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Health Promotion

Health promotion seen genealogically as a discursive practice in its production of worlds, and a micropolitical reading of social determinants

A promoção da saúde vista genealogicamente como prática discursiva em sua produção de mundos e uma leitura micropolítica dos determinantes sociais da saúde (resumo: p. 14)

La promoción de la salud vista genealógicamente como práctica discursiva en su producción de mundos y una lectura micropolítica de los factores determinantes sociales (resumen: p. 14)

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Abstract

Health promotion is examined as a discourse present in concrete governmental actions such as the Brazilian National Health System (SUS), and built on some propositions: conception of the health-disease process based upon social determinants of health; advocacy for a better quality of life; and definition of key fields and strategies for health promotion actions. We discuss the emergence of this discourse and its presence in collective health and in Brazilian public policies. Some meaning interplays of health promotion between its progressive and also conservative/de-politicizing strands are problematized, as well as its communication/information strategies, in the face of its ability to transform the health reality. At the end, we propose to add to this discourse/action a perspective that takes into account the agencying of life and health and the crossings of illness and death, in the context of control societies.

Keywords: Health promotion. Public Health. Sociocultural territory. National Health Promotion Policy. Micropolitics.

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By way of analytical method: our point of view of choice regarding health promotion

Health promotion (HP) is a discourse. In the case this statement was done at the level of common sense, those who read us could interpret that we would be insinuating something like a polarization between speaking and acting, as if we were proposing that HP is only a set of propositions closed in themselves. But no, we bet on the inseparability between writing/speaking and acting. A discourse is a reality maker, it produces worlds.

Discursive practices are constitutive of all health policies, and of all policies for that matter, as they are expressed in their guiding/proposing texts and also in their strategies of mobilization and production of values in different levels. Being discourse, and being disputed as such, HP is affirmed as policy and transversalizes the field of health policies and practices. Starting from this recognition, we state that - and therefore starting this reflection by the "end" - it is possible to identify several good resonances of this discourse through concrete governmental actions, in Brazil of the Brazilian National Health System (SUS), such as: the Health in the School program, the Life in Traffic project, the national Violence Prevention Network, the national Plan for Non-notifiable chronic diseases, the network of care for women involving pregnancy, delivery and puerperium, as well as for children (the so called "Stork Network"), in addition to Brazil's adherence to the WHO Framework Convention on Tobacco Control, among others[1]. Important resonances also include a strong presence of this discourse in the constitution of the Family Health Strategy[2], besides some appropriation, by social movements in Brazil, of concepts that, if not invented in the context of HP, were conveyed by this referential, such as "participation", "empowerment" and "community control"[3].

On the other hand, there are those who question the power of HP as an effective "promoter" of change. Let's put the problem in another way: which discourse is that, why is it questioned? Does it deliver what it proposes? In that case: what do we mean by "discourse"? A set of sentences, amenable to linguistic analysis, extracted from certain institutional texts? A set of concatenated propositions that make up a logical-deductive project? The psychological formulation of an identity of forms of consciousness, a "mentality" in short? A political manifesto? Yes and no. Sometimes a little of this or that, but here in this text, with Foucault, first and foremost:

> We shall call "discourse" to a set of utterances, insofar as they rest on the same discursive formation; it does not form a rhetorical or formal unit, indefinitely repeatable and whose appearance or use we could mark (and explain, where appropriate) in history; it is made up of a limited number of utterances for which we can define a set of conditions of existence[4]. (p. 132-3, our translation and emphasis added).

This essay intends to look at this set of utterances that has been attributed to HP, with the help of this author. We want to look at the verbal performances of which it is composed and some of its main terms in their regularities; their gaps and

limits; the play of possible positions for the subjects involved. This is an effort to put this discourse in relation to its "targets," to see how it is used and repeated, what materialities it engenders or fails to engender. This means to submit to *a* certain analytical perspective a set of propositions/strategies that emerge, is mobilized by HP, in the dispute for the production of values, practices and effects in the field of health production.

In this sense, we intend only to describe the discourse of HP, and in doing so, try to understand how it came to exist from a certain moment and in which places, and to what extent its uses and incorporations of new enunciates happen, in order to share a little of how we think the HP in a micropolitical perspective.

Therefore, we aimed for this essay, using a genealogical point of view[4,5], to take HP in its discursive practice aspect, conception that we will develop below, and to start a debate about some of its possible implications in the micropolitical dimension. In order to realize this project, we used some of the main documents that outline the proposals of HP, especially the "Health Promotion Charters"[6], as well as the debates that authors in the field have been having about the HP project as a whole[1-3,7-12], being interested in the conditions that made possible the discursive disputes around HP.

After all, what would be the discourse of health promotion that we select for this reflection?

For the purposes of our reflection, we present below a quick synthesis of this HP discourse, counting on the help of some specialists[7,13,14], but reducing it to only three propositions, with a special focus on the Ottawa formulation[6], for the purposes of the discussion that will follow:

Proposition I. A broad concept of the health-disease process, which depends on certain conditions: housing, transportation, sanitation, work and income, food, education, health services, stable ecosystem, sustainable resources, all of these factors together called: social determinants of health (SDH). The assumption is that biological, psychological and behavioral, economic, cultural, racial/ethnic, and social stratification factors influence the occurrence of health problems and their risk factors in the population. Such SDH are usually arranged in conceptual models or diagrams, such as that of Diderichsen, Evans and Whitehead, 2001[14].

Proposition II. If the characteristics or social conditions within which people live and work, where their lives take place, is central to HP, then in addition to preventing disease and prolonging life, one must improve "quality of life," a value that is articulated to others, such as: autonomy, well-being, equity, social justice, solidarity, multiple accountabilities, democracy, citizenship, community participation, peace, and freedom of choice.

Proposition III. Given the determinants and the values, there is a call to action, which must influence reality in order to achieve what the propositions above point out, and which are listed in: "key fields of action" and "fundamental strategies". The central fields of action include: healthy public policies, providing environments favorable to health, stimulating community action, promoting the development of

personal skills and new social representations of health and disease, and reorienting the health system. Among the fundamental strategies, governmental and non-governmental, we may list: health advocacy, training, articulation of technical and popular knowledge, mediation, intersectoriality, mobilization of institutional and community resources, public and private.

Whenever in this article we refer to a certain "health promotion discourse", we are taking up the propositions above, to a discursiveness that is not distant from the formulation of the Ottawa Charter[6], considered in this text as a strategic milestone in the emergence of this project.

The emergence of the health promotion discourse

We use the concept of "emergence", according to Foucault, as a process of emergence of other conformations of subjectivities that is expressed as displacements and proposed inversions and substitutions, both in new knowledges and new doings, since "emergence is always produced in a certain state of forces"[5] (p. 23). We consider that, regarding the emergence of the HP discourse, which we presented above, there are some possible consensuses to be outlined.

One consensus, for example, is that Canada is the historical birthplace of certain formulations at that moment, in fact where a formulation of health "determination" was first mentioned in 1974, and even the country-year in which the Lalonde Report founds HP, and that this document produced quite definite statements[8,13,15]: the health "field" is subdivided in four poles (human biology, environment, life style and organized system of services), and the main causes of diseases and deaths would have their origins in these poles. Actions would then be translated through changes in "lifestyle", because the reiteration of bad habits would bring self-imposed risks[3].

It is worth remembering that immediately after this one, another strategic historical event, also promoted by the World Health Organization (WHO), followed: the well-known 1978 Alma Ata Primary Health Care Conference. Although it does not explicitly mention the SDH, this event creates the blueprint, in its final Declaration, for a concept of health needs that makes analogy to the same domains to which the SDH refer[6]. At the same time, in Latin America (Brazil, Ecuador, Chile, Cuba, Colombia and Mexico), began to gain shape a so-called "social" or "critical" epidemiology and a Latin American social medicine, scientific and practical field that begins to criticize the current paradigm of health and risk, and to question the limitations of the biomedical model and its positivist approach inscribed in the natural history of disease model, the pillar of the most traditional epidemiology[15]. This critical movement is associated with the emergence of the so-called collective health.

In that context, there was a growing tension between the two contemporary movements, above. The behaviorist project of the Lalonde Report was soon acknowledged as problematic, limited, and that derived in guilt of individuals, its privileged target. Such criticism would come from authors of the nascent collective health, as this field of knowledge and practices would be called in the 1970-80s, which, at that moment, affirmed its affiliation to the so-called "social medicine", fruit of the

industrial revolution in England, France and Germany, from 1830 to 1880, an aspect that, since the previous century, had already pointed to the health crisis as a political and social process[9,15]. In time, there are authors who link this same referential of social medicine to the birth of HP[13].

Beginning in the 80s, HP consolidates its discourse, but also its tensions, both internal and facing the new world order that had been established since the oil crisis of the previous decade, and the neoliberal pressures made by the minimal State project on the Welfare State of countries such as England and Canada, among others: a new public health, which will emerge in the beginning of the following decade, will demand a new health promotion[3,15].

In this context, the Ottawa Charter is published, a branch of HP that establishes the SDH model and the propositions that we noted at the beginning of this essay, among others[6]. The possible actions are thus amplified, the intersectoriality gains space, there is talk of community empowerment and greater participation in the control of processes[2]. Many international conferences, promoted by WHO, follow this moment, adding several discursive layers to this matrix, sometimes focusing on specific actions and programs.

Some public policies guided by HP are then implemented in several countries, for example the Healthy Cities Project, and it is worth registering the incorporation of HP in SUS, because that moment is when it is integrated into the Brazilian Health System[10], and some of its effects we have already exemplified at the beginning of this text. The then "non-negotiable" principles of HP (equity, integrality, autonomy, co-management in the work process, intersectoriality and social participation, which are also principles of SUS) start to populate publications of the Brazilian Ministry of Health since the early 2000s, in a spiral of incorporation of this ideology that culminates with the publication of the first version of our National Health Promotion Policy, in 2006[1,16]. From that point on, this policy will be perfected in the years that follow, and the weaknesses for its implementation become increasingly evident, such as the funding, which receives the fatal blow with the freezing for 20 years that was approved in 2016 to come into force in the health sector from the 2018 fiscal year[1,16,17].

The interplay of meanings of health promotion

At least one clear internal tension will accompany the development of the HP discourse. On the one hand, it is discernible the defense of a progressive, emancipatory[e] project, with the proposition of intersectoral public policies aimed at improving the quality of life of the populations. On the other, there is a side that, since Lalonde, is linked to HP and goes hand-in-hand within the proposals that sophisticate this discourse, from the 1980s on, and is considered conservative, operating in practice a choice according to a market logic with regulated "autonomy", and tending to decrease the responsibilities of the State by leaving groups of individuals to their own devices[3,18]. This perspective is strongly incorporated within clinical practices, both in SUS and in supplementary health services.

[e] We use the concept of human or social emancipation in the sense of "emancipatory political action"[15] (p. 27), which, on the part of the then emerging Brazilian collective health, will mark the debate on the production of autonomy in health.

The collective health movement has always incorporated - but also problematized - the HP, and in this field, it has been pointed out that the difficulties in the operationalization of projects and policies related to HP make clear certain inconsistencies, contradictions and obscure points[15,18]. This debate goes through several focuses. One of them is the criticism to the use of the concept of risk, taken as a probable-possible, mathematically measured to infer causality, having been responsible for undeniable advances in the organization of services, and in practices such as health education, but also for some contradictory effects when it comes to health care[18-20]. Another focus of questioning pervades the determinants vis a vis determination theme, which is worth a few lines.

The model of SDH presents itself as a chain of mediations or levels of analysis of the health reality, since there would be closer determinants (intermediate) and others more distant (structural) from the lives of individuals, and therefore the relation of determination is said as not being able to be reduced to a direct relation of cause and effect[14]. Related to this perspective, authors of collective health bring up different points: that it would carry a conceptual imprecision by not meeting the concept of determination, this one essentially structuralist[8]; that the determinants, on the other hand, would in fact be structuralist-causal and not dialectic, as other authors would prefer[11]; and that the model of SDH would not advance beyond independent factors among themselves, a conception pointed out as insufficient in face of the idea of "process", which has shown itself more interesting to think health-disease[9].

Finally, in this line of criticism that progress in the internal side of the collective health movement, the SDH model tends to a conception of health as the absence of disease, and, by positioning the "social" as external to individuals, it would not let us see the reproduction of social inequities in health, and would make social participation and empowerment that the model itself proposes innocuous, and all this would explain its low capacity to transform the health reality[12], despite its discursive propositions.

We tend to agree that, being essentially political, the HP discourse needs to make clearer to whom it is allied in decision-making circles, and how it thinks its project can have its implementation negotiated in adverse economic and political scenarios. Still in the field of politics, we point out the need for a greater flexibility of the HP field to the epistemological and ethical-political diversity that the collective health field - as a whole - may offer.

To dialogue with health promotion is to dialogue with the determinants of health

It must be admitted that, especially in its "progressive" version, the HP discourse has provided undeniable and multiple kind of gains for social and health life. In Brazil, it has gained several social and political-institutional spaces, has produced materiality in public policies, and has become a vocabulary accepted and reproduced even by leaders that are adept to the liberal State project. On the other hand, it often misses the lingering emancipatory effect that its reading makes us expect, leading to hypothesize that this discourse still needs to resolve tensions that are central to its project if it wants to deliver what it promises on the scale of social change.

According to Testa Tambellini and Schütz, none of these words: inequality, inequity, disparity and poverty appear in the original English document of the Lalonde Report[8], but, on the contrary, an advance in this sense must be recognized in the Ottawa Charter[6]. Indeed, it is necessary to reinforce the incongruence of a depoliticization when it comes to a discourse with such pretensions, and, first of all, it is necessary to denounce losses of financing of projects and programs[10] and other processes that generate inequities, if we want to be coherent with the basic formulation of the HP. In 15 years of HP in SUS, we may ask, beyond the programs and actions listed at the beginning of this article, what effects this discourse-policy has produced in the defense of the system itself, always and increasingly threatened by the jettisoning carried out by the model of the "minimal state", constituted by restraints in its interior as to the achievement of equity due to the conformation of public-private relations[21]. This debate also seems central to the HP discourse as it presents itself.

Considering that communication/information is still the main activity that the actions of HP present, in the daily practices it derives to the topic of health education. We have already proposed that pedagogical processes do not make sense away from the perspective of health care, or without taking into account singularities. "Each one can be defined by innumerable affections and becomings; that is to say that each one is, in itself, a multiplicity of events that, in turn, generates effects in the encounter with the other"[20] (p. 256). We understand it to be difficult to conceive of powerful health education without intercessory encounters, and so we have already proposed a "pedagogical twist, when we deviate from the worker 'prescribing healthy living' in us, and allow the user to deviate from the patient 'in flight from the risk of living' "[20] (p. 257).

In the next section we briefly present one way of making HP discourse dialogue with the strand we call the micropolitics of health work and care.

To dialogue with the determinants of health is also to think of agencying and crossings in health

Before we proceed, it is important to establish some of the concepts that circulate in the micropolitics of work and health care and that are central to this discussion: what we mean by "assembling" and "crossings" in health. These are complex concepts, and we do not intend to deal with them in the philosophical depth they deserve in specialized discussions, but to extract from them only what is essential for the use we want to make here, in order to make them work in the face of the problematic we have previously posed. We used as sources some publications[22-24], which even being few, they help to meet the objective that we have just stated. We will start with the first of these concepts.

Let's talk about assembling, but for this we must first consider what is meant by territory. In micropolitics, territory is the affirmation of a certain normatization of processes of all kinds, whether organic or psychic or existential, when expressions and actions are repeated[24,25]. On the level of expression, for example, we tend to repeat a defined set of significant referents such as a certain family conformation, a religion and/or certain political convictions, also sports preferences, not forgetting the information conveyed by certain media, and/or transcendent values such as "the"

true, "the" good, or "the" beautiful, among others[24]. We live in an existential territory, and there is also a corporal territoriality in this, because this life is conformed in a very specific configuration of habits that interfere with the body and health.

An existential territory is in permanent construction, transformation or dissolution through assembling. Assembling could be presented as the encounter between heterogeneous elements for the invention of a new co-functioning, with new actions and expressions, in short, with the production of new territories, a true leakage between territories[22-24]. If I de-territorialize myself from one territory, I can reterritorialize myself in another, and for this end I occupy gaps, I enter into flows that are called lines of flight, here in the sense of deviation and not retreat, I act or I am acted upon, or both at the same time.

For Deleuze and Guattari each assembling is composed of two fundamental aspects. The first of these is the collective assembling of enunciation, which is the expression or all that is spoken, the sign (or semiotic) regime in which we are immersed and of which we are coauthors. At the same time, the machinic assembling of desire is all that is done or the content in passions and actions: the pragmatic system[22,23]. Both aspects of assembling function at the same time, in the conformation or dissolution of each territory. Quick note: for the authors, and we agree, there is no prior content that precedes expression, but a reciprocal presupposition between these elements, and expression may even precede content[23].

We believe that both the social determinants of health and the so-called risk factors, consequently the products of determination that we read in association measures, depending on the referential used, can be understood as different assembling processes, in a micropolitical perspective of health production, and we have been doing this exercise, both in analyses on care and in those related to health management. We propose that to stick to the assemblings that produce life and health is to look at how every movement that, by activating existential connections around one or more lives, produces health and greater potency in living.

On the other hand, crossing is a concept we have used in a peculiar way, but which we got from two different sources. It can represent a flow between territories that overwhelms us, as we said above, sometimes constituting an assembling[23], but now in the production of illness and death, as well as constituting itself, now in the eyes of authors of Institutional Analysis, as interpenetration of everything that is established, organized or instituted at the level of function, a movement of reproduction of an already existing system, functioning through domination[26]. This second proposition for the concept has originally a social and institutionalist perspective, but in our alchemy, we have used it in a broader sense, involving all dimensions of life, also organic and psychic, collective but also individual.

Understanding crossings from a conceptual composition as the one we proposed above, in the same way we want to believe that the social determinants of health and/or risk factors, and their unfolding consequences, can be understood as crossings, especially when, by crossing an existential territory, they produce what Deleuze and Guattari call the capture: an appropriation that makes a knot in our possibilities of life and health[24]. We propose to think of crossings when we think of sickness and death.

It is usually clear, and sometimes obvious, when something represents a risk or harm to health. If we use tobacco as an example, we have no doubt today of the harm it causes to health (crossing), but some smokers may see it as a "companion" in difficult times (assembling?), then health intervention starts to become more complex. Another example could be physical activity: for all people is known that it produces health and quality of life (assembling), but for some who live with certain heart diseases, unfortunately it can be a risk factor, for example, for situations of coronary ischemia, and, therefore, can be life-threatening. Thus, many elements that we encounter in daily life can, in a certain biological and existential circumstance, be both assembling of life and health and also crossings of illness and death.

In other words, thinking and acting from a micropolitical perspective, as the one we present here, implies understanding the health-illness-care process not as vectors of determination and/or conditioning, but as a web of different assemblings of more life and crossings of less life. Besides, it does not result in a single final vector to be modified or redirected, conforming a scenario that only allows changes for the production of more health when treated as such: a multiplicity of processes full of meanings that need to take place in the speeches, so that the pacts of individual or collective therapeutic projects are then the means for this production.

Health promotion and control societies

As a last section, we will reflect under a certain point of view regarding some criticisms already made to the HP discourse, mentioned above, and which we will try to synthesize here. Among them, there would be, as part of the constitutivity of the HP discourse, a movement to regulate the autonomy of subjects in order to align them to market logic, resulting in a final discourse that sometimes exempts the State from its effective responsibilities. This movement would hinder the effective implementation of some projects and policies, straining, internally to the HP itself, its more emancipatory aspects and equity advocates.

We agree in part with this analysis, but we understand that there are several subtleties here. Let's start with this bet on the State, which is quite fair, but: which State can we really count on today? Deleuze, in the last decades of the 20th century, analyzed what Foucault had called "disciplinary societies," that is, the confinement of the "individual" - considered as a unit of a mass - in closed systems such as the factory, the school, the barracks, among others, distributing individuals in time-spaces programmed to compose a productive force superior to the sum of the elementary forces[27]. However, Deleuze points out that the capitalism in the 20th century was no longer the same as in the previous century, and now a "firm", more and more immaterial we might say, having its "managers" as its face and marketing as its soul, is assuming the function of organizer of spaces and times, "freeing" the confined man, since the control that is exercised is now "out in the open" - either one has or does not have the "password" - and indebtedness would be the new form of control[27]. We would add the connectivity that communication technology offers us now, and the transparent dispersion of our personal data, desires and behaviors, apparent because there is control by virtual algorithms. This is the "control society" of today.

In other words, the "State" as we knew it, for example when we built the SUS, may no longer exist. Already in the 1990s, Deleuze said that this structure was now "deformable" and "transformable", just like the factories themselves. If in disciplinary societies the State was already subject to control, on the part of the holders of all forms of power, it is now an integral part of the "*controlato*" itself, a plot that self-regulates itself in the midst of the fixing of prices and the fading of the concrete "products" of human's activities, that is now no longer confined but indebted, in the midst of this plot called "market"[27]. Here is a critical point that the discourse of HP has to deal with.

An additional point is what to do with the individual, in the *controlato*. While his/her body was disciplined in time and space in order to make training and productivity more efficient, as part of a mass that it is, it was enough to add behavioral norms to the behaviorist HP for a good sanitary discipline. When control starts to be done via desires and values, it comes from "inside", it is immanent, and what was weak and not very efficient becomes practically innocuous. And regarding the discourse of the "new health promotion": how does it enter here?

The world now is undulatory, slippery. To be young in the *controlato* is to beg for motivation to try to prepare oneself, with who knows what course or internship[27], for who knows what opportunities. Urged to compete for merit to satisfy the desires that he/she thinks are his/hers, even because the system is always unstable, and the subject himself is divided, there are few options left among those that seem to be "their own" choices. Living a life that promotes health, in that which meets the "market" tends to present total synergy, but outside of that, it's another matter. If this list of options is among his goals and the young person is from a population group that has "cash flow", great, everyone wins. A true consumerist agency, like the unbelievable synonymy that we have heard, in our times, between the use of food supplements and what has been called "preventive medicine". If one of these points does not connect to the others, we turn the page. Taking care of one's own health may then turn out to be a "good side of control," or it may not. It depends on the quotations.

Closing remarks

Even though we are not "experts" on the subject of HP, we accepted to participate in this debate because it is worthwhile. We recognize it as a powerful discourse and one that has gained ground in truth interplays over several decades, and also produced reality. It is welcome as an ethical-political reinforcement in the fight for life, and an important ally for the defense of health, of SUS, and therefore, of life.

But, agreeing with certain authors cited here, perhaps this project has created more expectations than results, since it is an essentially political discourse that does not always present itself in this way, not always problematizing the societal projects that intersect in the actuality in front of it, a concrete field for its realization. In wanting, as an emancipatory project, to influence them, HP will have to take a clear position regarding this political path.

It must also accept the coexistence with other possibilities of reading and action regarding the health-disease-care process, beyond the SDH, without disregarding their

importance. For example, any concrete reality that we face in life, "we" here considering individuals or collectives, can become an assembling of life and health or a crossing that captures us and brings sickness and death force, depending on the unique existential configurations with which we need to meet.

Therefore, it is necessary to consider singularities both in analyses and in actions. In the control society in which we live, the construction of another concept of empowerment seems to us that it is already a constitutive part of a post-industrial version of the HP discourse, in which the possibility of effective equity is increasingly smaller.

We tend to conclude that, for this HP discourse to gain more and more transformative power, it will be necessary to take all lives, human or not, without exception and equally, as an indispensable set to be "promoted" and protected in their health, making the market - and its subordinate states - be at the service of these lives, and not the opposite. By not taking this ethical-aesthetic-political way out decisively, HP runs the risk of being used as one more tool in the homogenizing diagramming of lives and existences, individual and collective.

Adding other perspectives to the HP policies, other than those already legitimized in its institution, could be enriching, because – and this is a bet of this article - we have in HP one of the emancipatory movements that needs to work, since we live in a world in which most of the main leaders and market operators insist in the opposite direction. We are, at the end of the day, allies in the defense of life in its various dimensions.

Authors' contribution

All authors actively participated in all stages of preparing the manuscript.

Conflict of interest

The authors have no conflict of interest to declare.

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Resumo

A promoção da saúde é tomada como discurso presente em ações governamentais concretas, como no Sistema Único de Saúde, e construída sobre algumas proposições: concepção de processo saúde-doença calcada em determinantes sociais de saúde; defesa de uma melhor qualidade de vida; e definição de campos centrais e estratégias fundamentais para as ações de promoção da saúde. Discute-se a emergência desse discurso e sua presença na Saúde Coletiva e em políticas públicas brasileiras. São problematizados alguns jogos de sentidos da promoção de saúde entre suas vertentes progressistas e conservadoras/despolitizadoras, bem como suas estratégias de comunicação/informação; tudo isso frente à sua capacidade de transformação da realidade da saúde. Ao final da pesquisa, propomos agregar a esse discurso/ação uma perspectiva que leve em conta os agenciamentos de vida e saúde e os atravessamentos de adoecimento e morte no contexto das sociedades de controle.

Palavras-chave: Promoção da saúde. Saúde Coletiva. Território sociocultural. Política Nacional de Promoção da Saúde. Micropolítica.

Resumen

La promoción de la salud se toma como discurso presente en acciones gubernamentales concretas como en el Sistema Único de Salud y construido sobre algunas propuestas: concepción de un proceso salud-enfermedad con base en factores determinantes sociales de salud; defensa de una mejor calidad de vida; y definición de campos centrales y estrategias fundamentales para las acciones de promoción de la salud. Se discute el surgimiento de este discurso y su presencia en la salud colectiva y en políticas públicas brasileñas. Se problematizan algunos juegos de sentidos de la promoción de la salud entre sus vertientes progresistas y también conservadoras/despolitizadoras, así como sus estrategias de comunicación/información, todo eso ante su capacidad de transformación de la realidad de la salud. Al final, proponemos agregar a este discurso/acción una perspectiva que lleve en consideración las gestiones de vida y salud y los cruces de enfermedad y muerte en el contexto de las sociedades de control.

Palabras clave: Promoción de la salud. Salud Colectiva. Territorio sociocultural. Política Nacional de Promoción de la Salud. Micropolítica.