)

**I –** to encourage the health promotion as a part of the integrity of protection in the RAS (*Rede de Atenção à Saúde*), coordinated with the other social protection networks; (Source: Ordinance MS/GM No. 2.446/2014, Art. 7, I)

**II –** to contribute to the adoption of social and health practices focused on equality, participation and social control, with the purpose of reducing systematic, unfair and avoidable inequalities, respecting differences in social class, gender, sexual orientation, gender identification, between generations, ethnical and racial, cultural, regional, and those related to people with disabilities and special needs; (Source: Ordinance MS/GM No. 2.446/2014, Art. 7, II)

**III –** to enable human mobility and accessibility; safe, healthy and sustainable development; (Source: Ordinance MS/GM No. 2.446/2014, Art. 7, III)

**IV –** to create a culture of peace among communities, regions and cities; (Source: Ordinance MS/GM No. 2.446/2014, Art. 7, IV)

**V –** to support the development of social production spaces and healthy environments that enable human development and good living; (Source: Ordinance MS/GM No. 2.446/2014, Art. 7, V)

**VI** – to value traditional and popular knowledge and integrative and complementary practices; (Source: Ordinance MS/GM No. 2.446/2014, Art. 7, VI)

**VII** – to foster empowerment and the capacity to make decisions, as well as the autonomy of individuals and groups through the development of personal skills and competencies in life and health promotion and protection; (Source: Ordinance MS/GM No. 2.446/2014, Art. 7, VII)

**VIII** – to create specific educational, professional education and qualification processes in health promotion, in accordance with the principles and values stated in this Ordinance for workers, managers and citizens; (Source: Ordinance MS/GM No. 2.446/2014, Art. 7, VIII)

**IX** – to set forth media and social communication strategies aimed at reinforcing health promotion principles and actions, and defending healthy public policies; (Source: Ordinance MS/GM No. 2.446/2014, Art. 7, IX)

**X** – to encourage the research, production and dissemination of innovative knowledge and strategies within the scope of health promotion; (Source: Ordinance MS/GM No. 2.446/2014, Art. 7, X)

**XI** – to provide means for the inclusion and qualification of the recording of health promotion activities, and of equality in information and inquiry systems, thus allowing for the analysis, monitoring, assessment and financing of the actions; (Source: Ordinance MS/GM No. 2.446/2014, Art. 7, XI)

**XII** – to encourage discussions on consumption and production methods that are in conflict of interest with health promotion principles and values, and which increase vulnerabilities and health risks; and (Source: Ordinance MS/GM No. 2.446/2014, Art. 7, XII)

**XIII** – to contribute to the coordination of intersectoral and intrasectoral public policies with domestic and international agendas. (Source: Ordinance MS/GM No. 2.446/2014, Art. 7, XIII)

**Article 8** The PNPS cross-cutting themes, which are understood as references for the preparation of health promotion agendas and for the adoption of strategies and priority topics, operating in consonance with the SUS and the PNPS principles and values; (Source: Ordinance MS/GM No. 2.446/2014, Art. 8)

**I** – Social Health Determinants (DSS, *Determinantes Sociais de Saúde*), equality and respect to diversity, which means to identify differences in life conditions and opportunities, seeking to allocate resources and efforts to reduce unfair and avoidable inequalities through a dialog between technical and popular knowledge; (Source: Ordinance MS/GM No. 2.446/2014, Art. 8, I)

**II** – sustainable development, which refers to providing visibility to the consumption and production methods associated with the priority topic, by mapping possibilities to

intervene in those that are harmful to health, adapting technologies and potentialities according to local specificities, without compromising future needs; (Source: Ordinance MS/GM No. 2.446/2014, Art. 8, II)

**III –** production of health and care, which represents the incorporation of the topic in the logic of networks that enable humanized protection practices that are based on local needs that reinforce community action, participation and social control, and which foster recognition and dialog between the several forms of popular, traditional and scientific knowledge, building practices based on the integrity of protection and health, which also means the connection of the topic to a broadened health conception, taking into consideration the role and organization of the different sectors and actors that, in an integrated and articulated manner, through common goals, act in health promotion; (Source: Ordinance MS/GM No. 2.446/2014, Art. 8, III)

**IV –** healthy environments and regions, which means to associate the priority topic with the group's and people's life and work regions and environments, identifying opportunities to include health promotion in the developed actions and activities, in a participative and dialogue manner; (Source: Ordinance MS/GM No. 2.446/2014, Art. 8, IV)

**V –** work life, which consists of inter-associating the priority topic with formal and non-formal work and with the different sectors of the economy (primary, secondary and tertiary), considering both urban and rural spaces, and identifying opportunities to operate in the logic of health promotion for actions and activities developed in the different places, and in a participative and dialogue manner; and (Source: Ordinance MS/GM No. 2.446/2014, Art. 8, V)

**VI –** culture of peace and human rights, which consists of creating opportunities of interaction, solidarity, respect to life and reinforcement of bonds, developing social technologies that enable the mediation of conflicts in situations of social tension, ensuring basic freedom and human rights, reducing violence and building peace culture and solidarity practices. (Source: Ordinance MS/GM No. 2.446/2014, Art. 8, VI)

**Article 9** The following are operational axes of the PNPS, which are understood as strategies to establish health promotion actions, respecting values, principles, guidelines and goals: (Source: Ordinance MS/GM No. 2.446/2014, Art. 9)

**I –** regionalization, as an operational strategy: (Source: Ordinance MS/GM No. 2.446/2014, Art. 9, I)

**a)** recognizes regionalization as a SUS guideline and a structuring axis to give guidance to the decentralization of health services and actions, and to organize the RAS (*Rede de Atenção à Saúde*); (Source: Ordinance MS/GM No. 2.446/2014, Art. 9, I, a)

**b)** the regionalization process takes into consideration the coverage of health areas and their coordination with the social equipment existing in the regions; and (Source: Ordinance MS/GM No. 2.446/2014, Art. 9, I, b)

**c)** complies with inter-federative agreements, the definition of parameters of scale and access, and the performance of actions that identify regional singularities for the development of policies, programs and interventions, widening health promotion actions and contributing to reinforce regional identities; (Source: Ordinance MS/GM No. 2.446/2014, Art. 9, I, c)

**II –** intrasectoral and intersectoral coordination and cooperation, which are understood as the sharing of common plans, objectives, resources and goals between the different sectors and different areas in the same sector; (Source: Ordinance MS/GM No. 2.446/2014, Art. 9, II)

**III –** as an operational strategy, the RAS (*Rede de Atenção à Saúde*) needs the following: (Source: Ordinance MS/GM No. 2.446/2014, Art. 9, III)

**a)** cross-cutting of promotion in the RAS (*Rede de Atenção à Saúde*), enabling humanized care practices based on local needs and on the integrity of protection, in coordination with every health production equipment in the region; and (Source: Ordinance MS/GM No. 2.446/2014, Art. 9, III, a)

**b)** coordination with the other social protection networks, linking the topic to a broadened health conception, taking into consideration the role and organization of the different sectors and actors that, in an integrated and articulated manner, through common goals, act in health promotion; (Source: Ordinance MS/GM No. 2.446/2014, Art. 9, III, b)

**IV – s**ocial control and participation, which consists of an increase in the participation and inclusion of individuals in the preparation of public policies and in the relevant decisions that affect the life of individuals and the community, and their contexts; (Source: Ordinance MS/GM No. 2.446/2014, Art. 9, IV)

**V –** management, understood as the need for prioritizing processes of democratic and participative regulation and control, planning, monitoring, assessment, financing, and communication; (Source: Ordinance MS/GM No. 2.446/2014, Art. 9, V)

**VI –** education and qualification, as encouragement to the permanent attitude of learning sustained by problem, dialog, freedom, emancipation and critical pedagogical processes; (Source: Ordinance MS/GM No. 2.446/2014, Art. 9, VI)

**VII –** surveillance, monitoring and assessment, as the use of multiple approaches in the generation and analysis of information on the health condition of individuals and populational groups to subsidize decisions and interventions, as well as to implement public health promotion policies; (Source: Ordinance MS/GM No. 2.446/2014, Art. 9, VII)

**VIII –** production and dissemination of knowledge and information, as encouragement to a reflective and solving attitude towards issues, needs and potentialities of congested groups,

by broadly sharing and disclosing results to the groups; and (Source: Ordinance MS/GM No. 2.446/2014, Art. 9, VIII)

**IX –** social communication and media, as the use of several formal and popular communication expressions to enable the hearing and vocalization of the different groups involved, contemplating information on the planning, performance, results, impacts, efficiency, efficacy, effectiveness and benefits of the actions. (Source: Ordinance MS/GM No. 2.446/2014, Art. 9, IX)

**Article 10** The following are the PNPS priority topics, which are evidenced by health promotion actions performed by and compatible with the National Health Plan, inter-federative pacts and the Ministry of Health strategic planning, as well as international agreements signed by the Brazilian government, in permanent dialog with the other policies, other sectors and sanitary specificities: (Source: Ordinance MS/GM No. 2.446/2014, Art. 10)

**I –** permanent qualification and education, which consist of mobilizing, sensitizing and providing training to Health managers and workers, as well as those in other sectors, for the development of health promotion education actions, with the purpose of including them in permanent education spaces; (Source: Ordinance MS/GM No. 2.446/2014, Art. 10, I)

**II –** proper and healthy diet, which consists of performing actions associated with proper and healthy diet for purposes of health promotion and food and nutritional safety, contributing to poverty mitigation actions and goals, social inclusion, and the guarantee of the human right to proper and healthy diet (Source: Ordinance MS/GM No. 2.446/2014, Art. 10, II)

**III –** physical practices and activities, which consist of encouraging actions, counseling and disclosure of physical practices and activities, encouraging the improvement of the condition of public spaces, taking into consideration the local culture and including plays, games, and popular dance, among other practices; (Source: Ordinance MS/GM No. 2.446/2014, Art. 10, III)

**IV –** fighting the use of tobacco and its byproducts, which consists of performing, coordinating and mobilizing actions to reduce and control the use of tobacco, including educational, legislative, economic, environmental, cultural and social actions; (Source: Ordinance MS/GM No. 2.446/2014, Art. 10, IV)

**V –** fighting the abusive use of alcohol and other drugs, which consists of performing, coordinating and mobilizing actions to reduce the abusive consumption of alcohol and other drugs, with the co-responsibility and autonomy of the population, including educational, legislative, economic, environmental, cultural and social actions; (Source: Ordinance MS/GM No. 2.446/2014, Art. 10, V)

**VI –** promoting safe mobility, which consists of: (Source: Ordinance MS/GM No. 2.446/2014, Art. 10, VI)

**a)** attempting to advance in intersectoral and intrasectoral coordination, involving the region's health surveillance, basic care and urgency and emergency networks in the production of care and in the reduction of traffic-related morbidity and mortality; (Source: Ordinance MS/GM No. 2.446/2014, Art. 10, VI, a)

**b)** directing integrated and intersectoral actions in the regions, including actions involving health, education, traffic, inspection, environment and in the other sectors involved, in addition to the society, with the purpose of defining an integrated plan, partnerships, assignments, responsibilities and the specificities of each sector to foster safe mobility; and (Source: Ordinance MS/GM No. 2.446/2014, Art. 10, VI, b)

**c)** advancing in the performance of educational, legislative, economic, environmental, cultural and social actions based on qualified information and on an integrated plan, in order to ensure safe traffic, the reduction of morbidity and mortality, and peace in traffic. (Source: Ordinance MS/GM No. 2.446/2014, Art. 10, VI, c)

**VII –** creating a culture of peace and human rights, which consists of performing, coordinating and mobilizing actions that encourage interaction, solidarity, respect to life and the reinforcement of bonds, for the development of social technologies that enable the mediation of conflicts, the respect to diversity and gender and differences in sexual orientation, between generations, ethnical and racial, cultural, regional differences, as well as those related to people with disabilities and special needs, ensuring human rights and basic freedoms, coordination of the RAS (*Rede de Atenção à Saúde*) with the other social protection networks, producing information that is qualified and capable of generating individual and collective interventions, thus contributing for the reduction of violence and the culture of peace; and (Source: Ordinance MS/GM No. 2.446/2014, Art. 10, VII)

**VIII –** promotion of sustainable development, which consists of performing, mobilizing and coordinating governmental and non-governmental actions, including the private sector and the civil society, in the different scenarios, such as cities, field, forest, waters, districts, regions, communities, homes, schools, churches and companies, among others, allowing for the interaction between health, the environment, and sustainable development in the social production of health, in coordination with the other priority plans. (Source: Ordinance MS/GM No. 2.446/2014, Art. 10, VIII)

**Article 11** The following are competencies of the Federal State, Federal District and Municipal spheres of the SUS: (Source: Ordinance MS/GM No. 2.446/2014, Art. 11)

**I –** to disclose the PNPS, reinforcing its values and principles; (Source: Ordinance MS/GM No. 2.446/2014, Art. 11, I)

**II –** to establish partnerships, promoting intersectoral and intrasectoral coordination; (Source: Ordinance MS/GM No. 2.446/2014, Art. 11, II)

**III** – to contribute to the reorganization of the health care model based on the PNPS values, principles and guidelines; (Source: Ordinance MS/GM No. 2.446/2014, Art. 11, III)

**IV** – to foster rules and regulations for a safe, healthy and sustainable development in environments, communities, cities and regions; (Source: Ordinance MS/GM No. 2.446/2014, Art. 11, IV)

**V** – to reinforce participation and social control, as well as the scope of democratic and participative management, as mechanisms to implement the PNPS; (Source: Ordinance MS/GM No. 2.446/2014, Art. 11, V)

**VI** – to build mechanisms to identify potentialities and vulnerabilities to subsidize the reinforcement of the team; (Source: Ordinance MS/GM No. 2.446/2014, Art. 11, VI)

**VII** – to define priorities, goals, strategies and objectives in the scope of the joint boards, and establish interagencies to implement health promotion programs, plans, projects and actions; (Source: Ordinance MS/GM No. 2.446/2014, Art. 11, VII)

**VIII** – to establish instruments and management, planning, monitoring and assessment instruments and indicators; (Source: Ordinance MS/GM No. 2.446/2014, Art. 11, VIII)

**IX** – to allocate budgetary and financial resources to implement the PNPS; (Source: Ordinance MS/GM No. 2.446/2014, Art. 11, IX)

**X** – to encourage the exchange of experiences and the development of studies that intend to enhance and disseminate technologies and knowledge focused on health promotion; (Source: Ordinance MS/GM No. 2.446/2014, Art. 11, X)

**XI** – to develop organizational strategies and mechanisms to qualify and value the health-related workforce, stimulating permanent education and qualification processes focused on the establishment of the PNPS; (Source: Ordinance MS/GM No. 2.446/2014, Art. 11, XI)

**XII** – to stimulate health promotion initiatives and actions, as well as to produce data and disclose information; (Source: Ordinance MS/GM No. 2.446/2014, Art. 11, XII)

**XIII** – to include health promotion in Health Plans and in Annual Health Agenda, in compliance with the SUS planning and management instruments, to implement the PNPS, taking into consideration local and regional specificities; (Source: Ordinance MS/GM No. 2.446/2014, Art. 11, XIII)

**XIV** – to coordinate the insertion of actions focused on health promotion in the SUS information systems, among others; and (Source: Ordinance MS/GM No. 2.446/2014, Art. 11, XIV)

**XV** – to enable partnerships with international bodies, and governmental and non-governmental organizations, including the private sector and the civil society, to reinforce health promotion in the country. (Source: Ordinance MS/GM No. 2.446/2014, Art. 11, XV)

**Article 12** The following are competencies of the **Ministry of Health**: (Source: Ordinance MS/GM No. 2.446/2014, Art. 12)

**I –** to foster coordination with States and Municipalities to support the establishment and implementation of the PNPS; (Source: Ordinance MS/GM No. 2.446/2014, Art. 12, I)

**II –** to agree upon priority topics and the financing of the PNPS in the Three-Party Interagency Commission (CIT, *Comissão Intergestores Tripartite*); (Source: Ordinance MS/GM No. 2.446/2014, Art. 12. II)

**III –** to support the implementation of the PNPS, taking into consideration the epidemiological profile and health needs; (Source: Ordinance MS/GM No. 2.446/2014, Art. 12. III)

**IV –** to enable mechanisms to co-finance health promotion plans, projects and programs; (Source: Ordinance MS/GM No. 2.446/2014, Art. 12, IV)

**V –** to include Health Promotion actions in Multi-Annual and National Health Plans; (Source: Ordinance MS/GM No. 2.446/2014, Art. 12, V)

**VI –** to present health promotion strategies, programs, plans and projects in the National Health Council; (Source: Ordinance MS/GM No. 2.446/2014, Art. 12, VI)

**VII –** to institutionalize and maintain in operation the PNPS Committee in compliance with its principles and guidelines; (Source: Ordinance MS/GM No. 2.446/2014, Art. 12, VII)

**VIII –** to provide institutional support to State, Federal District and Municipal Health Departments, with the purpose of establishing, implementing and consolidating the PNPS; (Source: Ordinance MS/GM No. 2.446/2014, Art. 12, VIII)

**IX –** to support and prepare disclosure materials to socialize health promotion information and actions; and(Source: Ordinance MS/GM No. 2.446/2014, Art. 12, IX)

**X –** to encourage, monitor and assess health promotion processes, programs, projects and actions. (Source: Ordinance MS/GM No. 2.446/2014, Art. 12, X)

**Article 13** Competencies of **State Health Departments**: (Source: Ordinance MS/GM No. 2.446/2014, Art. 13)

**I –** to foster coordination with the cities to support the establishment and implementation of the PNPS; (Source: Ordinance MS/GM No. 2.446/2014, Art. 13. I)

**II –** to agree upon the strategies, guidelines, goals, priority topics and financing of the PNPS establishment and implementation in the Two-Party Interagency Commissions (CIB, *Comissões Intergestores Bipartite*) and Regional Interagency Commissions (CIR, *Comissões Intergestores Regionais*). (Source: Ordinance MS/GM No. 2.446/2014, Art. 13, II)

**III –** to establish and implement the PNPS in the RAS (*Rede de Atenção à Saúde*), within the scope of their region, respecting its guidelines and promoting adaptations to local and

regional specificities; (Source: Ordinance MS/GM No. 2.446/2014, Art. 13. III)

**IV –** to present health promotion strategies, programs, plans and projects in the State Health Council; (Source: Ordinance MS/GM No. 2.446/2014, Art. 13, IV)

**V –** to include health promotion actions in Multi-Annual and State Health Plans; (Source: Ordinance MS/GM No. 2.446/2014, Art. 13, V)

**VI –** to allocate budgetary and financial resources to establish and implement the PNPS; (Source: Ordinance MS/GM No. 2.446/2014, Art. 13, VI)

**VII –** to provide institutional support to Municipal Departments and health areas in the process of establishment, implementation and consolidation PNPS; (Source: Ordinance MS/GM No. 2.446/2014, Art. 13, VII)

**VIII –** to monitor and assess health promotion programs, projects and actions within the state and district scope; (Source: Ordinance MS/GM No. 2.446/2014, Art. 13, VIII)

**IX –** to support and prepare disclosure materials with the purpose of socializing information and disclosing health promotion, programs, plans, projects and actions; (Source: Ordinance MS/GM No. 2.446/2014, Art. 13, IX)

**X –** to foster cooperation, create spaces for discussions and exchange of experiences and knowledge on health promotion; and (Source: Ordinance MS/GM No. 2.446/2014, Art. 13, X)

**XI –** to support and execute programs, plans, projects and actions associated with health promotion, taking into consideration the epidemiological profile and needs of their region. (Source: Ordinance MS/GM No. 2.446/2014, Art. 13, XI)

**Article 14** Competencies of **Municipal Health Departments**: (Source: Ordinance MS/GM No. 2.446/2014, Art. 14)

**I –** to foster intrasectoral and intersectoral coordination to support the establishment and implementation of the PNPS within the scope of their competency; (Source: Ordinance MS/GM No. 2.446/2014, Art. 14, I)

**II –** to establish and implement the PNPS within the scope of their region, respecting local and regional specificities; (Source: Ordinance MS/GM No. 2.446/2014, Art. 14, II)

**III –** to agree upon the strategies, guidelines, goals, priority topics and financing of the PNPS establishment and implementation in the Two-Party Interagency Commissions (CIB, *Comissões Intergestores Bipartite*) and Regional Interagency Commissions (CIR, *Comissões Intergestores Regionais*); (Source: Ordinance MS/GM No. 2.446/2014, Art. 14, III)

**IV –** to present health promotion strategies, programs, plans and projects in the City Health Council; (Source: Ordinance MS/GM No. 2.446/2014, Art. 14, IV)

**V –** to include health promotion actions in Multi-Annual and City Health Plans; (Source: Ordinance MS/GM No. 2.446/2014, Art. 14, V)

**VI –** to allocate budgetary and financial resources to perform health promotion actions; (Source: Ordinance MS/GM No. 2.446/2014, Art. 14, VI)

**VII –** to provide institutional support to the managers and workers in the process of establishment, implementation and consolidation PNPS; (Source: Ordinance MS/GM No. 2.446/2014, Art. 14, VII)

**VIII –** to promote and conduct the permanent education of workers in the local health system in order to develop health promotion actions; (Source: Ordinance MS/GM No. 2.446/2014, Art. 14, VIII)

**IX –** to identify and create channels for the participation in the decision-making process for the development and sustainability of health promotion actions; (Source: Ordinance MS/GM No. 2.446/2014, Art. 14, IX)

**X –** to foster participation and social control and reinforce community health promotion actions in the regions; (Source: Ordinance MS/GM No. 2.446/2014, Art. 14, X)

**XI –** to identify, coordinate and support the exchange of experiences and knowledge on health promotion actions; (Source: Ordinance MS/GM No. 2.446/2014, Art. 14, XI)

**XII –** to participate in the process of monitoring and assessing health promotion programs, plans, projects and actions; (Source: Ordinance MS/GM No. 2.446/2014, Art. 14, XII)

**XIII –** to prepare educational materials with the purpose of socializing information and disclosing health promotion, programs, plans, projects and actions; and (Source: Ordinance MS/GM No. 2.446/2014, Art. 14, XIII)

**XIV –** to support in a privileged manner and execute programs, plans, projects and actions directly associated with health promotion, taking into consideration the epidemiological profile and needs of their region. (Source: Ordinance MS/GM No. 2.446/2014, Art. 14, XIV)

**Article 15** The assignments reserved to the State and Municipal Departments of Health are competencies of the Federal District State Department of Health (SES/DF, *Secretaria de Estado da Saúde do Distrito Federal*). (Source: Ordinance MS/GM No. 2.446/2014, Art. 15)

**Article 16** The financing of the PNPS priority topics and their operational plans are the subject matter of a prior agreement in the CIT. (Source: Ordinance MS/GM No. 2.446/2014, Art. 16)

## CHAPTER II

## THE MANAGEMENT COMMITTEE OF THE NATIONAL HEALTH PROMOTION POLICY

**Article 17** The Management Committee of the National Policy for Health Promotion (CGPNPS) is hereby established. (Source: PRT MS/GM No. 227/2016, Art. 1)

**Article 18** It is incumbent upon the CGPNPS: (Source: PRT MS/GM No. 227/2016, Art. 2)

**I –** consolidate PNPS implementation; (Source: PRT MS/GM No. 227/2016, Art. 2, I)

**II –** to coordinate the implementation of the PNPS in the Unified Health System (SUS) in articulation with the other governmental and non-governmental sectors; (Source: PRT MS/GM No. 227/2016, Art. 2, II)

**III –** consolidate health promotion agendas in line with the policies, priorities and resources of participating institutions and the National Health Plan; (Source: PRT MS/GM No. 227/2016, Article 2, III)

**IV –** promote the integration of health promotion actions within the scope of the SUS, in the context of the institutional planning and management instruments; (Source: PRT MS/GM No. 227/2016, Article 2, IV)

**V –** to encourage and support the inclusion of themes on Health Promotion in the elaboration of projects and local plans according to the values and principles, objectives, guidelines, transversal themes and operational axes of the PNPS, the Federal District and the municipalities, respecting the instituted instruments of SUS planning and management; (Source: PRT MS/GM No. 227/2016, Art. 2º, V)

**VI –** monitor and evaluate PNPS implementation and implementation strategies and their impact on improving the quality of life of individuals and communities; (Source: PRT MS/GM No. 227/2016, Art. 2, VI)

**VII –** to forge partnerships with international organizations with the purpose of promoting articulation and exchange among countries to strengthen PNPS; and (Source: PRT MS/GM No. 227/2016, Art. 2, VII)

**VIII –** develop other actions aimed at strengthening PNPS. (Source: PRT MS/GM No. 227/2016, Art. 2, VIII)

**Article 19** The CGPNPS shall be composed of representatives, members and alternates of the following organs and entities: (Source: PRT MS/GM No. 227/2016, Art. 3)

**I –** 4 (four) representatives of the Secretariat of Health Surveillance (SVS/MS), who will coordinate it; (Source: PRT MS/GM No. 227/2016, Art. 3, I)

**II –** 4 (four) representatives of the Secretariat of Health Care (SAS/MS); (Source: PRT MS/GM No. 227/2016, Art. 3, II)

**III –** 3 (three) representatives of the Strategic and Participative Management Secretariat (SGEP/MS); (Source: PRT MS/GM No. 227/2016, Art. 3, III)

**IV –** 2 (two) representatives of the Secretariat of Labor Management and Health Education (SGTES/MS); (Source: PRT MS/GM No. 227/2016, Art. 3, IV)

**V –** 1 (one) representative of the Secretariat of Science, Technology and Strategic Inputs (SCTIE/MS); (Source: PRT MS/GM No. 227/2016, Art. 3 (V)

**VI –** 1 (one) representative of the Executive Secretariat (SE/MS); (Source: PRT MS/GM No. 227/2016, Art. 3, VI)

**VII –** 1 (one) representative of the Special Secretariat of Indigenous Health (Sesai/MS); (Source: PRT MS/GM No. 227/2016, Art. 3, VII)

**VIII –** 1 (one) representative of the National Health Foundation (Funasa); (Source: PRT MS/GM No. 227/2016, Art. 3, VIII)

I**X –** 1 (one) representative of the Oswaldo Cruz Foundation (Fiocruz); (Source: PRT MS/GM No. 227/2016, Art. 3, IX)

**X –** 1 (one) representative of the National Health Surveillance Agency (Anvisa); (Source: PRT MS/GM No. 227/2016, Art. 3, X)

**XI –** 1 (one) representative of the National Supplementary Health Agency (ANS); (Source: PRT MS/GM No. 227/2016, Art. 3, XI)

**XII –** 1 (one) representative of the National Cancer Institute José Alencar Gomes da Silva (Inca/SAS/MS); (Source: PRT MS/GM No. 227/2016, Art. 3, XII)

**XIII –** 1 (one) representative of the National Council of State Health Secretariats (Conass); (Source: PRT MS/GM No. 227/2016, Art. 3, XIII)

**XIV –** 1 (one) representative of the National Council of Municipal Health Departments (Conasems); (Source: PRT MS/GM No. 227/2016, Art. 3, XIV)

**XV –** 1 (one) representative of the National Health Council (CNS); (Source: PRT MS/GM No. 227/2016, Art. 3, XV)

**XVI –** 1 (one) representative of the Pan American Health Organization (PAHO); and (Source: PRT MS/GM No. 227/2016, Art. 3, XVI)

**XVII –** 1 (one) representative of the Thematic Group on Health Promotion and Sustainable Development of the Brazilian Association of Public Health (Abrasco). (Source: PRT MS/GM No. 227/2016, Art. 3, XVII)

**§ 1.** The representatives, incumbents and alternates, will be formally indicated by the leaders of their respective bodies to the coordination of the CGPNPS. (Source: PRT MS/GM No. 227/2016, Art. 3, § 1)

**§ 2.** The representatives may be replaced at any time, provided that the request to the CGPNPS coordination is formalized, and each indication or substitution must be confirmed each year. (Source: PRT MS/GM No. 227/2016, Art. 3, § 2)

**§ 3.** The entities referred to in items XV to XVII will be invited to appoint representatives to compose the CGPNPS. (Source: PRT MS/GM No. 227/2016, Article 3, § 3)

**§ 4.** The CGPNPS may invite employees of the organs and entities of the Ministry of Health, other Federal Public Administration bodies, nongovernmental entities, international organizations, as well as specialists in subjects related to the topic, in addition to those indicated in the caput, whose presence is considered necessary to fulfill the functions assigned to the CGPNPS, upon prior consultation with the CGPNPS coordination. (Source: PRT MS/GM No. 227/2016, Article 3, § 4)

**Article 20** The CGPNPS shall meet ordinarily on a bimonthly basis and, extraordinarily, on the initiative of any of the members of the CGPNPS coordination, at least 15 (fifteen) days prior to the date proposed for the meeting. (Source: PRT MS/GM No. 227/2016, Art. 4)

**Article 21** The CGPNPS may propose the creation of Working Groups, established through acts of the Minister of Health, to advise him on issues related to Health Promotion, through consolidation and implementation of PNPS , as well as follow-up of its implementations, and issuing of opinions and reports to subsidize the activities of the Committee. (Source: PRT MS/GM No. 227/2016, Art. 5)

**§ 1.** The WGs, at the end of the work, shall send reports or opinions, as requested by the CGPNPS, for approval and subsequently to disclose them. (Source: PRT MS/GM No. 227/2016, Art. 5, § 1)

**§ 2.** The WG shall be composed of up to five (5) representatives of the CGPNPS and may invite specialists, representatives of the technical areas of the Ministry of Health and other Ministries, as well as representatives of other entities, institutions and social movements, according to their needs and specificities. (Source: PRT MS/GM No. 227/2016, Article 5, § 2)

**Article 22** The functions performed within the scope of the CGPNPS will not be remunerated and its exercise will be considered as relevant public service. (Source: PRT MS/GM No. 227/2016, Art. 6)

**Article 23** The debates that take place in the meetings of the CGPNPS should be embodied in records with wide dissemination in the field of health. (Source: PRT MS/GM No. 227/2016, Art. 7)

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