IS HEALTH EDUCATION GOOD FOR YOU?

THE SOCIAL CONSTRUCTION OF HEALTH EDUCATION IN THE BRAZILIAN NATIONAL HEALTH SYSTEM

Denise Maria Gastaldo

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ABSTRACT

This study is about the social construction of health education in the Brazilian national health system. Health education is examined as a social policy and as a health practice. The theoretical framework is based on the work of Michel Foucault, with special attention to the concepts of bio-power, bio-politics of the population and anatomo-politics of the human body. The thesis pursued is that health education represents a singular contribution to the exercise of bio-power through the health system. Its involvement with prevention and promotion of health, as well as its educational character, enhance the set of power techniques employed in the management of the individual and social body. The data presented are created by analysis of documents and surveys covering federal, state, and municipal levels of government in Brazil and also health centres. Interviews with policy-makers, health professionals, and users of the health system and the observation of two health centres as case studies are also sources of information. Health education policy contributes to expand the surveillance that the work of health professionals represents over any aspect of individual and community life. As a practice, health education can make use of prescriptive or participatory approaches to promote healthy life-styles. However, both of them discipline and normalize individuals and communities. This study also suggests in its conclusion that Foucault's concept of bio-power as power over life centred on the control of sex should be re-thought, focusing on health as the key element in the exercise of bio-power.

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GLOSSARY

National Health System - Is the health care provided by the federal, state, and municipal governments through their own services or through contracted private clinics and hospitals. It is divided into public health and curative medicine. It is also called 'Brazilian national health system' in this study.

Public Health - Is the area of health knowledge that focus on disease prevention and promotion of health at the community level. As part of the national health system in Brazil, the public health system is composed mainly of health centres (see below) to provide primary health care.

Community Health Worker [*agente comunitário de saúde*] - This is not a profession, but a position filled by a member of the community at the health centre. The initial idea was that this person would help to improve the link between the health centre and the community. Community health workers were not paid. However, in many places the health centre has been training them to do the work of other health professionals. They get paid and they are accessible to the community when the health centre is closed. So, they became the cheapest of the members of the staff, not being affiliated to any professional council or union.

Nursing auxiliary [*atendente de enfermagem*] - This profession was abolished by Law 7498/86, Decree 94406/87. No new worker could be hired after 1986 and in 1996 the exercise of nursing by these workers will be forbidden. In private hospitals nursing auxiliaries were 72.6% of the whole nursing staff in 1985 (COFEN, 1985, p.39). After 1996 only those who have been upgraded to assistant practical nurse will be able to continue to work.

Assistant practical nurse [*auxiliar de enfermagem*] - The educational entry requirements for this profession are a minimum of 8 years of primary education and a course of 1100 hours at a vocational secondary school. Assistant practical nurses can work only under the supervision of a nurse (see below) and being registered by the Brazilian Nursing Council.

Practical nurse [*técnico/a de enfermagem*] - The education of a practical nurse is made up of secondary school education and a 1600 hours nursing course. The work has to be supervised by a nurse and the professional has to be registered by the Brazilian Nursing Council.

Nurse [*enfermeiro/a*] - A profession created in the twenties in Brazil following the U.S. model of nursing. Currently in Brazil a nurse has to attend a four or five-year university course and be registered by the Brazilian Nursing Council to practice the profession. All other nursing professionals work under the supervision of nurses.

Health assistant - This title is used in the thesis to cover a whole range of positions created in the public health sector which are not defined by law. There are no educational training requirements to these professionals. The Rio Grande do Sul Health Secretariat calls them *atendente de ambulatório* (outpatients assistant), *auxiliar de serviços médicos* (medical care auxiliary) or *auxiliar de serviços de saúde* (health services auxiliary), among a range of twenty other titles. Their work is mainly nursing care. They are to be professionalised from 1996, as assistant practical nurses.

Specialized auxiliary - Doctors and nurses have a nursing team to help them in many procedures. So do other health professionals. In this thesis, the specialized auxiliaries are: social work auxiliary, dentistry auxiliary, nutritionist auxiliary, and so on.

Health centre - Is a primary care institution which belongs to the government and which offers free health care to the population. Some of the names in Portuguese are: *unidade sanitária, posto de saúde, centro de saúde,* and *unidade básica de saúde.*

Regional Health Authority [*Delegacia Regional de Saúde*] - Each state in Brazil has its own institution which manages primary health care in a specific region of the state. It can also be called *Regional de Saúde* or *Superintendência Regional.*

Municipal Health Council [*Conselho Municipal de Saúde*] - This is a decision-making forum composed of health professionals, community representatives, and health secretariat members. In big cities, there are local neighbourhood Health Councils and a Municipal Health Council composed of representatives from the local health councils. The Municipal Health Councils have the power to decide about money allocation, supervision of health services and policy priorities.

GENERAL INTRODUCTION

This thesis is about the social construction of a particular health practice: health education. The focus of the thesis is the investigation of health education as an exercise of power. This study is undertaken through the analysis of health education as a policy and as a health practice in the context of the Brazilian national health system.

Many choices had to be made in order to limit the scope of this study: it concentrates on a single country, on its *national* health system, and on a small part of the health system's plans and activities. Pragmatic reasons can be presented to justify those decisions. The thesis is the work of only one researcher; limits of time and financial support helped to shape the study; the funders expected the study to focus on the Brazilian national health system; and so on. But there are also intellectual principles which informed the necessary choices.

From a methodological point of view, the choices made are intended to permit a better and more creative understanding of the construction of health education, covering aspects such as the everyday life of patients (receiving) and professionals (carrying out health education), as well as hidden elements in the process of policy formulation.

From a theoretical perspective, health education is examined with the help of Michel Foucault's conception of power. From a Foulcauldian viewpoint, power is exercised in a complex web of relations and when force has to be used to maintain social order it means that the relation is no longer based on power, but it is mere violence. Power is about achieving some form of control through tactics more sophisticated than mere violence; power means to create and transform, rather than to repress. Through the health system the government can reach society and transform

it through the use of constructive means in many social arenas, such as discipline and norms at school.

Thus, overall, health education is investigated in its political dimension in the arenas of health and health promotion. Health has become increasingly important politically during this century as a major point of contact between government and population. With the establishment of a net of human rights and citizenship practices, the art of government had to be refined in its strategies in order to keep control over the population, while avoiding coercive actions. In this perspective, concepts of power are central to the analysis.

In this thesis, power will be examined in its relations to life and health, in its individual and collective aspects, concentrating on the concept of 'bio-power'. Bio-power is a concept developed by Foucault in 'The History of Sexuality' and it is a useful concept for the study of health education. Bio-power, or power over life, relates to the mechanisms employed to manage the population as well as to discipline individuals. Biological life is conceived as a political event by Foucault. Within this perspective, the usefulness of bodies to economic processes and the power of reproduction, and disease, to change population patterns are also political dimensions of life which should be controlled, rather than being accepted as simple biological processes. Health education can make a contribution to the exercise of bio-power because it deals with norms of healthy behaviours and promotes self-discipline for the achievement of health. Its educative character involves the promotion of healthy behaviours that should be adopted by the population and its educative character involves some interference with individual choice, providing information to foster a certain set of lifestyles.

In order to explore the relations between health education and bio-power, this study analyses the information gathered during fieldwork in the Brazilian national health system. The thesis employs the concept of bio-power at the same time that it re-thinks it, after considering evidence from the data analyzed.

The thesis is organized around the main issues through which health education is socially constructed within the national health system - policy and professional practice.

The first chapter presents an overview of the theories of the thesis, discusses the literature on health education, and introduces the research question. The second chapter is concerned with methodology. It presents the 'history' of the research and makes explicit the choices of method made during the period when the thesis was produced.

Subsequently, the thesis is divided in two big Sections. The first analyzes how health education is constructed as a social policy in the national health system. The second investigates health education as a professional practice in the same system.

The first Section, Chapters 3 to 7, deals with health education policy and the national health system. Many discourses from policy formulation to policy implementation are embedded in the process of promoting health. The scrutiny of these discourses reveals that the art of governing is not a single process, but a site for resistance and re-construction of health education as a technique of power. The title of the Section, 'Health Education as Bio-politics', is borrowed from Foucault (1990, p.139), following his idea that bio-politics is the part of bio-power which is related to the management of the population through the control of collective life processes, such as birth, death, and disease.

Each of the two Sections has a specific theoretical framework developed in one or more chapters. In Section I, Chapter 3 is dedicated to the main theoretical issues. Three concepts are reviewed: social policy, bio-politics, and governmentality. Chapter 4 presents the history and current situation of the national health system in Brazil. The system is analyzed theoretically in its potential use to the management of the poor population. Chapter 5 concentrates on federal health

education policies produced in Brazil in the eighties and nineties. Chapter 6 presents the results of a survey among State and Municipal Health Secretariats investigating their production of policies and whether there is a process of continuity or rupture between federal, state and municipal levels in policy formulation. Chapter 7 describes the results of a survey among health centres in the State of Rio Grande do Sul and analyzes the implementation of policies at the local level. It shows that, at the health centre level, professionals and users have the power to redefine policies formulated at different levels of government.

The second Section of the thesis contains Chapters 8 to 10. It concentrates on health education as a professional practice carried out in health centres. Health education authorizes health professionals to teach the community about what is expected from them as healthy citizens. The contact of the users with the health centre in itself can be considered an educative experience. This Section is entitled 'Health Education as Anatomo-politics', again following the vocabulary and lines of analysis offered by Foucault. Anatomo-politics is the other 'pole' of the exercise of bio-power. It is centred on the human body; a body to be made docile through discipline and training, and a body to be useful in the economic system (Foucault, 1990, p.139).

The theoretical framework of the Section II is spread in the three chapters, a deliberately different technique from that used in the previous Section. Chapter 8 focuses on the process of gaining access to consultations, and related health education activities and experiences. It is argued that the contact with health education and the health system can be an 'educative' experience that produces docile bodies. Chapter 9 analyzes health education practices developed during the consultation, whilst Chapter 10 concentrates on group activities entirely devoted to health education. Both chapters discuss the constructive power that health education can represent in the context of the national health system.

Examining the social construction of health education through the concept of bio-power, as both bio-politics and anatomo-politics, is the analytic

perspective sustained through the whole thesis. Chapter 11 concludes the discussion, re-examining what health education is, and reflecting on the importance of the concept of bio-power for understanding health education, and suggesting a re-evaluation of the importance of the concept of health within the concept and practice of bio-power.

CHAPTER 1

HEALTH EDUCATION AND POWER - LITERATURE REVIEW AND RESEARCH QUESTION

1.1. Introduction

The central focus of this Chapter are the main theoretical issues of the thesis as well as the research argument. The Chapter discusses health care in Brazil, health, health promotion, health education, power, bio-power and 'the social'.

The social construction of health education could be explored using a variety of theoretical approaches. In this thesis health education is examined using post-structuralist theories developed by Michel Foucault. Foucauldian categories are well suited to the analysis of health education as social policy and as health practice in the Brazilian national health system. The analysis was limited to the national health system due to its importance as a means of health care delivery. The national health system provides health care to 75% of the population (Teixeira, 1992, p.7) and represents the only alternative available to the vast majority.

1.2. Health care and poverty in Brazil

Brazil is formally a democracy. It is also one of the so called 'third world' countries[1]. Paradoxically it is the eighth economy of the world - with a GNP

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[1] The expressions 'third world', 'first world', 'rich countries' and 'poor countries' will be presented in this thesis in inverted commas. Those terms imprison the reader in a simplistic definition, embodying a capitalist economic perspective of the world. In this thesis, the inverted commas are reminders that in the 'rich countries' economic growth did not eliminate pauperism and a low quality of life for part of the citizens. According to Buarque (1992, pp.15-17) the world is now divided in 'rich countries', 'ex-socialist countries' and 'rest of the world'. The last is concentrated in the southern hemisphere. In many cases, the 'third world' countries have been experiencing dictatorships through which industrialization and urbanization models were imposed. The implementation of these models resulted in an economic apartheid: a minority of the population got access to 'first world' consumption levels and a majority was economic and socially excluded. At the end of the process, in the nineties, 'third world' countries have all the problems of a 'first world' country, but few of its advantages. Therefore in the 'third world' people can experience, according to their social class, a 'first world' or 'third world' reality.

of 450 billion dollars (IBASE, 1993, p.1).

The analysis of some basic information about Brazil shows that economic growth and democracy are not enough to ensure equitable life conditions to the population. Data on poverty, infant mortality, and reproductive rights are presented below to give a picture of the context of life and health in Brazil in recent decades.

In order to discuss the delivery of health in Brazil, the foremost feature to be mentioned is widespread poverty. The situation is so serious that food and housing can be considered the first two health needs of the population. 5.2 million Brazilians work only for food or housing, not a money wage; 15 million receive up to 80 American dollars per month (the minimum legal wage). Of the 62.1 million Brazilians who make up the labour force, 33 million receive less than two minimum wages (including the 20 million mentioned who work for food or up to US$ 80). So, in 1990, the poorest 20% received 2.3% of the national income, whilst the richest 20% received 62.9%. This makes Bangladesh and Botswana, for instance, countries with a more equal income distribution than Brazil (IBASE, 1993, p.2).

The concentration of wealth in the hands of so few imposes an economic apartheid between rich and poor (Buarque, 1992, p.48). Poverty is such a complex and extensive phenomenon that the word 'poor' is not enough to describe the big differences among the 31.679.095 destitute people in the country - 50.68% in rural and 49.32% in urban areas (IBASE, 1993, p.3). It is important to differentiate 'poverty', defined as a low standard of living and the absence of conditions for a dignified human existence, from 'indigence', defined as absolute destitution including food and housing. Perhaps the differences are about permanent low access to food and almost constant hunger, i.e. both cases are a scandal in terms of human rights. Many million people who were born in the eighth biggest world economy are subjugated to indigence.

There are variations between poverty and indigence in different areas of the country. Poverty is predominant in the urban areas whilst indigence is concentrated in the rural zone (IBASE, 1993, p.2). Consequently, migration from rural areas to urban ones is a never-ending process for indigent families who live in the countryside: it is an attempt to be upgraded from indigence to poverty. However, many arrive in the main urban centres of the countries to experience a very similar pattern. In the nine biggest cities of the country there are around 4.5 million indigents. Overall, 22% of the population of 146 million inhabitants live in absolute poverty.

The contrast is not only between rural and urban areas but also between different regions of the country. For instance, 90% of the food production is concentrated in the south and southeast regions and 60% of the starving individuals live in the north and northeast regions (IBASE, 1993, p.3). In 1989, 35% of the population of Fortaleza (a northeastern capital) had no supply of water at home; 32.7% had no refuse collection; and 33.8% had no fridge though living in a tropical region. In contrast, 5.8% of the population of Porto Alegre (southern capital) had no supply of water at home; 13.4% had no refuse collection; and 11.4% had no fridge (FIBGE/PNAD, 1989, quoted in RS/SSMA, 1993, p.14).

The distribution of poverty per region is shown below (Table 1.1), based on the 'Map of Hunger', produced by the *IPEA* - Institute of Applied Economic Research.

The delivery of health to a population which lacks food and basic sanitary conditions such as water and sewage across all the regions of the country is something which is proving impossible to accomplish. Information about the health of the population reveals a direct link between poverty and ill-health. The case of infant mortality illustrates this. While in some regions of the country infant mortality increased by 10 or 15% since 1993, in the poorest region (northeast of the country) it increased by around 30% (Situação do nordeste só piora, 1994, p.8).

Table 1.1. Distribution of severe poverty in Brazil

Region	%
Northeast	54.57
Southeast	25.20
South	12.89
Centre-West	5.18
North	2.16

Source: IBASE, 1993, p.3 (% of distribution of around 31 million inhabitants).

Data on infant mortality also show that progress and development during this century were not enough to ensure a steady improvement in health standards. According to Bähr and Wehrhahn (1993, p.1381), infant mortality in Brazilian capitals reveals a low standard of health in these urban centres. Examining the case of São Paulo, they show that infant mortality decreased constantly between 1918 and 1961, from 223 per thousand to 60 per thousand. After 1961, the infant mortality rate began to rise. In 1970 it was above 88 per thousand, as it had been a quarter of a century earlier. In 1990 the rate was back down to 60 per thousand (UNICEF, 1992, p.63). This rate decreased until 1993. Since then, it rose again by around 15% in the whole country (Situação do nordeste só piora, 1994, p.8). UNICEF (1992, pp.61-63) placed Brazil in the category of countries with high rates of infant mortality (60 per thousand). There are just two countries in South America with higher rates: Peru (82 per thousand) and Bolivia (102 per thousand).

UNICEF (1992, pp.67 and 73) also showed that Brazilian central government expenditure, as a percentage of GNP, was 3% on education and 6% on health (1986-90). Many countries with low rates of infant mortality spend around 10% on health. But Canada invests the same percentages in health and education as Brazil. According to Dowbor (1994, p.1), Brazil invests a bigger part of its GNP than other 'developing' countries in the social area - 80 to 100 billion dollars a year. Nevertheless, the social indicators of well-being are much lower than in other developing countries. This may be because 80% of the expenditure in the health area is dedicated to curative health (Dowbor, 1994, p.1).

The issue of reproductive rights provides additional information about the delivery of health in Brazil. In 1983 a policy called *PAISM* - Women's Integrated Health Care Programme - was launched aimed at improving women's sexual and reproductive health. After 12 years the programme was adopted for 5% of the health centres of gynaecological care and 19% of the health centres of family planning in Brazil (Faltam métodos anticoncepcionais para 1,1 milhão de mulheres no nordeste, 1994, p.6). So, it is not a surprise that, overall, 34% of Brazilian married women between the ages of 15 and 44 did not have access to contraception in 1986. In the Northeast region 47% of women did not use contraception and in the South region and in the State of São Paulo 26% (Faltam métodos anticoncepcionais para 1,1 milhão de mulheres no nordeste, 1994, p.6).

The regional variations in contraceptive provision, infant mortality and poverty provide a picture of the context in which health care delivery is organized in Brazil. The highest rates of fertility and infant mortality are among those living in the worst material conditions and with fewest years of education (Faltam métodos anticoncepcionais para 1,1 milhão de mulheres no nordeste, 1994, p.6).

These appalling conditions compel the poor population to make use of the national health system, looking for assistance in health centres, hospitals, and other services. Therefore, a permanent contact between the government and the poor takes place in the national health system. The users do not have any other alternative because they cannot afford any private care. It is the view of this study that the health system becomes a potential site for the government of the population - at least the poor part of it.

1.3. The concepts of health and disease

The way life is structured in different groups and cultures can contribute to different understandings about what health means. The conceptions of health in Brazil may vary greatly according to region, class, ethnic group, etc.

Perhaps the clearest contrast in concepts of health is between those of the different indigenous groups and the population living in urban centres.

To the Tenetehara Indians the forest is full of spirits who can cause disease. People can offend the spirits voluntarily or even unconsciously. The spirits respond by placing the disease in the body of the victim. Disease is thus seen as the result of an extraneous object - an *ymaé* - being placed in the individual's body by a spirit. The Indians recognise the action of the spirit when they feel that something is wrong with their health. Health can be regained with the help of a shaman who will remove the object, 'removing' the spirit who caused the illness (Wagley and Galvão, 1969, pp.110-111). In this view, religion and morality are part of the process of being healthy or recovering health. The procedures conducted by the shaman are carried out in public and disease does not seem to be a cause for social discrimination.

Among those who are integrated into urbanization and industrialization - the signs of 'development' of the country in the last decades - health has been experienced within an individualistic ethos. Disease is seen as a personal responsibility and mainly as a consequence of the individual's choices. When social reforms are not successful in diminishing social inequalities, personal inadequacy is the predominant explanation to high rates of death, sickness and accidents among the poor (Ross, 1991, p.26).

However, there are authors which refuse to limit health and disease to personal responsibility. Giddens (1989, p.587) says that social factors influence life expectancy, the kind of health service people will have access to, and even the chances of contracting some types of disease. Seedhouse (1986, p.43) corroborates this point saying that avoiding or surviving diseases like diabetes, bronchitis, heart disease, and cancer, among others, depends on material conditions - social class and levels of illness are definitely linked.

As mentioned above, disease is linked to poverty, but since the

nineteenth century disease has been explained mainly by theories that relate it to individual care of the body. Perhaps the 'germ theory' (Turshen, 1989, pp.52-53) is the best known. The identification of bacteria gave rise to a 'cause' and 'cure' approach to disease. The development of microbiology promoted identification of the agent of disease, its location in the body and a focus on curing the problem. 'Gene' theory is another way to explain disease without accounting for social and economic factors. Genetic disorders can make individuals specially susceptible to certain diseases or can be the reason for disease (Turshen, 1989, pp.55-56). In a critique to individualistic approaches to health, Thurshen (1989, p.57) comments that:

> *Individualistic approaches are class biased and unable to address broad economic, social, and political determinants of health such as development.*

The discourse of health as a personal responsibility and the structuring of health services to treat the ill-health of individuals relates to the social construction of individuals as actors capable of making rational choices. Hindess (1988, p.4) points out that there is an "explicit methodological individualism" in the understanding that individuals act rationally according to a stable set of wishes and beliefs. He criticizes the reductionism of such an approach which tries to explain social life as the consequence of the sum of individual choices.

Another reductionism would be to expect theories of disease causation to provide an understanding for health. These theories provide only a negative view of health - health being perceived as absence of disease (Aggleton, 1990, pp.6-7). It is not accurate to say that if a person does not feel any mental or physical pain s/he is healthy. However, as Aggleton (1990, pp.8-9) argues, some positive views of health are idealistic. The 1946 Constitution of the World Health Organization (WHO), for example, defines health as:

> *... a state of complete physical, mental and social well-being and not merely the absence of disease or infirmity.*

Other positive views of health add more dimensions to it. In the literature aspects like sexual, emotional, and spiritual health can be found (Rogers, 1991, pp.208-235; Aggleton, 1990, pp.9-12). To make this concept more complete

does not change its basic assumption of health as a 'perfect state'. Seedhouse (1986, pp.30-33) points out that adopting a standard of absolute health condemns almost all human beings to a condition of constant ill-health and that it obscures the real nature of health.

There are other theories which emphasize humanist, social or biological facets of health. In Seedhouse's analysis (1986, p.29) the four groups of health concepts are:

- Health as an ideal state;
- Health as physical and mental fitness;
- Health as a commodity which can be bought and sold;
- Health as a personal strength (either physical, spiritual or intellectual).

Seedhouse (1986, pp.61-62) adds a further concept: health as a foundation for achievement. In this view, health enables individuals and groups to achieve biological and social goals; it provides the basic means and withdraws obstacles. In this framework education, economic situation, class, race, personal relations, environment, etc are all influential and "the state of a person's health is equivalent to the state of these conditions".

A new definition of health has been used in Brazil since 1986, produced at the VIII National Conference of Health. It is closely related to the one formulated by Seedhouse. It presents health as linked to the life conditions of the population[2].

Perhaps the most striking feature in the conceptualization of health is the division between what are considered 'lay' and 'scientific' concepts. Giddens (1989, p.588) comments that modern medicine not only sees illness as a physical

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[2]According to the VIII National Conference of Health (Brasil-VIII Conferência Nacional de Saúde, 1986, p.381) "in general terms, health results from access to food, housing, education, earnings, job, leisure, freedom, access to and property of land, and access to health services. The right to health means that the State will guarantee proper conditions of life and universal and equal access to services which promote, protect, and restore health ..."

process, but presents it as explicable through science. For him, the main characteristic of modern health systems is to provide health care based on scientific method. It is this official domain of science that differentiates a 'scientific concept' from a 'lay belief'. Rogers (1991, pp.3-4) points out that this perception is shared by many professionals:

> *... currently prevalent among many psychologists and health professionals ... that the 'lay health beliefs' held by ordinary people are at best only watered-down and simplistic versions of proper professional medical knowledge, and at worst 'old wives tales', superstitions and quackery ... (the assertion) that doctors are the 'architects of medical knowledge' portrays ordinary people as ... mindless.*

The dominance of scientific knowledge means that it is presented as the only and exclusive reliable knowledge (Beattie et al., 1993, pp.3-4). These authors suggest that the dominance of the scientific medical model is problematic, producing

> *public dissatisfaction with the dominant authority of medicine within formal health care. A powerful source of this dissatisfaction is dissonance between lay people's lived experience of health, and official accounting for health. People feel that their personal stories of health are not heard, or, if they are, they are marginalised or seen as illegitimate.*

The different status of lay and scientific views about health allows the conclusion that health is not merely a physical experience, but is also a discourse that selects people as possible 'contributors' - or not - to its construction. Nevertheless, those excluded from the understanding of the scientific method keep formulating their own 'accounts' of the processes of health and illness (Eyles & Donovan, 1990, pp.18-37). This is why gender, class and culture, among others, can influence the ways health is understood.

These considerations about what health is have an explicit influence on the way health promotion and health education are conceived. The relations between them are explored in the section below.

1.4. Health promotion and health education

The term 'health education' was created in 1919 by Sally Lucas Jean, in the United States, at the time when public health was being consolidated as an important domain in the sphere of health (Pereira, 1983, p.9). In Brazil, health education was recognized as a field of knowledge by the Institute of Hygiene in 1925 (Pereira, 1983, p.9). The control of infectious diseases and the promotion of higher standards of hygiene were aims pursued by public health at that time (Gastaldo, 1990, pp.23-25). Thus, health education was developed under the influence of theories of disease prevention and health as an individual responsibility (Griffiths & Adams 1991, p.221; Seedhouse, 1986, p.82). Initially, criticisms were developed about the relationship between public health and health education to the capitalist mode of production. According to critics, public health and health education were seen as part of the capitalist machinery because they fail to promote better health and limit themselves to the 'repairing' of the bodies of the working class to make them fit for labour force (Ross, 1991, pp.26-40; Campos, 1991, pp.35-54).

More recently, health education has been challenged by the concept of 'health promotion'. In 1978 the WHO's Alma Ata Conference proposed a common goal for all countries: health for all by the year 2000 (WHO, 1988, p.3). Health promotion was seen as a key strategy to achieve this goal. In 1981 the WHO Regional Office for Europe started to develop a health promotion programme (Kickbusch, 1990, p.1). In 1984 this office launched a document exploring the idea of 'health promotion' which includes health education, but goes beyond it. Health promotion is defined as:

> *... the process of enabling people to increase control over, and to improve, their health. This perspective is derived from a conception of 'health' as the extent to which an individual or group is able, on the one hand, to realise aspirations and satisfy needs; and, on the other hand, to change or cope with the environment.*(WHO, 1985, p.6)

In 1986 the Ottawa Charter for Health Promotion stated that health entails social prerequisites: peace, shelter, education, food, income, a stable eco-system, sustainable resources, social justice, and equity. To promote health became a social and political issue and not a biological-environmental one, eg a commitment

to tackle health inequalities within and between societies. Therefore, to promote health is not only to educate about health but to reduce inequalities in health, to improve living conditions at home and at work, and to involve other areas of the social life to make healthy choices easier (WHO, 1985, pp.6-7).

As a consequence of shifts in international health policy, the nature of the relationship between health education and health promotion has been debated. O'Neill (1989, p.224) argues that there was a conceptual evolution as well as a semantic evolution from health education to health promotion. Some authors definitely adopted the expression 'health promotion' instead of 'health education':

> *Health promotion as an activity is distinguished from its predecessors, health education and community medicine, by two features. First, it recognizes the proposition that health is bigger than the prevention of disease, illness and disability. ... Secondly, ... it concentrates on mass effects and the creation of environments, and options which encourage healthy choices.* (Ashton, 1988, p.41)

> *Above all the new health promotion must avoid the fundamental flaw of the old health education: it was based on an individualistic approach which 'blamed the victim', making people feel guilty about 'wrong' behaviour, as though poverty, bad housing and other social pressures were non-existent.* (Griffiths & Adams, 1991, p.221)

Other authors see health education as part of health promotion (Seedhouse, 1986, pp.82-92; Palko, 1985, p.3; Tones, 1990, p.6; French, 1990, pp.7-10). Others still refer to health education as the core of health promotion (Catford & Nutbeam 1984, p.38).

In this thesis health education is conceived as one of the strategies to promote health, but not the most important part of health promotion. What is recognized is the potential of health education to empower individuals and communities because it nurtures the acquisition of knowledge. French (1985, p.116), for example, argues that:

> *Health education is an aspect of health promotion, and its role is to maximise the involvement in health promotion, as well as providing people with information, skills and experiences through which they can exercise a greater degree of control of their own health.*

This tight relationship between health promotion and health education has produced a re-thinking of health education. Part of this debate on health education has been about the 'old' and the 'new' way of carrying out health education (Seymour, 1984, p.37). However, Taylor (1990, p.13) reminds us that there is no single model for health education; in Britain alone there are more than seventeen taxonomies. Furthermore, one can argue that health education is being conceptualized and practised today according to both 'old' and 'new' approaches, and that this distinction does not elucidate what health education is about. However, for purpose of developing the theoretical perspectives of the thesis, two main health education trends will be explored: the traditional ('old') and radical ('new') approaches.

1.4.1. Traditional health education

The emergence of health promotion and the 'new' health education helped to define the parameters of 'traditional' health education. In reality, under this heading lie many different conceptions of health education. Seymour (1984, p.37) associates traditional health education with the following activities: providing information, suggesting changes in behaviour, and campaigning about health issues. The individual responsibility for health is an important feature of this model. Taking into account these features, in this study the term 'prescriptive' health education will be used as a synonym to traditional health education.

Linked to the notion of individual response is that of prevention, defined as changing behaviour. Seedhouse (1986, p.82), for example, shows that health education still focuses on preventing diseases by providing information about food, exercise, and the risks of smoking or drinking. He criticizes this view of prevention and points out that the preventive approach should encompass 'social prevention':

> *... the prevention of ignorance, the prevention of the abuse of human beings by social systems, and the prevention of the waste of innumerable personal potentials and talents.* (Seedhouse, 1986, p.82)

Nevertheless, preventing disease may in itself represent an important

form of enabling people to achieve their potential and satisfy their needs. The criticism refers to the narrow and limited focus on individual health and personal choice. Health educators are accused of believing that people can be informed and motivated to adopt and keep healthy habits by personal choice (Turshen, 1989, pp.54-55). Commenting on USA data, Sullivan (1992, p.175) provides a good example of this:

> *Personal responsibility is vital to good health. Healthy life-styles and healthy diets increase the ability of each person to avoid disease and disability. ... Better control of fewer than 10 risk factors - such as poor diet, lack of prenatal care, infrequent exercise, the use of tobacco, alcohol misuse and drug abuse, failure to use seat-belts - could prevent between 40 and 70% of all premature deaths, a third of all cases of acute disability and two-thirds of all cases of chronic disability.*

In the same paper he adds that "far too many" of those who experience disability and disease belong to ethnic minorities; e.g. 60,000 more deaths per year occur among America's minority groups, whilst for the general population health status has been improving (Sullivan, 1992, p.176). It is this kind of contrast between the individualistic-preventative and social causes approaches of ill-health that sustains the criticisms of traditional health education.

The third feature of traditional health education is its reliance on professional expertise:

> *Characteristics attributable to this model include the belief that experts know what is best for the public. This belief justifies the use of didactic or coercive methods. It is assumed that professionals and lay persons share values relating to health, while ownership of the appropriate health education knowledge lies with the experts.* (Taylor 1990, p.13)

Weare (1992, p.71) explains that this view of health education comes, in part, from the training of health educators, many of whom are nurses and doctors. In the traditional conception, the healthy choice is the only choice. Therefore, professionals know what the ideal choice is and they are expected to persuade patients to take up the healthiest possible life. The possibility of a patient opting for unhealthy behaviours after some health education activity is interpreted by professionals as a failure.

The issue of choice is a crucial one in health education. Rose points out that the first commitment of any government should be to protect the liberty of every citizen. He adds:

> *Neither governments nor managements have a right to impose constraints on people simply because they are believed to be good for them.* (Rose, 1992, p.120)

In its focus on individual responsibility to prevent illness, following professional expert advise, traditional health education denies autonomy. By ignoring social contexts (eg the health effects of social inequalities) traditional health education also limits the possibilities that individuals have to make healthy choices.

The confrontation of the traditional approach with the emergent concept of health promotion in the eighties has nurtured new perspectives in health education. The main shift was to change from an individual to a social view of health. O'Neill (1989, p.224) refers to the evolution that this process represented.

> *Whereas the transmission of information was for a long time almost the only legitimate task for the health educator, it is now widely admitted that trying to influence the physical or socio-political environment into which individuals are evolving becomes a necessary part of the job.*

This new socio-political approach, here termed 'radical' health education, will now be examined.

1.4.2. Radical health education

Radical health education focuses on empowering people to control their own health. It is also committed to combatting social inequality in a broad way and promoting community participation in health issues. In this study the term 'participatory' health education will be used as a synonym to radical health education.

The 'new public health' movement can be seen as an influence on radical health education (O'Neill, 1989, 224). The term is used to mean environmental approaches to public health (Draper, 1991, p.10; Ashton & Seymour, 1988, pp.13-40). A main strand in this movement is to tackle health-related problems

through 'healthy public policy'[3]. Policies regarding transport or energy can damage health, but can be transformed into 'healthy' policies to promote health (Draper, 1991, p.16). Healthy policies are multisectoral; they involve industry, non-governmental organizations, central and local government; they are educational rather than prescriptive; and they are political, ie focused on social and political change, but not party-political (Draper, 1991, pp.17-19).

Downie et al.(1990, pp.40-42) call radical health education 'health-oriented health education'. They argue that in order to educate about health it is not possible to deal with individual health *in vacuo*. Rather the approach should be "a holistic view of health and its determinants" with programmes co-ordinated by users, pressure groups, professionals, etc. However, radical health education does not mean giving up the important site of individual contact with users to promote specific aspects of their health. Positive health attributes can be achieved through health education as stated by Downie et al. (1990, p.42):

> *... a community can be helped to acquire a higher level of self-esteem and a set of empowering skills, skills which help it to take greater control both over its health as a collective entity and over that of its individual members.*

The WHO has been working on the idea of community participation in health since the eighties in its publications about health promotion. Health education is supposed to encourage community participation and its new approach is based on the social concept of health (Kickbusch, 1990, pp.1-3). This same document criticises health education authorities, in charge of spending public funds, because they have not been tackling controversial issues - e.g. social and economic exclusion.

Radical health education is about empowerment through participation. Tannahill (1985, p.167) and French (1990, p.9) point out that an important objective for health education is the empowerment of individuals and groups in society to

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[3] The concept of 'healthy public policy' comes from the work of Milio (1986) in United States and Draper (1991) in United Kingdom (Ashton and Seymour, 1988, p.91). The World Health Organization defines 'healthy public policy' as "characterized by an explicit concern for health and equity in all areas of policy and by an accountability for health impact" (quoted in Bunton, 1992, p.130).

enable them to organise themselves to develop actions based on their own priorities. Rose (1992, pp.123-124) also stresses the political aspect of health education. In a very broad conception of health education he comments:

> *Anything which stimulates more public information and debate on health issues is good, not just because it may lead to healthier choices by individuals but also because it earns a higher place for health issues on the political agenda. In the long run this is probably the most important achievement of health education.*

Another author, Freundenberg (1986, pp.1-8), also conceptualizes health education in a political way. He argues that effective health education must deal with many areas - information, law, economy - and *must* penetrate the political arena both through conventional or alternative politics. The WHO (1988, pp.135-136) suggests that non-governmental organizations are a political alternative to deal with the narrow delivery of health care in so many 'third world' countries.

However, the WHO comments that participation in management and decision-making process in health systems seems to be poorly implemented (Kickbusch, 1990, p.16). Other published works corroborate this view, showing concern with the real achievements that participation could bring. Godbout (1981, p.158), commenting on experiences of community participation in health, states that

> *... citizens are co-opted rather than elected, and their power is consultative rather than decisional. ... In the process, the base of citizen legitimacy is transformed: instead of reposing on client's rights, it becomes based on mobilization in favour of the organization and tends to increase the power of the staff.*

Tones (1990, p.2) supports this same understanding, suggesting that many community-based projects "colonise rather than empower"; they carry scientific theories into the community instead of starting with community views and beliefs.

Bunton (1992, pp. 4-5) points out that health promotion policy and healthy public policy can also be manipulated. Approaches that involve community participation have the same political potential to manipulation than others and policies in this area have been criticized by its vague and broad nature, leading to little commitment by governments (Bunton, 1992, pp.4-5).

This critical understanding of participation puts into perspective the transformative power of radical health education. After ten years of radical health education, traces of traditional health education are very much present in the practices of health professionals and healthy policies still have a long way to run until become a common practice (Weare, 1992, p.73). One can argue that to encourage people to change society is a difficult task because they may want to start changing the power relations in the health services, thus challenging the traditional role of health professionals and their authority. Nevertheless, to acknowledge a political dimension to health education at all levels - from policy formulation to community organization - means a consolidation of the radical approach. In order to acquire a better understanding of the radical model, the concept of power will be further investigated.

1.5. Power

In this work power will be conceived as relational. It cannot be held or possessed; it only exists when it is exercised. A basic feature of power is that it permeates any relationship and it is inherent in other relations, such as knowledge relations or economic relations (Foucault, 1990, p.94; O'Neill, 1989, pp.222-223; McNay, 1994, pp.90-91). According to this view health education is political in all its activities and power is exercised in all its aspects. Consequently, relations of knowledge that are a basic feature in health education are also power relations.

Foucault's concept of the relation between power and knowledge is diametrically opposed to that of social scientists who believe that we are living an advanced era because we have an enhanced knowledge about human beings and their bodies, and that this knowledge will make people's lives freer in some way (Amariglio, 1988, p.602). This view of the neutrality of knowledge has been present in health education and it relates to the way the body is conceived, as Amariglio (1988, p.603) points out:

> *... despite knowledge's employment in the service of humanity, knowledge is said to be disinterested, neutral in regard to programs and politics of all kinds. Knowledge is thereby wholly beneficial to the body. In the promotion*

> *of self-knowledge, Man comes to respect his body; he learns to augment its powers; he learns how to free himself. ... While affirming its own power to aid in the development of Man's body, knowledge must at the same time prevent the operation of a power that it views as subversive of this development. True knowledge is thus radically divorced from power.*

This perception of the neutrality of knowledge, and thus of health education, is a denial of the political dimension of human activities. This neutral position can be associated with a form of conservatism or immobilism in power relations. O'Neill (1989, pp.227) comments that the political capacities of governmental institutions such as community health services are underestimated. He says about these services that

> *their first and most essential function is one of social control more than one of radical, or even reformist, social change. It is not surprising, then, to realise that, in many countries, the skills and attitudes required to intervene politically in health promotion are not taught to the community health workers, who are clearly expected to help maintain the status quo rather than to challenge it.*

This quotation illustrates that health education is always education about something: about the health of individuals or groups in society. The concepts of traditional and radical health education relate to clear political trends. Foucault would argue that both forms of health education are bound by power/knowledge, but in different ways. The traditional approach justifies professionals' power because they posses 'neutral' scientific knowledge. The radical one tries to re-balance power relations in society, enabling people to control their health and life.

Foucault (1991, p.27) points out that knowledge, however conceived, is never neutral:

> *... we should abandon a whole tradition that allows us to imagine that knowledge can exist only where the power relations are suspended and that knowledge can develop only outside its injunctions, its demands and its interests. ... We should admit rather that power produces knowledge ...; that power and knowledge directly imply one another; that there is no power relation without the correlative constitution of a field of knowledge, nor any knowledge that does not presuppose and constitute at the same time power relations.*

Furthermore, power does not belong to those who create knowledge as professionals nor is it concentrated in certain groups in society. Power/knowledge relations have to be conceived in a dynamic way:

> *Power must be analysed as something which circulates, or rather as something which only functions in the form of a chain. It is never localised here or there, never in anybody's hands, never appropriated as a commodity or piece of wealth. Power is employed and exercised through a net-like organisation. And not only do individuals circulate between its threads; they are always in the position of simultaneously undergoing and exercising this power.* (Foucault, 1980, p.98)

Thus, NcNay (1994, p.90) says that power cannot be viewed as a repressive force, the property of an elite employed to maintain social hierarchies. Foucault (1991, p.194) states that power is constructive:

> *We must cease once and for all to describe the effects of power in negative terms: it 'excludes', it 'represses', it 'censors', it 'abstracts', it 'masks', it 'conceals'. In fact, power produces; it produces reality; it produces domains of objects and rituals of truth.*

1.5.1. From repressive to disciplinary power

According to Foucault (1990, p.87) since the Middle Ages power has been formulated in Western societies as law. Western monarchies based their power strategies on the legal system and this power was established mainly as a repressive approach. Foucault (1990, p.82) describes this representation of power as 'juridico-discursive'. It does not mean that it is employed only through law and the legal system. Like any other form of power it is exercised throughout society.

> *... it operates according to the simple and endlessly reproduced mechanisms of law, taboo, and censorship: from state to family, from prince to father, from the tribunal to the small change of everyday punishments ... This form is the law of transgression and punishment, with its interplay of licit and illicit. Whether one attributes it the form of the prince who formulates rights, of the father who forbids, of the censor who enforces silence, or of the master who states the law, in any case one schematizes power in a juridical form, and one defines its effects as obedience.* (Foucault 1990, pp. 84-85)

The juridical model of power aims at achieving submission. Foucault (1990, p.85) views this exercise as negative, a kind of "anti-energy".

> *... this power is poor in resources, sparing of its methods, monotonous in the tactics it utilizes, incapable of invention, and seemingly doomed always to*

repeat itself.

This limited capacity of creating control in a more refined way has moved Western societies from the juridical model as a dominant strategy. Perhaps the issue of resistance can be related to this move for more refined ways of exercising power. Raw strategies of domination can provoke strong reactions against them. However, when discipline is widespread and gentle it becomes much more difficult to identify a reason to fight and a source of oppression. Foucault (1990, p.89) describes this process of replacement of repressive with more sophisticated strategies through the creation of

> *... new methods of power whose operation is not ensured by right but by technique, not by law, but by normalization, not by punishment but by control, methods that are employed on all levels and in forms that go beyond the state and its apparatus.*

By the eighteenth century, repressive power was transformed into a disciplinary power. The techniques or strategies of power that have been employed to achieve obedience here involve norms, examination, grades, hierarchy, and reward. Foucault (1991, pp.175-177) describes the formation of disciplinary power that became accepted and organized through continuous surveillance.

> *Surveillance thus becomes a decisive economic operator both as an internal part of the production machinery and as a specific mechanism in the disciplinary power.* (Foucault, 1991, p.175)

Discipline operates in a network of relations that Foucault (1991, p.177) calls 'absolutely indiscreet' - because it is everywhere and every person, including those who supervise, is constantly under "calculated gazes" - and 'absolutely discreet' - because it works constantly and quietly. It is not only the constant gaze that plays a role in moulding conduct, but also its minor codes of behaviour which result in small punishments when not observed. Foucault (1991, pp.177-178) discusses many sites not covered by the law which have their small penal systems. Humiliation for those who lack politeness or arrive to work late, for instance, are forms of penalizing and producing a disciplinary society.

The concept of bio-power is explored in the next section, relating the

construction of a disciplinary society to the exercise of power over individual bodies and population.

1.6. Bio-power

Foucault (1990, pp.135-139) points out that there was a shift in the way the population is managed since the seventeenth century, from a repressive approach to a constructive one. The sovereign's power over life was exercised by killing or abstaining from killing. However, gradually the interventions were replaced by power to promote life. Bio-power, or power over life, is constituted by power employed to control individual bodies and population. Hakosalo (1991, p.9) defines bio-power as the use of mechanisms of control and coercion "for the productivity and health of human bodies and populations", based on a view of them as "resources and manageable objects".

It was only in the Classical Age that this kind of political rationality was established - the concern with growth of the population and fostering of life (Dreyfus & Rabinow, 1982, p.133; Foucault, 1990, p.136). Foucault (1990, pp.142-143) states that it was the first time in history that power concentrated on life instead of just deciding about death; biological and political existence started to interface with each other.

The body became the focus of analysis as an individual entity; it was no longer an indissociable and collective entity, like a population (Foucault, 1991, pp.136-137). Looking at this process through a social constructionist perspective, the individual body was *invented* at the beginning of the eighteenth century. Many power techniques have been developed since then to make this political existence docile - a body which can be "subjected, used, transformed, and improved" (Foucault, 1991, p.136).

Dreyfus & Rabinow (1982, pp.153-154) say that some form of control

over the body is found in all societies. However, the employment of disciplinary power divides the body in parts and trains it, aiming at efficiency of the parts and of the whole. It happens in a subtle and constant way, in a web of micropowers, each including the use of space, time, and everyday practices.

The individual use of the body was turned into an object of knowledge. In order to govern the population, each individual body should be reached and knowledge about it gathered. For the first time the future of the society is related not only to the number of citizens and family organization, but to the use each person makes of sex (Foucault, 1990, p.26). Foucault has drawn attention to the fact that

> *Through the political economy of population there was formed a whole grid of observations regarding sex. ... There also appeared those systematic campaigns which ... tried to transform the sexual conduct of couples into a concerted economic and political behavior. ... It was essential that the state know what was happening with its citizens' sex, and the use they made of it, but also that each individual be capable of controlling the use he made of it.*

Knowledge about populations also acquired a distinct perspective in the eighteenth century. Governments recognised that dealing with individuals or people was different from handling a population - it emerged then as an economic and political issue. Some facets of the question were: health, illness, death, births, etc. These issues are directly related to the labour force, economic growth, and distribution of wealth; and in the two last centuries they became the target for comprehensive measures, statistics and sites for intervention in groups or the whole population (Foucault, 1990, p.146).

In order to manage the population, every individual should be reached by techniques of power. The control of the social body[4] through life demanded a whole new set of strategies. For example, the practices of examining bodies, asking questions about habits and other private issues, the prescription of behaviours and drugs would not be easily accepted in health without similar experiences in other sites

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[4] Foucault does not refer to 'society' but he uses the expressions 'social body' and 'collective body'. They are not figurative expressions. Barret-Kriegel (1992, p.194) comments that the term 'body' represents a "complex and multiple materiality" and that talking about the social body emphasizes its physical element.

of social life. Foucault (1991, p.28) argues that 'body politic' relies on communication routes which construct bodies as objects of knowledge. Confession, for instance, is an important communication strategy which has been used to circulate knowledge about individual bodies.

Since the Middle Ages, confession was introduced in Western societies as an important ritual and played a central role in both religious and civil power (Foucault, 1990, p.58). During confession people are expected to reveal their sins to the judge, to their parents, to the priest, to the teacher, to the doctor. Confession is described by Foucault (1990, p.59) as one of the best techniques for producing truth. It became part of everyday life, part of love relations, medicine and education.

> *The truthful confession was inscribed at the heart of the procedures of individualization by power. ... Western man has become a confessional animal.* (Foucault, 1990, pp.58-59)

From the practice of confession, other ways of disciplining and normalizing were created. The clinical examination of the body has many similarities with confession: the inducement to speak becomes scientifically acceptable; health professionals should have access to all information and have the right to ask questions because there is information that is 'hidden' from the patient her/himself; the examination and interview produce truth because they have to be interpreted by the professional; there is a shift from sin to abnormalities or pathology (Foucault, 1990, pp. 64-65).

Confession, as well as the therapeutic practice of medicine, bridges the microphysics and macrophysics of power because they link individual bodies to the social body. Gordon (1991, pp.4-5) suggests that bio-power is the link between micro and macro; it is

> *... a politics concerned with subjects as members of a* ***population****, in which issues of individual sexual and reproductive conduct interconnect with issues of national policy and power.*

The link between the individual and population does not mean that bio-

power is a general system of domination of a group which permeates the whole social body. It is also not a set of mechanisms which guarantee control by the state of its citizens (Foucault, 1990, p.92). Rather, bio-power is a subtle, constant and ubiquitous power over life. Bio-power has been exercised through a set of power techniques, but two basic forms are identifiable as the poles of this 'line of power'. They were named by Foucault the 'bio-politics of the population' and the 'anatomo-politics of the human body'.

Bio-politics is the pole of bio-power that employs regulatory controls and interventions to manage the population (Foucault, 1990, p.139). The biological processes that are generated by the collection of individuals are directly linked to economic and social issues - an epidemic may abruptly attack the labour force of a region; an increase in life expectancy implies the extension of health care and social support to elderly people. Social policy is a visible strategy to handle collective processes concerned with the life and health of the population. Other invisible power techniques, such as the gaze of the health system over private life, collaborate to gather information and to establish what is normal and pathological.

Anatomo-politics, at the other pole, focuses on the body as a machine (Foucault, 1990, p.139). Docility and usefulness are identified by Foucault as ways to integrate the body into economic and social life. In order to achieve that, the operation of disciplinary power pervades relations in families, schools, hospitals, work, etc. In the case of medicine, the effect of discipline is that the therapeutic space became a political one. Individuality has been constructed based on symptoms, disease, or life style and the control over these processes is at the core of medical care (Foucault, 1991, p.144).

Between these two approaches to the exercise of bio-power there is a cluster of power relations that also contributed to the formation of the political technology of life. Foucault (1990, pp.145-146) highlights that life and sex as political issues demanded

> *infinitesimal surveillances, permanent controls, extremely meticulous orderings of space, indeterminate medical or psychological examinations, to an entire micro-power concerned with the body.*

Foucault (1990, p.145) points out that sexuality is a point of intersection between bio-politics and anatomo-politics. Sex and sexuality became the focus of attention of statistics, policies, and pathology. In the nineteenth century, sex could explain the etiology of any disease. Foucault (1990, p.65) calls this process "the postulate of a general and diffuse causality" because sex had an "inexhaustible and polymorphous causal power". Sex was related to nervous diseases, children's bad habits, problems of old age, and so on. Sex and reproduction were both a concern to population management and a locus for disciplining individuals.

Bio-power goes beyond the limits of health care and policy; it touches sex and sexuality in many aspects of life. But the political space that health care and policy constitute is an important site for the exercise of disciplinary power. Focusing on individual bodies or on the social body, health professionals are entitled by scientific knowledge/power to examine, interview and prescribe 'healthy' life styles. The clinical gaze is omnipresent and acceptable because it aims at promoting health - as much as promoting a disciplinary society.

1.7. The social

The power relations that take place in the health system or at home are traditionally described as events of public and private domains. However, the understanding of bio-power challenges these concepts and in this thesis the concept of 'the social' will be adopted.

The context of this study, the Brazilian national health system, brings the traditional idea of two different spheres in society: the private and the public. From a sociological perspective, 'public' refers to aspects of individuals' lives that are carried out in 'society', such as work; those aspects which 'belong' to the

individual's family life are seen as 'private'. In political terms, 'public' can also mean every institution or service provided by the government and 'private' is concerned with all other initiatives in society, including the economic. However, the boundaries of both spheres touch and the dividing lines between public and private life are fuzzy.

In this study, the understanding of the space occupied by governmental and private initiatives is borrowed from Jacques Donzelot and his concept of 'the social'. Deleuze (1980, p.x) commenting on the concept of 'the social' says:

> *Nor does it emerge with the public sector or the private sector, since on the contrary it leads to a new hybrid form of the public and the private, and itself produces a repartition, a novel interlacing of intervention and withdrawals of the state, of its charges and discharges.*

The formation of 'the social' is explained by Donzelot (1994, p.262) as a process that has been developing over the last one hundred years. It can be related to Foucault's idea of a society of security[5] because 'the social' was invented to deal with social differences, not through law or economics, but through re-inventing social spaces and creating norms that circulate between what is traditionally called in sociology public and private. 'The social' is the result of the hybridization of both sectors. Deleuze (1980, p.ix) argues about the specificity of this social locus:

> *... the social refers to a particular sector in which quite diverse problems and special cases can be grouped together, a sector comprising specific institutions and an entire body of qualified personnel ("social" assistants, "social" workers).*

Deleuze (1980, p.x) states that 'the social' takes form creating new relationships between wealth and poverty, doctor and family or administrator and users. In the case of the Brazilian national health system this concept is useful because it broadens out the understanding of the health system, which deals with the poor and has professionals to work within 'the social'. Health programmes can be about food distribution and health practices can be the work of social workers who keep the

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[5] "... from the eighteenth century onwards, security tends increasingly to become the dominant component of modern governmental rationality: we live today not so much in a *Rechtsstaat* or in a disciplinary society as in a society of security" (Gordon, 1991, p.20). In this thesis the transition from disciplinary society to society of security is acknowledged in the way governmental initiatives are analysed in the Sections I and II.

poorest families in the community in touch with the health centre. Family life, reproduction, and the feeding of children are no longer private issues as a consequence of the operation of the health system, but something private, something public; they are at the domain of 'the social'. The exercise of bio-power happens in this hybrid space because its constructive facet allows intervention in what was called private lives in people's own best interest: to promote health. The flexibility between public and private establishes a new domain. Gordon (1991, pp.33-35) talks about the private as "a 'virtual' public sphere".

Donzelot (1994, p.186 and 262) argues that poverty in a democratic capitalist society is a permanent accusation against the socio-economic-political system; poverty shows these regimes as a "formal alibi to oppression". 'The social' has emerged:

> *De l'impossibilité d'obéir à l'injonction politique de la masse comme de se cantonner à la seule protection de la société civile ...*[6]

To civilize, to educate or to improve hygiene in order to achieve progress, solidarity and security are ideas that are taken for granted in democratic regimes. They are also disciplinary techniques that sustain the exercise of bio-power. The question which the concept of 'the social' raises is about the genealogy of such values and beliefs. Donzelot (1980, p.xxvi) demonstrates that throughout this century society has created means to be relatively safe from economic and political changes. Society is also in charge of achieving progress and security; the government is not the only agent of security.

Gordon (1991, p.34) stresses the governmental side of 'the social'. He refers to 'the social' as:

> *... a field of governmental action operating always within and upon the discrepancies between economy and society. ... the focal question of politics is now not so much the justification of state action as the governability of the social.*

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[6] Translated by the researcher: From the impossibility to obeying the political injunction of the masses as well as to assigning oneself to the only protection of the civil society ...

The government of the poor, the refinement of the art of governing, and the establishment of a society of security have been achieved through power relations that take place in 'the social'. Life, and its many 'private' sites, is the link between 'the social' and bio-power. The exercise of bio-power has been constructing 'the social' and the acceptance of health as a mixed public-private domain has reinforced the acceptability of bio-power interventions over life. Health education will be examined in the next section as a power exercised in 'the social'.

1.8. Health education as bio-power

Conceiving health education as a socially constructed discipline is the starting point of the thesis. Health education dates from the beginning of the century, at the time of a shift in the medical paradigm. During the nineteenth century, the predominant model was Hospital Medicine, concentrating on symptoms and signs that together configured a pathology (Armstrong, 1995, p.3). This model maintained its influence in the twentieth century, but gradually a new paradigm, Surveillance Medicine, has been re-creating the conceptions of health, illness and normality (Armstrong, 1995, pp.4-5).

Surveillance Medicine moves the attention of medicine from pathological bodies to every member of the population. The categories of healthy and ill give place to the notion of risk - illness is *per se* not a problem, but a significant portion of health is redefined as an "at-risk state" (Armstrong, 1995, p.13). Also the limits between health and illness have been re-shaped - healthy people can become even healthier and a person can be healthy and ill at the same time (Armstrong, 1995, p.12). Because ill and healthy people are at risk, the old tradition of teaching hygiene proved insufficient and has been transformed into the promotion of health (Armstrong, 1995, p. 10). Health education became part of a whole strategy to promote health for all human beings, a strategy supported by the World Health Organization.

Throughout the century lifestyle became a new locus for identifying risk of disease and an area for intervention to promote healthier lifestyles (Armstrong 1995, p.13). Risk factors involve almost any aspect of human life, therefore campaigns, screening tests, focus groups, consultations are a necessary means to promote health. What happens as consequence is a wider contact between the health care system and the population. Armstrong (1995, p.12) points out that

> *The extension of a medical eye over all population is the outward manifestation of the new framework of Surveillance Medicine.*

The development of Surveillance Medicine overlaps with the creation of the 'whole-person'. People have to be treated in a complex way, including their social, psychological, biological and spiritual dimensions. Holistic health education advocates the achievement of links, balance and relationship in a conception of knowledge in which participation is the key element. It criticizes the traditional approach to health education (Laura, 1990, p.98). However, this holistic health can be seen as a shift in the way the medical gaze looks at bodies. Armstrong (1986, pp.32-33) remarks that in the past it was enough to control the body, but now the mind, the self, and the environment also have to be subjugated.

> *Holistic medicine's expressed aim is to ignore no facet of individual identity in the totality of its healing: yet in terms of the social control argument this means that the secret innermost private spaces which constitute the moral core of the individual are thereby exposed to medical surveillance and their essential autonomy destroyed.*

The development of Surveillance Medicine and the belief in a holistic approach to health are important mechanisms in the consolidation of what Foucault called 'an era of bio-power'. Foucault centres his analysis on sex, but in this thesis bio-power will be examined in its connections with a 'regime of total health'. The development of the concept of new public health, 'green healthy policy', and the contributions of the health promotion movement have also been expanding health from a sectoral to an intersectoral domain; health can justify interference in economic policy as much as in personal behaviour. Armstrong (1993, p.66) describes this process:

> *Influencing, manipulating, transforming, the new medicine of continuous*

surveillance is a dream of enlightenment in which the population achieves liberation under a totalitarian regime of health.

The reading of literature on health promotion and public health shows the extent to which health has been advocated as a criterion in decision-making in a variety of areas of life. Jaramillo (1995, p.1), for example, mentions that trauma and violence are the main public health problems in Colombia. Therefore, to promote health in Colombia means to intervene in the sources of violence: poverty, illegal drugs trade, corruption, external debt, etc. Rose (1992, p.122) criticizes the English government because it gives subsidies to farmers who produce milk and butter, but does not to vegetable oil producers. Kickbusch (1990, p.9) refers to links between the environment and a new role for governments in promoting health. The World Health Organization (WHO, 1985, p.6) states that health promotion should involve the whole population in the context of their everyday life, as well as different levels of government should promote a 'total' environment favourable to health. At the end of the twentieth century health is supposed to reach almost all sites of human life and justifies political and socio-economic transformations.

Armstrong's concept of a 'regime of total health' presents health education as a mechanism of power in the surveillance of the population. However, health education has traditionally been recognized as an amelioration of health care; perhaps more recently as an alternative to democratize health knowledge. The belief that informed people make better choices lies behind this assumption.

What this thesis intends is to challenge what is taken for granted: namely, that health education is good for you! In this work, Foucault's theory will be used to examine taken for granted phenomena ("phenomena that often support petrified networks of power by their very 'naturalness'" - Hakosalo, 1991, p.209) and to demonstrate how they are socially constructed, within a 'regime of total health'.

Foucault (1973, p.34) situates the rise of the interest in the healthy

person in the medicine of the eighteenth century.

> *Medicine must no longer be confined to a body of techniques for curing ills and of the knowledge that they require; it will also embrace a knowledge of* ***healthy man****, that is, a study of* ***non-sick man****, and a definition of the* ***model man****. In the ordering of human existence it assumes a normative posture, which authorizes it not only to distribute advice as to healthy life, but also to dictate the standards for physical and moral relations of the individual and of the society in which he lives.*

The relations between individual medicine and totalizing codes of conduct illustrate how 'to be healthy' is an approach to governing the population which operates through widespread sites, linking different disciplinary experiences and creating a common language among different institutions (Ewald, 1992, p.170). Ewald says that "disciplines create society"; and part of this creation comes from contact with health institutions and the promotion of health. Bunton (1992, p.4) points out that health promotion is not only a new approach to health, "but also a new form of social regulation and control".

In order to normalize and discipline the individual/social body, health care and the therapeutic act have been transformed. From the recuperation of bodies to the promotion of health, health disciplines have been constructing individuals. First we became individual bodies (seventeenth century) and now we are whole human beings, members of communities which should be empowered to achieve health. To understand the contribution of health education to the exercise of bio-power, first this thesis will explore the peculiarities of medical care. Hakosalo (1991, p.7) comments that medicine and psychiatry exercise a vital kind of power:

> *diffuse, normative, predominantly non-coercive and therefore easily overlooked.*

In general, the provision of medical care by the government is seen as aiming at ensuring access of the entire population to curative medicine and health promotion. Foucault (1973, p.31), however, sees the presence of doctors in a different way:

> *... a generalized presence of doctors whose intersecting gazes form a network and exercise at every point in space, and at every moment in time, a constant,*

mobile, differentiated supervision.

The health care system in Brazil is centred on medical care. The contact the patient has with the system usually starts with a medical consultation. The consultation individualizes bodies, compares them, and creates norms about levels of normality and pathology.

There are two main phases in a medical consultation: (i) gathering of information through the patient's description of the problem and through an examination of the body, leading to diagnosis; (ii) prescription of the treatment (Ogilvie, 1980, pp.37-40). The clinical examination not only allows the doctor to enhance her/his knowledge about normality and pathology but also concentrates the knowledge and information in the professional. As a constructive practice, the prescription of treatment is restricted because it focuses only on the individual and those aspects of health that are concerned with the specific problem s/he presents.

What this thesis analyzes are the shifts that the development of health education brings into this health scenario. Foucault (1973, p.31) argues that settling doctors everywhere is not enough for the surveillance of the population. So, each citizen must be taught medical knowledge. Through this teaching, human existence becomes permanently linked to individual and collective consciousness about life as a potential health problem. Every space is a potential site for teaching and reinforcing health awareness.

It is the view of this work that the most important contribution health education brings into health care is the creation of a new style of control. Health education 'empowers' individuals; in other words, it transfers to them the responsibility for a healthy lifestyle. It promotes self-discipline, whereby the gaze over the population comes not only from outside but also from the inside. It becomes a constant and ubiquitous exercise of power. Pizzorno (1992, p.207) points out that the 'self' can be an instrument of power:

> *... a tool actively working at reducing its own recalcitrance, resistance, unpredictability, and at obtaining its own docility. Indeed,* ***self-discipline***

seems to be the most efficacious technique of power in modern society.

It is the educational character of health education that promotes self-discipline and makes it a constructive way to exercise power. Health education also constitutes 'the social' because it creates a new space, previously conceived as private or public. For instance, MacQueen (1975, p.94) refers to places for effective health education:

> *Individual teaching - one-to-one discussion - is the biggest and most successful component of health education. The best place for it is the home, where the client is most relaxed, but it can also take place in health centres, clinics, consulting rooms, and hospitals.*

Commenting on the different levels of prevention, Tones (1990, p.2) suggests that primary prevention could be seen as persuading people "to adopt 'healthy' life-styles", secondary prevention as persuading them to report any changes that could demand investigation, and

> *... tertiary prevention involves the provision of tender, loving ... care for the veteran to keep it ticking over as sweetly as possible until the final seize-up!*

The vocabulary chosen by Tones to explain the levels of prevention in health education illustrates an inherent feature of health education: someone knows better than the patient her/himself how to take care of health. The power strategy commonly used in health education to minimize resistance against this disempowerment of the patient is to encourage the patient to talk, be aware of economic and cultural differences, to foster 'loving care' for the patient, and to promote participation. How could someone resist or oppose such a friendly practice that aims to achieve a better quality of life to the population?

It is the 'good', perhaps 'liberatory', character of health education that justifies the creation of new spaces where it can achieve better results. To educate for health means to ally two highly positive aspects of life in Western societies. Education and health are both desirable 'commodities' in attaining a better standard of life. They are also both constituted as a right and as a significant international and national political issue (The need for a new paradigm for health, 1992, p.173).

It is the understanding of this work that health education is constructive, instead of positive. Taking Henry Peter's (quoted in French, 1985, p.116) definition of education into account, what emerges is a constructive facet of health education as an exercise of power. The definition is:

> *Education makes a people easy to lead, but difficult to drive; easy to govern, but impossible to enslave.*

The constructive character of health education can be seen in this definition because, in the vast majority of Western societies, to drive or to enslave would be unacceptable ways of governing. Gordon (1991, p.20) states that to violate rights is to show ignorance about how to govern; "liberty is the circumambient medium of governmental action". So, to educate for health is to make the act of governing admissible; it is a strategy to construct acceptance.

The construction of acceptance does not happen without resistance. At a personal level, people can respond to health education not following the healthy life style suggested, in spite of having the material conditions to do so. At an institutional level, groups can be organized to campaign against and denounce power over life. The most focused example in health education found in the literature review is the 'Arise' - The Associates for Research into the Science of Enjoyment (Bunting, 1994, p.29). This group questions, through scientific work, the 'truth' of the notion of a healthy life disseminated in government information. They accuse the government of 'health fascism' and recommend pleasure instead of control. Arise members recall the Orwellian state in '1984' where the quantity of chocolate you could eat was regulated by the state. Caffeine, nicotine, licit and illicit drugs, sugar, and many others are directly related to quality of life and longevity in health education advertising and information. The appeal to self-discipline and the regulatory measures imposed by the state (banned drugs, for instance) constantly construct 'healthy citizens' but also resistance.

The idea that the traditional and radical approaches to health education could make some difference in the way they generate resistance has to be

acknowledged. However, the change from more repressive to more constructive techniques is not enough to transform power relations. They share many common elements. For instance, both traditional and radical approaches do not challenge the notion of confession in their practices. Like clinical examination, health education produces truth; it deals with the ideal of healthy and long life and anything that relates to life is a potential issue to be examined by health professionals. The power/knowledge relations sustain the professional right to provide the interpretation of what the patient 'really' needs or wants. As stated by Weare (1992, p.81), health education is part of the problem rather than the solution to the achievement of health.

Radical or traditional health education both share an underlying notion of empowerment through education or subjugation through ignorance. They share the understanding that human beings are liberated beings unless something oppresses them; and empowering them through education is a way to remove the 'chains' of oppression - ignorance, lack of political understanding, submissive behaviours, etc. In this thesis both processes, subjugation and liberation, are acknowledged as elements of health education power relations. However, they are not the final outcome of these power/knowledge relations. What health education does construct is identity. Health education is an educative experience that provides elements to professionals and patients to build up representations about what is expected from 'healthy' and 'sick' people. These social roles are reinforced by a complex system of reward and punishment. Health education is an experience of being governed from the outside and a request for self-discipline. From inside, health education is a constructive exercise of power that improves the medical gaze; through the promotion of health it circulates everywhere in a sphere which is new to bio-medicine, namely, 'the social'.

The central argument of this thesis is that health education represents a singular contribution to the exercise of bio-power through the health system. Its involvement with the prevention and promotion of health, as well as its educational character, enhance the set of power techniques employed in the management of the individual and social body.

CHAPTER 2

THE HISTORY AND METHODOLOGY OF THE RESEARCH

2.1. Introduction

This Chapter presents the methodological choices made in the process of defining the scope of the research, creating instruments, collecting and analyzing information and writing up the final version of this thesis. The information were gathered through many research techniques but the analysis was mainly a qualitative one.

The two main domains of the research, health education policies and practices, demanded very different approaches in investigation. Whilst the understanding of policies in a national context involves document analysis, surveys and interviews, the examination of practices needs a continuous contact between the researcher and the professionals developing health education - an ethnographic approach.

The ethnographic approach was selected because it allows the researcher to observe and interact with people in their everyday life, rather than only concentrating on their accounts (Hammersley & Atkinson, 1983, p.ix). Ethnography is especially useful in the understanding of social processes because it covers many sources of information (Hammersley & Atkinson, 1983, p.2).

However, ethnography has limits as does any other approach. Methods should be selected according to the purpose of the study. As Hammersley & Atkinson (1983, p.x) point out no technique is superior, it all depends on what the study is meant for. For instance, ethnographic studies tend to concentrate for a long period in a single place. But if a research intends to cover different levels of government in a

certain period of time, like this one does, ethnography can prove inappropriate.

The inaccessibility of decision-making spheres of power at the government and the national scale of this study are factors that point to a 'non-personal' kind of strategy. To quantify answers, assuming that facts collected through a questionnaire can explain reality, is not the objective of this investigation. However, to gather information among policy-makers a clear thematic focus had to be established and a traditional research technique - which is familiar to them - seemed to be the best choice.

As described above, in this thesis, multiple sources of information was the more appropriate choice, mixing quantitative and qualitative approaches. The history of the research from 1991 to 1995 is presented in the sections below: epistemology and the regime of truth; the limits of the study; creating a written document; survey, documents, and interview; ethnography; and ethics.

2.2. Epistemology and the regime of truth

... we can no longer know the whole truth, or even claim to approach it.
Clifford (1986, p.25)

This section concentrates on the epistemological status of the data presented in this thesis. Rabinow (1986, p.235) states that epistemology stands up among all forms of knowledge as the judge to the production of truly accounts of reality; it is knowledge about knowledge. The possibility of 'knowledge' comes from the use of an objective method and from the capacity of human beings to represent events in a way to extract from them universal principles or, in other words, scientific (truthful) knowledge (Rabinow, 1986, p.235).

In this thesis, however, a particular view about the production of truth will be used. Foucault's critical understanding about the construction of what is truth and false in Western societies seems to be of capital importance in a work of social

science.

Perhaps the first step to be considered is Foucault's (1980, p.126) critique of the role of the intellectual as someone who is the "master of truth". This sort of claim cannot be made because, according to Foucault (1980, p.133):

> *'Truth' is to be understood as a system of ordered procedures for the production, regulation, distribution, circulation and operation of statements.*

Foucault (1980, pp.131-132) explains these elements from production to operation in a system he called "political economy of truth". Political economy of truth means that truth is produced mainly in the form of scientific discourse and under the control of few political and economic apparatuses, such as writing, the university, the media, and the army. Truth is widely demanded and consumed in society, circulating through apparatuses of education and information.

This understanding of truth helps to deconstruct traditional epistemology. Rabinow (1986, p.241) suggests that epistemology is an historical event, a social practice which started in the seventeenth century Europe. From that time onwards schooling and information systems spread through out the world, making 'truthful accounts' the basis for political, educational, and economic relationships. Foucault (1980, p.131) details this point saying:

> *Each society has its régime of truth, its 'general politics' of truth: that is, the types of discourse which it accepts and makes function as true; the mechanisms and instances which enable one to distinguish true and false statements ...*

Taking into account this perspective, this study does not claim to deliver 'truthful accounts' of the social construction of health education in Brazil. What it does is to present a partial, but serious analysis about the issues health education elicits in the process of policy formulation and health practice.

2.3. The limits of the study

To deal with the limits since the research was planned is one way to try to ensure success in its accomplishment. This is a study of a single researcher, in which fieldwork was not funded, covering health education issues in the Brazilian national health system.

The choices established made it possible to collect information about the whole country and to concentrate in a particular state to obtain a greater depth. The final design of the study is presented in Table 2.1. The national level was covered by a survey, document analysis and a federal policy-maker interview, all of them carried out without being necessary to leave the State of Rio Grande do Sul. This state was chosen by the researcher for two reasons: (i) it has a tradition of initiatives in health education at the state and capital health secretariats and the research was planned to investigate health education in action and not simply to identify the lack of initiatives; (ii) the researcher was known by some professionals at both health secretariats which proved to be of great help in gaining access (to documents, health centres, etc).

Table 2.1. Fieldwork procedures in Brazil in 1993 (March-May)

National Level (Brazil):
Questionnaire to all State Health Secretariats
Questionnaire to all Capital of State Health Secretariats
Health education documents from the Ministry of Health
Interview with federal policy-maker
State Level (Rio Grande do Sul):
Questionnaire to 25% of health centres
Interview with state policy-makers
Municipal Level (Porto Alegre):
Questionnaire to all health centres
Interview with policy-makers, health professionals, and users of the system
Ethnography at two health centres

Questionnaires covered a large geographic territory at a small cost and did not demand extra personnel, but the understanding of health education as a health practice could only be examined in depth with an ethnographic approach. The time

per health centre to be observed was decided in one month. According to the routines of the health centres one month is enough to cover every health education activity they develop - some once a month, others each fortnight, and the majority every week.

Therefore, considering the aims of the study but also costs, practicalities such as limitation of time and personnel, this research was planned and carried out combining different procedures that allowed a macro and micro view of health education in the context of the Brazilian national health system.

2. 4. Creating a written document

... science is in, not above, historical and linguistic processes.
Clifford (1986, p.2)

According to Clifford (1986, p.2), for a long time, writing in the social sciences was seen as a matter of method - from field notes to mapping information and then writing up. Clifford also points out that this particular way of conceiving writing reflects a conception of scientific writing as transparent and truly representative of the experiences observed by the researcher. Perhaps the figure of a bridge could help to describe this conception. The researcher, through her/his writing, is thought to simply bridge the reader and the people and places observed during the fieldwork, as if s/he had made 'nothing' to bring these two poles together. Pratt (1986, p.27) comments that the ideal of writing in social sciences as a neutral practice can still be noticed. She describes it as the ideal to achieve a:

> *...tropeless discourse that would render other realities "exactly as they are", not filtered through our own values and interpretive schema.*

In this study, however, another position will be adopted. The final version of this research was constructed based on a series of choices made by the author. The production of a final document depends on what and how is selected to be presented to the reader. The information gathered during the fieldwork exceeds any possibility of a 'full' report. Many conversations and observations are peripheral to the focus of the study. Authors like Clifford, Rabinow, Marcus, and Tyler (Clifford

& Marcus, 1986) represent some of those concerned with the literary aspect of writing in social science.

> *They assume that academic and literary genres interpenetrate and that the writing of cultural descriptions is properly experimental and ethical. Their focus on text making and rhetoric serves to highlight the constructed, artificial nature of cultural accounts.* (Clifford, 1986, p.2)

Most of the information presented in the thesis in a written form has been observed and recorded by the researcher in an oral form at the time of the fieldwork. From that moment onwards there was a transition, with intermediate steps, such as transcribing and writing field notes, to finally oral expressions reach the stage of a written document. As Marcus (1986, pp.264-5) mentions:

> *... ethnography originates in orality and only makes the transition to writing with difficulty.*

It is naive to consider that authors who are aware of the impossibility of producing a 'neutral text' or a 'perfect account of reality' can control all the aspects involved in the production of a text. Clifford (1986, p.25) comments on this issue, saying:

> *The writing and reading of ethnography are overdetermined by forces ultimately beyond the control of either an author or an interpretive community. These contingencies - of language, rhetoric, power, and history - must now be openly confronted in the process of writing. They can no longer be evaded.*

In this work the issue of writing has to be considered under many aspects, such as the nature of a PhD thesis, style, translation, power relations, and so on. Those issues will be examined next.

There are elements that should be considered in the production of a PhD thesis and in its reading. A thesis is a document which will be formally evaluated and later used by others, and, bearing this in mind, the author could feel compelled to adopt a traditional style and structure to the work. Writing a thesis in a conservative fashion seems to be one of the consequences of the process of evaluation (Marcus, 1986, p.265). For instance, in the final version of a document some

information could seem to be important but not easy to locate within the chapters. The options then would be to leave the information out or to create a particular 'place' to present them. In this thesis in specific, some 'stories' or 'cases' observed or told by the social actors of the study seemed very different in style from the rest of the text. In order to keep them, due to their importance, the solution found was to introduce vignettes in the text to illustrate some of the points that have been raised.

The issue of style has to be acknowledge in the process of writing up. For example, the writing of the thesis in the first person ('I') can provide a sense of closeness to the reader and make clear the influence of the author in the selection of information the reader will get from the text. It can also be problematic because it overemphasizes the issue of authorship, creating an impression of control that no writer has over her/his text. Conversely, the use of an impersonal style could give the impression of a claim of neutrality and truth which do not exist in any scientific text. The choice made in this thesis has been to use predominantly the third person of singular, producing a constant and coherent style. However, in some opportunities, the narrative demanded a clear remark about the presence or choice of the researcher. So, in these occasions, the 'I' form was preferred.

Another particular aspect of this research is the fact that the researcher is a foreigner and the fieldwork was undertaken in Brazil, her home land. So, all the documents and talks which appear in the thesis have been translated. The treatment used to deal with language issues is described below; it is an attempt to do a serious, although partial, account of the information gathered.

The vast quantity of documents, field notes, and transcriptions made impossible the translation of all the information collected. The strategy adopted was to work with the data in Portuguese and to translate the parts that were selected to be inserted in the text. The translation was checked by another person who works with translations of both Portuguese and English, comparing the original with the translated text.

The questionnaires were formulated in English to be discussed with the supervisors. After the last version was written, they were translated by the researcher to Portuguese and translated back to English by the same academic who helped with the rest of the translations. Both translations were contrasted against each other and the few differences were sorted out. The next step was to do the piloting of the questionnaire in health centres, sending it to four heads of health centres in Rio Grande do Sul. Their suggestions were incorporated and the final version of the document in Portuguese was re-written and later it was incorporated back in the English version.

The issue of writing in English about a research carried out in Brazil also influences the selection of information that will be presented to the English reader. In some extent, it is inevitable the tendency to provide details about the Brazilian national health system that could be omitted in a Portuguese text. As an author, I keep reminding myself that I am writing to foreigner readers and at the same time confronting my writing with the objectives of the study, trying to get a balance between the information that help the understanding of the context and the information which make the core of the study.

In terms of power relations, the political and institutional views of the researcher can shape the writing of a document. Clifford (1986, p.6) mentions that researchers may write against or within groups, institutions, and traditions. In this study, I felt committed with the views of the users of the national health system. Probably a larger amount of criticism and scepticism was used in the analysis of official documents and information gathered within policy-makers than in the analysis of the users accounts. The long queues, low quality of health care, lack of medication, and the background of poverty of many of the users, were factors that operated as a 'magnetic political force', driving me to treat the information collected within the users of the national health system with more 'empathy', as 'true' accounts. It is as if because most of them are humble poor people they deserved a 'better' treatment as informants - some kind of 'compensation' for the hard times they face searching for

health care. This judgement was recurrent and interfered in the way I selected information. Nevertheless, being aware of it helped me to try to prevent this set of values to prevail in the analysis. As a final result of this process, the tension between my personal values and the accounts provided by the social actors involved in the study ended up enmeshed in the narrative.

Still within the political side, it is possible to challenge the authority of the researcher to represent claims or views of the groups involved in the study. The information collected is analyzed only by the researcher and in many cases, like in this research, this data does not go back to those who provided it, to be assessed in its representativeness. So, what can be said is that the final report of a research juxtaposes the views of the social actors to the interpretive schema of the researcher. This means that the text produced does not represent the positions of a group, but also are not solely made of the understanding of the researcher about other people's accounts.

An attempt to minimize the 'translation' of people's views by the narrative of the researcher (a trope, oxymoron, irony, and others) is to present quotations, letting the social actors to 'speak by themselves'. However, as Rabinow (1986, p.246) reminds us, quotations are still selected by the researcher. Atkinson (1992, pp.23-26) corroborates this view saying that in order to make the talks of interviews readable it is necessary to select and edit. He points out that there is no speech so fluent, punctuated, and grammatical that makes an easy reading. The use of oral and written words is different. The editing of everyday speech aims at providing a readable text with 'people's voices', but brings along the editorial control of the writer.

These considerations do not cover all the aspects involved in the process of creating a written document. They are, perhaps, those which were more reflected by the author during the period of converting oral accounts from the fieldwork into a PhD thesis.

2.5. Survey, documents, and interview

In order to gain access to health education documents produced by the Ministry of Health in the eighties and nineties, the Ministry was contacted and asked to provide a list of documents or the documents themselves. No list was provided and some documents were sent to the researcher but many others had to be found through libraries and lists of official publications. Once the documents were collected the challenge had been to develop the analysis.

The first step towards the analysis was to conceive each document as a narrative, a textual production. Manning & Cullum-Swan (1994, p.464) corroborate this view saying that:

> *Documents are "products", like speech itself, of a system within which they are defined and made meaningful.*

The documents analyzed have the status of official publication and are traditionally seen as the views of the federal government on health education. However, the analysis was made regarding them as texts. As any text they contain multiple views, rather than the solely position of the federal government. As Manning & Cullum-Swan (1994, p.468) explain:

> *A text, in poststructucturalist terms, is not an objective or thing, but an occasion for the interplay of multiples codes and perspectives.*

The elements that had been pursued through the analysis of policies were 'continuities' and 'ruptures'. Taking the National Division of Health Education Guidelines (1980) as a starting point, the process was to deconstruct the discourses on health education policies. Codd (1988, pp.244-246) points out that the task of deconstruction starts when documents are read in a specific historical and political context. He adds that deconstructive analysis searches for 'linguistic strategies' that mask contradictions in the text and pursues the understanding of the possible effects the document could have upon readers.

The political and power relations that a text has inscribed in it should also be at focus of the analysis (Seidel, 1993, pp.175-176). Borrowing the Foucauldian understanding that knowledge is produced by power relations (Foucault, 1980, p.93), the knowledge circulated by policies has to be examined as aiming at the construction of certain views on health education.

The approach used to structure the analysis was the reading of each document searching for ruptures in the way health education is conceived. This was followed by a second reading where categories were identified and a summary of the document was produced. The next step was to confront the continuities and ruptures among all the documents in a chronological order. The previously emerged categories were then put against the original texts and then they were 'sent back' to each text, to see whether the categories (after being grouped) still fit and represent the ideas of the original text.

The document analysis was validated by triangulation with the data generated by interviews, questionnaires and other documents, in the type of triangulation named by Patton (1980, pp.330-331) "comparing multiple qualitative data sources".

The other methodological tool used in the collection of information was the questionnaire. The option of sending questionnaires by mail has clear disadvantages, but under the circumstances it was the only possible way to cover 25 states in Brazil and around 900 health centres in Rio Grande do Sul. Simon & Burstein (1985, p.172) refer to a range of problems, e.g. only those interested in the subject may reply, nonresponse can be high and the reasons not determined, etc. Indeed the number of responses gathered in this research was not sufficient to make the information collected generalizable.

Two questionnaires had been produced by the researcher (Appendix 1). They concentrate on the policy process covering policy formulation and evaluation.

The first one was sent to all State Health Secretariats and Capital of States (Municipal) Health Secretariats. The study and questionnaires developed by Mullard (1983, pp.1-28b) had been used as a reference for the production of this questionnaire to health secretariats. The second one was sent to state and municipal health centres in Rio Grande do Sul of which the capital is Porto Alegre. The second questionnaire was formulated according to the first one, trying to check information provided by health secretariats and to expand topics directly related to health centres. The method employed to collect the information through questionnaires is described in the Table 2.2.

There were some difficulties in the work with questionnaires at the state level. The Health Secretariat of the State of Rio Grande do Sul authorized interviews and the questionnaires after a formal agreement within the School of Public Health and Health Secretariat. However, a member of the staff got worried because the research would gather information that the Secretariat itself did not have and so, delayed as much as possible the access to the list of addresses of health centres. According to this senior member of the Health Secretariat, my questionnaire would be "an X-ray" of the Secretariat. Initially the plan was to cover the whole state (17 Regional Health Authorities), but after so many difficulties I had to restrict the work to around 25% of the health centres. The sample was therefore non-random and comprised the health centres of seven Regional Health Authorities.

The results from the questionnaires are presented in a descriptive way in this thesis because the number of responses was not enough to allow generalizations. However, these data were not found in any part of the literature reviewed and represent a contribution to the understanding of health education as a public policy.

Table 2.2. Collecting information with questionnaires

a) Preparation of two sets of questionnaires (a. Brazilian States and Capitals Health Secretariats; b. Rio Grande do Sul health centres)
b) Piloting the health centres questionnaire with four health centres heads in Rio Grande do Sul
c) Sending questionnaires: Health Centres: -A non-random sample of 26.4% of health centres of Rio Grande do Sul (n=238) -All health centres of the capital of Rio Grande do Sul - RS (n=11); Health secretariats: -All health secretariats of the capitals of states (n=25) -All health secretariats of the states (n=25)
d) Sending a second letter after 45 days.
e) Sending acknowledgment letter: the capital and state health secretariats that answered the questionnaire received a letter expressing appreciation for their help.
f) Sending a third letter and the questionnaires once more: three months after the first letter, a new letter and questionnaire were sent to states and capitals which did not answer.
g) Receiving questionnaires back: -Capital health secretariats: before second letter 28% (n=7); after it 40% (n=10); after third letter 64% (n=16). -State health secretariats: before second letter 32% (n=8); after it 36% (n=9); after third letter 40% (n=10). -RS Capital: before second letter 81.8% (n=9); after it no further replies. -RS health centres: before second letter 13.9% (n=33); after it 20.2% (n=48).

There are many issues that the use of questionnaire does not help to investigate. In order to achieve a better understanding of the health education policy process, overcoming the limits imposed by the questionnaires, policy-makers at the state of Rio Grande do Sul were interviewed. The interviews were semi-structured and the basic questions which composed them are in Appendix 2.

Bogdan & Biklen (1982, p.135) argue that the objective of the interview is to:

> *... gather descriptive data in the subject's own words so that the researcher can develop insights on how subjects interpret some piece of the world.*

There are many elements which can influence the kind of response to be obtained through interviews. Fontana & Frey (1994, pp.366-368) highlight the

importance of accessing the setting, presenting oneself, and establishing rapport to the process of interviewing. During the fieldwork the difficulties experienced in sending questionnaires did not happen while gaining access to interviews with policy-makers. The strategy adopted was to introduce myself as a research student from the University of London, writing a thesis in English, and unaware of the recent developments in health education in Brazil. The fact that the interviewer was out of the country for the last two years made clear to informants that they could effectively contribute to an update of the researcher - and they referred to it in interviews. The information that the thesis would be published in English also proved of some help. Policy-makers know that very few people in Brazil would read a thesis in English, and also that PhD thesis are not easily available. So, the risk of having the content of their interviews highly disseminated was a small one. Although the issues of confidentiality were explained in detail to each policy-maker to be interviewed, those in top positions knew that they are few and some of their opinions could led to them as informants. Two people interviewed asked me to turn the tape recorder off when they were talking about more sensitive matters. Other two provided more details after the tape recorder was off, at the end of the interview. The confidential information was written after the interview and added later as field notes to the transcription. One policy-maker asked me to turn off the tape recorder after each question, allowing her/him to check whether the question was properly understood and the answer to be provided was 'adequate'. Clifford (1986, p.13) talks about institutional constraints and how they can influence the kind of information provided to the researcher. In this research what also seemed to interfere in some interviews was the fact that the researcher was carrying out a PhD. Some policy-makers, the minority it should be said, demonstrated concern and repeatedly checked to see if they were providing the 'right' answer. However, in a semi-structured interview there is room to reassure the informant, answer questions instead of only asking them, and establish a conversation that helps to overcome the idea of 'test' that some might experience when being interviewed.

After the transcription, the work done with the interviews was: to summarize each interview until just a group of a few and main ideas were identified.

These ideas were put together and the ideas common to many interviews were joined under the same category. Then the categories were put against the original texts of interviews to see if they still hold together. The other part of the process was to see if the categories demonstrated a clear conceptual difference between themselves (Patton, 1980, pp.311-313).

2.6. Ethnography

Hammersley & Atkinson (1983, p.40) point out that the researcher should select a setting to the research where the questions of the study *can* be investigated. Taking into account this basic principle, the ethnography took place in two health centres of the Municipal Health Secretariat of Porto Alegre. The Secretariat identified two health centres - one considered as having a good standard of health education and another with a high profile - as requested by the researcher. These health centres were chosen within the Municipal Government because - in the future - all health centres will be organized at this level, as stated in the Unified Health System law.

The choice of two health centres specially involved with health education could be described in terms of methodology as a radical case study (or critical case study - Hammersley & Atkinson, 1983, p.44). They were intentionally selected as places where health education activities are developed according to the pattern expected by the Health Secretariat and they were acknowledged among other health centres as producing health education in accordance with the new guidelines of community participation.

This study, as any other ethnographic study, is bound in time and place. The intentionality in the selection of places restrain the data here provided to an illustrative status (Atkinson, 1992, p.29 and Platt, 1988, p.14). In this study, the two health centres are treated as examples of achievement in health education in the Brazilian national health system. They offer one possibility of examining health

education practices undertaken by a group with many health professionals, in health centres with some kind of community participation, where local initiatives have being developed.

Once the health centres were selected, I spent one month in each one of them. The observation started at 7:30 or 8:00 am and finished between 5:00 and 5:30, according to the timetable of the health centre. Lunch was taken at the collective kitchen of the health centres with part of the team. Both centres were situated in poor neighbourhoods in the capital of the state, the city of Porto Alegre. The pictures in Appendix 3 provide a general view of the areas where the health centres are placed. In Appendix 4, there are pictures of both health centres studied[1].

The health centres selected are called here 'Health Centre 1' and 'Health Centre 2'. The Health Centre 1 was chosen as a place with a high standard in health education. The centre makes more than 1500 consultations per month and its staff is composed of: 1 secretary, 2 cleaners, 1 assistant dietitian, 2 dentistry assistants, 8 assistant practical nurses, 2 nurses, 2 dentists, 1 social worker, and 4 doctors. The health centre is represented on the Municipal Health Council and there are links between representatives from the community and the health centre.

Health Centre 2 was referred as a good health centre in terms of health education. This Centre makes more consultations per month than Health Centre 1 and the staff is also bigger: 10 assistant practical nurses, 1 assistant dietitian, 2 pharmacy assistants, 4 assistants of social worker (3 working as secretaries), 1 psychologist, 1 dietitian, 1 dentist, 2 social workers, 3 nurses, and 8 doctors. The health centre is represented on the Municipal Health Council but community representation does not have a formal space within the health centre.

The observation strategy adopted with professionals and community

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[1]The pictures in Appendix 4 will be removed from the thesis after the examination in order to preserve confidentiality.

was an *overt approach* (Bogdan & Biklen, 1982, p.120), making clear from the beginning that the presence of the researcher had the objective of collecting information for a PhD study. I made clear my interest in observing all health education activities inside and outside the health centre during my time there and in the first days I established with the head and professionals which consultations I would shadow. As a result, I went to community meetings, home visits, shadowed four health education groups per week, shadowed nurses, doctors and assistant practical nurses consultations, and shadowed all staff meetings.

Some of the decisions made previously to the fieldwork could be fully implemented - like shadowing health education groups and consultations. Others, however, were just known at the time of the fieldwork. Hammersley & Atkinson (1983, p.44) mention that both the research problem and the case under study are reviewed and have their scope refined during the fieldwork. In this research, the fieldwork became an opportunity and a demand for permanent reflexive action, where choices about who and when to interview, for instance, had to be made based on information not known by the researcher before the contact with the health centres. This process also helped in narrowing the scope of the study.

The acceptance of the researcher was in general very good. The fact that I am a woman did not seem to interfere in the relationship established with professionals and patients. The staff of both health centres was balanced between men and women. What could be considered a positive point was my knowledge of health issues and my former professional background as a nurse. The staff took for granted that I still am a nurse - they used all the jargon of the field of health when talking to me and many times we discussed technical aspects of the health care provided in the health centre. The negative aspect of being identified as a health professional was the demand for help in some procedures or for providing information to patients, while I was observing.

I had a good acceptance too in the health education groups. For

instance, at focus group for pregnant women I was easily accepted but before the meeting started a series of questions were raised by the patients. I was asked about being married, having children, why I was studying in other country, etc. Bogdan & Biklen (1982, pp.119-120) mention that trust must be built since the beginning of the work and minor things like informal talks are important in this process.

A place where the access was more difficult was in the observation of a focus group for adolescents. They were specially susceptible to new members in the group and the possibility of confidentiality being broken. Their main concern was the possibility of their parents knowing what was said in the meetings. To be sure that I was a researcher studying in England they asked me to speak in English to them and concluded it sounded like the music they used to hear. After the 'exam' they asked why should I be interested in their private lives and finally I had to promise to return and erase all the tapes before leaving the health centre. I provided the information requested and promised to observe all the rules of the group. So, I was asked to wait outside the room while they voted and I finally was accepted.

One activity planned in the work with patients failed. To confront professionals' scientific discourse and patients' lay knowledge about health, patients were asked to draw the internal parts of the human body in a empty body. In general the activity caused embarrassment and all patients said something like: "it is too difficult" or "I could not remember everything". So, after sometime spent trying and not obtaining any result I gave up the activity.

The information from fieldwork was recorded (consultations and health education activities) and the general observation was written as field notes. In both health centres all the professionals shadowed were interviewed as well as the head of the health centre. Among assistant practical nurses I faced a problem because they were eight and I selected those who I shadowed more frequently to interview. This happened at the first health centre and the head told me that there were rumours that I 'preferred' some (perhaps because they were more competent) and the others were

resentful. So, in the following day I interviewed the other half, explaining that I did it in two days because they were a large group. In the second health centre I interviewed all to prevent the same problem.

There was no resistance to giving me access to written documents, such as policies available at the health centre and records of meetings. Nevertheless, in the Health Centre 1 the person in charge of the administrative sector had many forms to type and was late with the records of the meetings, which I wanted to read and photocopy. A compromise was reached between me and her: I helped with some bureaucratic work and also told her my impressions about Kafka's book 'The Metamorphosis', which was part of her studies at the university. Doing so, I saved some of her time and she managed to finish the records of the meetings before I left the field.

The main problem experienced with the observation was the amount of information gathered. The transcription and analysis of such a vast quantity of information was a difficult task for a single researcher. The validation of the data was done again through the triangulation of information of different sources (observation, interviews, and questionnaires). The data was then organized in terms of similarities and differences between the two health centres and presented as non-generalizable because the case studies were intentionally selected as radical (successful) experiences in health education.

2.7. Ethics

During the development of the research there was a permanent concern with privacy and confidentiality of information. In terms of questionnaires, the secrecy of the identity of the respondent was ensured. However, health secretariats answered making clear who was the respondent. Health centres preferred not to identify themselves. A code was added to the envelope in order to have control over which health centres were answering, and a second letter was sent to the others.

The interviews were recorded and transcribed using a code for each one and all original names were suppressed. The names of professionals and patients were all altered. Descriptions provided by those interviewed that were so precise that they could be used to identify a health centre or professional have been avoided in this final document. Nevertheless, at the time of the fieldwork the municipal health centres chosen as case studies were known by other health centres. The fact that these health centres just have two nurses or one social worker makes mentioning the profession or the kind of focus group enough to identify the professional in charge of it. Trying to diminish this problem, professions are not always mentioned in the thesis.

The approach with patients followed a strict routine of authorization for every procedure I would observe. To shadow consultations the pattern employed was to ask permission to interview the patient, to ask to go into the consultation room and to interview her/him afterwards. Every time the confidentiality of the study was emphasized and authorization for the use of tape-recorder was requested. In the focus groups the researcher was introduced by a member of the staff and authorization was asked before the beginning of the meeting. The interviews were conducted in private or in small groups before the staff had arrived and after they had left the room.

A constant theme in these procedures was to apply the same ethical principle to everyone involved in the study. But a lot of adaptation was necessary because the conditions were far from ideal: lack of space, queues, too many patients in the waiting room, etc. The solution was to interview in the kitchen, vaccination room, outside the health centre, etc, when these places were free.

2.8. Conclusion

Like in a short story of Jorge Luis Borges[2], the risk of making a complete and extensive map is to cover the whole country in paper; the risk of

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[2]Borges, J.L. A arte da cartografia [The art of cartography]. in ***Obras Completas***. São Paulo: Nova Fronteira, 1985.

working with so many techniques is to get lost between piles of transcriptions and documents without finding a way to systematize them. It is the constant moving between empirical work and theoretical framework that helps to make sense of the information collected and to decide how to present it as an academic study.

The decisions about which techniques to use in the study were made following McKinlay (1992, p.S18) and Hammersley & Atkinson (1983, p.x): there is no 'superior' research technique. A research technique should be considered appropriate when it collects the information that is necessary to investigate the research problem.

This Chapter has described a series of methodological procedures from the way information were collected to the production of this final document. This does not mean that it claims a complete account of the social construction of health education in Brazil. Conversely, the partiality of this account is a trenchant feature which cannot be forgotten in the reading of the thesis.

From the point of view of design, Hargreaves (1985, pp.21-46) argues that some researches concentrate on the macro level, others in the micro and there is a gap in the middle range. Many theories are macro or micro and they lack bridges to link them. The challenge to any research, he states, is to "connect theory with evidence and modify each accordingly if they do not fit" (p.36).

The methodological options undertaken in this research are an attempt to link the macro and micro levels of health education policies and practices, checking Foucault's concept of bio-power at the macro, mezzo and micro spheres of power. In the next Section health education will be examined as a strategy of bio-politics of the population.

SECTION I

HEALTH EDUCATION AS BIO-POLITICS

INTRODUCTION

In this section health education will be conceptualized in its relations to social policy and health policy. The domain of policy formulation and implementation constitutes part of the discourse of health education. Health education is produced on a large scale by government initiatives. Through the selection of priorities and of certain approaches, the government forges some understandings about the meaning of health education.

There are many possible ways to examine health education as a health policy. In this section of the thesis, health education is approached through the concept of bio-politics. This concept was chosen because, in the view of this thesis, it overcomes the traditional approaches of health policy analysis - which concentrate on the sequential steps to achieve a specific objective or concentrate on the incremental possibility of each policy (Pederson et al., 1988, pp.12-13). The analysis of health education policies trough the concept of bio-politics brings policy analysis to the arena of social science. Bio-politics means that power is centred on the life of population and health education policy is embedded in power because deals with biological existence; not because health education policy is the result of the government initiative. The shaping of the population, to economic and social life, demands supervision, intervention, and regulatory controls over biological processes. Hence, health education policy is examined in this work as a technology of a society of security.

Acknowledging that health education policy is a technique for achieving a certain population pattern in terms of birth and death rates, epidemics, and so on, does not mean that it is a single or dominant strategy. As any other exercise of power it faces resistance; under the groups 'policy-makers', 'health professionals' or 'population' there is a web of micropowers, many of them representing conflicting interests. All kind of alliances are possible in such a complex cluster of power relations, among those who plan, implement and use health education services.

In order to explore these elements that influence the social construction of health education, this section concentrates on the information gathered during the fieldwork and its analysis. Reading and analyzing documents, questionnaires and interviews aims at identifying gaps and ruptures in the process of policy formulation and implementation. According to a Foucauldian perspective, it is through the analysis of 'discontinuity' that it is possible to unveil the power relations that make the policy process an exercise of power and resistance that results in, for example, policies which are formulated but not implemented or only partially implemented; and policies which are not formulated in written form, but implemented.

To investigate the ideas expressed above, in this Section data from questionnaires and interviews at the federal, state and municipal levels of the Brazilian national health system will be placed alongside the analysis of policy documents, and with health centres' professionals answers to questionnaires and interviews. The data presented in this Section is the result of methodological options already described in the Methodology Chapter.

The data provided here help to construct a history of the present of health education in the Brazilian national health system. Based on the data analysis, this Section has as its main argument that health education is that aspect of health policy which increases the power of the government to rule individual and collective life. The forms of control can vary from authoritarian to constructive approaches. In both cases, however, it means that health policy can be more effective in shaping the population through the political-educational nature of health education.

The sub-arguments in this discussion are:

- The government of the poor in a democratic regime demands more constructive power and less repressive power.
- Health education policy is the result of many discourses. It cannot be seen as a coherent power strategy that circulates down from the central government until it reaches the user of the national health system.

- Health and health education policies disseminate different conceptions of health education. Together with the lack of implementation of policies in the national health system, the result is the continuation of the traditional health education model.
- Micropolitics at the grass roots are as influential in the exercise of bio-politics through health policy as the policies created at other levels of government.

CHAPTER 3

POLITICS OVER LIFE AND THE ART OF GOVERNMENT: SOCIAL POLICY, BIO-POLITICS, AND GOVERNMENTALITY

3.1. Introduction

This Chapter contains a literature review on social policy, bio-politics, and governmentality. These concepts will support the analysis of the data on the construction of health education as a social policy through this Section of the thesis. In Chapter 1 the general theoretical framework was introduced, but in each of the two Sections of the thesis some extra, specific, theoretical points will be added.

It is the general argument of this thesis that health education represents a singular contribution to the exercise of bio-power through the health system. Thus, in order to explore such argument, it is necessary to focus on the government of the population through social policy on health and health education.

3.2. Social policy

Social policy is a particular field within a wider range of policies. In this study, social policy will be defined as a sub-category of policy and public policy. Blum (1981, pp.229-230) defines policy as:

> *a long-term, continuously used, standing decision by which more specific proposals are judge for acceptability. It is characterized by behavioural consistency and repetitiveness on the part of those who make it and those who abide by it. Policy ... could be a position taken by an individual, a group, a firm, a unit of government, or any entity that makes decisions for itself, whether independently or under mandate or regulation of a public policy.*

Other definitions of policy emphasize different aspects of it. Jenkins (quoted in Ham & Hill, 1984, p.11) defines policy as:

> *a set of interrelated decisions ... concerning the selection of goals and the means of achieving them within a specific situation ...*

While Jenkins refers to achievements, Kuper & Kuper (1985, p.606) present policy as a "a symbolic entity 'out there' merely uttered, chosen or promised". According to this definition policy can also be a statement of intentions or the platform of a political party.

Within the field of policy, public policy stands as probably the largest area of policy-making. Public policy relates to initiatives in different levels of government to put forward projects and reforms that can promote social change or continuities. Blum (1981, p.230) defines public policy as:

> *an established and legislatively enacted proposal by a public body duly constituted to make policy in the area of concern. It stipulates ends and it may provide resources. It may spell out specific means to reach these ends.*

Public policy covers the initiatives of the government in all areas. Some of them regard social aspects of life in society, such as housing, health, and education. The matter of defining social policy is the same of defining policy itself - there are many definitions emphasizing different aspects of the process. Cunningham's (quoted in Ham, 1992, p.94) humorous definition illustrates the complexity of the issue. He says that a policy is like an elephant - "you recognise it when you see it but cannot easily define it". Ferge (1993, p.603) points out that there is no universal accepted definition of social policy.

In order to explore some of the different perspectives about social policy, what follows is an analysis of theoretical frameworks that support the policy process. Ferge (1993, pp.603-605) and Ham (1992, pp.220-224) relate social policy to pragmatic, functionalist, marxist, and structuralist approaches. According to Ferge, the pragmatic approach to social policy is the one that sees institutions and activities "positively affecting the welfare of individuals". Within this same approach Marshall (quoted in Ferge, 1993, p.603) presents social policy as "the policy of governments with regard to action having a direct impact on the welfare of citizens by providing them with services or income".

The functionalist approach is based on the assumption that social equilibrium is possible and that instability is a sign of deviance which should be corrected. It perceives social policy "as a systemic element operating in the context of social and economic reproduction" (Ferge, 1993, p.604). The functionalist approach regards the function of social policy to be re-establish the social equilibrium when there is imbalance between 'social problems' and 'change'.

Social policy, health policy and the health system can also be explained as part of the capitalist mode of production. The marxist perspective relates health care to the maintenance of a healthy labour force. Ham (1992, p.221) points out that class division is used in the marxist perspective to explain the lack of assistance to those excluded from the productive process - the mentally handicapped, for instance - and to justify the different quality of health care which workers and bourgeoisie receive. Because it is a macro structural theory it has limits in explaining the policy process in a more detailed way.

Social policy can be also understood using a structuralist approach. In this branch of social thought social policy relates to power and its existence reveals social processes which prompt changes. Social policy is constructed by social struggles for rights. Walker (quoted in Ferge, 1993, p.605) says that "social policies are those that determine the distribution of resources, status and power between different groups". Taking structural forces into account, Jobert (quoted in Ferge, 1993, p.605) states that:

> *social policy is not only of the means of the existing social order. It is also the locus where tensions and injustices related to this order are most evidently revealed.*

Ham (1992, p.223) shows that the structuralist perspective discloses the interests of groups: dominant, challenging and repressed. For instance, the situation of the national health system in Brazil could be explained according to this paradigm as: the professional monopoly of the medical profession represents the *dominant* interest, whilst policy-makers can *challenge* it, and the community has its interests *repressed*. In the structuralist perspective these arrangements are a key explanation of power

relations and to the distribution of benefits.

In this study, however, another theoretical perspective has been chosen to support the analysis of social policy. Health education policy will be analyzed according to a post-structuralist perspective which will be addressed later in this Section.

Before moving to the specific approach to be used in this thesis, the focus of this review on social policy will be turned to the policy process itself. According to Ham & Hill (1984, pp.8-10) policy analysis can be divided in two types: 'analysis **of** policy' and 'analysis **for** policy'. The first type is composed by studies of policy content, policy process, and policy out puts. The second type of analysis is made up of studies for gathering information about policies or evaluating policies.

Traditionally the focus of policy analysis is the policy process itself (Pederson et al., 1988, pp.12-13). Lee and Mills (1982, p.21) define the policy-making process as a series of steps which cover policy objectives, planning, actions for implementation, and the impact once the policy has been implemented.

The problem with this kind of sequential view of the policy process is that it can overlook the complexity of the process. Easton (quoted in Ham, 1992, pp.94-95) argues that a policy involves a web of decisions instead of one decision. He points out five reasons for this: (a) the process of planning and implementing is usually developed by different groups; (b) policy does not express a single decision, rather it manifests a series of decisions; (c) adjustments are made during the 'life' of a policy; (d) non-decisions and inaction are an important part of the policy process; (e) practices that are routinely developed without previous planning should also be considered policy.

Another element to be taken into account in the policy process analysis is the idealistic assumption that policy can be put into action in a straightforward way

(Ham & Hill, 1984, p.96). Ham & Hill (1984, pp.96-97) mention that studies about policy implementation have shown that between policy formulation and the results of implementation there are many elements that can change the predicted results.

Ham (1992, p.95) corroborates this view on the complexity of the dynamics of the policy process stating that:

> *Further, writers on policy have increasingly turned their attention to the actions of lower level actors ... in order to gain a better understanding of policy-making and implementation.*

The lower level can represent a space for challenges or inaction in the process of policy implementation. Nevertheless, the process of policy-making also involves many elements that can shape a policy in very different ways. Ham & Hill (1984, pp.102-103) argue that sometimes it is difficult to evaluate what has been achieved by a policy, not because of the process of implementation, but because the policy is obscure in its aims. They suggest that the meaninglessness and ambiguity of some policies are intentional. These are symbolic policies, never meant to be implemented. Kuper & Kuper (1985, p.606) add that is difficult to trace responsibilities in this process because there is a dichotomy between the political and the managerial facets of policy and what is stated does not necessarily have to happen. Ham & Hill (1984, p.103) also mention on this respect that:

> *Any system in which policy-making and implementation are clearly separated ... provides opportunities for the promulgation of symbolic policies.*

Ham & Hill (1984, p.103) point out that policies are products of negotiation and compromise, no matter they just represent an idea which will not reach implementation or if they are planned to be fully implemented. The complexity of the policy process points to the possibility of many readings of this process. Ham & Hill acknowledge that saying that the studies of policy process are an important part of the field of policy analysis, however the understanding of policy process could benefit from other disciplines, in especial sociology and political science. Other authors, such as Dror (quoted in Ham & Hill, 1984, p.11), suggest that policy

analysis is "a new supra discipline". Ham & Hill (1984, p.11) argue that this is not the case, but remind us that policy analysis does not easily fit the existing disciplines of knowledge. As they point out:

> *the purpose of policy analysis is to draw on ideas from a range of disciplines in order to interpret the causes and consequences of government action ...*

The particularities of the analysis of the policy process mentioned above represent some of the tendencies of the study of social policy in the eighties and nineties. Others might include: bureaucracy and decision-making (Ham & Hill, 1984); social change through policy (Blum, 1981); community involvement in planning and user's participation (Reeves & Coile, 1989; Bjorkman, 1985, Morone, 1984). Some of these perspectives are also addressed in this study, but the theoretical background to do so does not come from policy analysis, but from Foucault's concept of bio-power. Therefore, instead of evaluating the impact of health education policies, this study focuses on power relations that policy objectives, such as community participation in health education, help to promote.

The view emphasized in this study is a post-structuralist one, where social policy is conceived as a tool for the management of population.

> *Social policy plays a co-ordinating role in forming 'the social'. It promotes and organises knowledge, norms and social practices to regulate the quality of life of the population - its health, security and stability.* (Hewitt, 1991, p.223)

The choice for a non-conventional approach to analyze health education policy derives from the view of government as an 'experience' which occurs throughout society - and not as a centralized institution. Drawing on Hunter's (1993, p.131) analysis of a Foucauldian perspective of government, it is possible to say that a diverse range of political instruments, forms of expertise, and ethical principles support the notion of government and there is "no sovereign will and no unifying moral or intellectual rationale" that put together a coherent and single authority (this perspective will be further developed in the section 3.4.Governmentality). Although health policies represent the views of secretariats, divisions, and departments which

compose the government, they can also be analyzed as a 'pastiche' of different discourses[1] which promote 'truthful' accounts about health and the role of sick and healthy people in society.

Social policy as such or as a tactic is a prime structured approach to the government to manage the social body. Hewitt (1991, pp.230-231) argues that social policy "became one of the main apparatuses of the state for circulating power". The author compares social policy with capillaries in the social body. It allows the circulation of power, "constructing targets upon which power is inscribed".

It is the view of this study that the metaphor of capillarity could impart a wrong image, i.e. the idea that power is concentrated in the government. As with any other form of power exercise, social policy does not endow people with power. Foucault (1990, p.94) argues that:

> *Power is not something that is acquired, seized, or shared, something that one holds to or allow to slip away; power is exercised from innumerable points, in the interplay of nonegalitarian and mobile relations. ... there is no binary and all-encompassing opposition between rulers and ruled at the root of power relations ...*

Social policy constitutes its objects; it helps to give meaning to abstract concepts such as health or sanitation. Once health becomes the target of social policy, a new understanding of health will be constructed. Also the knowledge that health involves will be re-shaped according to social policy priorities. For instance, the population knows that hygiene and health are related because the health agencies (secretariats, health centres) emphasize this relationship. So, when the patient is asked about health, s/he knows that hygiene issues are supposed to be involved in the

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[1]The use of the expression 'discourse' concerning social policy has two different meanings in this thesis: i)'the different discourses that are embedded in social policy' refer to groups of ideas (most of the time conflicting ones) that try to prevail over each otherin the making of a policy; ii) 'social policy as a discourse' relates to a 'unit' which has "rules of formation for all its objects" (Foucault, 1972a, p.227). Social policy as a discourse is "an individualized discursive formation" because its operation, concepts, and theoretical options (which may be incompatible and disperse) construct an autonomous unit (Foucault, 1972a, pp.227-228). Social policy, by its form of operation, differs from other discourses and "involves the stabilization of discursive relations and the fixation of meaning" in social relations (McNay, 1994, p.75). Foucault (1972a, p.233) mentions that the emergence of a particular discourse instead of other (eg social policy instead of other strategy to organize and manage social life) has to be taken into account in the analysis of the events (discursive or not) that constitute a discourse.

conversation. This does not mean that the patient understands the reasons for this relationship. The emphasis on disease rather than on health in health policy and the presentation of medical care policy as the main health policy are also ways of forging a particular understanding of the meaning of health (Pederson et al., 1988, p.15).

Understanding health policy as a complex network of decisions and actions where different discourses about health and rights try to impose themselves over others, it is possible to relate health policy and 'the social' (see Chapter 1). Deleuze (1980, p.xiv) provides an account of the flux of competitive discourses that can take place in the sphere of policy:

> *... it is along the same line that the points of authoritarianism, the points of reform, the points of resistance and revolution, come face to face around this new stake, "the social", where medicine combines with the state to foster "hygiene", in several, sometimes opposing, ways that invest and reorganize the family.*

The possibility of looking at the relationship between government and health (or medicine) and the construction of 'the social' comes from the choice for a Foucauldian analysis of power relations in society and social policy. Perhaps the contribution of this approach can be illustrated in the analysis of a current trend in health policy - healthy public policy (previously mentioned in Chapter 1, 1.4.2.Radical health education).

The ideas of health promotion, new public health, and healthy public policy are interrelated. They represent a critique to the traditional approach of policy-making in the health area. Instead of focusing on the analysis of the policy process, they expand the universe of health policy. Pederson at al. (1988, p.15) suggest that health policy has been re-conceptualized by the healthy public policy movement.

Milio (1990, p.292) states that the traditional scope of health policy is not enough to tackle health problems because:

> *... the sources of health are too widespread and complex for conventional health strategies.*

Milio (1990, p.293) also mentions that health-promoting living conditions researches are few if compared to health care economics research, for example. Albeit this situation, healthy public policy has benefited from researches on the relations of health and economic instability, unemployment, and working conditions.

Other authors endorse the critiques to traditional health policy and present suggestions. Bunton (1992, pp.129-152) points out that the healthy public policy movement should deal with inter-sectoral cooperation and new organizational strategies and alliances in order to promote health. Pederson et al. (1988, pp.15-18) and Hancock (1989, p.77) corroborate this view stating that healthy public policy requires a new magnitude of health policy, where health policy relates to economy, agriculture, environment, citizenship, and any aspect of social inequality.

The new scope given to policy-making in health and the critique to the traditional research approach centred on the policy process are two important contributions of the healthy public policy movement. Nevertheless, looking at this movement from a Foucauldian perspective allows a different set of criticisms in terms of social policy and power relations in society.

Health policy seems to be achieving a remarkable position within all fields of social policy, becoming the theoretical framework for interdisciplinary initiatives. The final goal of promoting health justifies intervention in public and private spheres and also justifies the collection of information (census, research, ...) about almost every aspect of the population's life. Therefore, in a Foucauldian analysis, it is possible to say that the healthy public policy movement expands the potential of health policy being used as a technique of power in the management of the social body. This management of collective life will be explored in the next section, through the concept of bio-politics.

3.3. Bio-politics

According to Foucault (1990, p.139) in the beginning of the nineteenth century the body started to be understood as a potential object of biological power. Important aspects of social and economic life were directly connected to the use of the body such as birth, disease dissemination, life expectancy and death. In order to control the collective body, intervention mechanisms and regulatory controls were established. Foucault calls these *bio-politics of the population.*

Hewitt (1991, p.228) states that this new political domain of "the politics of the body or bio-politics" was consolidated within the rise and establishment of capitalism. Some events during the rise of capitalism made this new domain recognizable:

> *... the investment of the body with properties making it pliable to new technologies of control; the emergence of normalisation; the divestment of power from an absolute sovereign to a magnitude of regulative agencies located throughout the social body; and, the advent of the empirical human sciences, making possible these new technologies of control.*

The reason why bio-politics emerges within the rise of capitalism is that bodies had to be controlled to work in accordance with the logic of machinery and the population had to be regulated in accordance with economic processes (Foucault, 1990, p.139). In social and economic terms the maintenance of order was also important. Barret-Kriegel (1992, p.196) describes the body at that time as the site "of application of the management and the administration of the good police", rather than the 'property' of the individual. In the nineteenth century,

> *... the body was not an object of individual appropriation, not the privileged object of civil law, but the place of predilection for the mastery and possession of the 'police'.*

More recently bio-politics became important because, more than a coercive force, it has been exercised as reinforcement leading to docility. Its consolidation was based on its widespread availability in the social body and on its long term disciplinary and regulatory action. Foucault (1990, pp.142-143) emphasizes

that it was the first time in history when biological existence was reflected in political existence.

> *For millennia, man remained what he was for Aristotle: a living animal with the additional capacity for a political existence; modern man is an animal whose politics places his existence as a living being in question.*

This power centred on life, or bio-power, involves the processes of gathering information about the population and creating knowledge. Taking these points into account Barret-Kriegel (1992, p.194) defines bio-politics as:

> *Population science, public hygiene, education, it is the meeting point of all these disciplines - the point of application of which is the body, henceforth submitted to norms set up in an authoritarian way in the name of knowledge [savoir] about punishment and pathology.*

The exercise of this power over life can vary largely, according to social, economic and cultural realities. Evidence concerning a raw tactic of shaping the population is presented by UNICEF (1992, p.51). Data from worldwide research claim that if all women of the 'third world' who wish to prevent pregnancy had access to contraception, population growth rate would decrease by about 30%. It is by denying access to contraception that governments and religious leaders manage the biological power of the collective body.

Taking Foucault's concept of bio-politics and relating it to the example above, it is an assumption of this work that bio-politics operates in the contradiction between the rights and needs of the citizens and also in government intervention in 'the social'. It operates in the space between the right of every citizen to decide privately about his/her own body and the government, 'agreeing with this principle' and not providing contraception because it is a private matter. Once life becomes a right it is taken for granted that intervention and regulatory controls are strategies to provide life; whereas non-intervention represents respect for privacy. The management of death - through punishment - gradually lost its force because the power of a better and longer life is more appealing and produces more 'acceptable' regulatory controls over the population (Foucault, 1990, p.136). Bio-politics in its

constitutivity is a power which makes the act of governing easier. The coercive power of death generated many *foci* of resistance. The constructive feature of bio-politics makes its oppressive power more difficult to identify and to contest.

Vignette 1

'12 times a month should be enough'

There was lack of distribution of oral contraceptives at the health centres observed during the fieldwork. At the 'Health Centre 2' some professionals discussed how to solve the problem. The only alternative was to supply condoms to those looking for pills. The most difficult part of the discussion was to decide how many condoms per month, per person. The final arrangement was to provide 12 condoms to ordinary couples or single people and other patients, such as prostitutes, could have more. In the case of shortage of stock, the person in charge of distributing them could try to negotiate a smaller number. For instance, adolescents could have fewer condoms and were advised to take more from another health centre. There was a worry about having some stock for those who really are 'the patients' of the health centre. The professionals felt more committed to them. Complaints from patients were heard and the answer was: 'I think you are right in being angry, but this is the best we can do. We already asked for more, but ...'. At other times, comments with some sense of humour would solve the problem: 'I know it is the only pleasure we can have for free, but the best we can do this month is 12. I'm afraid you will have to do some 'saving'!'

The Vignette 1 shows how the art of government is spread throughout the social body. Health professionals decide about what is the 'norm' of human sexuality and the privacy of individuals is governed from outside themselves. The resistance expressed is treated with understanding and a sense of humour. The health centre makes it clear that the problem is the government's responsibility and that they are trying to do whatever is possible. The experience of coercive power over the body of the citizen - the lack of contraception - is mediated by the constructive approach of the health centre: they create a norm, an acceptable one, that is equally a regulatory control, but is more difficult to contest.

The government of the body is tolerated to such an extent because the Brazilian national health system is intended for the lower classes of the population. Middle and upper class people pay for their contraception and buy it in pharmacies. It is the poor people who depend on the health centres for access to contraceptives. It means that women and some men have imposed on them the routine of going once a month to the health centre. In so doing so the government re-defines what is public

and what is private in peoples lives. The government of the poor creates a series of mechanisms of regulation, making processes that invade so-called 'private lives' appear acceptable. After all if the government can interfere even in the frequency of sexual intercourse, why should we consider it odd to go to the health centre once a month for a period of many years - in some cases as long as the duration of the reproductive life of the citizen?

Bio-politics can be explained in its capacity to 'individualize' and to 'totalize' (Gordon, 1991, p.3). Both trends work in an integrated way. In Vignette 1 attention given to individual cases makes the norm more flexible, while at the same time the application of the policy on contraception 'totalizes' the cluster of individuals of reproductive age, concentrating on women. With the help of both approaches, bio-politics covers many aspects of life making power circulate through the social body. Bio-politics establishes a set of power strategies - from collecting information to suggesting 'healthy' behaviours - which aims at managing the population. A discussion about how to govern (governmentality) is presented next.

3.4. Governmentality

The literature shows that, from a macro perspective, the rationale for social policy in a state like Brazil can be a minority in power which has a pattern of high consumption of goods and consequently access to comprehensive health services, through a private system; and a huge majority which has a very low standard of living with access to minimal health care (Kisil, 1985, pp.274-287; Medici, 1989, pp.21-26; Castro, 1992, pp.15-21). In this analysis, the elite would concentrate its political power and the national health system could be described as an instrument to keep working class bodies healthy for work.

This explanation can illuminate some aspects of reality - income highly concentrated within the elite; social reproduction of the class system, for instance, through education and health; the state governing for the benefit of one class. But, it

fails to explain many other things. In this conception, the state governs in an unitary way and the contradictions between the different levels of the government are not taken into account; both classes, upper and working, are coherent in their roles and repressive power is the dominant strategy.

The state - as territory and population - is not a useful concept for understanding health. Foucault (1979, p.20) suggests that it is better to focus on the idea of 'government'. It is the government that keeps the state and its population in a certain shape, according to the power strategies it chooses. According to Balibar (1992, p.198) Foucault avoids an unitary concept of the state - people who dominate vs those who resist - and this is the understanding of the state that will be explored in this study.

> *... the State, ... does not have this unity, this individuality, this rigorous functionality nor, to speak frankly, this importance; maybe, after all, the State is no more than a composite reality and a mythical abstraction whose importance is a lot more limited than many of us think.* (Foucault, 1979, p.20)

The focus here will be on how the government rules the population. The ways used to govern are comprehensive and dynamic, going beyond law and policy. Gordon (1991, pp.2-3) argues that the term 'government' can be understood in the work of Foucault as:

> *'the conduct of conduct': that is to say, a form of activity aiming to shape, guide or affect the conduct of some person or persons. ... Government as an activity could concern the relation between self and self, private interpersonal relations involving some form of control or guidance, relations within social institutions and communities and, finally, relations concerned with the exercise of political sovereignty.*

This expanded notion of government allows for a broader reading of the possible meanings of health education policy or activities. The rationality of government - or governmentality - can be found in many practices of governing internal to the society. The different experiences of governing are interconnected and some of them are applicable to the general government of the population. The ideal experience of governing is the one that is embodied in many sites in society,

producing as a final result a continuity of strategies of government both upwards and downwards the social body.

In Foucault's definition (1979, pp.9-10) upward continuity means that to govern the state first one has to govern oneself and one's own patrimony in a productive way. An example of upward continuity is the fact that it becomes 'natural' that politicians are people who had access to education and wealth, fitting in some degree the model of the upper class person. It is from these experiences that they have learnt how to become rulers, so while governing they perpetuate the same logic of governing. Downward continuity is based on the idea of modelling. Once the state is successfully governed in a certain way, it means that there is a right way to govern. This 'proper' model is there to be followed by the parents ruling their families or the teachers ruling their classroom, "which means that individuals will, in turn, behave as they should" (Foucault, 1979, p.10).

Governmentality embodies the idea that the government rules through the continuity of power strategies and tactics in order to manage the population. The exercise of continuity, as well as some level of disruption, make the government legitimate. Continuity and disruption are contradictory sides of the same process - legitimization of government power. Within certain limits disruption is desirable because it shows the government as democratic and just, open to dealing with a variety of interests within society. This approach can cope with tensions, thus diminishing radical attacks against the government.

Governmentality depends also on access to knowledge. The government needs to understand, and further rule, the politics of daily life. According to Foucault (1979, p.11), government is not concerned about people, but about people in relation with other things, like means of subsistence, ways of doing things, fertility, etc. It is also convenient to have knowledge about possible population accidents, such as epidemics or famine. Gordon (1991, p.16) underlines this point saying that political economy is not enough to govern because it does not generate information to allow

the creation of programmes of government.

According to Gordon (1991, p.36) the modern governmental rationality is both individualizing and totalizing. Knowledge about processes related to the population as a whole and knowledge about individuals are equally important. The process of governing is related to:

> *... finding answers to the question of what it is for an individual, and for a society or population of individuals, to be governed or governable.*

The power/knowledge of the government over the population makes the citizens subjects and objects of the act of governing. They are objects when the government uses its knowledge about the population to shape it according to a certain purpose. Foucault (1979, pp.17-18) illuminates this point saying that the population is the ultimate end of government.

> *... government will intervene either directly through large-scale campaigns, or indirectly through techniques that will make possible, without the full awareness of the people, the stimulation of birth-rates, the directing of the flow of population into certain regions or activities etc. ... the population is the object that government must take into account in all its observations and 'savoir', in order to be able to govern in a rational and conscious manner.*

The knowledge that supports the intervention of the government comes from many sources. Strategies like the census are a direct form of gathering information. The services that the government offers or supports are usually obliged to return information to the government. Ultimately, there is a formation of a *savoir* based on all the knowledge that the processes of government related to the population can provide (Foucault, 1979, p.18).

Social policy is a tool to make population and individuals objects of knowledge. However, the rationale behind the art of governing is not only to manage the population as the object of governing, but also to sustain the discourse of the population as the subject of the government. The government has to work in a constructive way to achieve this balance that legitimizes its decisions. Strategies like meetings to adjust policies to the needs of the community, decision-making forums

to monitor the health system, and community representatives at health centres allow individuals and communities to use the knowledge gathered to re-shape policies; at the same time, these strategies legitimize any information collected and most of the decisions made by policy-makers.

Foucault's account of this *savoir* about the population is a critical one. But one could argue that the knowledge gathered about the public and the private lives of the population is both important and acceptable because behind government action dwells the principle of public interest: it is the role of the government to increase and spread welfare among the population. In order to provide it in a fair way the government has to acquire as much information as possible. There is no doubt that this assumption could be questioned. Nevertheless, the best evidence for the credibility of this principle is obedience to the law. Because the government governs everybody, it is taken for granted that policies have to be implemented and laws be obeyed for the benefit of every citizen.

It is an assumption of this work that this same principle explains why health centres and schools are not there to be criticised by the population. Their role is to deliver health and education to every person in society, according to social policies formulated by the government to spread welfare. Health centres can be understood as representatives of the government, consequently to be legitimally obeyed. The resistance which health professionals show to changes implemented as a result of community complaints is *per se* an example of this assumption.

The link between knowledge and obedience is that government representatives achieve both through the management of the population. Foucault (1979, p.19) stresses that the management of the population is not just a collective event, but it also means the management of the population in depth and detail. The key concept to accomplish this comprehensive management of the population is discipline. It is through discipline that the power of the government - and its representatives - is reinforced, making it acceptable and allowing some interference

in private life. However, it is the way power is exercised that makes it acceptable. Discipline is presented as a necessary element in organizing the national health system, promoting a more efficient governmental service. Policy is seen as a constructive way to promote an egalitarian society.

This means that, over and above laws being imposed, the government needs tactics (Foucault, 1979, p.13). The way a law is presented and treated can be related to tactics. For instance, to say in a law or policy that every citizen has the right to health and education means that the government fulfils its role in spreading welfare to the whole population. But, the law can be poorly implemented. Thereby, the government assures that any service it offers in health or education will be valued by the population. This is a tactic also to avoid criticisms because any new service offered is a fulfilment of the law and not a demonstration of how poor the service was before it.

The art of government - or governmentality - is the art of managing the social body. The government's power over life is related in some aspects to individualization, but it also relates to general strategies, such as social policy, to the management of population.

3.5. Conclusion

The main issue of governmentality - how to govern and to make people governable - relates social policy to bio-politics. Social policy can work as a stream of diffusion of discipline and norms in a constructive management of the population. The power over life, reproduction and sex through social policy is an instrument in the exercise bio-politics. However, no unitary strategy of power permeates all levels of the government and social body. Upward and downward circulation of power are constantly challenged by forms of resistance. Gathering information about the population and implementing policies are activities developed under a complex web of micropowers. However, as discussed in this Chapter, social policy and bio-politics

can prove a constructive alliance to governmentality.

In Brazil, the potential use of the national health system to achieve social order has a peculiar facet to be explored: the government of the poor. The next chapter will inquire further into the national health system.

CHAPTER 4

THE NATIONAL HEALTH SYSTEM AND THE GOVERNMENT OF THE POOR

4.1. Introduction

The organization and complexity of the national health system in Brazil have increased dramatically in this century. The national health system had a long tradition of centralized management and unequal distribution of health care. However, in the late eighties the system had a conceptual and structural reform. Changes in the Constitution and in the main health laws abolished the *INAMPS* and created the *SUS*[1]. Two basic concepts were emphasized in this change: decentralization and universal care. They are attempts to solve old problems of the Brazilian national health system.

This process of reform towards democratization does not represent a radical rupture within the system. The national health system has been an important site for contact between population and government, constructing 'the social' as a hybridization of the public and private, and as a site for intervention. The changes proposed reflect a new style of 'doing' health. However, the national health system maintains its potential for governing the population: not the whole population, but the poor. Teixeira (1992, pp.5-6) and Médici (1991, p.26) point out that Brazilian social policies in the nineties have two main features: they have focused on the poorest population groups; but they have not addressed the problem of poverty.

According to Foucault (1990, p.139) the management of life can concentrate on the population or on individuals. In the case of the national health system, policies focus on the population as a whole, but health professionals

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[1] *INAMPS* means in Portuguese *Instituto Nacional de Assistência Médica e Previdência Social* [National Institute for Social Security and Medical Care] and *SUS* means *Sistema Único de Saúde* [Unified Health System]. The *INAMPS* was abolished in 1993, by Law 8689 and the *SUS* was created in 1990, by Law 8080.

implementing these policies work mainly with the poor. The regulation of poor bodies through health care is examined in this Chapter. The recent changes in the Brazilian national health system shed light on the range of power relations that take place in the management of the social body.

The argument pursued in this Chapter is that the government of the poor in a democratic regime demands more constructive power and less repressive power[2], as the reforms of the Brazilian national health system demonstrate. From the early twenties repressive strategies were pursued, such as compulsory vaccination and the demolition of houses for sanitary reasons. By the end of this century, caring for health has become a sophisticated practice which involves the participation of users and universal access to health services. The transformation of the techniques of power used in the exercise of bio-politics is related both to national changes in Brazil and to the international health scenario.

The style of argument used to investigate this hypothesis concentrates on an 'epochal' approach. Donnelly (1992, pp.199-203) suggests that the analysis of bio-power can be pursued through genealogical and epochal approaches. The genealogical approach is inappropriate to the analysis of this Chapter because it focuses on a specific target in a certain moment in history. Here, the epochal approach will be used because it relates to general trends and covers long periods of time, permitting a search for the effects of bio-power within the social body. This approach is more appropriate for taking into account some aspects of the history of the national health system.

There are some reasons for starting the analysis of the information collected through the history of the national health system. First, all the analysis of health education policies and practices is done in the context of the Brazilian national

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[2] The expressions 'constructive' and 'repressive' power are used here in accordance to Foucault's (1991, p.194) terminology: "it represses; ... it produces". These concepts have been previously explored in Chapter 1, Section 1.5. Power and 1.6. Bio-power.

health system. Secondly, the theoretical background of the national health system as an element which contributes to the art of government and to the construction of a society of security should pervade the whole thesis. So, this analysis is presented here beforehand to support the discussions developed in further chapters.

As already said in Chapter 2, the data presented here do not claim to be the only possible way to conceive the history of the national health system, neither a 'truthful' account of its history. The focus on poverty and society of security is in itself a partial 'reading' of the national health system history.

4.2. Poverty, social security, and public health

Poverty can be explained in modern societies as a consequence of the lack of accountability of welfare structures to moral principles, as a result of the way social and economic structures are organized, and also in terms of personal problems. However, the fundamental issue to be discussed is the rationality behind the acceptance of poverty as part of social life (Dean, 1992, pp.244-245).

The idea that poverty is not a phenomenon that always existed in the history of humankind is a good starting point for the understanding of this issue. The concepts of poverty and pauperism have been constructed in the last three hundred years. Dean (1992, p.235) situates the invention of the concept of poverty at the end of the eighteenth century. He refers to a new relationship between "propertyless individuals and the state". Poverty became a 'natural process' experienced by part of the population and the consequence of:

> *... the general condition of humankind, subject as it is to the bio-economic forces of population, subsistence, and capital.*

The relation between economy and society was assumed to be a positive one, lacking any criticism of the exclusion of so many in poverty and pauperism. Procacci (1991, p.163) comments that pauperism was a homogeneous category used to describe part of the poor population, without any regard to the

different groups in this category. In her opinion this reveals that this category is imaginary and what it intends is the delimitation of a social segment, populated by those who "confront the project of social order".

Taking a different paradigm of analysis and talking about the eighties in 'developing' countries, Harpham (1992, pp.64-65) raises the same point - ignorance about the urban poor. She criticizes the notion that urban is necessarily opposed to rural, and that the urban population is considered a homogeneous mass. She adds that large-scale research projects on primary health care for the urban poor are a phenomenon of the late eighties and the nineties. The interest in this segment of the population is directly related to the lack of control over it. In order to deal with this problem, poverty and pauperism are seen as two different processes. Procacci (1991, p.158) explains the difference:

> *Pauperism is thus poverty intensified to the level of social danger: the spectre of the mob; a collective, essentially urban phenomenon. ... It is a magma in which are fused all the dangers which beset the social order, shifting along unpredictable, untraceable channels of transmission and aggregation. It is insubordinate, hidden from the scrutinizing gaze of any governing instance.*

Since then, the development of 'the social' and of the mechanisms of a society of security have been played an important role in guaranteeing social order. Discussing the refinements in the process of dealing with poverty and pauperism Donzelot (1980, p.57) says:

> *... the philanthropic strategy replaced the ancient techniques of sovereign power with new forms of positive power: effective advice rather than humiliating charity, the preserving norm rather than destructive repression.*

In the new forms of positive power, family and sexuality became increasingly the target of counselling in the eighteenth and nineteenth centuries. According to Donzelot (1980, p.172):

> *The family doctor intervened in the domestic organization of the home; through his suggestions concerning hygiene, through his educative advice, he substantially altered its internal arrangement.*

The intervention in the lives of the poor can be seen as an important

strategy in the construction of a society of security. Gordon (1991, p.20), commenting on this concept of Foucault, refers to security:

> *... not just as a broad, self-evident requisite of political power, but as a specific principle of political method and practice, distinct alike from those of law, sovereignty and discipline, and capable of various modes of combination with these other principles and practices within diverse governmental configurations.*

The techniques of power used in the management of the poor corroborate the idea that poverty is a phenomenon that cannot be prevented. The rationality of this process of management of the population is that there is nothing to be done to solve the occurrence of poverty and pauperism. They are 'natural' processes. So, the only possible approach is to reduce the risk of disruption of the social order. Gordon (1991, p.31) points out that at the end of nineteenth century the bourgeoisie was aware of the danger represented by the pauperized urban masses:

> *Urgent efforts are addressed to the reconstruction of the population of the poor according to a model of collective economic citizenship: the social incorporation of the working class as an element of the body politic.*

In Brazil, in the first years of the twentieth century, sanitary principles were imposed on the population of the main urban centres. In order to prevent the spread of diseases, sanitary campaigns inflicted radical intervention on the life-style of the poor. Around 1920, epidemic diseases threatened exports of agricultural products, especially coffee. Some countries planned to introduce sanctions against Brazilian products. The problem was not related to the products themselves, but the sailors, who were seen as vectors of contagious diseases. The economic order of the country was preserved through a legal repressive approach. Vaccination became obligatory, houses were destroyed and among other reactions there was a week-long rebellion in a port in Rio de Janeiro which ended with one thousand people being imprisoned (Gastaldo, 1990, pp.23-25). The campaigns of the sanitary movement (*sanitarismo campanhista*) perceived disease as a mass problem to be tackled through a prescriptive, militarist and highly centralized approach.

Under the dominant model of the sanitary campaign, health education

as bio-politics was mainly interventionist and as anatomo-politics it was a repressive exercise of control. Health education as a discipline was founded on eugenic principles. Hygiene became a vital concept in the process of disciplining and creating 'norms' - standards - of comparison between good workers and housewives and the others - those who resisted the proposed new 'life-style'. Health education was committed to the cleanliness of the social body - socio-economic issues and health were related in an oppressive approach:

> ... *'sanitarism' was at the service of 'hygienization' of the masses. It means that clean people - educated elites with the economic power to implement the measures prescribed - should be separated from those who were dirty - workers living in poor housing conditions and lacking information.* (Gastaldo, 1990, p.24)

Behind the prescriptive approach adopted at the beginning of the century, there was a conception of poverty as a 'state of moral and mental development'. To be poor was to be ignorant, childish, in other words, not fully developed. It was this view of poverty that helped to sustain the interventionist approach of public health. Poor people had to be directed, like children, into the correct paths of hygiene and family life in order to learn how to conduct themselves.

In terms of the approach to health education, the practice was law rather than tactics and rules rather than advice, a primitive-oppressive pattern of bio-power. Health issues became the subject of law. Health education was not enough to ensure social order and prevent diseases from spreading. In São Paulo, for instance, municipal laws were issued in 1897, 1900 and 1908 to promote the construction of cheap houses, creating healthy workers' neighbourhoods in sparsely populated areas (Costa, 1987, pp.13-15). In extreme cases, the use of force to impose radical changes resulted in equally radical reaction, such as riots. As the years passed, the population learnt, with the help of health education, the 'importance' of hygiene and preventive health care and no more rebellions occurred to avoid mass vaccination. The government also learnt that diseases and other population issues can have negative effects on economic and international relations. The results of such experience did not challenge the understanding of poverty as a 'natural' process, but after achieving the

first intended results, the government developed future measures in a less repressive way.

In 1920 the government created a central body to deal with collective health issues. On the 2nd of January the National Department of Public Health was launched. In the following year a system of health visitors was established to help to put into practice the new public health policies (Paixão, 1969, p.109; Pinheiro, 1962, p.433). Through the work of health visitors the government could try to accomplish its aims in public health in a more constructive way, avoiding mass strategies; rather it was concentrating on the individualization of the process of health education.

The twenties also saw the beginning of a social security system *Caixa de Aposentadoria e Pensão - CAP* (Retirement and Pensions Fund). Silva et al. (1992, p.76) argue that the Law 'Eloy Chaves', which created the Rail Workers' *CAP*, launched the basis of the Brazilian social security system. It was developed in response to the demands of workers and after this *CAP* others were created. Silva et al. interpret the provision of some form of health care and pensions as means to postpone or prevent conflicts between the government and part of the working class. In this work perspective, the development of health care is a refinement of the exercise of bio-power. Instead of campaigns, a permanent connection between the poor population and the government creates 'the social', a space for governmentality.

Very slowly, there was the development of a network of secretariats in states and cities, expanding the universe of health care in Brazil during the thirties, forties, and fifties. The Constitution of 1934 established municipal autonomy, turning the government into a complex unity of three levels of power - federal, state, and municipality (Muller Netto, 1991, p.57). In 1939, for example, the health centres of the city of Rio de Janeiro were transferred from the federal to the municipal government (Pinheiro, 1962, p.454). In many places there was not an exclusive 'health secretariat', but health was under the control of 'welfare', 'social action' or 'social service' secretariats.

According to Mendes (1992, pp.102-104), from the end of the last century until the sixties, the sanitary campaign model had been the dominant discourse on public health in Brazil. The organizational structure of the secretariats derived from this model of public health. Mendes describes the work performed by the secretariats during these decades as 'central-verticalism'. It was 'centralized' because policies were formulated at the federal government level and 'vertical' because they were disseminated from the top to the local level, where they were supposed to simply be implemented. The influences of this paradigm on the organizational structure of the state secretariats were a strong administrative centralization; departments divided according to diseases or medical specialties, centralized planning, and implementation through campaigns. The health secretariats were very selective, working only with public health issues (Mendes, 1992, p.102); public health meaning here disease prevention campaigns.

The second organisational paradigm, which started in the sixties, has been used since then by the health secretariats. Mendes (1992, p.103) called this model 'horizontal-decentralised'. It took shape in the second part of the sixties and was consolidated as the model of health secretariats in the seventies. The features of this paradigm are: guidelines created at the central level; the creation of regional offices to deal with specific tasks; less power for the central level departments and programmes; implementation through specialized units set up to develop programmes; the health secretariats are committed only to some aspects of primary health care and selected campaigns (Mendes, 1992, p.104). This organizational shift also implied a change in aims: to promote healthy workers' bodies, rather than sanitary conditions - a shift from public health to health care.

Thus, the main concern of the government during the first part of the century was the *public* side of health. The campaigns and programmes regarded disease and its prevention as a public problem. Hygiene and morality came together to discipline the social body in its collective life. Gradually a shift in this tendency occurred with urbanization and industrialization. At the beginning of the fifties public

health gave way to private medical care; the influence of the pharmaceutical industry increased in the health area, and the number of workers covered by the health system also increased. In the early sixties medical concern with workers supercedes public health as a priority of social policy (Ruffino, 1985, p.253; Muller Neto, 1991, p.59). In terms of governmentality, this shift represented an expansion of the health system in its possibilities of contact with the population. Moving form campaigns to workers' health , the control of the poor was refined, concentrating then on the part of the poor population formally engaged in the labour force. The difference between both models is the permanent presence of the 'health system to workers' in the daily life of the population. Rather than campaigns, the new model deals with health care, covering life from birth to death.

4.3. The *INAMPS* System and the workers' health

The next step in the organization of the national health system was the creation of the 'Institutes of Retirement and Pensions'. They were the same *CAPs* that had been created after the twenties. The problem with the previous system was the discrepancies between the different *CAPs*. Some offered very little in terms of health care, but provided food at better prices; others had a better programme for retirement pensions etc. The Institutes (*IAPI, IAPC, IAPM*) were organized for different sectors of the economy, like industry or commerce, and provided uniform benefits to their workers and families, after the Organic Law of Social Security was approved in the sixties (Silva et al., 1992, p.77).

In 1966 these Institutes were unified and the *INPS-INAMPS* system was created by the federal government. The main characteristic of the *INAMPS* system was its design to provide health care to workers. Until 1990 access was conditional on paying social insurance. All workers had an automatic deduction taken from their wages and the employer also paid a contribution per worker. The problem was the large group of workers who were paid below the minimum wage, unemployed people and those working in rural areas who never contributed to the system. They were

named *indigente* (dispossessed users), commonly the poorest part of the population.

The *INAMPS* system meant a victory to many workers - full access to health care. However, it also established a classification of different types of poor people. Dean (1992, p.220) points out that three categories defined the poor in the eighteenth century: 'industrious Poor', 'idle Poor', and 'impotent Poor'. About the industrious it was said that they should be encouraged and offered work. One can argue that the organization of the national health system during this period can be seen as 'encouragement' to the industrious poor to maintain their commitment to their job.

The *INAMPS* system is understood in this work as having also an explicit economic role: to keep the workers' bodies fit for the machinery of production. The employer had to pay the government a tax per worker, but was repaid in healthy or 'repaired' workers. The investment in the training and discipline of each worker was partially guaranteed through this compulsory fund for workers' health. It becomes easy to understand why non-workers (idle or impotent poor) were not formally included in the national health system and why there was a clear focus on curative care, rather than on prevention. Foucault (1990, p.139) states that one of the faces of bio-power is the concept of body as a machine. In this perspective, the body is there to be integrated "into systems of efficiency and economic controls", and the health system can contribute to the docilization and optimization of the bodies. Hewitt (1991, p.230) adds that "health, welfare and productivity of bodies became the aim of bio-power."

It is the view of this work that the oppression people experienced through this system could be identified in the 'repair' process that the national health system represented, 'fixing' bodies to the capitalist machinery. The national health system has been organized to provide curative procedures and the professionals available are usually only doctors and assistants (more details in Chapter 7). At the same time, in the sixties and seventies the notion of health as a commodity and a right of the worker becomes stronger. But, how to explain all those underpaid workers who

were excluded from the right to health care?

One explanation is that the cluster excluded from the national health system had also a symbolic role. The *indigentes* (dispossessed users), as they were called, frequently had special units at the hospital or a limited number of beds. They were the poorest of the poor and they could not be differentiated from those who did not work - vagabonds or disabled people. The label and special units were a visible reminder to all workers of what it meant to be unemployed or underpaid. To keep one's job was the only way to prevent the worker's family and him/herself from being reduced to this condition of lowest status in society and thus becoming a 'member' of this undifferentiated mass of those not adjusted to society (for economic, moral or social reasons).

During the seventies the possibility of affiliation to the social security and national health system was extended to rural workers, to domestic servants, and self-employed people (Silva et al., 1992, p.77). But the benefits rural workers received were not the same as those of urban workers (Almeida, 1982, p.37). They were a particular kind of poor known as *FUNRURAL* patients because they belonged to the rural fund of the social security. Luz (1991, p.29) comments that there is a traditional view about social policy in Brazil which relates the acquisition of social rights to work, especially to employment as it exists in urban centres. She adds that this perspective, common among businessmen and some sectors of the unions, denies access to health care to the majority of the population - children, housewives, students, old people without retirement pensions, the unemployed, and all workers located in the informal market. This tendency was very much alive in the *INAMPS* model of health care. The urban employee was placed in a privileged site of the national health system.

Though the worker had to maintain his/her family with the minimum wage, usually less than one hundred dollars a month, the work card represented an additional 'social wage'. Health care and retirement pensions became guarantees

desired by all workers. Thus, the national health system acquired a new meaning. It was not a right, but a privilege. Access to the system became a criterion of differentiation among the poor. Perhaps a moral value was added to it - access to the system promoted dignity. In any case, at this time, the national health system was still a reward and not a right. However, this particular balance of power relations did not prevent criticisms. Workers used to complain about the quality and quantity of the services offered, such as lack of drugs for distribution, long queues to get a consultation, or consultations so short that the patient did not have enough time to explain her/his complaint in detail to the doctor.

The social security system provided health through a highly centralized scheme. The Ministry of Welfare and Social Security had the *INAMPS* system as the manager of health issues. *INAMPS* provided its own services and also purchased services from private hospitals and individual physicians. In Kisil's evaluation (1985, p.275), the main clientele of *INAMPS* were the urban labour force and the services provided were almost exclusively curative medicine. The control *INAMPS* had over its own services was poor, but much poorer was the control over the private services it purchased. The conclusion the author offers is that *INAMPS* was serving specifically a small group of better-paid urban workers and those in need of intensive care units (ICU). There was a lack of assistance to the bulk of beneficiaries in terms of curative care and all beneficiaries lacked preventive care. So, the system not only excluded many citizens, but also showed its commitment to some forms of curative medicine. Queiroz & Vianna (1992, p.132) corroborate this view saying that at the same time as costly high technology was introduced, the public health service had been deteriorating under *INAMPS* administration. Harpham (1992, pp.65-66) points out that the dependence upon 'westernised' curative service - mainly from hospitals - and the lack of implementation of primary health care policies are common problems for the poor of urban centres of 'developing' countries.

According to Kisil (1985, p.274) in the eighties there were three main groups of health care providers: (a) the social security system (*INAMPS*), which

covered about 50 million people; (b) other public services (state and municipal clinics) which covered about 25 million people; (c) the private sector, covering about 23 million people. That left 20 million Brazilians without any health care. Those covered by the national health system were facing difficulties too. The 'fortunate' workers who received the minimum wage and had a work card did not have enough money to provide decent conditions of life for their families. The health assistance they received was inadequate. Those who received the minimum wage or less and had no work card experienced a worse situation when in need of health care. The unemployed until the eighties had no unemployment benefit and many of them spent their lives entirely outside the formal economy.

All these circumstances denote a lack of commitment on the part of the government to the health of the population. They also question the idea that the national health system works in consonance with the capitalist machinery, as said before. The *INAMPS* system has to be understood as a health system under a military dictatorship, in a country that opted for a model of concentration of wealth to achieve economic development. As a site for power relations, the national health system is not a place for a single and 'efficient' power strategy. The system does govern the poor, but also fails to do so in many ways already described. The possibilities for the reform of the system were born from the discontent it caused. The inefficiency and inequality of the national health system had been denounced by users, health professionals, press and academics (Queiroz & Vianna, 1992, pp.132-133; Muller Neto, 1991, p.59; Luz, 1991, p.28). This momentum was not a structured one but produced a basis for further reforms. The Ministry responded to these complaints by developing initiatives, together with municipal and state governments and the universities. The aim was to create a better national health system.

In a Foucauldian perspective, one could argue that in the eighties the repressive strategy of exclusion to the right of health care has been generating resistance and the acceptance of the national health system as an experience of government has been challenged. Then a new shift takes place and a more

sophisticated strategy of government is proposed as the model to the national health system, not as a machiavelic manoeuvre of the government, but due to a complex re-arrangement of forces within society.

4.4. The Unified Health System (*SUS*) and the democratization of health care

In 1986 there was a breakthrough in the history of health planning in Brazil during the VIII National Conference of Health in Brasília. It was a joint event with the participation of representatives of the population, pressure groups, professionals, politicians and political parties, and the government. During this event the basis of a national reform in the health sector was settled. The Unified and Decentralized Health System, as it was first called, presented a new conception of health and a new project of equality within the health services. Under this new national health system model, health was conceptualized in social terms as an area which reflects the living conditions of the population.

The Conference proposals were turned into law. In 1988 the new Constitution was written and, as a result of much pressure and lobbying, the principles of the conference were included (Luz, 1991, pp.28-29; Carvalho, 1992, pp.11-14). According to the 1988 Constitution, health is a right of any Brazilian citizen and a duty of the government. In the Section II, articles 196 to 199, the following issues are mentioned:

- access to the national health system, in all its aspects of promotion, protection and cure is universal and egalitarian;
- the national health system is under rules, supervision and control of the government;
- the national health system belongs to an unified system and follows the guidelines of decentralization, community participation and holistic care, with priority given to preventive activities;
- the private sector is free to provide health care in accordance with the law.

In the Sections related to family and children other aspects of health care are listed, such as the right to family planning, and the duty of the government to provide educational and scientific resources for the exercise of this right. Child health is also a priority in the Constitution. According to the Ministry of Health (Brasil-Ministério da Saúde, 1991, p.9), this Constitution is innovative because it is the first Brazilian Constitution to have an exclusive section dedicated to health issues, in the Social Security Chapter.

Some remarks should be made about this achievement. A great deal of effort was necessary to insert the issues related to health in the Constitution. To many skeptics the effort was not worthwhile because the Constitutional text is unlikely to be implemented. To many others, however, it represented a radical victory in the process of consolidating citizenship and democracy in the country. Nevertheless, the point of view to be explored here goes beyond the discussion of law as a static written statement or a blueprint for change.

The democratization of health at the end of the eighties in Brazil is understood in this study as a refinement of the art of government. It was the first time health received such special treatment because the re-establishment of democracy demanded democratic practices in health. Queiroz & Vianna (1992, p.133) say that acceptance of the legitimacy of the government depended upon its capacity for delivering some of the demands of society, in spite of the pressures of the private medical 'industry', which lobbied for private and curative care. In theory, this new democratic space represented by the national health system puts the government in direct connection with the entire population. In practice, it connects the government and the poor. Bio-politics was turned into participatory strategies, in similar fashion to the health promotion discourse at an international level which focused on empowerment.

The text of the Constitution tackles the chronic health problems of the country and begins to overcome the serious inequality in health care which was

available to work card holders but not to *indigentes*. The new system destroyed the label of *indigente* because the system is universal and no identification card has to be shown in order to receive health care. In practice this meant a lot to those 20 million Brazilians deprived of health care. But, this meant also that the better-paid urban workers, many of them belonging to the middle class, lost privileges. After the implementation of the *SUS* it was impossible to get private rooms by paying the difference between the government minimum and the price of private accommodation. According to the principle of universal care, the services had to deal with all patients and queues for health care became even more common. The middle class which had been pressurized by relative economic decline had to face another loss. In the first year of implementation of the *SUS* a segment of the press, politicians and part of the middle class population accused the system of making the health care worse than before. Fiori (quoted in Teixeira, 1992, p.6) called this movement 'conservative withdrawal', whereby the middle class could opt for private health coverage leaving the *SUS* to the poor.

The universalization of the system did not increase middle class usage, but extended usage over the poor. By the end of the eighties, 2 to 3% of the population (3 to 4 million) was linked to a 'high technology' system of health care, 22% (around 31 million) used some form of private health policy, and 75% (120 million) were left to the national health system (Teixeira, 1992, p.7). In a democratic society health was no longer the site for official exclusion and primitive forms of discrimination. This does not mean that the national health system is no longer discriminatory, but that the forms of oppression are more refined. Augmenting the terrain of health sets up the national health system as one of the important strategies available to the government to shape the social body. The exercise of bio-politics through the national health system reaches the whole population, but anything that happens in the system will be mainly addressed to the poor.

Prior to the changes in the national health system, a series of discussions culminated in the proposal of a new concept to health. It was formulated

at the VIII National Health Conference and can be seen in the Constitution and in the subsequent Organic Law of Health, in 1990. The second article of the Organic Law (Law 8080/90) refers to health in a broader way, taking into account that health has multiple determinants such as food, housing, sewerage, work, incomes, education, transport, leisure, and access to essential goods and services. In this document the health of the population is seen as an expression of the country's social organization and economy.

Armstrong (1993, pp.55-67) comments that the 'regime of total health' includes illness but covers also many aspects of life. Like the new concept of health which relates health to economic and social conditions, the 'regime of total health' places health in a central position to affect decisions regarding the most different aspects of social life. The project 'Healthy Cities' illustrates the powerful position health can have in the whole process of social policy and decision-making process. Ashton (1992, pp.1-11) comments that health-related problems have to be tackled in a broad way, including education, housing, pollution, etc. Health now operates as a metatheory to orient multidisciplinary decisions about how to provide a better life for urban populations. This powerful position of health aligns it with Foucault's conception of bio-power.

Although the national health system can be an important locus for the management of the population, the empowerment it provides should also be considered when the issue is democratization of access. In national terms the implementation of the *SUS* happened after the Organic Law of Health was approved. The approval was again the result of many negotiations between political parties and pressure groups within the National Congress and the Executive Power (Luz, 1991, p.30). After being approved in Congress, some articles of the Organic Law were vetoed by President Collor, including those related to transferring the budget to states and municipalities and establishing the power of the Health Conference and Health Council - composed of the representatives of population and health professionals, among others - to decide about health policy. The veto was criticised and the

government presented the Law 8142/90 which re-established community participation in the co-ordination of the *SUS* (Muller Neto, 1991, pp. 64-65).

Law 8142/90 states that at each level of government there will be a Health Council and a Health Conference, which will take place every four years. Both are composed of equal numbers representing users, providers and government. The Health Council meets once a month and has decision-making power; it formulates strategies and monitors the implementation of plans, including finance. The aim of the Health Conference is to evaluate the situation in the health arena and to suggest guidelines for policy formulation.

The *SUS* system represented a new approach to governmentality. From focusing on the urban poor (*INAMPS*), the national health system has moved to every citizen (*SUS*). Participation and accountability are the new approach to deal with the poor; no longer excluding, but integrating the poor in the national health system. The *SUS* represents an increase in the possibilities of contact between government and poor population.

However, the reform of the national health system represents most of all a new discourse on the relations between government and the poor. The difficulties in achieving the aims of the reform, described by a policy-maker interviewed about his experience at the federal level, illustrates that the discourse on participation circulates but is not easily implemented:

> *It is true that the national health conferences, especially the VIII, were a watershed. ... Nevertheless, the SUS has been legitimating the medical lobby. The positions on the Municipal Health Councils have been occupied by doctors. Other professionals face resistance. ... In my point of view the public institutions are mainly concerned with curative medicine. They are centred on the figure of the doctor. The treatment provided is for disease and not to the ill person. There is this view that a health problem is an issue of drug prescription, a medical issue.*

The impressions of this policy-maker contrast sharply with the whole set of documents and policies produced by the federal government at this time. In

1990 the Quinquennial Health Plan 1990/95[3] was published by the Ministry of Health as a guideline for health planning. This document does not have the power of law, but represents a change in terms of health planning because it puts together constitutional principles, the critical health situation of the country and establishes goals, activities and a schedule for achieving objectives. However, the Minister who signed the plan was dismissed and the President, elected to attain such improvements in the country, was impeached in 1992. In the Health Plan 1990/95 (Brasil-Ministério da Saúde, 1991, pp.5-28) there is an explicit commitment to reforming the national health system. The Organic Law of Health and the Unified Health System are seen as "tools" to achieve the expected changes. The low quality of the health care provided is openly criticised in the document. In such a situation there is no way to show commitment to high standards of quality without criticising the current pattern of health delivery. Gordon (1991, p.46) clarifies that the politics of governments have been changing:

> *Government itself assumes the discourse of critique, challenging the rigidities and privileges of a blocked society. Promises of expanded individual autonomy and responsibility become electoral necessities.*

The Health Plan 1990/95 describes the *INAMPS* system as privileging disease and punishing the sick person. In the document the Ministry relates this situation to many factors, summarized here as follows: the national health system is centralized and does not have contact with the user; it is a fragmented system of health assistance which is geographically unequally and traditionally inefficient; and, there is an insufficient proportion of the GNP (1,8%) devoted to health, as compared with other countries at the same level of development. The solution proposed by the Ministry to overcome these historical problems follows the constitutional principles of the Unified Health System: decentralization, holistic care, community participation, universality and equity. An extra challenge is presented in the Health Plan 1990/95. The achievement of these aims is said to depend on the expansion of financial support of municipal and state governments to 10% of expenditure and an expansion of GNP investment from 1.8% to 5.4% (assuming that GNP will remain stable or grow).

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[3] In Portuguese it is called *Plano Qüinqüenal de Saúde 1990/95: a saúde do Brasil Novo.*

It is the point of view of this study that the coherence between the legal model of the new health system and the Health Plan 1990/95 shows that the reformulation of the national health system in Brazil has passed through a complex interplay of forces. The Plan cannot be seen as the sole creation of a government or one ministry, but rather as the result of a collective compromise. At the government level the plan is the outcome of the work of a large number of specialists and staff at the Ministry of Health. It is also the result of social pressure such as the VIII National Health Conference and the new legislation on health. The social commitment of the document is also motivated by the populist approach of this neo-liberal government (Castro, 1992, p.16). The policies are based on the facts that is very difficult for the population to demand the implementation of any policy at ministerial level and that to write about providing social justice through the national health system is politically profitable and does not, by itself, ensure any change in society. Linking implementation to increasing economic support provides space for any failure in implementation to be excused by lack of financial feasibility.

The example of the reform of the Brazilian national health system, described here in a summarized way, provides an account of the complexity of power relations that take place in the process of making bio-politics. The difficulty of the process dwells in dealing with progressive ideas that serve both to empower and control the social body and the lack of easy ways to resist the use of bio-power to discipline society.

Paulo Freire (1992, p.28) says that to transform the inequalities of Brazilian society is just a matter of putting into practice the laws that the dominant class approved, but which were never meant to be deployed. The *SUS* was not fully endorsed by the dominant class and its implementation is already showing how difficult it is to overcome an old model (Castro, 1992, pp.15-21). In many municipalities the establishment of the Health Council was postponed and there were accusations of manipulation in their composition. The access the Council - meaning the community - has to the financing of health care and its decision-making power

were not easily accepted. The lack of organization of the community and the power of the municipalities to get their projects approved in the Councils are also part of this process (Queiroz, 1992, p.139). Thus, implementation varies between states and regions within states. But, in spite of these difficulties, one Health Conference has already taken place at all three levels. The IX National Conference was the first conference of its kind to be truly representative: 50% of the participants were users of the national health system and all others were chosen at the municipal level in more than half of the five thousand municipalities of Brazil and endorsed by the state conferences as their representatives at the national one. There, almost three thousand representatives and one and a half thousand national and international observers met to discuss, to present the aspirations of the population, and to propose new guidelines for the health system (Brasil-IX Conferência Nacional de Saúde, 1992a, p.3; Brasil-IX Conferência Nacional de Saúde, 1992c, pp.1-2).

The IX National Health Conference was postponed for two years by the Collor administration. The main excuse was the cost of such a giant meeting. In 1992 the conference was held in Brasília and its slogan was: "Decentralizing and democratizing knowledge". The central themes were society, government and health; social security; the implementation of the *SUS*; and control of the health system by the society. One common criticism was raised in the municipal and state conferences and came up again at the national level: the government in its three levels was not doing enough to implement the SUS. To contain this criticism seems to be the main reason why the Ministry of Health postponed the IX Conference many times.

The first part of the recommendations of the IX Conference is an open letter to Brazilian society. The letter denounces the neo-liberal model of government because it causes economic recession, and extremes of wealth and poverty, and prevents millions of people from living in dignity. The letter also denounces pauperism and social violence, deals with international creditors and the corruption of the Collor government. It finishes by demanding that the President should leave the government (Brasil-IX Conferência Nacional de Saúde, 1992c, pp.1-45).

The President was impeached but the challenge of providing good quality care to the population remains the same. The control over the population exercised through the national health system has been discussed here mainly as if the government was incapable of representing the interests of the population. The changes already achieved by the *SUS* empowered the population and re-shaped power relations, but the legacy of the military dictatorship - the lack of democracy - is still alive within the national culture. So, in the Brazilian context, the exclusion of so many million inhabitants for such a long period in history is still associated with the art of government and the victories in the reform of the national health system are not enough to overcome this experience.

Nevertheless, the implementation of the *SUS* and the discussions around the changes in the national health system brought up new meanings to health care and health itself. The process described here shows that the notion of health care just to those who work (in the urban centres and according to a narrow capitalist view of what work means) is not a principle accepted anymore in the nineties in Brazil. For this decade, health tends to be linked to citizenship and participation. The user of the national health system comes from the 75% of the population who cannot afford private health care, but the strategy of governmentality is to treat this vast group of poor as 'poor-citizens', who have the right to participate and, in some degree, decide about the future of the national health system.

4.5. Conclusion

Throughout this century, the national health system has undergone many changes. The shift from *INAMPS* to *SUS* represented an important achievement for the population in terms of access to health care.

The argument pursued in this chapter was that the national health system, before and after the *SUS*, preserved its potential for managing the population. In the *INAMPS* model of health care, the urban worker was the focus of the system.

Excluding the poor, who were not formally engaged in the productive system, had been a strategy of control.

The reform of the national health system introduced universal access and users' participation into the decision-making process. It has been suggested that this change represents a refinement of the strategies for regulating the poor. In moving from exclusion to participation, the national health system changed its exercise of bio-power, concentrating on a constructive approach of promoting health (shifting and moving away from coercive techniques to the management of the population).

The analysis of the Brazilian national health system also helps to illustrate the idea of governmentality suggested by Foucault. The experiences of governing and being governed pervade the social body and this Chapter has raised same examples of how power relations within the national health system contribute in the art of government.

CHAPTER 5

HEALTH EDUCATION POLICY: TRADITIONAL APPROACHES AND EMPOWERMENT DISCOURSES

5.1. Introduction

This chapter analyzes health education documents and policies produced by the federal government approximately in the last 15 years (Table 5.1). Some recent policies of state and municipal governments are also analyzed. The documents discuss the theoretical framework to health education policy in Brazil, but also describe some experiences of implementation.

Table 5.1. Federal health education policies in 1980s/90s analyzed in this Chapter

1980: Health Education in the Federation Unities (states)
1981: Educative Action in the Basic Health Services
1982: Participatory Action: methodology
1982: Participatory Action: evaluating experiences
1982: Participatory Action: human resources education
1983: Participatory Action: production of educational materials
1984: Participatory Action: perspectives on health education practice
1987: Participatory Action: evaluating experiences (re-printed)
1989: Education: reflection and creative participation in gaining health
1989: Health Education Guidelines
1992: Education for Participation in Health

The reason for analyzing federal documents comes from the fact that in the last fifteen years the federal government has been systematically producing documents and policies on health education. No other level of government has discussed and written so much about it and in the analysis of state and municipal policies there are references to these federal documents. As already mentioned in Chapter 4, the military dictatorship which governed the country until 1985 centralized initiatives in all areas and in order to explore the ideas about health education circulated in the eighties it is necessary to turn the focus of analysis to the federal government documents.

It is the argument of this chapter that health education policy is the result of many discourses. It cannot be seen as a coherent power strategy that circulates down from the central government until it reaches the user of the national health system. Policy has a role in promoting a certain image of the government (currently community participation), but at the level of implementation the traditional way of carrying out health education will re-shape it. The formulation of policies at the various levels of government gives place to the emergence of different discourses on health education. However, every policy has to pass through the health centre level to achieve implementation. This process allows health professionals to accommodate the propositions of policies to their views and usual practices in health education.

The sequence in the policy analysis undertaken here, from the central government policies to health centre policies, could be related to a 'top-down model' of policy analysis (Ham & Hill, 1984, p.96). The similarities dwell in the search for evidence of implementation in the documents analyzed and in the attempt to relate federal policy to state, municipal, and health centre policy. This approach can impart a structuralist view of government as something 'out there', steady and ready to be examined.

Nevertheless, the analysis carried out in this Chapter has major differences to the conventional top-down model of analysis. Ham & Hill (1984, pp.101-103) mention that one of the criticisms that should be made to the top-down model of analysis is to take implementation for granted. As already discussed in Chapter 3 (section 3.2. Social Policy), in this study policy is also seen as a statement or proposition that does not necessarily leads to implementation. The top-down model concentrates on implementation and its impact, while the analysis carried out in this Chapter is rather focused on the understanding of policy as a discourse that promotes views about health, being healthy or sick, and how the management of the population can happen through health policy.

The kind of analysis employed in this Chapter does not provide elements

to suggest more effective ways of reaching policy implementation; it does not focus neither on the impact of health education policy in the health of a certain community. From a pragmatic perspective, it is not a useful approach to help policy-makers who work with health education. The analysis chosen is appropriate to reflect on the sociological aspects involved in the policy process. This approach is based on the conception of governmentality and the ways practices of government permeate society in both upwards and downwards continuities (as discussed in Chapter 3, section 3.4. Governmentality). Hence, it is important to state that more conventional approaches to policy analysis could illuminate many issues that will be left behind by the Foucauldian approach used here. However, the perspective of governmentality through health education policy sheds light on how health policy can contribute to promote constructive power strategies to the exercise of bio-politics.

The chapter is divided in federal, state, municipal, and health centre policies. For the sake of clarity, when a new policy is discussed the name will be printed in bold.

5.2. The federal level: documents and policies from the National Division of Health Education

5.2.1.Last years of military dictatorship (1977-1985)

In 1977, the Ministry of Health launched the Information [*Portaria*] 425 of 26/12/77. In Article 33 the objective of the National Division of Health Education is defined as:

> *To promote and increase activities, to be carried out by the health services, that will enable people and communities to acquire knowledge and to adopt behaviours that will encourage health promotion, protection and recovery.*

In order to accomplish its goal the recently created Division needed to gather information about health education at a national level. In 1979 the National Division of Health Education developed a research project called '**National Human Resources in the Area of Health Education**', focusing on 1978. Health Secretariats

and Education Secretariats, among other institutions, answered two questionnaires.

The research was cited as a first step in the development of the National Division (Brasil-Ministério da Saúde, 1980, p.9). The information collected provided elements in the definition and implementation of the Division guidelines. This first research concentrated on the presence or absence of specific health education teams at the secretariat level and whether they were composed of sanitary educators or public health educators[1]. São Paulo Health Secretariat provided the model of health education where a health education specialist was in charge. In 1971-72 the State of São Paulo defined the role of the health educator as a professional with responsibilities to develop health education at the health centre level. Until the end of the seventies the Health Secretariat supported the view that health educators should not work in direct contact with the population. The educators were expected to work only on planning and as consultants to other members of the team (Salomão, 1984, p.45).

At the time when the Ministry was collecting information on health educators at the national level, in the State of São Paulo the health educator's role was under review. It was felt that the health educator's job description was 'out of touch with reality' because they lacked a specific space to practices at the health centres. In the seventies health educators linked their work mainly to nursing (Salomão, 1984, p.45).

The results show that in 1978 fewer than a half (47%) of the State Health Secretariats had a specific team in charge of health education. Commenting on the importance of the public health educator, the research reveals that, in average, health education constitutes 58% of the activities described by the health secretariats. Moreover, 87.5% of the health secretariats said that they were developing health education plans, materials and activities. Around 50% of the secretariats had

[1] The public health educator is a professional with a university degree and graduate studies (specialization level) in health education. The sanitary educator is a professional with a secondary school diploma or a university degree and with a certificate in health education acquired after a short course (Brasil-Ministério da Saúde, 1980, p.31).

quantitative and/or qualitative reports of their work (Brasil-Ministério da Saúde, 1980, p.27).

It is interesting to note that the presence or absence of public health/sanitary educators does not change the basic pattern of activities developed by the institutions. But the presence of this educator increases from 5 to 11 the range of activities developed at the institution. The activities mentioned in the study are:

> *Educational activities within schools, institutions and community through lectures, meetings and other activities with groups. Also interviews, home visits and campaigns.* (Brasil-Ministério da Saúde, 1980, p.23)

The conclusion of the study points out that the absence of public health/sanitary educators jeopardizes the work in health education. The document suggests that the presence of these professionals helps to keep health education on the agenda of the institution. Another conclusion is that there is a poor standard of communication between the State institutions and the National Division (Brasil-Ministério da Saúde, 1980, p.35).

The document suggests the creation of Health Education Teams in the Health Secretariats; establishing the position of public health educator; training more professionals; and improving communication between the National Division and those in charge of health education at the state level. The aim of this last recommendation was to promote a greater uniformity in health education activities throughout the country (Brasil-Ministério da Saúde, 1980, p.36).

The type of information required in the questionnaires, the conclusions drawn and the recommendations arising out of this national survey show that the organizational model proposed to manage health education by the National Division is centralized and based on the expertise of only one professional group. The clear preference for a specialized health educator proved to be unrealistic: in the nineties the health education teams rarely refer to the presence of this professional (data from questionnaire). The recommendation about creating specialised teams to deal with

health education in the state health secretariats could not be checked by my study. Only one out of ten state health secretariats does not have a specific health education team. However, this does not mean that the recommendation to establish these teams was implemented because the other fifteen health secretariats who did not return the questionnaire might not have a specific health education team.

The structural model of a National Division of health education at the federal level and health education teams in the state health secretariats does not really say very much about how health education was understood at that time. However, this is spell out clearly in the **'National Division's Health Education Guidelines'** (presented in the document: Brasil-Ministério da Saúde, 1980, pp.37-39). These guidelines are crucial to understanding the ruptures and continuities in the official discourse. In this document, health education is defined in the following way:

> *Health Education is a planned activity that aims at creating conditions to produce the desired behaviour changes in relation to health. These changes should guarantee the improvement of the health conditions of the collectivity.* (Brasil-Ministério da Saúde, 1980, p.37)

The Guidelines state that a planned action in health education depends upon knowing the population; having a clearly designed policy; and having well trained health educators. They make clear that planned actions depend on the understanding the planner has of other policies. This remark appears as an 'obvious' statement in the text, but is not followed through when the role of health professionals at the health centre level is explored. Policy-makers who were interviewed for this study considered that health centres simply implemented policies instead of 'understanding' and 'planning' (Brasil-Ministério da Saúde, 1980, pp.37-41). Perhaps this is because health professionals are not perceived as knowledgeable planners. This position denies the micropolitics that take place at the grassroots level of the national health system. Implementation was and still is taken for granted as a direct consequence of policy dissemination to health centres.

According to the Guideline, 'the way' to carry out health education is to produce long lasting changes in behaviour. Health education is seen as responsible for

changes, but in a very selective form. It means "transferring knowledge and redefining values" in a pre-defined direction, but the document also suggests to take into account the perceptions of the population (Brasil-Ministério da Saúde, 1980, pp.37-38).

The proposition of promoting behaviour changes 'in a pre-defined direction' raises questions about the relations between health education and bio-politics. The 'expected direction' of change is not defined in the document, but it is implicit that it means healthier life styles to the population. What is healthy is what the health policy says it is healthy. In other words, health education as defined in the Guidelines aims to reinforce health patterns conceived by the government for the population. Therefore, it can be understood as a strategy of governmentality through bio-politics.

Websdale (1991, p.419) says that part of the process of governmentality is to insert norms of behaviour into different areas of social life. In the health area, health education can fulfil this role. When health education aims at producing changes in behaviour, it becomes mainly normative. Thus 'healthy behaviour' is presented as the norm and all other behaviours become deviant. The principle behind the norm of behaviour is that somebody else outside the individual knows best what is appropriate or 'good for you'. This same principle, experienced in many locations in social life, reinforces the society of security which regulates and tries to increase the docility of bodies.

The 1980 Guidelines state that changes in behaviour have a long lasting effect when knowledge and values are modified. According to the Guidelines, the values which should be promoted are, among others, perceptions of citizenship, education, freedom of choice and social responsibility of the individuals and health professional teams. So, it is possible to say that health education has been understood as a political practice by the National Division since 1980. An efficient health planner is the one who achieves "observable health behaviour changes" and also is efficacious when these changes are "coherent with the values related to individual and social responsibility in terms of health" (Brasil-Ministério da Saúde, 1980, p.38).

It is also stated in the document that health education should never be coercive (Ministério da Saúde, 1980, p.39). Therefore, successful health education makes people change their behaviours without feeling it as an imposition. In Foucauldian terms, the strategy suggested by the Guidelines is to develop health education as a constructive power.

The conclusion of the document is that health education is successful when:

> *...the behavioral changes reflect values shared by the health planner and the population.* (Brasil-Ministério da Saúde, 1980, p.39)

The issue that remains unresolved is how to reach a consensus between population and policy-makers. Again the political aspect of health education is highlighted without being explicitly mentioned.

In 1981, another document was published by the National Division of Health Education, called **'Educative Action in the Basic Health Services'** (Brasil-Ministério da Saúde, 1981). This policy did not focus on promoting behaviour changes. Rather, the document concentrates on the role of health centres and health professionals in promoting critical education to enable participation. The language used in the text reveals a focus on the ideas of Paulo Freire and his theory of education for liberation. The references used in the text confirm this.

The 'participatory action' proposed in this document is a method of working recommended for health professionals. Community participation is stressed and presented as a partnership between professionals and users. But the leaders of the process are the professionals. The participation of the community relates to: providing information about itself, contributing to the discussion of problems identified by the professionals, implementing planned actions among groups and individuals within the community, and discussing the results of the implemented plans (Brasil-Ministério da Saúde, 1981, pp.10-12).

The notion of partnership between professionals and community is developed in the document using the example of activities to promote vaccination. This supports leadership by health professionals in the decision-making process. Apparently the scientific knowledge held by the professionals legitimates their decisions (Brasil-Ministério da Saúde, 1981, pp.12-15). What is not discussed in the document is how to deal with situations where there is no consensus. Vaccination is an easy example because it involves protecting children from painful or disabling diseases. However, other issues can be controversial. Nonetheless, the document reinforces the idea that health professionals know what is healthy for the community.

Considering that this document was written at the time of military dictatorship of General Figueiredo's government, it looks very progressive. The transition to democracy begun by this same President, which perhaps explains the tolerance towards the same ideas that, in 1964, forced Paulo Freire into exile. Another element which helps to explain the transformation of the discourse is the contribution provided by the Health Education Group of the School of Public Health of the University of São Paulo and two other members of State Health Secretariats. What the idea of partnership between professionals and community reveals is that health education policy is formed by different discourses and the government position should be just partially contemplated.

There are two main ruptures in the discourse of the National Division of Health Education between the 1980 Guidelines and the 1981 Educative Action in the Basic Health Services. The first one is in the way the community is perceived. In the first document (1980), the community is a group of individuals who would benefit from changes in their health habits, acquiring healthier life-styles through contact with health professionals. The opinions of the community are relevant only in so far as they preclude coercive approaches to health education. In the second document (1981), however, the community is presented as capable of promoting health changes without the help of health professionals. The participatory method is based on the community interacting with professionals and contributing to solve problems. Although the notion

of participation is not unproblematic, it represents a clear rupture if compared with the previous document.

The second point of rupture between the discourses of the two documents is that in the 1980 document central health planners (policy-makers) are in charge of all planning. In the 1981 document the participation method of action demands planning, implementation, and evaluation at the health centre level. The needs of the users are presented as an important criterion and health professionals are expected to address local issues when planning and implementing activities.

The documents also contain elements of continuity. In both there are expressions (like 'destitute'), and references to certain kinds of social problems (eg, refuse, water distribution, sewerage etc.) that remind the reader for whom these policies are written: the poor, the vast majority of the Brazilian population who does not have access to basic material conditions to live a decent life. However, references to such basic problems can be also understood as a commitment to those who have been oppressed throughout Brazilian history. Again the issue of participation is a dual one: it can mean both empowerment and control.

In 1982 a new document was issued - **'Participatory action: methodology'**. This is the report of a meeting between the National Division and the Northeastern States of Brazil. The professionals present at the meeting made some comments about and proposals about the implementation of the National Division's participatory method. They stated that normal health education practice was to provide information about diseases and unhealthy habits, and to explain the benefits of using the national health system (Brasil-Ministério da Saúde, 1982a, pp.21-25).

The first part of the document is composed of two lectures: one by the Director of the National Division and the other by a lecturer of the Federal University of Pernambuco. The lecture of the Director of the Division focused closely on the same discourse of 'education to promote participation', and parts of the 1981 document are

included in the lecture. The second lecture discusses education as a participatory strategy in the field of health. The aim of both lectures is to develop a much stronger commitment to the notion of participation and a better understanding of it. Health education itself is not the centre of the discussion, but participation as an educative experience. It is as if the use of the health centre, *per se*, should provide an educative experience (Brasil-Ministério da Saúde, 1982a, pp.9-19).

The educative experience at the health centre aims at creating channels of communication with the population that encourage appropriation of official knowledge and foster autonomy and development. The traditional practice of health education is described as a combination of authoritarian-patronizing methods and objectives which failed. The educative action proposed is based on the notion of a dialogue of equals - community and professionals. The respect for the popular knowledge is re-constructed among community and professionals, and the development of the critical consciousness of both (Brasil-Ministério da Saúde, 1982a, pp.10-11).

The document refers to the different perspectives on participation that can be found in government policies of those times - from the end of the seventies to the beginning of the eighties. They can vary from 'symbolic participation' to 'real participation'[2]. 'Real participation' demands new conceptions of education and professional practice. Professional practice itself becomes an educative act. Every single activity within the community is seen here as an educative activity. To achieve such a principle, the professionals have to abandon the conception that scientific knowledge is more important than any other knowledge (Brasil-Ministério da Saúde, 1982a, pp.15-19).

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[2] According to Pinto (Brasil-Ministério da Saúde, 1982a, pp.15-16) four types of participation can occur within the health system:
Symbolic participation: the population can be requested, in a compulsory way, to participate. The participants are included in the institution (such as a union, association, political party) but do not have any role in its organization.
Receptive participation: when a person or group receives a service, like going to the health centre to receive health care.
Active participation: the population participates actively when it contributes to an action proposed by the government; for instance, when a new health centre is planned, the population can participate by helping in its construction.
Real participation: when the decision-making process encompasses the population's requests.

The construction of a 'participatory discourse' can be noticed in this document. The rupture with the 1980 Guidelines (Brasil-Ministério da Saúde, 1980, pp.37-39) is sustained through the notions of participation and equality between professionals and community. The emergence of this participatory discourse on health education is understood here as a refinement of the exercise of bio-politics: the creation of a common knowledge, respect for the patient's views, as well as an educational practice based on dialogue bridge the national health system and the population. Participation makes the patient a 'co-author' of the national health system initiatives and the expanded concept of health mentioned in the document (every activity within the community is an opportunity to promote health education) envisages health initiatives also outside of health centres.

The document also talks about the re-education of the health professional based on the idea that the professional is both a worker and a citizen. From these two positions the professional could develop a new meaning for his/her work (Brasil-Ministério da Saúde, 1982a, p.17). One criticism of this proposition is to point out that the professional is a citizen, but not a user. Perhaps the lowest paid professionals at the health centre use the national health system. But, on the whole, professionals with a university degree do not do so. So, although health professionals may understand the political role of the national health system, it is not possible to expect them to identify themselves with the users simply because the national health system concentrates on the poor. Thus the concept of citizen obscures relations between (professional) providers and (poor) users.

An element of continuity in the documents presented thus far is that access to information about the community is always stressed as an important task for health centres. To gather information to change unhealthy behaviours or to propose changes agreed with the community, partially explain why information is a permanent issue in health promotion.

However, the argument of this thesis is that it is the nature of health

education itself that constructs this connection. Health education deals with individualization of health knowledge. In its more prescriptive form (traditional health education), health education 'teaches' how to become healthy, but in order to do so properly it requires information about the community or population to adapt its methods (e.g. language in booklets or pictures instead of words). In its more flexible form (radical health education), it gathers information from what is usually understood to be 'private life'. The professional must be allowed to explore the intimacy of family life in order to adapt the information s/he will offer to the patient. Even when the approach is a participatory one, health education always has the power to collect information in order to constitute its own practice.

In 1982 two other meetings took place to disseminate the programme of the participatory method. One was held in the North Region (**'Participatory Action: human resources education'**, Brasil-Ministério da Saúde, 1982c) and the other in the Centre-West Region and the State of Minas Gerais (**'Participatory Action: evaluating experiences'**, Brasil-Ministério da Saúde, 1982b). Both meetings focused on 'participation' in health education. Though theoretically similar to the previous document (Participatory Action: methodology), the Centre-West and Minas Gerais meeting report also describes projects being developed in this region.

The report on the Centre-West meeting (Brasil-Ministério da Saúde, 1982b, p.25) states in its theoretical part that the basic approach to participation is for people and groups to develop their own processes for transforming reality. So, it is in the core of this policy that education is a transformative act, which also reinforces the rupture between the 1980 Guidelines and the subsequent documents:

> *Educative action does not mean leading people to support programmes formulated by others. Rather, it means that the population should present propositions and solutions to the health problems they identify, in a reflexive dialogue with health professionals. ... Health education, as a transformative process, is the aim at all times and for all professionals. It can be done through the experience of participation because health is a social practice.* (Brasil-Ministério da Saúde, 1982b, pp.25 and 37)

The standards of community participation stated in the document are

very high and the professionals must be committed to participatory and transformative movements. Health education as such is rarely mentioned and education for participation is a key concept underlying the work of the health centre. The reading of the theoretical part of the report shows an even more refined discussion on community participation than in the other documents of the same kind. However, what makes this one remarkable are the initiatives recommended to achieve such aims. These are: training of health auxiliaries to work within the community; training of teachers as health auxiliaries to promote health issues within their schools, and to bridge the divide between the health centre and school; and developing educative actions in the community (Brasil-Ministério da Saúde, 1982b, pp.25-38).

A series of critical issues arise from these narratives. The issue of human resources training was presented as a problematic one. Traditionally those dealing with the community had received training, and the training offered did not concentrate on social problems. The experience of training described is aimed at health auxiliaries (Brasil-Ministério da Saúde, 1982b, pp.26-29). In many ways it looks very successful, but, according to the document, once the auxiliary is back at the health centre s/he has to deal with university-trained health professionals. One example of this problem is the first interview with patients at the health centre. Once trained, the auxiliary can perform this work. The document also suggests that nurses and social workers could do this, under the supervision of a doctor. Such a suggestion is unwise in terms of rational use of the human resources, but perhaps it can be explained in terms of hierarchy of power domains at the health centre. Actually, the document suggests that training for participation also challenges the structure of the service: it is an attempt to break the monopoly of medical knowledge. Nevertheless, there are references to worries that doctors might reject such a horizontal model of work. The working groups at the meeting queried the openness of professionals to transmitting knowledge to other professionals and to the community. They also questioned whether some members of the health team would accept the redefinition of roles that would inevitably take place at the health centre with the introduction of the participatory approach.

The element that permeates this discussion is the understanding of the health centre as a place of learning. From a perspective of governmentality, patients should learn how to behave (how to govern and how to be governed) and the contact with the health centre can promote autonomy and submission. The document suggests autonomy as the behaviour to be promoted. By proposing changes in the power relations between professionals themselves and between professionals and community, the National Division intends to overcome the current pattern of learning - submission to scientific knowledge, to professionals' values, etc.

The reading of 'Participatory Action: evaluating experiences' challenges the concept of health education. The document overcomes the traditional notion of health education and stresses the political site that the health centre represents because it conceives every contact between patients and the health centre as an educative act. This seems to suggest that the National Division acknowledges that health centres are a political arena and that the Division's policies are much more focused on the use of these political sites than on educational activities related to health.

In spite of the fact that the discourse on participation is central to this policy, an evident gap between discourse and practice can be noticed. A description of activities organised with community participation described in 'Paticipatory Action: evaluating experiences' helps to clarify this rupture. In order to evaluate the service provided by the health centre, one meeting per month with the community was introduced in some health centres. This is far removed from the ideal of the community planning together with professionals, but it was enough to make some professionals unhappy. This innovation did not last. But talks to women at the 'Mothers' Club' and young peoples groups about first aid, common diseases and other issues proved more successful (Brasil-Ministério da Saúde, 1982b, pp.25-38). These embody a less challenging notion of participation, with the medical model, and not the community, defining issues.

Thus, there is a big gap between the theory of community participation

and its actual achievements: one meeting per month that did not survive is a poor example of community participation. This gap between theory and practice raises some questions: Why should doctors supervise other university-trained professionals? Why did the Ministry decide to go straight to the health centre level rather than focusing on over-arching health secretariats? What is the purpose of this utopian discourse on participation when the Ministry itself has a record of very poor achievements?

These examples of health education fit the *INAMPS* model of health care (see Chapter 4, section 4.3). Preventive care was not a priority and many of the problems rehearsed in these documents are the result of the 'policy of inaction' of the National Division of Health Education. The national health system had been discriminating against part of the population; the Division issued documents which did not demand anything specific from state and municipal governments; provided no timetables or goals for an implementation at a national level; and regarded the path to transformation to consist in 'telling' health centres to adopt participatory practices. From a theoretical point of view, the professionals are supposed to know how to deal with the difficulties of making the health education experience an educative act which enables participation. From the practices described, even those who believe in such an approach did not manage to maintain one monthly meeting with the community. So, what is the power of social policy?

According to Hewitt (1991, p.225) social policy "promotes and organises knowledge, norms and social practices", regulating health and security to manage the quality of life of the population. What the example above demonstrates is that social policy is not a single stream of power from the federal to the local level. The process of promoting knowledge and norms happens within a web of micropowers of forms of control and resistance. In this period of highly centralized government, the federal government addresses its policies straight to health centres, avoiding the state and municipal secretariats. While this centralized strategy delivers the central government discourse to the health centre, there it will face resistance and be re-constructed. The little progress achieved in the experiences described shows that micropolitics at the

grass roots level can be a powerful source of resistance - the understandings of, and traditions in health education are as important for health centres as the policies which are received there.

The analysis of the content of these health education policies reveals that they do not concentrate on health education itself - methods, resources or topics; rather they propose a methodology of participation that is mainly related to the social sciences. Hewitt (1991, p.243) argues that the human sciences were brought into administration and management to differentiate bodies, to compare and to classify houses, behaviours and wages. The social sciences introduced all these aspects of life into health policy. Previously, they were not part of health. The contribution this represents is to place individual bodies at the centre of the actions of professionals, enabled by the social sciences to judge, compare and standardize.

In 1983 the Ministry published a document entitled '**Participatory Action: production of educational materials**'. This is an analysis of two sets of information (one leaflet and one brochure) evaluated in different regions of the country which is to be improved before distribution to the population. The document offers some insights on the understanding mothers and health auxiliaries have about health issues. The Director of the National Division (Brasil-Ministério da Saúde, 1983, p.7) emphasizes that information in itself is not enough to change the health-disease process in a context like Brazil. The materials produced took into consideration the fact that the population is not fluent in reading texts. So, pictures are intended to be as expressive as the text itself. The Director also states that this kind of material has not status in itself, but it is an incentive to promote an exchange of information between scientific knowledge and the life experiences of the community.

Also in 1983, the XII Meeting of Health Educators took place in Piracicaba, State of São Paulo. The National Division of Health Education published the lectures and reports of group discussions of the Meeting in 1984 ('**Participatory Action: perspectives of health education practice** '). This document contains different

definitions of health education, some of them conflicting. This happened because each lecturer gave her/his own account of health education. The common threads linking this document and the earlier publications of the Division are the notion of education for participation as a strategy to improve health services and the idea that health educators are a special kind of professional.

The speech of the Director of the National Division of Health Education provided some clarification on issues already introduced in previous policies. The first remark was concerned with the risk that the policy-maker at the central level might forget the real purpose of the policy - the people themselves. The work at the central level was described as dealing with papers, rates, epidemiological studies and this 'environment' is likely to put the policy-maker "with her/his back to the population" (Brasil-Ministério da Saúde, 1984, p.33).

The second point clarified by the document is that of roles and responsibilities. The role of the National Division is to develop national guidelines in health education and to provide technical assistance to the states in implementing the guidelines. The role of the states is to implement educative actions in the health process. To this end State Health Secretariats should have educators in their teams.

The document (Brasil-Ministério da Saúde, 1984, p.35) criticizes the lack of interest shown by the State Health Secretariats in health education. In 1983, after three years of requests for a specific budget for health education within the general budget of the Ministry of Health, the National Division received money for health education activities. In order to receive financial support to health education, the states were expected to provide a plan demonstrating how the budget would be spent. Only a few states listed health education as a budget item. The majority mentioned health education without providing any resources to it. The Director alluded to the belief that health education is done with 'saliva', ie talking. She commented that this is a wrong belief and that without money it is impossible to transform reality.

Again there was an emphasis on the local level. What is expected from the health educator is to get involved with the population. The essential tasks of the health educator are: to take on board the complaints of the population, and thus promote a better performance by the health centre; and to learn from the community, avoiding the position of leader. It is also expected that the health educator will start the process of reflection about health education among the other members of the team (Brasil-Ministério da Saúde, 1984, pp.35-37).

The type of health education described at the local level concentrates on two extreme models - the doctrinal and the transformative. According to the Director of the National Division (Brasil-Ministério da Saúde, 1984, p.34), health education at that time was an activity to support health programmes, with a strong element of propaganda and 'indoctrination'. The other option is the new model: health education as a space where health professionals and the population can together question everything, including the programmes (policies), when considering the changes required to promote a better life for them.

The description of two radically different approaches provides an account of the many actual combinations that take place at the health centre. Instead of the 'old' versus the 'new', both discourses are different manifestations of the process of totalizing-individualizing and disciplining-normalizing. These conflicting discourses are spread all through the process of policy-making and implementation. The doctrinal approach relates more to totalizing and disciplining. The totalizing aspects are concerned with general codes of healthy conduct applicable to any person. The disciplining experience comes from the authoritarian approach used to communicate the contents in situations such as a talk followed by questions related to the topic of the talk or the possibility of a constant gaze over the conduct of the patients (at any moment they can be asked to explain if they are doing and how they are doing what was taught). Disciplining can be a process of individualization (Foucault, 1991, p.177) but in the point of view of this study, health education with an authoritarian practice stresses its potential for totalization.

The other paradigm, proposed by the Ministry but hardly implemented, deals with individualisation and normalisation. It is easy to see how it represents an advance in terms of participation and empowerment of the users. But it is also part of the process of bio-politics in its continuities. The participatory approach respects the ideas of the group and individuals involved in health education activities. The contents and methods are not imposed and participation should permeate the whole process. Through this constructive approach each individual can have the basic prescriptive principles of health education adapted to his/her situation. The strategy of the user and professional working together to decide about health education makes the user co-responsible for the process. So, a set of reactions to the prescriptive method can be avoided by participation. The normalization process occurs in the comparison the professionals make about the users and the users themselves establish. The norm is a measure for comparison that individualises concurrently. Ewald (1992, p.173) asks the question 'what is a norm?' and answers:

> *A principle of comparison, of comparability, a common measure, which is instituted in the pure reference of one group to itself, when the group has no relationship other than to itself, without external reference and without verticality.*

Returning to the XII Meeting of Health Educators, the reports of the group discussions and the lectures pointed to a scenario of problems and opportunities for health education in the mid eighties. The document states that the role of the health educator is to reach the population, to re-think the current pattern of health education and to combine the other professionals in order to achieve social participation. The health educator is presented in the document as a powerful professional, responsible for transforming the power relations between the health centre and users (Brasil-Ministério da Saúde, 1984, pp.65-71). Behind this proposition is the idea that health education has a particular position within health disciplines/subjects. It is much closer to the social sciences than to the scientific discourse usually applied to health issues. But this same social formulation and the discourse of participation have produced a big gap between practice and social policy.

The fulfilment of the role of the health educator drives health

professionals to a central position in the construction of 'the social'. Health is proposed as a discipline that links political, social, and biological experiences. The health educator should learn how to deal with all these aspects to promote participation, rather than focusing on healthy behaviours. According to the document, the contact between population and the national health system should be based on constructive power relations, promoting a 'healthy and participatory user' who keeps in touch with the health centre.

Many difficulties were identified in the achievement of this 'gold standard' of professional practice. Among others, the groups claimed that health education is a priority just in theory, whilst in practice it is devaluated; that there are insufficient human, material, and economic resources to carry out health education; an authoritarian approach is still present in the health centres and in health professionals' practice; that health policy fails to define the position of the health educator in the health centre and her/his specific activities. This last difficulty mentioned by the working groups challenges the whole policy of the Ministry of Health (Brasil-Ministério da Saúde, 1984, pp.20-28 and 65-71). Since 1979 the National Division had been promoting the existence of an 'expert' in health education and based its view of the development of the health education on her/his presence in the health centre team. However, this report shows that there were problems and uncertainties about the work of the health educator. The analysis of documents shows that this model of a health educator at the health centre level was consolidated only in São Paulo. This experience was recommended to the other states by the Ministry, but after 12 years (in 1983) working with health educators São Paulo, as a case study, did not provide the substantial results which would justify the adoption of the model at a national level.

The role of health educators at the health centres is further challenged when more criticisms are added to the way health educators carry out their work. Salomão (1984, p.47) sees authoritarianism in the way educators treat the population and other health professionals. According this author, this practice is based on the perception educators have about themselves as intellectuals, and on the division of

labour between those who think and those who practise. In spite of this, the health educator is accused of not reflecting on her/his own work, as well as of not having a clear theoretical framework. An additional problem is the fact that the health area as a whole lacks a specific policy on education. The criticisms raised by Salomão (1984, pp.48-49) in relation to the model of a professional group in exclusive charge of health education are:

- The health educator does not share her/his knowledge, trying to avoid a loss of space to other professionals;
- There is no educational philosophy of work to guide health educators;
- The absence of a specific policy on health education is used as an excuse to justify the small amount of work undertaken in this area.

Talking at this same Meeting, Mehry (1984, p.17) states that very little had changed in educational practice in health from the twenties to the eighties in Brazil. He points to a huge ineffectiveness in the work of the educators at institutional level. Health education was a junior discipline also because of the increasing 'medicalization' implemented through the system of health care. Mehry (1984, p.12) argues that in the mid eighties in Brazil broader primary health care activities became replaced by simple medical assistance.

Another contribution to the understanding of health education is the analysis outlined by Salomão (1984, pp.45-49) at the same Meeting. She stated that 'real' health policy demands should be made on federal and state governments. Health educators were stagnating, committed neither to the population, nor to health professionals. The suggestion is to see education as a political option, in this case, an option for the majority of the population. The critique of this study to this formulation concerning the political position of health education is that it would result in two totally different systems of health care: the poor would spend their time participating in activities and plans at the health centres, whilst the rich would receive preventive and curative care without having to spend part of their lives engaging in politics in the national health system.

The idea of political participation of the poor in the national health system is a permanent issue in the policies of the National Division of Health Education. This position illustrates the point raised in the Chapter 4 about 'the social' and the government of the poor. The 'industrious poor' not only works, but also participates of the national health system, making her/his private life virtually public, providing information and experiencing forms of government in the daily life of the health centre.

At the same time that the Meeting members presented problems, they also suggested that the political moment called *abertura política* (political openness) of the last years of the government of General Figueiredo was propitious to propositions about community participation and a repositioning of health educators. The suggestions were mainly concerned with the future of the health educators as a professional group. Issues related to the strengthening of the Health Educators' Association were the main concern, but propositions such as developing community councils to act within the health centre and demanding the government to fulfil its promises are also on the agenda (Brasil-Ministério da Saúde, 1984, pp.65-71). This specific political background of the mid eighties permitted a review and critique of the repressive and/or inefficient role of health education. It was also a moment for re-thinking goals and utopias within a new (democratic) social frame.

5.2.2. Democratic transition (1985-1989)

In 1987 the Ministry re-launched the 1982 document '**Participatory Action: evaluating experiences**' which describes the experiences of the State of Minas Gerais and the Centre-West Region (see previous section in this Chapter).

In 1989 two documents were published by the National Division. One was called '**Education: reflection and creative participation in gaining health**' (1989a). This document is a handbook for developing group activities for health professionals. The National Division proposed the need for reflection about health professionals' practice at the health centre level. The document encourages group discussion and the handbook concentrates on raising questions, telling stories about

patients, suggesting videos, music and poetry to promote reflection on the quality of health services provided to the population. The central issue is whether it is possible to develop health education in the national health system (Ministério da Saúde, 1989a, pp.1-18).

The other document published in 1989, '**Health Education Guidelines**', was oriented to the daily educational practice of health professionals placed at all levels (Brasil-Ministério da Saúde, 1989b, p.6). The Ministry acknowledges that from 1980 to 1984 the National Division was discussing and disseminating guidelines for educational practice in health. However, practices then current in health education (1989) were criticized as not consistent with the guidelines. The 1989 changes in the guidelines took as their basis the changes in the Constitution and the creation of the Unified Health System (see Chapter 4, section 4.4); both provided legal supports for changes in pedagogic practice. The Ministry proposed that the guidelines issued by the National Division, which view health education as a transformative pedagogic practice, should be adopted.

The assumptions of the new guidelines form the core of the document published by the Ministry and these do not differ very much from those in previous documents. Once more participation is the key concept in health education (Brasil-Ministério da Saúde, 1989b, pp.9-10; in Appendix 5 the assumptions of the guidelines are presented).

The guidelines strongly support a participatory methodology. It is participatory because health education should be transformed and re-created by both professionals and community in the process of policy implementation and evaluation. The document suggests some steps to achieve participation. It emphasizes that the phases they suggest in the methodology are merely a didactic division, and that in reality the phases overlap (Brasil-Ministério da Saúde, 1989b, pp.11-13). The steps are: defining the situation (concerning patients, community or health centre problems); discussing the problems and analyzing the causes; planning and implementing activities;

recording and evaluating.

The texts referenced in the Guidelines are the Constitution, a draft version of the Organic Law of Health, and previously published documents or working papers of the Ministry of Health. The 1989 Guidelines are an updated version which embody the new trends in the health area: decentralization; health as a right of every citizen and a duty of the State; and community participation.

A continuity in the discourse of the National Division during the eighties has been the idea that health education is a social discipline in charge of putting together the community and the national health system. The focus on participation since the beginning of the eighties has been an avant-guard position which was also adopted by many other areas in the health sector and disseminated; at the end of the decade it was an official discourse promoted by the Minister of Health and by many politicians.

In terms of governmentality it means that the discourse on health education has shifted from repressive strategies - like talks, demands on hygiene, and compulsory healthy habits - to constructive tactics - such as group activities and the construction of a common knowledge between professionals and patients. It is worth noticing that the changes in the discourse do not necessarily relate to new practices at the health centre level.

5.2.3. The 'New' democracy (1990-1995)

In 1990 the democratically elected President Collor de Melo took office. His government changed the structure of the Ministry of Health and the National Division of Health Education became the 'Health Education Coordinating Group' (*Coordenação de Educação para a Saúde-COESA*), under the control of the Health Programmes Department.

In January 1992 *COESA* issued a document called '**Education for Participation in Health**' (Brasil-Ministério da Saúde, 1992). The Minister of Health,

Alceni Guerra, wrote the foreword. Two main issues are the focus of his text: the new approach to health established by the Constitution and the new approach to health education launched in this document. The Minister points out that the Constitution emphasizes prevention, hence the field of health education. This preventive approach can be identified in the clauses of the Constitution which relate social and economic policy to health. The Minister states that this legal text (health as a right) upgraded Brazil to a leading position among the world's nations on the eve of the twenty-first century (Brasil-Ministério da Saúde, 1992, p.1).

Taking into account this legal context, the Minister argues for need to re-create health education policy at the federal level. In his view, the merely continuing with the previous policies would not be enough to achieve the goals enshrined in this new legal right. Hence the new National Guidelines.

The enthusiastic approach of the Minister welcoming constitutional changes in the health area and the production of new national guidelines for health education are understandable. However, in the second part of his text, he outlines the 'new approach' this document proposes: it is centred on social participation, with a pedagogic model which emphasizes an exchange and integration of 'knowledges' as a means to a better quality of life. Looking back to the documents produced by the National Division at the beginning of the eighties, there is not very much difference between the 'new' approach described by the Minister and the previous proposal of the Director of the National Division: to explore alternatives based on the ideas of democratization of the health knowledge, community participation and extension of the health services (Brasil-Ministério da Saúde, 1992, p.1).

The document 'Education for Participation in Health' (Brasil-Ministério da Saúde, 1992, pp.5-9) reviews the work already done by the government in the area of health education. The document acknowledges that health education activities took place throughout the eighties and as a result a wealth of experience had accumulated. However, community participation occurred only in isolated projects. The criticism in

the document is that those experiences happened not as a result of national guidelines but from local initiative.

Another part of the document provides an analysis of the situation of health education at the national level, based on governmental documents. It identifies some of the problems as: verticalism (the person who teaches imposes knowledge); discontinuity (programmes are interrupted and cancelled without any explanation); biologism (mirroring the biological and individual pathology approach of medical treatment); split 'knowledges' (separation between popular and scientific knowledge); publicity campaigns (excessive reliance on mass media campaigns); non-participation (projects formulated without the participation of the community); traditional medical model (health practice aiming at the improvement of the bio-physical condition of individuals, and not concerned with their consciousness); lack of a single framework (there is no common understanding about what health education is: information and communication are seen as education). The conclusion of this analysis is that because the current approach to health education does not promote changes in consciousness, it is unable to promote changes in the quality of life (Brasil-Ministério da Saúde, 1992, pp.7-9).

The analysis offered by a federal policy-maker interviewed for this study about the situation of health education at the national level adds some further issues to the Ministry perception:

> *Due to successive changes of Ministers of Health any general plan related to health education at the national level lost its impact. At the state level, only in the Southern Brazil is something happening, although it is very traditional - pamphlets, posters, television ads. It is not a work recommended in the policy 'Education for Participation in Health'; it is not educational work in health. The North and Northeast do not even have that. Just recently, with the problems of cholera, they were forced to do something.*

The 'project' Education for Participation in Health states that it tries to be coherent with the legal texts that back it: the Constitution, the Organic Law of Health, the Quinquennial Health Plan, and international agreements signed by Brazil. The justification for this 'new' approach is that it will achieve a better quality of life

through a pedagogic process of participation. In this context, participation process means constructing organic knowledge in dialogue between scientific and popular knowledge; the 'ownership' of the health programmes by the population, ensuring their continuity and making them free from party changes in government; the strengthening of community organization and self-government (Brasil-Ministério da Saúde, 1992, pp.10-12).

The fundamental concepts in the document are: "process, conceptualization, participation, organization, dialogue, autonomy, and quality of life" (Brasil-Ministério da Saúde, 1992, p.15). Its generative principle is the process 'action-reflection-action'. The final aim of this process is a better quality of life, defined in the document as a developmental stage of the individuals in relation to their self-esteem, solidarity, criticism, respect, commitment, and participation (Brasil-Ministério da Saúde, 1992, pp.14-15).

This document provides more detailed operational goals than earlier documents. The aim of a national policy on health education was to unify and disseminate a theoretical framework among all members of the national health system. The idea of education for participation in health should integrate the whole national health system.

The document argues that the achievement of such a goal would be possible through training courses which are cascaded down by those who attended turning into teachers themselves. The *COESA* would provide consultancy support to state and municipal governments. Its task also includes pilot projects, linking evaluation with implementation, a national timetable, etc. The references of this part of the document do not mention any previous federal document.

This last federal document about health education gets closer to what should be expected from a policy - goals, timetables, and details of implementation at a national level. Comparing it to previous documents, it reveals the extent to which

federal policies in the eighties were 'non-action' policies in terms of implementation. These eighties' statements were about what health education should be, but they lacked a national plan for the implementation of these ideas. They were policies not for action, but for the circulation of ideas.

However, the reading of policies is not enough to uncover the different influences in the process of policy formulation and implementation. Vignette 2 provides information about health education policy in Brazil in the nineties.

Vignette 2

The Minister's Wife

The wife of the Minister had a very good lecturer at the University and the Minister was looking for someone to work in the area of health education. The wife decided to introduce this lecturer to the Minister. The lecturer 'sold' the idea of health education as an activity that could promote changes in the national health system in the short and medium term. The idea was to produce a wider impact than the construction of hospitals could achieve. The Minister 'bought' the idea and decided to create the *COESA* group using some funds from a UN project and other funds from the Ministry. The Minister's wife joined the group and as a result the group received a huge office, access to fax, photocopying, etc. These facilities were not the result of the importance of the area of health education or the quality of the group. It was the presence of the minister's wife that ensured these good conditions of work. Obviously the group became important in the administrative structure of the Ministry: any document produced by the group was circulated. But it was all the result of a specific conjuncture; it had nothing to do with the Collor Government. (Based on the interview with a federal government policy-maker)

The information provided by Vignette 2 challenges the notion of the existence of **a** federal government policy. The importance attributed to the *COESA* was apparently not related to the importance accorded to health education. The policy-maker interviewed explains that there were other factors shaping this process:

> *Another important element is the pressure of the international agencies. The financial institutions have their own priorities. So, if the priority of the World Bank now is to build hospitals, the policy will be 'hospital'. Possibility, rather than necessity is the criterion... Nothing from the population reaches the Ministry level. The Collor Government was not keen on the participation of the population in the governmental decision-making process. It was a surprise that our document was accepted, but it was not a policy. It was a proposal.*

Vignette 2 and the policy-maker's comments suggest that the political scenario for policy formulation in the federal government is a site for macro-(international/national) and micro-(professional/personal) politics. The international

mainstream of health promotion, the re-democratization of the country, the participation policy, the lack of concrete plans for implementation, and professional/personal preferences for some areas of health knowledge can be identified as elements tangled up in the federal policy-making process.

In 1992 Minister Alceni Guerra had to resign, after a scandal about overpriced products bought by the Ministry of Health. At that time *COESA* lost much of its power within the Ministry. Later in 1992, President Collor was impeached. The new President, former Deputy President, Itamar Franco abolished *COESA*. After the closure of the Co-ordinating Group it was very difficult to gather information and materials about health education from the Ministry of Health.

One of the policy-makers interviewed spoke about health education at the federal level:

> *I do not think the situation of health education at the federal government level is good. The creation of the health education group - COESA - was an utterly contradictory situation.*

The fact that *COESA* came to an end, and no other group was created to replace it, challenges the importance of health education for bio-politics. Health education has been proposed in the federal documents as a method to achieve empowerment of the users and the extinction of the national co-ordination could jeopardize the achievements in community participation. However, the gap that exists between federal policy and the actual practices of health education re-dimensions the problem. One aspect to be considered is that other sectors of the Ministry kept campaigns and policies running and the closure of the *COESA* did not affect these other services (HIV/AIDS, cholera, etc.). Health education can be operated without a federal organization on a temporary basis because the real foundation for policy dissemination are the policies already embodied in the system, those which take place routinely and that sustain the discourse of health education as a prescriptive practice aimed at changing behaviour. The other aspect to be taken into account is the publicity character of federal health policy. They constitute an attempt to circulate a certain discourse, in

this case on health education, and traditionally they have done little to achieve any implementation. The reading of state and municipal policies helps to illuminate these points, as suggested in the next section.

5.3. Health Education Policies at State and Municipal Levels

5.3.1. State Health Education Policies

Few State and Municipal Health Secretariats responded to the request for including their health education policy within the questionnaire. Four policies were received from the State Secretariats. One is a photocopy of the 1989 document of the Ministry of Health called 'Education: reflection and creative participation in gaining health' (discussed in section 5.2.2 of this Chapter); another is composed of two sets of objectives, linking health education, sanitary consciousness, and decentralization to be achieved by means of a participatory methodology.

The other two Health Secretariats sent reports and plans that provide more details. The first of them sent a Report of Activities 1991-92. The first part of the document refers to the assumptions that orient the Secretariat's practice. It contains a summary of parts of the federal document entitled 'Education for Participation in Health', but they are not quoted or referenced as such. Instead, they were copied and presented as if formulated at the state level. The second part of the report evaluates different projects. The document argues that the work carried out collaboratively between the Secretariats of Health and Education failed after changes were made at the Education Secretariat. In their perception, there are enough legal linkages between the two institutions, but they lack a real political commitment because every attempt to work together failed in the past. The activity planned and not implemented was a series of seminars for school teachers. The only successful activities were to have meetings, sending health materials to teachers, and a course about adolescence. A new effort was planned for the future.

This same Health Secretariat developed activities as a consultant to

groups, unions and associations. The activities here concentrated on the distribution of written materials, participation in meetings, organization of seminars and teaching about health issues. Providing consultancy to the Unified Health System is presented in the document as a major challenge. All different areas can request consultancies on many issues and the health education team has to respond to all of them. They refer to technical and material problems as well as the dominant emphasis on medical assistance. But the list of achievements is varied and includes courses for the Municipal Secretariats, participation in activities at the federal level, production of materials, participation at the State and Municipal Health Conference, etc.

The description of activities presented in both documents illustrates that at the state level, as it occurs with federal policy, written documents circulate ideas but do not ensure implementation. The gap between official discourses and practices carried out at the health centre level has been sustaining the bio-medical model in the health area. Once more, discourses of empowerment are re-shaped at the grass roots level and the traditional approach to health education is reinforced.

The last State Secretariat which defined a policy actually sent two documents. The first one is a 1991 document that re-launches health education as a department in the Health Secretariat, to systematize educational activities. In the references of this paper they listed, among others, the 1989 Health Education Guidelines from the Ministry of Health (discussed on the section 5.2.2 of this Chapter). However, in the introduction to the document they stated that any definition of educational activities should be based on the local epidemiological profile (at Municipal and health centre level).

The same ideas of community participation and citizenship are used to justify delegation to lower levels, like in the federal policies. But they introduced the notion that the human and material possibilities of each health centre might present reasons not to fully implementing a policy. The 1991 document includes decentralization and planning at the Regional Health Branches and integration with the

federal government. One specific goal of the Secretariat was to ensure that educative actions are present into all activities. The methodology proposed is a participatory one which is based on a collective construction of knowledge. So, the educative practice is defined as:

> *... both a formative and an informative work; all those who are involved in such a work would be able to understand this practice as a basis for change in behaviour, through the creation of links between education and prevention to achieve a better standard of life for the population.*

The strategies to achieve this aim focus on the importance of the health centre team knowing the community with whom they work. Actually, the strategies are a copy of part of a federal document from 1982, reprinted in 1987 (Participatory Action: evaluating experiences, discussed on section 5.2.2 of this Chapter).

This policy illustrates how participatory approaches and the knowledge about the community are handled as a single phenomenon in social policy. In order to establish a participatory approach in health there is a basic request of knowledge about the community. This process has been socially constructed to an extent of 'naturalness'. The exercise of bio-politics includes both gathering information and proposing forms of government to individuals and communities, as this policy suggests.

The second document sent by this last Secretariat was a plan for 1993. Unlike the previous document, the project does not use the same language as the federal government and it does not refer to any other policy. Instead the plan argues that educational activities should be organized around the local epidemiological profile. There are references to a marxist vision of world, such as developing health based on the "social relations of production". At the same time, there are many other references which appear to define health as a disease and its treatment. For instance, the project on school health - where the marxist reference appears - is mainly a campaign about sexually transmitted diseases and AIDS; the popular theatre project in the countryside focuses on cities which already implemented one State policy (of lay health visitor) or which are taking part in a State project to combat infant mortality.

The analysis of these policies points out to the complexity of promoting changes through social policy. There are policies being produced at the state level with no common elements with the federal policies; other policies present copies of texts from the federal government to show a coherent formulation between federal and state levels of government; there are also those which are related to the federal policies in terms of principles but do not achieve implementation. The policies examined point out to the site for resistance that the different levels of government represent and to the complexity of power relations that take place there.

5.3.2. Municipal Health Education Policies

Of the 16 Municipal Health Secretariats that answered the questionnaire only two sent their policies. One Secretariat sent a Plan of Work and the other a policy on Education for Family Planning.

In the Plan of Work for 1993 of the Municipal Secretariat the introduction and goals make points like: the plan has to be coherent with national policy; the aims of educational practice are to help people to develop an understanding about the real causes of the diseases in the population; education should be present in all health programmes; health education helps people to achieve better control over their lives and health. However, when looking at the projects planned, they represent firmly traditional health education activities: mass media campaigns and cars with loud-speakers sending messages about the vaccination campaign; twice weekly meetings or focus groups in different places (health centres, schools or neighbourhood association) carried out by the municipal health education team and publicized in the community by social workers. In three schools far from health centres there were plans to discuss with students the signs, symptoms, treatment and prevention of parasitic diseases with the help of illustrations; oral hygiene education activities were also planned. The cholera project intends to provide more information to people who live in contaminated areas. This information will be provided through leaflets and speakers on a car. The secretariat plans to produce educational materials to accompany these activities and lists all the resources which will be required for implementation: fuel, tapes, videotapes and

stationery, including paper, pencils, envelopes, etc.

The central government influence is clear in the cholera project, but the vocabulary and ideas are not present in the jargon of the federal policies, except in the introduction, where the notion of health education as empowerment is mentioned. It is this stark contrast between discourse and activities that stresses how far removed from implementation the recommendations of the federal government are. The federal government policies and concepts go no further than the introduction to the document.

The other policy (on family planning) exhibits this same gap between theory and practice. The justification and methodology state that all people have the right to free choice in their reproductive life; that choice has to be based on informed consent; that the method is a participatory one, promoting the exchange of information between women.

In practice the document proposes a weekly talk about the different methods, given by a nurse, social worker and psychologist. This talk will be illustrated by posters, pictures and leaflets. Every single woman will be examined by a doctor, irrespective of the method chosen. The talks will be directed to all women who are users of the national health system and the users will be expected to answer a questionnaire providing information about their reproductive life. This policy provides an example of the exercise of bio-politics, gathering information about biological processes. Health education justifies the access to information about the private use of the body because it aims at 'educating' patients and promoting a 'better quality of life'.

Brief descriptions of strategies to develop health education will always leave a space for speculation about how participatory or how authoritarian the activities will in fact be. Many issues can only be decided at the time of implementation and professionals have the power to adapt and transform participation into prescription of behaviours and vice-versa. Perhaps traditional practices in health education are the most important 'policy' because every new document must be accommodated to the 'usual'

way of doing health education. This same trend can be identified in the 'treatment' federal policy receives at state and municipal governments. Secretariats can copy pieces of federal policy into their own policy and it means only that they are aware about the need for showing coherence between policies in the different levels of government. The way of doing it afterwards depends on the micropolitics of the health centre, as the data above illustrate. Thus in this study the small sample of policies of State and Municipal Health Secretariats contained the same gap between theory and practice, where the theory was radical and the practice was traditional.

The radical discourse on participation has been circulating in policies for more than a decade. Analyzing both radical and traditional discourses through the concept of bio-politics, one can argue that the traditional (prescriptive) approach is now criticized because it was mere transmission of information to 'ignorant' patients. The radical (participatory), however, makes the transmission of information (now called construction of knowledge) a right of the citizen. What both approaches have in common is the maintenance of traditional health education practices at the grass roots level.

5.4. Health Education Policies at the Health Centre Level

Drawing on the idea that a practice that has been constantly developed without previous planning should be considered a policy (Easton, quoted in Ham, 1992, p.95), this part of the chapter concentrates on health education practices not connected to an official policy, but developed and implemented at the health centres observed.

The health centres observed as 'positive' case studies for the thesis allowed the scrutiny of policies formulated at the grass roots level. The health centres were selected because they were acknowledged by their peers as providing a good standard of health care and because health education is a concern to the professionals working there. Thus, it is possible to say that in other health centres the health education policy is not to develop any local initiative and, further, to implement just partially or

not at all any federal or state or municipal health education policy. As Easton argued (quoted in Ham, 1992, p.95) non-decisions and inaction are an important part of the policy process, perhaps as important as initiatives and decisions.

Health education projects are carried out in the interface between different policies. Perhaps some initiatives developed at the health centre level are not completely original and already had been written among many policies. What make them a policy not written as such is the interdisciplinary character of the experience, not limited to one single area of health knowledge.

The first unwritten policy which was implemented was observed at 'Health Centre 1'. Some of the health centre professionals had been feeling that some groups within the community, particularly adolescents were difficult to reach. Through its representatives, the community requested that some work should be carried out with its young population. Their main concerns were related to drug addiction, sexuality, and AIDS. The first step was to attend a dancing party that took place on Sunday evenings at a nearby discotheque. There the professionals (nurse, social worker, and doctor) introduced themselves and talked about the services and facilities that are available at the health centre. The young people were receptive to the idea of talks but demanded total confidentiality. After some informal talks with the community and discussions among themselves the health education team concluded that those adolescents already had a view about the health centre as a place to go to in cases of disease. So, they decided to create a group for 'young' adolescents, children aged nine years and over. The principle was to promote a new understanding about health and the role of the health centre, making it a friendly environment for adolescents. A nurse, a social worker and a doctor (from another health centre) started this group for adolescents on Thursday afternoons in the meeting room at the health centre. When the observations carried out for this study took place it was already the second year of activities.

Each time the group meets, the group decides in the first moments of the meeting what activities they will carry out during that session. This group activity is

participatory, where each member has a vote and professionals are in the minority. The activities are discussions, plays, drawing, listening to music, dancing, reading, and a small snack is served (paid for by the professionals because the health centres have no autonomous budget). There is one principle every member of the group must respect: the issues discussed in the group are strictly confidential, and can be only mentioned in the meetings and nowhere else. One of their favourite activities is to explore all the rooms and handle pieces of equipment, asking for information about them, after the health centre is closed.

The group has proved successful because these adolescents have the health centre for themselves and are permitted to bring friends. Sometimes they spend afternoons there and volunteer to do some work. Some simple paper work, like punching forms, is offered to them and their point of contact is usually the social worker. At other times they just pop in for a quick talk and leave.

This project is constantly evaluated by the professionals involved and changes have been introduced. At the health centre meetings the work of different focus groups is analyzed. The adolescents' group was criticized because it is too noisy, because they handle equipment, and because they disturb the ordinary routine of the health centre. Those criticisms were taken to the group and solutions were proposed. The professionals try to help the adolescents to implement these solutions and the results are evaluated in the next general meeting of the staff.

This policy on adolescents reveals that at the local level policies are planned, developed, implemented, and evaluated. This group is specific to this health centre and its creation is directly related to the initiative of the community and professionals. The fact that the doctor came from another health centre can be seen as an example of the capacity health professionals have to manage the staff when they consider important. Another decisive factor is the professionals' keen interest because they faced resistance and initial failure and overcame these problems. They even spend their own money to keep the policy in place.

Other 'policy' observed was the officially named 'Hypertension Group'. It was a focus group informally called *Grupo do Dr. Carlos* (Dr. Carlos' Group) at 'Health Centre 2'. They meet once a week and the patients define themselves as suffering from 'nervous hypertension'. These patients are hypertensive but changes in their blood pressure are closely related to emotional problems. Some other patients joined the group and they are not really hypertensive, but they have some organic disease and some kind of mental health problem. The activities developed at the group vary from activities such as personal expression of problems to organization of a commission to speak to the mayor of the city about the health centre conditions.

These practices carried out at the health centres can be seen as a possibility of resistance and alternative implementation of policies. When the professionals decide to implement something created by them, it means that they are reducing the possibility of implementing other policies sent by the government. What is particular to these examples of Health Centres 1 and 2 is the fact that they are examples of participatory practices. They demonstrate that at grass roots level policies can be formulated and implemented. They illustrate that the exercise of bio-politics is far more complex than a federal policy circulating from the central to the local government.

5.5. Conclusion

There is a thematic continuity in the discourse that federal health education policies have been circulating in the eighties and nineties: the issue of participation. The meaning of the term 'participation' varies from policy to policy, but health education is seen from 1982 onwards as a 'method' to transform power relations at the health centre level. Health education has been related to social science in the same way as mainstream health promotion theory at an international level.

However, as the data analyzed show, policy formulation happens at all levels. What does not seem to be a constant issue at the core of policies is

implementation. It is taken for granted as part of the policy process but few concrete measures can be identified in federal policies to guarantee implementation. This chain of policy formulation makes the different discourses on health education clash, with some policies containing conflicting discourses accommodated in the same document. The explanation for this 'patchwork' is the need for using social policy as a window to show commitment to the population and at the same time combining the ideas which distinct groups, such as international agencies and different policy-makers have about health education. The complexity of the process in its elaboration and implementation denies the possibility of a linear understanding of social policy as a single strategy of power that imposes only one discourse.

It could appear therefore that health education policy is not an efficient strategy for the circulation of power because it frequently does not reach the implementation stage. What the data reveal is that bio-politics operates through a complex cluster of relations. Federal health education policy is written and disseminated as a form of circulating ideas. The discourse on participation is the predominant one. Perhaps it was accepted in the first place because it relates to the international discourse on health, some policy-makers were committed to transformative principles, and it was convenient for a government in transition to democracy.

To promote participation through policy can be seen as a form of resistance from those policy-makers who would like to achieve a better quality of health care and use health policy as an instrument to do so. The examples of policies implemented at the health centre level show that the ideas of participation and empowerment reached all levels and are being implemented. However, this does not mean that the implementation is a direct result of federal policy itself.

Bio-politics is 'efficient' because it deals with different discourses through a certain pattern of implementation of all policies. Implementation seems to re-shape policy into the discourse of the 'traditional way'. The power of micropolitics and the way health education has been carried out by the health team (and those who were

there before them) ensure a steady exercise of power based on discipline.

In fact, participatory and prescriptive approaches are extreme forms of power exercise present in all levels of the policy process and they happen at the same time as discourses and practices with different intensity. The data analyzed in this chapter show that the way Hewitt (1991, p.225) describes social policy - circulating power and organizing knowledge - does not provide a clear account of the complexity of the phenomenon. The attempt to map some of the power relations that take place in the policy process uncovers elements which challenge any notion of an 'easy' circulation of power through social policy.

CHAPTER 6

RUPTURES AND CONTINUITIES: THE MAKING OF HEALTH EDUCATION POLICY BY THE HEALTH SECRETARIATS IN BRAZIL

6.1. Introduction

Health education as a public phenomenon was developed in this century in Brazil mainly as the result of the work of the government. In the first half of the century the Ministry of Health was the main organizer of campaigns to combat specific diseases. Gradually, the most developed states also started to organize their own health departments and some health education activities were implemented (Gastaldo, 1990, pp.23-26; Vianna, 1984, pp.51-53; Mehry, 1984, pp.11-17).

The information gathered in this study shows that currently State and Municipal Health Secretariats are responsible for the production of health education policy, overcoming their subordination to the Ministry of Health. Sometimes they just replicate the Ministry of Health guidelines, sometimes they create new policies. In any case, the Health Secretariats have been in charge of developing health education as social policy.

The questionnaires they completed for this research are an important source of information about health education policy formulation in Brazil, the theme explored in this Chapter. Altogether 10 State Secretariats[1] and 16 Municipal (Capital of States) Secretariats[2] returned the questionnaire. The distribution of the states and municipalities in Brazil can be seen in Appendix 6.

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[1] The State Health Secretariats which answered the questionnaire are: Espírito Santo (ES), Mato Grosso (MT), Mato Grosso do Sul (MS), Pará (PA), Paraíba (PB), Piauí (PI), Rio Grande do Norte (RN), Rio Grande do Sul (RS), Roraima (RR), and Santa Catarina (SC).

[2] The Municipal health secretariats were: Belo Horizonte (BH), Boa Vista (BV), Cuiabá (CUI), Curitiba (CUR), Florianópolis (FLO), João Pessoa (JP), Manaus (MA), Natal (NA), Palmas (PAL), Porto Alegre (PA), Rio Branco (RB), Salvador (SA), São Luís (SL), São Paulo (SP), Teresina (TE), and Vitória (VIT).

The different kinds of people who answered the questionnaires (heads of departments, professionals who know the researcher, health educators, etc.) provided at least two accounts of the health secretariats' role in relation to health education. The first one is the official account of health education within the structure of the secretariats. The second is the 'inside story' of health education provided by people who saw the questionnaire as a way to express their complaints about the problems they faced in developing health education in recent years.

These different accounts of the process of making health education policy helped to investigate the argument that bio-politics is not a single technique of power to rule the population. In this chapter, further specificities of health education policy are put into perspective. The argument pursued is that health and health education policies disseminate different conceptions of health education. Together with the lack of implementation of policies in the national health system, the result is the continuation of the traditional health education model.

The search for information about policy-making in the health secreatriats in this Chapter is an attempt to deconstruct the idea of policy. Reviewing the literature (see Chapter 3, section 3.2) many definitions of policy point to an articulated set of goals to be implemented, promoting then better health. In order to study bio-politics and the role health education policy plays on it, it is necessary to challenge the traditional views on health policy. The conception of power borrowed form Foucault (see Chapter 1, section 1.5) places power relations throughout society and this includes the policy process. Perhaps the definitions that consider "conflict inevitable between actors with different interests and policy goals" or "the policy process ... as a negotiated order, the sum of agreements" are those which come closer to the perspective of power relations in this study (Pederson et al., 1988, p.33).

Pederson et al. (1988, pp.51-52) also mention that one possibility in analyzing health policy is to focus on the theory underlying the policy process. They say that the literature contains theoretical assumptions on social and political forces which

most researches on the policy process leave out of the scope of their analysis. Pederson et al. (1988, p.51) suggest research questions to deal with the theoretical framework of the policy process concerning the role of the state and the interest for some areas of knowledge (like health education or healthy public policy) in certain periods in history. Pederson et al. (1988, p.32) comment about the conventional policy analysis that

> *both the top-down and bottom-up perspectives appear to neglect the underlying structure and the power context of implementation.*

The contribution that this Chapter brings is to confront a theoretical framework, bio-politics, to the information gathered in a specific context and area of knowledge related to policy making - in this case the Brazilian national health system and health education policy. The analysis of the policies developed in the eighties and nineties presented in the previous Chapter provided elements to link health education policy to the management of the population. In this Chapter, however, the focus is on policy-making and what is taken for granted: health education policy representativeness of the government's ideas. In investigating into the process of policy-making some insights about the nature of the government of the social body by government's initiatives are explored.

The information obtained by questionnaires, observation, and interviews are presented here as follows: federal, state, and municipal relations and health education policy; the history of health policy formulation and health education; health education objectives; the health education team; policy formulation; policy dissemination; policy monitoring; health professionals and the duty of health education; and changing health centres.

6.2. Federal, state and municipal relations and health education policy

State health secretariats could be the agent of continuity of federal policies, working as a network throughout the country which reach the municipal governments and then the population. However, the centralized model used for many decades and the creation of policies at all levels provide a different - and more complex

- picture of the policy process.

The head of a state policy-making department explains that the federal government sends its policies, but not every policy is implemented.

> *The policies come from the Ministry as guidelines. They are developed at the state level; some are implemented, others are not. They are all adapted to our reality. ... We are very much dependent on the Ministry. They also send us UNICEF and WHO documents because we want all these guidelines.*

Alternatively, policies developed at the state level can influence the Ministry. The policy on post-menopausal health of the State of Rio Grande do Sul has been taken as a model by the Ministry of Health. Another example, discussed in the previous Chapter, is how the São Paulo model of 'health educators' was promoted in the whole country in the eighties (see Chapter 5, section 5.2.1).

From the answers in the questionnaires, the relation between municipal and state secretariats does not seem to be a strong one. Around two thirds of municipal secretariats do not refer to state policy as an influence in their own policy formulation. However, as a result of the municipalization of health (see Chapter 4, section 4.4) every municipality has to produce a Municipal Health Plan and send it to the State Health Secretariat. The head of the policy-making process explains that there is a commission which analyzes the plans and expects general trends to be obeyed.

> *For instance, 'birth control' is not allowed; the policy must be about family planning. The State Secretariat does not delineate how the municipality will work, but there are general trends in the programmes which must be developed.*

Another kind of relationship between federal, state, and municipal governments arises out of the centralization of the national health system. This means that the financing of projects is centralized at the federal government. The same person interviewed comments:

> *Programmes that depend on a large amount of financial support are problematic. Other resources can come from, for instance, the Pan-American Health Organization (WHO). The programme for respiratory diseases is totally funded by them.*

A striking feature of health education policy at all levels of government is that it permeates almost every health policy. However, the department that produces health education policy does not control all other departments which produce policies on women's health, children's health, occupational health, etc. So, in the process of policy formulation a large part of health education policy is formulated by departments divided into sub-areas of knowledge related to primary health care and curative care. Vignette 3 provides an example of relations between federal and state departments working on women's health (both produce their own health education policy and educative materials).

Vignette 3

Written policies vs 'Finance policy'

The State of Rio Grande do Sul received some million boxes of oral contraceptive during the period of my fieldwork. The team of the women's health policy was irritated by such delivery. The reason for their complaint is simple: for months the State had lacked contraceptives and kept requesting them from the federal government. The supply was never enough to cover the demand. When this big stock arrived the contraceptives were almost at their expiry dates. If the State distributes drugs beyond of their validity period, it can be accused of mistreating the poor. However, to criticize the federal government for incompetent management of public funds to the press is to create a conflict with the Ministry and perhaps a difficult situation in terms of political parties. What this large quantity of contraceptives showed the policy-makers was that at the time when they were requesting the pills they were in stock, but nobody distributed them.

The health budget of the State does not cover all the needs of the secretariat. In practice, the decentralization process on finance is still far from implementation. The states and municipalities depend upon Ministry resources to finance health programmes. The way funds are used, however, can raise questions about priorities in the policy implementation. To prevent people from having access to contraception goes far beyond what is written in contraception policy to family planning. It is because the national health system concentrates on the poor that such abuse of authority is tolerated.

The Vignette 3 provides an example of the idea already explored in this thesis, namely, that inaction is also a way of implementing policy. Not funding or periodically interrupting the funding of a policy is a strategy the federal government can

use to impose its priorities to state, municipal and health centre level. The lack of contraceptives disrupts the work of numerous health education activities about reproductive rights in all other levels of government. It also provides an illustration of the management of the population through the national health system. However, focusing on health education policy, the relations between the levels of government may not produce such strong effects as disrupting essential drug distribution. Health education is a particular health policy because of its educational aspect. Its implementation, or lack of it thereof, does not produce very visible results. Commenting on health education policy at the state level the head of department interviewed said:

> *The programmes that involve health education are mainly those related to children's and women's health.*

It is the understanding of this work that the relation between health education and women and children demonstrates the possibility of interfering in the domestic organization of the social body. At the state level the issues raised by federal policies, such as health education for participation for every citizen as a way to transform relations between users and professionals, suffer a rupture. Health education concentrates on women and children. This option reveals intentionality in relation to educate: to teach current families and the future generations how to be healthy.

Though the distinction among mothers and children can be seen as a tactic for the management of the population, Donzelot (1980, pp.57-58) points out that in the past women and children benefitted from this attention:

> *If the **hygienist norms** pertaining to the rearing, labour, and education of children were able to take effect, this was because they offered children, and correlatively women, the possibility of increased autonomy within the family in opposition to **patriarchal authority**.*

Other options taken up through the process of policy formulation and implementation demonstrate that ruptures and continuities can be found in many sites. The production of health education materials and policies in many departments inevitably produces ruptures between the federal, state, municipal, and grass roots levels. The mosaic of influences that compose the policy process, such as economic

support and policy-makers views, challenges the notion that social policy is an articulated tactic between levels of government which promotes the management of the social body. Power relations re-shape health education policies in many ways during the 'making' of it.

6.3. The recent history of health and health education policy formulation

The analysis of the information provided by the health secretariats in this segment deconstructs the notion of health education as a coherently articulated power technology. The changes in government, lack of information, the use of different documents to guide policy planning, and a variety of understandings of the word 'policy' show that the construction of health education as a social policy is a site where different discourses are tangled, not allowing a coherent articulation of power. However, the central authority of the Ministry of Health can be noticed and the lack of an articulated policy among the different governments at the state and municipal levels in different periods makes it a predominant discourse.

The questionnaires show that the creation of health education policy or health policy containing some aspects of health education is an event of the last two decades. Generally state secretariats started this process in the early eighties and the municipal secretariats at the end of the same decade. There are secretariats who cannot report accurately on dates because the current team of professionals is not informed about past actions of the secretariat - even the policy formulation process. It is as if every change of government every four years produced a 'new' history of the secretariat. Around one third of the health secretariats did not provide any dates. This can explain why health education looks like such a recent phenomenon. Maybe health education is not so recent, but the people dealing with it cannot tell more about its history.

According to the head of the policy process of a state secretariat the way changes of government occur cause lots of difficulties.

When we took office the information available was minimal. ... All the work

of this government has been re-organize and create policies, creating new teams and believing that the professionals who have been working here for years have a point of departure. In many programmes we started from nowhere, having not a single piece of information to evaluate what was done in the past.

Not all secretariats have implemented a health education policy. Two states and three municipalities refer to discussions and working papers, but no one implemented health education policy. One other state and two municipalities have been dealing with health education only since 1992-93.

Almost half of all secretariats provided no information about numbers of policies they formulated. The health secretariats which did, produced around 10 health policies related to or about health education in 1992. Most health policies, in general, include some facet of health education. As regards specific health education policies, two or three are produced a year. There is nobody who supervises to see whether health policies do or do not include health education aspects. Many secretariats did not know how many health policies contain a health education dimension.

Providing names of health education policies seems to be a much easier task for the secretariats. Actually, few policies have a name. But, two thirds of the secretariats provided lists of policies, with added comments. The policies mentioned represent a field of public health knowledge, e.g. Preventive Action Against Cholera; Child Health Project; Oral Health or AIDS/STDs.

Through the naming of projects or campaigns which the secretariats presented it is possible to identify a main influence on policy formulation in state and municipal governments: namely, the Ministry of Health. For example, some secretariats answered the question about the names of their own health education policies with the names of national policies formulated at the Ministry level. The tendency of other secretariats was to present 'policy' as campaigns, folders or leaflets, talks or radio programmes.

There is a contradiction between the kind of activity the secretariats refer to as health education and the documents they mention as their source of 'inspiration'. First there is no consensus about which was the most important health education document produced in the eighties and nineties. In many cases the document mentioned is not even specifically about health education. The common feature they show in their replies is a search for a new perspective on health or health education: what the documents mentioned, such as the VIII National Health Conference or the Strategic Plan for Health Education, have in common is a new understanding of health and citizens' right to health. The notions of 'participation', 'socio-political', 'sanitary reform', 'citizenship' and 'popular movements' are singled out as the most important ones. The same tendency can be observed in the articles and books which were listed.

The contrast between the documents mentioned as having had a significant influence on secretariat policy and the health activities secretariats described leads to the understanding that the health education discourse is split between the social ('radical') conception of health and the individual ('traditional') approach to health policy which considers health education as a prescriptive activity. Hence, secretariats acknowledge community participation and citizens' empowerment as important elements in health education when talking about relevant documents in this area of knowledge, but refer to campaigns and talks when explaining the policies they produce.

The point of view sustained in this work is that the presence of a health education team at the secretariat does not assure a wider control over health education policy. According to the secretariats, health education is spread across all health policies and different health departments can promote different aspects of health education. This is explained by one of the secretariats:

> *The Health Education Division has been discussing proposals which, although not assimilated by the whole Secretariat, slowly got incorporated by basic strategic sectors, such as Planning, Human Resources and Operational Directors. The health education area is defined only at the central level of the secretariat; at all other levels there is a lot of confusion about its meaning.*

This set of information on health education policy gathered by questionnaires and interviews challenges the idea that there is something unique called 'health education policy'.The fact that the history of the policy-making in the health secretariat is unknown by many policy-makers and the production of health education policy is done by different sectors without any theoretical framework linking those policies are elements that help to deconstruct the concept of health education policy. According to the examples provided by the secretariats and policy-makers, under the name 'health education policy' very different things can be found. This plurality of forms and conceptions that health education policy can present provide perhaps a better picture of the complexity of the web of power relations that permeate the government in all its levels.

6.4. The health education objectives

The health education objectives of health secretariats can be grouped into two: those related to aims to be achieved by the community, by the users of the national health system or by the whole population; and those related to professionals and the kind of practice they should deliver. The answers that did not fit into these two groups were provided by two municipal secretariats one of whom did not present any aims while the other replied that they do not have a set of objectives. At the state level, just one respondent said s/he was not aware of the official objectives of the secretariat, but presented the aims as actually conceived by the professionals in charge of health education at the secretariat.

The predominant approach aims at the community or population. The vast majority of answers stress objectives to promote changes at this level. However, there is an important difference between approaches: one emphasizes the control of diseases in the population and the other highlights the empowerment of the population, through a process of participation and awareness. The examples below show the contrast between the approaches:

To reduce the rate of morbi-mortality through prevention and control of

endemic diseases.

To promote a wider understanding of the relations between health and life conditions. ... To improve both the level of consciousness and the level of active participation of the community in the dynamics of the health system, aiming at the transformation of social reality.

Looking more closely at health education objectives, three secretariats mixed population control and empowerment in the same set of objectives, but the biggest concentration of objectives is related to empowerment in order to achieve a better quality of life.

Table 6.1. Health education objectives of state and municipal health secretariats

Objectives	Number of Secretariats
Empowerment	10
Disease control	3
Professional practice	4
Professional - empowerment	2
Disease control - empowerment	3

The group of objectives which establishes the enhancement of professional practice as its final aim also has behind it the idea of a better quality of life, though the conception of better life is that which results from professional intervention. This approach is a characteristic of the state secretariats. Only one municipal secretariat refers to professional practice, and this can be explained by the fact that it does not produce its own policy, but acts as a consultant to other professionals and departments. Some of the aims related to professional practice are:

Humanization of the care that health professionals deliver ...
Pedagogic training for health professionals ...
To make the SUS professionals sensitive to their role in educational work; ...

By splitting the objectives which cover more than one category, it is possible to concentrate all the objectives in three groups:

Table 6.2. Three categories of health education objectives

Objectives	Number of Secretariats
Empowerment	15
Disease control	6
Professional practice	6

The three main sets of objectives the secretariats have do not make them formulate or implement policies differently. The influences they have and the level of implementation at health centre level vary according to many factors, but common objectives do not create common approaches in policy formulation or implementation. This comparison between objectives and the policies produced by the secretariats reinforces the argument that what is written has a value in itself. There is a certain kind of discourse which is expected from those in the government. Ham & Hill (1984, pp.101-103), cited in Chapter 3, suggest that the difference between sectors in the government are an opportunity for the creation of symbolic policy and that certain ideals or goals are formulated to never be implemented.

In spite of the fact that there is a production of policies in the national health system emphasizing empowerment as one of its objectives, the analysis of the national health system demonstrates how restricted its boundaries are. It does not matter if the objective is professional practice, empowerment, or the control of diseases. Its target is the part of the population, the poor, which uses the national health system. Health education for empowerment or control are the poles of the same exercise of power which addresses this part of the population. This interventionist approach finds support in economic and social indicators; statistics confirm that there is a group in society who really 'need' attention.

The data presented in this section corroborate two arguments of this thesis - that community participation can represent a 'modern' strategy of control and that written policy has a value in itself even if it does not ensure implementation. As regards to the former, what health education objectives have in common, what is taken

for granted, is the possibility of reaching the population through health. The power of the national health system over life is accepted as a natural occurrence, not challenged by any secretariat. The statement that the policy aims to promote better conditions of life seems to justify the use of health issues to govern the social body. As far as the latter is concerned, the fact that the radical discourses of empowerment and participation are written into policy enables the government to keep control over health by presenting itself as politically committed to the vast majority of the population. Such an approach also produces policy alignment with international agencies which fund health initiatives in poor countries.

Governmentality, as a process of governing through tactics, demands some common sense about what the government is supposed to do. The government plays around with the image of commitment to every individual and the whole society. The act of governing should make life better, spreading welfare. Behind this belief is the general principle that society moves through history in a continuous process of enhancement of the quality of life. In this 'modern' conception, the government is an agent of progress and development and its policies are formulated to embody the same principles. However, the post-structuralist position adopted to analyze social policy in this work suggests that such beliefs sustain the possibility of the government of the population through bio-politics.

6.5. The Health Education Team

The State and Municipal health secretariats have two distinctive ways of organising health education in their structure: there are secretariats which have a special group in charge of health education and others where health education issues are a collective responsibility. Among the states, only one does not have a specific team within the secretariat to deal with health education. However, at the municipal level, seven out of sixteen secretariats do not have an established group.

The majority of those secretariats which have a health education group,

have it as a subdivision of a department directly under the control of the Secretary of Health. Two secretariats, one state and one municipal, have a different organizational structure. In one state there is a 'Health Education Technical Committee' composed of different Secretariats (Education, Agriculture, Social Services and Health), university representatives (Education and Health Departments), a member of a non-governmental organization and one representative from each Regional Health Authority. In one capital (São Paulo), in the departments and health districts they have a professional called 'public health educator' and they are all under the supervision of a central group. This is the professional that the National Division of Health Education viewed as the model of health educator at the health centre level in the eighties. The example of the 'Health Education Technical Committee' illustrates how the health sector allows a whole range of other areas to amalgamate and intervene in population issues in a 'regime of total health'.

The composition of the health education teams can be seen in the tables below. On average, each team is composed of four professions. This does not mean that the teams are composed of only four people because the same profession can be represented by more than one person.

Table 6.3. The health education team according to the rate of professional involvement

Social Worker
Nurse
Educator
Dentist

Because health education demands a specific knowledge of education, the presence of the educator can be explained. However, it is a surprise to see social workers as the professional most frequently present in the teams as well as the absence of doctors among the four top professions.

Table 6.4. Rate of professional membership in health education teams (n=18)

Type of profession	Professions	Number of teams
Health professions	Nurse	8
	Dentist	7
	Dietitian	5
	Doctor	4
	Psychologist	3
	Oral hygiene auxiliary Practical Nurse	1
	Nursing auxiliary	1
	Public health officer	1
	Physiotherapist	1
	TOTAL	1
		32
	Social Worker	
Other professions	Educator/Pedagogue	13
	Journalist/Public Relations	7
	Sociologist	4
	Artist (designer)	3
	Agronomist	1
	TOTAL	1
		29

The teams can hire the service of other professionals. There were references to services of a graphic designing group and a theatre group as associated professionals.

The total number of professionals involved in the teams also reveals that social workers are largest group. This means that social workers are the main group related to health education teams in the municipal and state secretariats which responded to the questionnaires. Around 60% of the professionals are from three professions: social work, nursing and education.

The large numbers of the social workers can be interpreted as a demonstration of the link health education represents between health and 'the social'. Private life becomes a public issue under the scrutiny of health and 'the social' is constructed through the redefinition of these two domains. The bridging performed by health education then becomes a proper place for social work activities. In a country full of social problems it is difficult to deal with health without dealing with poverty and its

consequences, but the presence of the social workers reminds us that health and poverty are very different things. So, health professionals should deal with 'health' - whatever that is taken to mean - and for those aspects which do not fit into the 'health' disciplines, there are social workers. Perhaps the aspects of health education which do not relate to pathology (health as the absence of disease) are devalued and so, left to other professionals.

However, the presence of a health education team does not exclude the possibility of other groups or departments carrying out their own health education activities. As one of the state secretariats explains:

> *... many specific programmes develop their own 'recipes', not always in accordance with the policies of this Division. They mistakenly think that information, publicity, and communication is health education.*

The secretariats which do not have a specific group in charge of health education explain it through the principle that health education is 'everybody's responsibility'. As one state secretariat said:

> *Health education is understood as part of the activities of health promotion. It must not be treated apart, but be part of all policies, programmes and projects, in line with the principle of holistic care.*

To have health education in each programme or activity means that each department has certain degree of freedom to select the theoretical approach they want to give to the policy. This is exemplified by one secretariat:

> *Health education issues are treated in a departmentalized way. The programme of medicinal plants defines and implements its own health education 'policy'. The same is true for oral health, for the women's programme, for parasitic diseases control, ultimately each sector defines its own instruments and working objectives in the area of education.*

It could be said that the different approaches to health education are more likely to come from this diverse range of policy-makers organized by specialties. However, the centralized teams probably cannot provide a coherent line of planning because some of them just meet for few hours a week or because their policies will be guidelines for other departments which will rewrite the policy according to the area of

health they are committed to. Moreover, looking at past history, the teams are likely to be reorganized every four years, when new elections take place. For around 15 years, during the period of military dictatorship, there were no elections and the teams were constituted by the 'same' government. Since then, periodic changes seem to interfere with the continuity in policy making.

The policy formulation seems to be restricted to the secretariat. Health centres are simply expected to implement the policies. As one secretariat in a capital city wrote:

> *Health education is carried out through Special Health Programmes, being implemented in the municipal health system by the health centres multiprofessional teams.*

Periodic changes in health education teams, the few hours per week that some teams work together, and the formulation of policies by other groups in the health secretariats are elements that contribute to the argument of this chapter: health education policy is extended into other policies. The maintenance of a traditional approach to it, in spite of the progressive discourse on participation at the federal level, is related to these 'old way' of doing health education, present in so many groups producing policies.

6.6. Policy formulation

When the issue is influence on policy formulation, states and municipalities are under a strong influence of the central government, but other sources of influence vary. The federal policy as well as their own policy are equally influential in the case of state secretariats, both getting 80% of answers. At the level of the municipal secretariat, federal government policy (70%) is followed closely by the municipal policy itself and 'social demands', e.g. the action of pressure groups.

The proximity between the municipal government and the population is acknowledged in the literature and is a central point in the reform of the health system in Brazil. The municipal health secretariats in this study confirm this view. Harpham

(1992, p.65) says that:

> *Local governments are generally more sensitive to community pressures and more open to community participation than development authorities or national ministries.*

The relation between state and municipal secretariats does not seem to be a great influence on policy formulation. Around two thirds of the municipal secretariats do not refer at all to state policy as an influence. Surprisingly, almost the same proportion of state secretariats acknowledge municipal policy as an influence.

Influences rising from below to the top are not strong. The most important one is obtained by pressure groups; half of health secretariats and 2/3 of municipal secretariats acknowledge their significance. Other influences on both State and Municipal Secretariats are health centres which were mentioned by fewer than half of the health secretariats. At the State level, the Regional Health Branches are influential in only two states and one of these answered it has no policy in health education.

Another group of response concerning influences on policy formulation pointed to statistics of morbi-mortality and the epidemiological profile of the state or municipality as significant.

Table 6.5. Influences on policy formulation

Influence	State (%)	Municipality (%)
Federal	80	68.7
State	80	31.2
Municipal	40	62.5
Regional Health Authorities	20	-
Health centres	40	43.7
Pressure groups	50	62.5

In spite of the fact that secretariats acknowledge influences on policy formulation, this does not signify that the degree of influence is the same. Municipal and state secretariats said pressure groups have influence on policy formulation, but it is 'some' influence. Conversely, health education specialists are said to have a 'strong'

influence and health centre professionals have 'some' influence.

A specialist in health education policy revealed in the interview that the experts can be influential in policy formulation:

> *The specialist should be an accessory, like a consultant. But, the lack of qualification of some teams turns what should be an accessory into something fundamental. When teams do not have ideas, whatever the specialist suggests will be accepted.*

Another source of influence on policy formulation can be the documentation deployed about health education. There are two main groups of documents which are acknowledged as influential by the secretariats. They are not different at the state and municipal level. One group of documents relates to the publications of the Ministry of Health. These vary from specific documents published by the National Division of Health Education (discussed in Chapter 5) to those of the National Vaccination Campaign Against Poliomyelitis. The other group of documents is composed of the reports of the VIII National Health Conference, State and Municipal Health Conferences, the Law 8080 - Organic Law of Health, *SUS* documents, and so on. Other documents, such as academic papers, statistics about the population or Pan American Health Organization (WHO) publications, have only a minor influence on policy formulation.

These data show that the policy formulation process is still very centralized. The federal government is the most important influence through its policies and documents. This can be seen in the municipal secretariats where the federal policies are influential, but the state policies are not considered so. The central level manages to reach the singularity of each town more efficiently than the state level. The funding process and the political structure of the last decades help to explain it.

However, the decentralization process, started with the *SUS* (see Chapter 4, section 4.4) can also be seen. One of the sets of documents acknowledged as an influence is related to the *SUS* itself and the Health Conferences, which take place under its aegis at the municipal, state, and national levels. The states and municipalities also

view their own policies as a strong source of influence on policy formulation. Nevertheless, as seen before in this Chapter, health education policy does not equally influence all the departments producing health policy. There is a level of discontinuity in health education policy formulation within the secretariats.

Decentralization does not necessarily mean the empowerment of the community. The process of policy formulation still looks vertical, from the policy-makers to the health centres, with the population as a target. The Health Councils (see Chapter 4, section 4.4) are an advance in popular participation, but health centres and pressure groups just have 'some' degree of influence in policy formulation, whilst health education specialists have a 'great' influence. The choice of pressure groups and health centres as a source of influence can be also explained by the fact that it is 'politically correct' to acknowledge them as influences in order to demonstrate a degree of commitment on the new discourse of participation embedded in the *SUS*.

Other sources of influence were revealed in the interviews and the very few opportunities for observation at the state health secretariat. Vignette 4 illustrates some points raised at a meeting of policy-makers.

Vignette 4

'Don't count on doctors to prevent breast cancer' policy

During an interview with a policy-maker, the head of the section on women's health, it was suggested to me to take the opportunity and shadow a meeting of the group in charge of the policy on breast cancer prevention. The meeting started with a presentation of a summary of international papers on the early diagnosis of breast cancer. A discussion ensued about the importance of mammography in the diagnostic of the disease. The conclusion was that this technology cannot be afforded by the health secretariat. The next issue in the discussion was the fact that doctors (gynaecologists) do not examine patients' breasts as a routine. The examination only takes place in response to a request. The solution proposed by the presenter was to train nurses and auxiliaries to do breast examination. According to him: "doctors are only interested in pathology, but to nurses this work will be a stimulus". He argued that there will certainly be wrong diagnoses, but it will be better for doctors just to check these cases, rather than to make all the examinations themselves. A member of the group reminded him that there are around five thousand doctors working in the health secretariat and only six hundred nurses. Nevertheless, the doctor presenting the draft of the policy pursued the same argument that doctors won't do it.

Vignette 4 challenges the data in the questionnaires. A member of the team writes a draft of a policy, discusses it with colleagues and later presents it to the

group who decides whether it will become a secretariat policy. Issues like community participation or pressure group demands have nothing to do with this kind of policy formulation. The source of information used in policy formulation is scientific papers and the policy is justified by the federal policy *PAISM* - Women's Integrated Health Care Programme. During the interview the head of the policy-making process also added information about the contact between policy-makers and users:

> *At the departmental level our contact is regional. We are not in touch with the local level, with health centres. Our work is done with the Regional Health Authorities which co-ordinate and implement the work at the local level. We, who work at the central level, do not have contact with the population. This happens at the health centres and at the regional level.*

There were ambiguities in the process of policy formulation; policy formulation moves, at the same time, towards the continuity of the federal government power over health and towards the new paradigm of decentralization. The main features of the process are the influence of the federal government policy, the lack of influence of state policy over municipal secretariats, and the restrict level of influence from pressure groups and health centres. These features point to ruptures in the process of health education policy formulation and to the many sites where competitive discourses on health education are constructed.

The example provided by the Vignette 4 illustrates the magnitude of interests related to policy-making. In this specific case corporatism and professional status of doctors and nurses seems to play a more important role than what is recommended in the scientific literature; again economic issues shape policy. The availability of professionals to implement the policy also seems to be less important than the politics of the medical profession. Pederson et al. (1988, p.18) point out that it is difficult to deal with different interests because, in the case of health professionals for instance, they can argue that they have careers interests directly linked to policy and this situation should give them a privileged position in the sphere of decision-making.

All these situations described in this section are illustrative of the diversity of interests in policy-making and they help to challenge the view of coherence

and strength of health education policy as an instrument to the exercise of bio-power.

6.7. Policy dissemination

There are different approaches to policy dissemination: they vary between one linked to community participation and decentralized policy formulation and the other to a traditional, vertical 'imposed' model.

In many cases the sketches provided by the secretariats did not offer a picture of the process itself. So, it is difficult to say which is the predominant approach. Some descriptions provided looked more like a theoretical model than reality. The description of one secretariat is as follows:

> *A project is elaborated by the Municipal Technical Advisers with the participation of the 'local level'; it is submitted for decision to the Municipal Health Council (after discussion at the Local Health Councils); health centre workers are trained; implementation and supervision follows.*

This model represents most clearly an adjustment to the decentralization and municipalization process of the Brazilian national health system. However, observation at two health centres which belong to this Secretariat showed that this model is not fully implemented and in many cases the policy implementation process does not differ from the following example mentioned by another policy-maker:

> *A small group of professionals in the secretariat come together to plan and implement a given programme. These are the professionals who will define the policy itself. Then, they will meet with the health centre professionals to discuss the 'norms' previously agreed at their own meeting. They promote a training course for the implementation of the programme.*

The dissemination process at the municipal level does not necessarily denote a greater closeness between those who plan and those who implement a programme:

> *There is a direct and one-way relationship. The formulation takes place at the central level and is implemented at the very end of the system.*

The policy dissemination process is based mainly on in-service training.

This does not mean that each policy is followed by training, but the most important ones (like the cholera programme) are based on in-service training:

> *The professionals are trained at the Central Level; they train the Regional Health Authorities staff who, in turn train the Local Level staff. This was the way we proceeded in the cholera programme. Therefore the model is centred on human resource training.*

'Verticalism' as a model of policy formulation and dissemination seems to be very alive:

> *Vaccination campaigns as a traditional practice: it is a vertical programme. The secretariat asks for the implementation without consultation (the vertical way).The health centre simply puts it into practice.*

These examples define the health secretariat as the institution in charge of policy dissemination. 'Verticalism' can take many forms but they all emphasize the passive role of health centres, as the ones which just have to implement the programmes.

The process of continuity and rupture shapes the construction of health policy. The examples shown above illustrate that, although the discourses of decentralization and participation are spread throughout the system, traditional practices are kept alongside. The rupture between the objectives of participation, empowerment and the vertical strategies employed in their implementation constitute another discourse in itself: reaching the objectives of participation in a non-participatory way. The health professionals are not supposed to think and contribute, but to deliver whatever the policy determines. The denial of the micropowers that are exercised in the process of policy dissemination and implementation demonstrates a misunderstanding of the concept of power. The authority of the government is misinterpreted as power to disseminate policies. The gap between what is written (empowerment) and the traditional approach to the dissemination of policies (verticalism) provides a site for resistance. In the phase of implementation, the policy can become 'one more paper' sent to the health centre and the 'reading' of the discourse on policy can provoke resistance among those who are in charge of its implementation.

6.8. Policy monitoring

To ask about 'how many' policies were implemented is very limited because the same policy can have different levels of implementation in different health centres. However, to ask about the number of health centres and policies implemented is enough to realize how fragile is the feed back health centres provide (or secretariats demand).

The state secretariats did not provide numbers when asked how many health centres are under their control. Instead of numbers, they offered explanations:

- *None, all were municipalized.*
- *With the municipalization process we lost data and control.*
- *The state secretariat has responsibility for all its health centres through the Regional Health Authorities and municipal governments.*

Precise numbers were presented by two state secretariats: 900 and 75 health centres. However, this does not mean a better accountability or control. One of the two secretariats had a list of all health centres. When I tried to contact them, it was noted that there were health centres on the list which had been closed for 2 to 8 years. On the list of the 125 health centres of one Regional Health Authority, at least 9 (7.2%) no longer were working.

At the municipal level, health secretariats have from 7 to 50 health centres under their control; but, unlike the state secretariats, they have exact numbers including how many are general health units and how many are specialized.

The issue of numbers in policy monitoring is a complex one. First, as already pointed out, there are different levels of implementation; secondly, producing reliable figures demands a very narrow control over implementation and constant evaluation. Also communication between health centres, regional authorities and secretariats has to work quite well. Half of the state secretariats did not answer when asked about how many health centres have implemented health education policies. This suggests that communication between central (state) and local (health centre) levels is not working adequately. Those which answered the question provided a variety of

options around partial implementation ("around 50%", "8 Regional Health Authorities and the capital", ...).

Thus implementation and information about implementation are complex issues. When asked about what happens when a health centre does not implement a policy, the answer provided by the head of policies of a state health secretariat was:

> *I believe nothing will happen. It depends on the number of professionals available and the work conditions at the health centre. ... There are some programmes for which we have to demand implementation. The follow up of neonates is a priority. We have to demand that, at least, the professional provides good care to children. But, there are other programmes - for instance health education against tobacco smoking - this doesn't mean they are not important, but in choosing between treating a child and educating against smoking ...*

In some states, although they do have defined objectives for health education and a health education team, health education is not necessarily the result of policy implementation:

> *Health education takes place without a real programme. The staff are advised to give better quality information to patients.*

The process of monitoring what is really being implemented does not look very efficient according to the description of the same state health secretariat head of policies:

> *When a policy is planned a supervision and evaluation team is created. Each department supervises its programmes. The ideal situation would be a multiprofessional team of supervisors to supervise every thing in the same trip. It does not happen yet. ... In the 'Programme of Prevention of Gynaecologic Cancer' the department receives the number of slides done each month. We can monitor the health centres that are working. For some other stuff we need more qualitative reports.*

At the municipal level things are not very different. The implementation is rarely complete; generally policies have been implemented partially or not in all health centres of the municipality. The best description of the scene is encapsulated in the phrase "in process of implementation". The information provided by the municipal secretariats is more precise, but this does not denote a remarkably better pattern of policy evaluation.

The lack of interest in or inability to monitor the implementation of policies raises questions about the real power of the national health system. The limits on monitoring can be seen here as demonstration of what the Brazilian national health system is really for: the government of the poor, maintaining a minimal level of health services thus avoiding too many complaints, and making what is available precious because there are no other alternatives. The lack of monitoring reveals that it is not really important to know and to differentiate details about this section of the population - workers, vagabonds, prostitutes - the concern is to keep this undifferentiated mass from creating problems, as already discussed in Chapter 4. The contact between the poor and the national health system is a source of general information that keeps the government aware of trends in population issues. However, the case of Brazil questions the idea that a great and detailed amount of information is vital to bio-politics. It suggests that, in Brazil, there are other mechanisms working in a steady way (like the traditional approach to health education at health centres) that play an important part in the exercise of bio-power.

The lack of monitoring is also the result of resistance by health centres. For many reasons (such as frustration arising from too much work and low wages, a lack of faith in the influence of the data provided by the health centre or lack of implementation) health centres refuse to provide the data policy-makers would expect from them. In Brazil this situation has been described in the following terms: 'the government pretends it pays the civil servants and they pretend to work'. During the fieldwork, the General Director of the Regional Health Authorities told me that sending my questionnaires was a waste of money and time because health centres do not respond to him, and so the same would happen to me.

The argument sustained in this section is that the ruptures that take place in the process of policy formulation turn policy into a tangle of discourses that in different moments try to prevail over another. Perhaps the biggest gap is between what is formulated and what is implemented. The fact that the government does not succeed in gathering information about implementation suggests that the written document itself

counts for a great deal to the government and that the way health centres practise health education is not a problem for the secretariats.

6.9. Health professionals and the duty of health education

Shifting away from what was proposed by the Ministry of Health during the eighties, state health secretariats believe that health education is not a task for one special professional within the health professionals team. The majority of health secretariats see health education as the responsibility of every single professional. Even those who believe that some professionals should be in charge of health education mention more than one professional group ("nursing auxiliary" or "social worker and nurse") or professionals with some special skills:

> *The professional in charge of health education in each municipality is chosen according to his/her sensitivity for the work.*

The municipal secretariats have a similar understanding of health education as potentially everybody's responsibility. Those who did select some professionals picked nursing auxiliaries, assistant practical nurses, practical nurses, nurses, dietitians, psychologists, social workers and educators. Again there is the option related to interest or skill:

> *Other: Health facilitator. The health facilitator can be anyone among the professionals in the health centre with interest in health education and who holds an university degree.*

It is implicit that the criterion of 'sensitivity' turns health education into quite a selective activity because all those professionals who are not 'sensitive' to the importance of educating the patient will not do so. It also focuses health education in some professionals, not according to professional competence, but according to individual interest in the subject. The criterion of sensitivity highlights the understanding that health education is an exercise of constructive power. Those 'talented' professionals are thought to carry out health education activities in a less authoritarian manner, enjoying what they are doing.

6.10. Changing health centres

Health secretariats were asked about whether and what changes were necessary in the health centres to achieve the health education aims they planned. The answers presented sets of structural changes related to professionals and material conditions.

80% of state and municipal secretariats consider that changes are needed to improve achievements in health education. The term 'change' was questioned by one secretariat which said that to 'change' could mean to assure that the basic conditions for educational practices will be provided, like written information (brochures to patients) and some equipment.

The main changes proposed by the secretariats are changes in 'mentality', improvement of material conditions, and quantitative and qualitative investment in human resources. Some secretariats chose more than one of these categories.

Table 6.6. Changes in health centres suggested by state and municipal health secretariats

Changes identified	Number of Secretariats
Material conditions	6
Labour - quantity	2
- quality	10
Changes in mentality	9

The material conditions identified by the secretariats are mainly associated with the development of health education activities. For example, one secretariat referred to:

> *Building a room for meetings only; sufficient educational materials; visual resources equipment in each centre;*

Human resources also require changes, according to the secretariats. The focus of attention is on the qualitative aspects of the professionals work. In-service

education and 'sensitization' of professionals to the importance of educational practices are the two preferred approaches to promote qualitative changes in health professionals.

> *... To develop an awareness of the importance of educational practice among professionals and administrative staff in the health centres through sensitivity groups.*
>
> *It is necessary to have training courses focused on participatory methodologies because usually educational practice is restricted to lectures only.*

The change in mentality consists in conceptual and structure changes in the whole system; professionals and community should change their attitudes in order to accomplish health education objectives. Some of the changes suggested are:

> *To change the routine and the nature of the role of the health centre and its staff.*
>
> *To re-think: the present model of vertical and normative programmes; the concept of health; the relations between the health centre and the users; community empowerment.*

The following text is the result of bringing together in the same text all changes suggested by health secretariats to improve the performance of health centres in terms of health education. The changes suggested are divided into two groups: structural (material conditions and human resources) and conceptual (called 'changes in mentality' by health secretariats).

Structural Changes

> *Improving the achievements in health education implies the existence of material conditions of a different nature, such as a suitable room for the development of group activities; didactic resources and equipment to illustrate discussions or talks; printed materials about a full range of issues related to health to be distributed to patients and community (schools, creches, ...); some money to cover expenses incurred at the health centre level.*
>
> *All health centres should have a minimum representation of the health professions to offer a basic standard of health care. The health professionals located at one health centre are expected to work as a team which is qualified for the work in health education. Health professionals should get training when they are admitted to the job and then on a regular basis through in-service education and specific courses. All this training should emphasize the areas of education and health education, rather than only concentrating on the professional's specialty.*
>
> *The flow of information between the secretariats and health centres and vice-*

versa has to be improved. The process of policy implementation has to reach all health centres.

Conceptual changes

There is also the necessity of upgrading the understanding that professionals and administrative staff have about health education, the relevance of preventive care and the current context of the sanitary reform which is taking place in Brazil.

The aim (of in-service training) is to have a team of professionals committed to their work in public health which develops effective health education activities at individual and collective levels; the single strategy of lecture is condemned as a dominant health education activity. Behind all activities is the principle of good communication between professionals and community. In general, changes should challenge ideas, from the concept of health to the profile of health assistance provided by health centres. The changes have to concentrate on the role of the health centre, its routines (daily activities) and community participation.

The model of policy dissemination - currently vertical and normative - has to be improved.

Thus, it is possible to say that the secretariats are aware of the problems health centres have and know what to recommend in order to improve health education. The discourse on changes is like the discourse on the empowerment of the user. From written documents to practice there is a big gap. Taking into account that the absence of implementation or monitoring can be seen as a policy of inaction, the results of such an absence of change should be explored. Health centres are accused of a limited and inadequate model of health education centred on lectures. However, the lack of implementation and monitoring results in the maintenance of this traditional approach to health education. It supports a set disciplinary techniques based on a prescriptive method, whilst the health secretariats recommend change to a participatory model of health education.

6.11. Conclusion

The information collected has shown that health secretariats in Brazil are at different stages in terms of developing health education policy and the Ministry of

Health is still an important influence in the process of policy formulation.

Looking at features that have been maintained through the last two decades, it is possible to identify a continuity in the gap between what is formulated and what is implemented. Perhaps in the nineties it is already possible to say that the participatory discourse in health education is establishing itself as a continuity as well. There is not yet a consensus, but secretariats show an awareness of the expected discourse in health education.

The information provided by Health Secretariats reveals that health education is part of many policies. Health policies are produced according to areas of knowledge in health and health education is included in many of these policies. The groups in charge of health education do not control the process of health education policy formulation in the whole secretariat. Health education is also produced at all three levels of government and the aims of such policies can vary from ideas such as disease control to more complex ones such as the empowerment of the users.

The confront between the concept of bio-politics and the information collected about health education policy in the Brazilian national health system sheds light in some points such as: (a) collecting information about the population and sending it to the central government does not seem to be a vital aspect in the exercise of bio-politics; (b) health education policy contributes to the management of the population, but not in a straightforward way because many policies do not reach implementation; (c) the lack of supervision over implementation allows the continuation of the traditional approach to health education, making health education activities a site to the establishment of norms of conduct and an experience of downwards governmentality.

The complexity of the policy process illustrated by the data presented in this Chapter also helps to deconstruct the notion of policy as a manifestation of the government's intentions. Policy stands as a sum of conflictive interests and as a process

of many ruptures. The notion government which derives from this analysis is a non-unitary one, the government 'looses' its Machiavellic intentionality in the management of the social body and becomes a site where different discourses try to impose themselves over others. In this context, health education practices are a contribution to governmentality, being one among many places in society which build up the management of the population.

CHAPTER 7

BIO-POWER/KNOWLEDGE: HEALTH EDUCATION IN THE HEALTH CENTRES

7.1. Introduction

Power and knowledge can be traced in the policy-making process using a top-down model - from federal to municipal policies and policy-makers comments. However, this approach is insufficient if the aim is to promote a better understanding of the way health education is socially constructed.

Ham & Hill (1984, pp.95-96) mention that many studies have been focusing on the implementation process. Some of them separate the policy process in two different moments: formulation and implementation. Studies of implementation try to link policy formulation to policy outcomes, both areas traditionally covered by research on the policy process (Ham & Hill, 1984, p.95).

In this study, however, the interest in relating health education policy to bio-politics moved the approach from policy implementation to an analysis of power relations at the grass roots level. Foucault (1980, pp.82-85) suggests that a whole range of subjugated knowledges could help to understand an "historical knowledge of struggles".

> *In the specialised areas of erudition as in the disqualified, popular knowledge there lay the memory of hostile encounters which even up to this day have been confined to the margins of knowledge.*

Taking into account the opinions of the health centres professionals, this chapter deals with subjugated knowledges: the 'unqualified' points of view of those who are just supposed to implement policy. The reading of their responses points to a series of micropowers that can resist and decline the duty of implementing policy. The issues of power and knowledge are striking features of the discourses of

health professionals; though many times health professionals do not refer to them in an explicit way.

In this Chapter Foucault's integrated concept of power/knowledge will be used to explore strategies to manage the social body. Because this Chapter focuses on power over life, Foucault's term 'power/knowledge' will be called here 'bio-power/knowledge'.

A health centre can be considered to be (i) an agent of governmentality and (ii) a collector of information to the exercise of bio-politics. Knowledge about the population becomes a source of power in its management. As seen in the previous Chapter this does not mean that there is extensive and detailed statistical information available - sent from health centres to the other levels of government.

After analyzing the policy process from the perspective of policy-makers and in different levels of government in Chapters 5 and 6, this Chapter concentrates on the views of health professionals because they are in charge of implementing policies and also on some of the features of the health centres which might influence the implementation of health education policy. Health centres are at the core of the bio-power/knowledge relationships. Therefore, the argument pursued in this Chapter is that micropolitics at grass roots are as influential to the exercise of bio-politics through health policy as the policies created at the other levels of the government.

The information gathered in health centres comes from the State of Rio Grande do Sul. These data have an illustrative status and were collected mainly by questionnaire. The findings are presented here in 9 sections: characteristics of the health centres in Rio Grande do Sul; community participation and health centres; policy formulation; policy dissemination; policy implementation; policy monitoring; professionals in charge of health education; health education activities and tools; conceptions of health education.

7.2. Characteristics of the health centres in Rio Grande do Sul (capital and countryside)[1]

The micropolitics that take place at the health centre level are responsible for many of the achievements and failures of social policy. However, the context of the health centres has to be considered first to situate micropolitics. In this segment a description of the structure and services of Rio Grande do Sul health centres will be presented in order to provide a better understanding of their role in policy implementation.

The state health secretariat manages its health centres with the help of 17 Regional Health Authorities (in March 1993, increasing to 18 at the end of 1993). There are 963 state health centres spread among 427 municipalities. The structure of the state secretariat of Rio Grande do Sul and the regions covered by the questionnaire can be seen in Appendix 7.

At the municipal level in the capital of Rio Grande do Sul, Porto Alegre, the health secretariat is in direct contact with its 11 health centres. There are regular meetings with the health centres heads and decisions about policy implementation are taken at these meetings or through direct contact by the policy-makers with the health centre.

Health centres have no control over their own budgets. They ask for the materials they need on a monthly basis. What is actually provided depends on availability of stock. Wages are provided by the government. Jobs are obtained by open competition (with some exceptions). Those with the best grades in exams, a good curriculum vitae and so on, get the job for life. It is almost impossible to fire a professional after appointment.

The questionnaires showed that half of the state health centres and two

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[1] For further information on the characteristics of health centres see Appendix 8.

thirds of municipal health centres have from 501 to 1500 consultations per month. In order to deal with this demand for consultations, state and municipal health centres count on different staff.

Table 7.1. Distribution of health professionals in municipal health centres (total number of professionals= 217).

Professional	% of professional categories employed in health centres	% of a category among all professionals
Health assistants	100	37.3
Doctor	100	19.4
Nurse	100	6.9
Dentist	88.8	6.5
Social Worker	88.8	4.1
Specialized auxiliary	55.6	10.6
Dietitian	55.5	2.3
Psychologist	33.3	1.4

The municipal health centres have a better distribution of professionals compared to the state ones. There are as many auxiliaries as at the state level, but they are formally qualified for the job and there is one nurse, dentist, social worker and doctor in almost every health centre. Health professionals with degree level qualifications are 40.6% of the staff in municipal health centres. Almost half of these (19.4%) are doctors. The auxiliaries are divided in two groups: nurse auxiliaries (40.5%) and other specialized auxiliaries (10.6%). The proportion of nonqualified auxiliaries (3.2%) is very low, perhaps because the health secretariat has its own school and in the capital of the state it is easier to hire the services of qualified auxiliaries (37.3%). There are no other auxiliaries working under different names and without proper qualifications, as happens in the state health centres.

State health centres are structured around a specific pattern of professional relations: doctors and health assistants[2]. They together form 66.7% of

[2] The health assistant is a member of the staff who helps the doctors with routine procedures such as injections, blood pressure measurement, vaccination, etc. According to the Law 7498/86 this is the work of two professionals: assistant practical nurse and practical nurse. Until 1996 any other person doing such work has to be

all health professionals present in state health centres. In terms of policy implementation, this is significant. In the category 'assistants' (35.4%) there are people of a variety of qualifications; many of them have only attended primary school (8 years); some have had even fewer years of formal education. The state does not use legally sanctioned professional titles for this part of its staff. So, it was impossible to determine precisely the qualifications which the 'assistants' have.

Table 7.2. Distribution of professionals in state health centres (total number of professionals=686)

Professional	% of professional categories employed in health centres	% of a category among all professionals
Health Assistants	100	35.4
Doctor	97.4	31.3
Dentist	70.8	7.6
Nurse	40.7	4.7
Psychologist	14.6	1.0
Social Worker	6.3	1.0
Dietitian	0	0

Doctors (31.3%) have a routine of work based on consultations. In general, a half-time doctor with a contract of 20 hours per week works two hours a day (i.e. 10 hours) and sees 16 patients per day (around 7 minutes per patient); a full-time doctor with 40 hours per week works two hours in the morning and two in the afternoon (i.e. 20 hours) and sees 16 patients each shift. Once doctors finish the consultations, their work for that day is completed. This is a peculiar routine that doctors and dentists share, but which other professionals do not usually experience. In general the rest of the staff works the number of hours stipulated in the contract.

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professionalised. Both professionals can only work under the supervision of a nurse. Though this Law prescribes professionalization and nursing supervision, the state keeps working with different assistants. The state health centres indicate that 37% of these employees are assistant practical nurses or practical nurses. The others do not have the minimum schooling period requested nor any formal training for the job they do. In the public health sector of Rio Grande do Sul there are more than 20 titles to describe a member of the staff who does the work of assistant practical nurses. They are all working illegally according to the Law 7498/86. Nevertheless, very little has been done to change the situation because checking irregularities committed by the government is a difficult task and the sanctions the Nursing Council can impose areusually restricted to the person who is practising illegally.

Official figures provided by the Health Secretariat of Rio Grande do Sul (RS-SSMA, 1990, p.20) also conform to the 'doctor-assistant' health centre model, showing that the predominance of these two professionals is a general feature of municipal and federal health centres. The official data reveals an even worse balance between doctors-assistants and other health professionals. At the state level doctors-assistants together constitute 83.6% of all health centres staff (66.7% in this study). Municipal health centres have 95.2% of their staff formed by doctors and assistants (66.3% in this study). At the state level nurses are 3.1% (4.7% in this study) of the staff and at the municipal level 1.3% (6.9% in this study). All other health professionals who are professionally qualified constitute 13.3% of the state staff and 3.5% of the municipal.

Official figures presented in 1990 (and suppressed in the 1993 document) also show the mean rate of health professionals per state health centre as follows: each health centre has two doctors and two assistants; 50% of health centres have another health professional with graduated qualification (dentist, psychologist, social worker, pharmacist or dietitian); 20% of health centres have a nurse (RS-SSMA, 1990, pp.20-21).

Comparison between municipal (capital) and state health centres staff shows that only at the capital of the state is the health centre not structured around the doctor-assistant model. It also shows that in the capital there is much more even distribution of health professionals among all health centres (in number and category of professionals) whilst in the state health centres there is a variety of patterns. What they share is the essential minimum: doctors and assistants.

According to the questionnaires, the management of the staff in the state health centres is carried out mainly by one head (87.5%) of health centre who is not elected but appointed. The head seems to be the link chosen by the secretariat to guarantee the continuity of policies at the health centre. As regards the municipal health centres, around half of them have a head and a deputy head. In 79.1% of the

state health centres the head's nomination comes from the state health secretariat and 14.6% from the municipal health secretariat. Probably this last percentage is the result of implementing the decentralization policy. There are only two cases of election at state health centres. At the municipal level all heads are chosen by the health secretariat.

From the fieldwork it is possible to say that the position of head is commonly seen as a trouble-ridden imposition and not a promotion in both state and municipal health centres. The management of the other professionals can become a problem, the community requests will be addressed to the head, and the position has little power attached to it. In financial terms it is not a worthwhile position, adding very little to the salary.

The data from the questionnaires show that there is no uniformity in the selection of the head of health centre, but the health secretariats tend to control the decision-making process. Other secretariats in the same state such as the state secretariat of education have implemented elections from the beginning of the eighties. So, it is not possible to say that appointment is the only traditionally known model.

Taking into account the predominance of doctors among state health professionals, it is not surprising that 64% of the heads of health centres are doctors. Dentists, nurses, social workers and pharmacists are also heads. Dentists hold almost half of the head positions among non-medical heads. There is no single instance of a head not having a university degree. One health centre, however, has no head.

At the municipal level there is a better balance among health professionals. In the 9 health centres, doctors are head in 2; dietitians, social workers and dentists are heads in one each; and nurses are heads in 4 health centres.

Another issue investigated through the questionnaire was the process of gathering information. Health centres have very little information about the

communities for which they work. At the state level only half of them (51.1%) know the number of inhabitants who belong to the health centre. There is lack of technical information provided by the state secretariat statistics or by the health centre itself. The vaccination figures are the most readily available with 66.7% of the health centres collecting them. Fewer than half of health centres collect other statistical information. The number of women in antenatal care is known in 24.4% of the health centres and the morbidity rates are known by 17.8% of the health centres. Moreover, what the health centres consider to be precise information about the community may vary from a general impression to the real number of patients. Health centres almost always ignore social indicators about their communities such as sanitary conditions, unemployment rate or families receiving food supplements from the Ministry of Health Programme.

The information municipal health centres have about their communities is only slightly better than the state. 77.8% of municipal health centres have information about the population which belongs to their catchment area. Vaccination numbers are the best known by health centres: 77.8% have information about it. One health centre explains that the numbers are not readily available, but it is possible to calculate this from the records at the health centre. What is not possible at this health centre is to calculate the percentages of children who have been vaccinated because they do not have figures for the total population. 88.9% do not have data on morbidity rates and 66.7% have no information on mortality rates. No health centre knows its local unemployment rate and 77.8% do not know about the sanitary conditions of their communities. Only half of the health centres have information about antenatal care and prevention of cervical cancer.

The features of state and municipal health centres described above reinforce the idea that a decade of discourses on participation through health education policies and the current structure of health centres do not have very much in common. The 'doctor-assistant' model restricts the implementation of any policy. It also raises the question: what is the health centre supposed to do? Its structure suggests that the

health centre is still understood as the place to repair bodies and to promote basic public health campaigns for the controlling diseases. There is an evident rupture between what health centres were planned to be and their structures.

The massive presence of doctors in the state health centres can be seen as an important influence on health education. The medical model and the preventive approach to health education are usually related to the traditional way of developing health education. The fact that doctors' work is controlled by consultations is also a factor in shaping health education.

The appointment of the head shows an authoritarian approach from the government. Instead of promoting democratization and decentralization of the decision-making process, it looks like an attempt to ensure government control. It is part of the process of bio-power/knowledge to keep a bridge between the secretariat and the health centre across which policies are sent and information is returned back to secretariats.

Governmentality requires knowledge about the social body. But, according to health centres, the information they have about their communities is fairly insignificant. The construction of a *savoir* that empowers the government to manage the population does not appear to be important to health centres or secretariats. The lack of information about the community is interpreted here as a demonstration of the main purpose of the national health system: to ensure that a minimum level of care is provided and that the government 'branches' out there keep in touch with the community. Health centres are far from being agencies of health, but the dependency of the poor population on the system ensures a constant contact between health professionals and community.

7.3. Community participation and health centres

Health centres have different perceptions of what community

participation at the health centre level means. The questionnaire replies indicate that the predominant pattern at the state level is no participation at all (81.2% of health centres). Only 18.8% of health centres acknowledge that they have some form of community participation. In the state capital the reality is different. Three health centres say there is no participation, but in all three cases health centre staff participates in the Municipal Health Council meetings. Perhaps the municipal health centres have a different concept of community participation, which does not include attending Municipal Health Council meetings.

The group of state health centres with 'no participation' should be extended. Some of the forms of participation presented by the health centres are:

> *The community participates giving suggestions to the professionals or to the head of the health centre.*
>
> *It participates in the vaccination campaign.*
>
> *The staff participates of many commissions in the area of community health.*

The forms of participation that represent channels of interaction are of two types: the newly implemented Municipal Health Councils, where the community has members with right to vote; or some kind of community organization, such as the Neighbourhood Association, which represents the community in presenting complaints and suggestions to the health centre. At the municipal level, health centres also mention meetings with the community and participation of the community leaders in the health centre meetings. Considering both kinds of participation, all municipal health centres have some community participation. However, as stated before, three of them do not consider their presence in the municipal Health Council as a form of community participation.

Formal community representation within the health centre is not yet a reality at the state level. Only two out of 48 health centres have community representatives. In both cases the representatives are elected or selected by a community association and then introduced to the health centre as representatives. In

one health centre, a list of three possible candidates is presented and one is chosen by the health centre.

Of the municipal health centres, only one mentions a formal representative chosen by the Neighbourhood Association. However, at least two other health centres have community representatives whose presence was observed by the researcher. Perhaps because they do not participate in staff meetings, they were not considered 'formal' representatives.

The limits of, and difficulties in the implementation of municipalization raises questions about the status of federal policies in health education for participation. A national reform supported in law and with a specific budget has been struggling to be implemented after many years of a democratic regime. But since the days of the dictatorship, health education policy deployed a discourse on participation and transformation of the relations between the health centres and the community. Moreover, health education policy had no support from law, no budget nor even a timetable for implementation, while proposing the transformation of the national health system through health education.

The power of health education policy to transform proved inefficient: the evidence showed that models of community participation, even after the implementation of municipalization (*SUS*), are far removed from the models proposed in the policies. The traditional approach of 'professionals know best' about what the community needs seems to be a continuity in terms of health practices as much as health education for participation is a continuity in terms of discourse. Tones et al. (1990, pp.242-244) argue that planners may indeed know what is good for a community, but to implement changes and not deal with the participation (empowerment) of the community living there is to develop a naive top-down programme. Participation strategies are criticized by these authors saying that community participation in health is a process that may fail to promote dramatic changes. They refer to possible problems inherent in participation strategies, as for

example: the dependence of the community on health workers; the creation of a new elite within the community; the manipulation of the community to instill the political views and values of health workers; and the lack of public funds for projects that propose radical changes in power relations.

Indeed, other authors have critical positions on participation. Procacci (1991, p.166) suggests that the process of participation is a refined strategy for governmentality. Remarking that people usually respect institutions in which they participate, she points out that participation constitutes a "politically responsible subject".

> *This indicates a completely different aspect of technical intervention, centred on the two key notions of 'participation' and 'association'. ... participation at the intermediate levels of hierarchical power as an instrument for co-option in decisions; ... and in a more general sense, association as a vehicle for structured and structuring ties which allow the progress of subjects from a merely individual level to that of joint interests which reproduce on a reduced scale the relations of discipline and authority.*

The strategy of sharing power with the community at the reformed national health system or the discourse of health education to participation embody the co-option of the users of the national health system into its model of accommodating and dealing with their requests. But it also represents a new channel of communication and demands. This approach is more consonant with the democratic regime Brazil has had for a decade. The empowerment of communities and users has to be understood in this political context. It means both a challenge to and a transformation of the techniques of bio-power/knowledge.

Though the process is far from fully implemented, as the data from health centres showed, this trend has been present in health education federal documents for some 15 years. The very limited level of participation at the health centres marks this constant gap between discourse and practices in health education in the Brazilian national health system.

7.4. Policy formulation

In order to explore influences on policy formulation, both state and municipal health centres were asked about which documents on health education in the eighties and nineties they considered to be most important. In fact, 58.3% of the state health centres and 55.6% of the municipal health centres failed to answer this question. Those at the state level who did so, can be divided into two groups: one group (18.8%) which said it was the vaccination programme of the state and federal governments and the second group (22.9%) which mentioned different sorts of documents. The municipal health centres which answered the question concentrated on the VIII National Health Conference (33.3%) and two other documents - an international declaration and a federal government policy.

7.4.1. Policy formulation at the state health centres

In the opinion of the state health centres the main influences on policy formulation at the state level are the Regional Health Authorities (36.2%) and federal policies (29.3%). They believe that at the municipal level, policy formulation is influenced not by the federal government, but mainly by the information and recommendations of the Regional Health Authorities (32.2%) and then by health centres and pressure groups (both 15.3%). The state health centres have an idealistic view that because municipal governments are smaller and closer to the community, they formulate their policies based on health centres and community contributions. Even to consider the Regional Health Authorities as the main influence on policy formulation at the state level is optimistic. Of course, it sounds reasonable, but according to policy-makers this is not the reality.

20.7% of the health centres did not answer about the state influences and 30.5% about the municipal influences on policy formulation. One state health centre suggested that political party interests are also a source of influence at the municipal level.

60.4% of the health centres said that they do not have any role in

policy formulation. Those which said they have are divided in two groups: the first who consider that such influence already exists; the second who believe that health centres ought ideally to have a role in policy formulation.

The most passive, and basic, role health centres identify for themselves is as the 'information gatherer'. In their own words:

> *Health centres can influence through statistical data, that technically analyzed are useful to anticipate new demands in the health area.*
>
> *The health centre is a source of information to evaluate public health indicators.*

The other role health centres perceive is the identification of problems based on a constant contact with the community. Again it is not a very active role. This is another way of saying that the health centre can gathered information, and at the same time identify problems that are specific to the community they are in charge of. This does not mean the process goes much further than the identification itself.

> *The health centre has a fundamental role. It deals directly with the community; it is, therefore, in a position to recognize its needs.*

Putting together all answers about the role of the health centres in policy formulation, half of them see a passive role which is sustained by gathering or sending information about the community. However, a more active role can be seen in the other half of the answers. Having identified the problems, the health centre can demand solutions

> *Because it is in contact with the community, the health centre can hear the community requests and send them to the state secretariat asking for improvements.*

Another role health centres see for themselves in policy formulation is to participate in the Municipal Health Council. This forum has deliberative power and helps to formulate the objectives in terms of public health for the municipality.

Very few state health centres mention other two roles - 4 out of 48 - namely, the role of evaluating and the role of formulating health policy at the health

centre.

> *Through its work the health centre has the opportunity to judge the effectiveness of some implemented programmes have had in its community, and so to contribute to the formulation of future policies.*

> *If we have a multiprofessional team which formulates programmes according to the Ministry of Health recommendations and the political wishes of the head of the health centre, it is possible to formulate public policy.*

Perhaps the low number of health centres which see a role for themselves in policy formulation explains why health centres are not committed to collecting information about their communities. To those which see themselves as responsible for implementation it does not make too much sense to spend time collecting information within the community. At the same time, health centres that concentrate on consultations of doctors, dentists and health assistants cannot be expected to deliver much more than some minimum statistics.

7.4.2. Policy formulation at the municipal (capital) health centres

The municipal health centres believe that the state policies are influenced by federal policies (36.4% of health centres) and by the Regional Health Authorities (27.3% of health centres). They think that what influences policy formulation at the municipal level are federal policies and pressure groups (1/3 of health centres each). Only two health centres think health centres are a source of influence.

Six out of nine municipal health centres see a role for health centres in policy formulation at the municipal level. The closeness between the heads of the health centres and the health secretariat seems to help the heads to see a clear role for health centres in policy formulation.

> *The health centre participates of the Health Centres Heads Forum. This Forum participates in policy formulation.*

Other forms of policy formulation identified by the municipal health centres focus around information: providing information, helping in epidemiological

studies, indicating priorities, and detecting community problems. There is also some criticism of the use the health secretariat makes of the information provided:

> *If the data from the health centres consultations were used in a better way, policies could deal with the needs of each community.*

It is curious to notice that municipal health centres do not refer to themselves as policy-makers. They remain in the phase of providing information or even selecting policies, but do not define for themselves any active role in policy formulation. However, based on my observations, at least two health centres formulate and implement policy at the health centre level, but they do not perceive their initiative as such. Policy still sounds like the work of policy-makers and initiatives at the grass roots are not acknowledge as policy.

The issue of policy formulation at the health centre level shows that there are differences among health centres under the control of different levels of government. Municipal health centres formulate policies and some of them see a role for themselves as 'policy-makers'. In general, the state health centres do not acknowledge this role. In any case, the micropolitics of health centres - e.g. disagreement with health secretariat's positions - can re-shape policies. Even more impressive is the fact that some health centres formulate their own policies. In terms of bio-politics this variety of approaches point to the importance of politics of everyday life in the understanding of the management of the social body.

7.5. Policy dissemination

The process of policy dissemination does not seem to be easy to follow. The State of Rio Grande do Sul did not answer the questionnaire about how many policies it produced in 1992. Half of the state health centres did not say how many policies they received that year. What the answers indicate is that there is not a strict control on policy dissemination. Health centres mention between zero and 11 policies received in one year. The same figures apply to specific health centre policies. Clearly what people understand by a specific health education policy is not always the same

thing. More curious is the fact that the State of Rio Grande do Sul does not have a team to formulate specific policies for health education. So, all policies are about an area of health and may contain health education activities in their programmes. The federal government does produce specific policies on health education, but it is difficult to explain why federal policies are reaching some health centres and not others.

There was more agreement among municipal health centres. Two health centres even listed the policies they received. They are not all the same, but there is a central core thematic. All but two received about six policies. There are two procedures that municipal health centres take when they receive new policy. Half of them have the policy examined by the head, but all of them have the new policy presented in a staff meeting.

At the municipal health centres the predominant way to discuss a new policy is again in a regular staff meeting (53.8% of health centres). Other alternatives (both 23.1% of health centres) are to form a group of study to discuss it or delegate someone to examine it. In both cases these strategies come together with a meeting.

When a new policy arrives at a state health centre different procedures for dissemination are adopted. From a first look by the head of the health centre until its implementation, there is a variety of power strategies which can prevent or ensure its implementation. These power relations can be of different spheres, such as professional competition, preference for policies of some health areas, the relations between health centre and community, etc.

In state health centres, procedures for dissemination are: the head will examine it (41.3% of health centres); less frequently there will be a meeting with the staff or a memoranda will be issued (both 20.8% of health centres). The health centres which preferred the memoranda do not have meetings and vice-versa. Every single policy which is displayed on the notice board is examined by the head, but only

in six health centres does the head examine the policy before a meeting. This suggests that there are two ways of disseminating policies in the state health centres: the first one, a more centralized strategy, is where the policy goes to the head who subsequently notifies the staff (memoranda or board); the second strategy, a more collective one, is an initial assessment by the whole group of professionals.

What the process of dissemination of policies shows is that different health centres use different power strategies to circulate the policy. Bio-power/knowledge has two alternative paths: either the policy empowers the head in her/his position as a leader of the team or it empowers the group who 'knowing' the secretariat's requests, makes use of its 'knowledges' to define priorities. At this level of micropolitics, subjugated knowledges about the community, the quantity and performance of the staff or a previous 'evaluation' of the policy - even before implementing it - are ways of re-shaping any policy. The fact that health secretariats do not monitor the implementation of every policy and that health centres which do not implement policies are not penalised in any way, provides a proper background to any form of policy dissemination - from a note on the board to a full discussion among all professionals. The dissemination policy does not involve the community. Policies are meant to be a formal communication between the government and those who will implement it.

This description of some of the practices of dissemination corroborates the view supported here that micropolitics at the grass roots level are very influential in the policy process. The web of power relations between employer (government) and employee (health professional), the head and other professionals, professionals and community, among many others, can end up jeopardizing the process of policy implementation.

7.6. Policy Implementation

At the municipal and state health centres, policy implementation

depends on things such as the internal structure of the health centre, democratic or autocratic ways of making decisions, the number and qualifications of the staff, and also the views of professionals about the meaning of health and health care in their community.

Health centres do not make clear how much they 'need' the health secretariat to implement policies. More than half of the state health centres (54.1%) get in touch with the health secretariat to elucidate doubts when a new policy is received. The preferred way to discuss new policies is in a regular meeting of the staff (25%). However, those who prefer the technique of meeting do not contact the secretariat to solve their doubts. It looks like if they prefer to develop their understanding of the new policy, using the staff meaning as **the** meaning. Once at the health centre, the policy creates a new meaning, a meaning constructed at that level. This is an example of what was referred to in previous chapters as the 'traditional way' (or 'current way') of doing things at the grass roots level; an approach developed at the health centre which re-constructs what is sent from the secretariat and implemented according to the knowledge of those who work at the health centre. Some state health centres (13.5%) also create a group of study to explore the new policy. However, there is no participation of the community in deciding priorities in policy implementation.

One in each three health centres consults the health secretariat when it wants to make adjustments on policies. However, only one health centre said it does not consult the secretariat about making changes. All the others (66.6%) refuse to express their opinions about this issue.

The policy implementation is partial in half (50%) of the state health centres. Only one health centre said it is total. It means that almost the other half prefers not to make explicit how far are policies implemented. One health centre added a comment to the statement 'the implementation is partial, according to the possibilities of the health centre'. It said: "and staff disposition".

Policy implementation at the municipal health centres is partial. One health centre says that, exceptionally, they manage to implement one policy fully. Adjustments are negotiated with the health secretariat (77.8%). The majority of health centres prefer a group to co-ordinate the policy implementation process, but the head can play this role in some municipal health centres.

According to the answers to the questionnaire, the decision about the priorities in each policy is made by the health secretariat team, some members of the team or the head; also, the state and municipal secretariats are identified as those responsible for selecting priorities. 17% of state health centres claim that the state secretariat and the Regional Health Authorities select priorities. However, in half of the cases this selection of priorities is done in consultation with someone at the health centre (the head or the doctor).

Finally, two state health centres acknowledge that there are no priorities in health policy implementation.

> *The national health system in the current moment is characterized nationally by a general 'chaos'.*

In spite of the apparent power of state and municipal health secretariats, the selection of priorities is mainly a health centre domain. 64.1% of health centres make these decisions. The head of the health centre, in some cases with the help of the secretariat, decides priorities in 35.9% of the health centres. The staff decides in 18.86% of the health centres. There is only one group of professionals with power to make independent decisions: doctors. In 9.4% of the health centres they decide.

> *In general, the doctor implements the policy which is related to his specialty according to his wish.*

The community participates in the decision of priorities in seven state health centres. But in none of these does the community have access to meetings or documents at the health centre level. Participation occurs through the presence of the community at the Municipal Health Council. The other way community participates

is through increased use of the health centre services, thus indicating its preferences by means of consumer demand.

The decision of priorities at the municipal health centres is made by the health centre itself. In some cases there is consultation with the health secretariat or the community may participate in some meetings. But as a rule, it is the staff who decides about priorities. One health centre explains that the staff members do not have all the same decision power.

> *It is a collective decision; basically it is made in a meeting among the most participatory members of the staff (head, nurse, social worker, dietitian, social service assistant, some assistant practical nurses). After it, the decisions are presented to the whole staff in the regular staff meetings.*

The community participates in almost half of the municipal health centres in selecting priorities in policy implementation. The Local Health Council seems to be the forum where the identification of priorities happens. Two health centres say that the discussion of priorities at the Local Council is incipient. One health centre has meetings with the community to detect priorities in general and later takes it into account when deciding policy implementation.

Looking specifically at the health centre policies, 66.7% of the state health centres said they know policies related to health education and already implemented some or all. At the other extreme, 16.7% of the state health centres said they do not know of any policy and have no activity related to health education. In between there are two groups (6.3% each) where health centres do not know any policy, but do have activities and another where they know the policy, but did not implement it. By contrast, all municipal health centres said they know the policies and implement them.

In the State of Rio Grande do Sul there are no specific policies about health education. The health centres consider any health policy as a potential health education policy. When they respond about successful health education activities and their respective policies, they present a mixture of policies and health activities. This

lack of precision shows that health centres are not used to establish connections between daily life activities and policies. It is as if the policy or part of it has to be fitted into the health centre routine and afterwards it becomes part of the way the health centre carries out any health practice.

About one third of health centres (35.4%) did not provide any answers about 'successful activities' in health education and more than half (58.3%) did not refer to 'unsuccessful experiences'. The successful activities cited in the questionnaires are of two kind: health activities in general (which would contain some health education) and specific health education activities. The examples of successful activities of the first group are vaccination, breast feeding, medical consultation, tooth brushing or prevention of cervical cancer. The health education activities are mainly talks. Health education groups, providing information, and audio-visual presentations are less likely to occur than talks. The most common place for talks is in schools. Activities which can be recognised as health education are only 20% of all activities mentioned as such.

Vaccination itself was identified by more than half of the state health centres which answered the question about a successful health education activity or policy. Indeed, the campaigns of the state and federal governments in the eighties and nineties emphasized vaccination. So, it is not surprisingly that vaccination was mentioned so frequently. Vaccination is one of the few procedures that is always available at health centres. At the state level, there was a joke among policy-makers at the time of the fieldwork: "In order to get money for your policy you must include some vaccine on it". No vaccine, no support, they argued. Though it is understandable why health centres acknowledge vaccination as a successful health policy, it is not clear why they consider it (and others cited above) as health education. Perhaps health centres have nothing else to present as health education and prefer to show some successful general health activity rather than nothing. Another explanation is that their concept of health education includes health promotion, preventive care, and health education all the three being seen as the same thing.

Almost any health activity can be justified under a variety of health policies available from the federal, state and municipal governments. Among successful and unsuccessful experiences there are clear references to federal and state policy, with identified names. Two federal policies (*PAISC - Programa de Assistência Integral à Saúde da Criança and PAISM - Programa de Assistência Integral à Saúde da Mulher*) and one state policy (*Sul Vacina*) are correctly mentioned. However, the predominant pattern is a partial reference to the name of a policy or the health area to which it is related to. For instance: Adult Health, STD Prevention, Women's Health.

Health centres reveal themselves as a place to women and children when they refer to the national policies to women and children and state policy on vaccination more clearly than to any other policy. These three policies have been supported with educational materials, mass media campaigns, basic equipment to health centres, and health centres have been trying to implement them, although having unsuccessful experiences in some cases. But the reference to the attempt to implement is seen as a sign of commitment to the policy. Many other policies would never receive this attention at the health centre level. The focus on women and children relates health education to the management of the spaces considered to be private. Successful or unsuccessful, the policies that the health centres are most familiar to are those which put them in touch with families, reproduction and 'next generation' of citizens. Donzelot (1980, p.xxii) illuminates this situation saying that:

> *... the woman was chosen by the medical and teaching professions to work in partnership with them in order to disseminate their principles, to win adherence to the new norms, within the home.*

The way policies are referred to suggests that health professionals know them in general terms. The initiatives at the health centre level can be easily linked to them. The long-running policies and those supported with materials and media campaigns are the only ones recognized. But again under their large umbrella they allow for many initiatives. For example, as *PAISM* activities, giving information, consultation, groups and talks are listed. Some of them should have very distinct

approaches, even contradictory to the policy orientation. Nevertheless, because there is a policy concerned to women's health every single activity involving women can be viewed as implementing *PAISM*. Just one health centre mentioned that its mental health group was an alternative experience to the *PAISMental* policy.

The group of unsuccessful experiences refers to the same policies, but points to some aspects which did not work well in a particular health centre. The most common problems are at the food distribution policy, contraception, breast feeding and old age-related activities.

The main problem with this kind of data is to understand what constitutes the criterion for success used by health centres. Certainly, some health centres are more stringent in terms of results than others. Whilst many referred to vaccination as a success, one health centre presented its unsuccessful experiences as follows:

> *Vaccination: many absences and we do not have control about it; Diarrhoea (PAISC): we do not have a way to start the treatment at the health centre; Acute Respiratory Disease (PAISC): we do not have the remedies.*

The example above talks about criteria of success but also clarifies how health education is perceived. There is a conflicting discourse on health education between policy and practice. Tones et al. (1990, p.242) question how to put together two distinct philosophies in health:

> *on one side, a radical, self-empowerment model of health education and, on the other, the preventive medical model seeking to change behaviour and maximize the efficiency of health and illness services.*

The successful health education activities in the municipal health centres are the focus groups (12 groups in 9 health centres), home visits (result of a municipal policy) and giving information to individuals. There are other activities that are considered health education: vaccination, condom distribution, etc. Overwhelmingly they refer to two federal policies: *PAISM* (7 times) and *PAISC* (10 times)like in state health centres. One health centre makes explicit that one of the

health education groups was a priority decided by the health centre. It is a group called 'Parents-Baby'. In this way, other health centres create their own health education activities. But, they justify the activity under the name of a broad policy. For instance, one health centre cited an activity called 'Community Survey' and referred it as a part of the Workers' Health Policy. Though it can be related to the theme, this activity was created by the staff of the health centre.

The nonsuccessful activities at the municipal health centres are related to old age, adolescents, pregnancy groups, food supply programme, and campaigns. Two health centres commented on adolescents' groups as a nonsuccessful activity. However, two other health centres mentioned it as a successful experience. Among the data collected there is no evidence that any secretariat promotes exchange of experiences between health centres.

Vignette 5

'Aids and the truck'

'Health Centre 2' observed during the fieldwork a group of the municipal secretariat was requested that the health centre should be the place for a pilot implementation of the HIV/AIDS policy. The first concern of the staff was 'why us?'. The implementation of a new policy is immediately associated with additional work. Some members of the staff manifested interest on the policy because they had been facing difficulties working with such issues.

The negotiations to persuade the health centre to become the 'pilot' of the experience involved a compromise from both sides. Health professionals used the fact that policies are not always implemented to bargain for some facilities for the health centre. In order to get their commitment, the head of the policy group had to find some solutions to old problems of the health centre. The main request was to clean the health education/meeting room, full of rubbish that the health centre itself has no authority to throw away (see Appendix 4, photo 4). They had frequently asked the secretariat to collect the old equipment stocked there, but this never happened. So, in order to persuade the staff that the HIV/AIDS policy group was responsible and supportive, in two days all the refuse had been collected.

What was not mentioned to the health centre staff was that there was no place at the health secretariat to store this old equipment. Bureaucratic reasons prevent an easy way to get rid of refuse. Then, the solution to overcome the initial difficulties to the implementation of the HIV/AIDS policy was to leave all the rubbish in the truck that collected it. A truck had to be reduced to half of its cargo capacity for some weeks to allow health policy to be implemented.

Vignette 5 shows that micropolitics at the health centre level can block or postpone a policy. Health professionals' political game of becoming 'volunteers' for a pilot implementation can be seen by them as an opportunity to change something that was disturbing their work. If they decide not to carry out the pilot project, it

would be difficult to achieve anything. However, not all policy-makers acknowledge this bio-power knowledge of health professionals.

The fact that it is almost impossible to fire health professionals and the fact that policy implementation is not taken for granted at health centres empowers professionals to negotiate their requests in some occasions. The knowledge health professionals have about the community is not systematic but is something policy-makers do not have themselves. The possibility of being in touch with every patient and checking some aspect of their lives empowers professionals. The exercise of bio-power/knowledge is part of their daily activities.

This section on policy implementation illustrates some of the many situations that take place at the grass roots level and which interfere with policies outcomes. The micropolitics at the health centre involve, as seen here, the understanding given to policies by health professionals, the concentration of decision-making among some professionals, the continuous trend of partial implementation of policies, the focus on women's and children's health, etc.

In some respects state and municipal health centres have shown different positions in implementing policies and the generalization made here, mentioning 'the health centre' as a single entity, could hide the diversity of power relations involved in the politics of everyday life..

Governmentality, in this context, is reached by the continuity of the 'current way' health professionals treat policies and everyday issues at the health centre. Professionals' ordinary approaches to health care, selection of priorities, and power relations among themselves, result in a certain pattern that shapes their relations with patients. It is in this locus that patients and professionals create upwards and downwards continuities in the way of governing.

7.7. Policy monitoring

The question about the process of policy monitoring was not answered by one third of the state health centres. This means 23% more health centres declined to answer this specific part of the question (as compared to the other parts of it). Two health centres said there is no evaluation and one said that there is no 'formal' policy evaluation. The community is seen as participating of the evaluation process in two health centres, both of them with no community representative at the health centre level and no health centre participation in the Municipal Health Council.

At the state level, the staff of the health centre carries out a preliminary evaluation (18.6%), but they said that only half of the evaluations are followed by a secretariat monitoring. In 22% of health centres the results of an evaluation at the health centre level are sent to the secretariat. One in four health centres acknowledges that the secretariat carries out some form of monitoring. The evaluation made by the health centres added to the monitoring made by the secretariat altogether covers fewer than half of the health centres (47.5%).

At the municipal level, the assessment of policies by the staff is the most frequent monitoring strategy. Out of six health centres which evaluate the policies they implemented, four send their findings to the health secretariat. The secretariat itself is seen as monitoring policies in half of the health centres. The haphazard methods of monitoring policy implementation suggests that the information obtained from this process does not have vital importance to the governments or health centres.

7.8. Professionals in charge of health education

Bearing in mind that doctors and assistants make up more than 80% of the professionals in the state health centres (RS-SSMA, 1990, p.20), it is worthwhile to see which professionals were indicated in the questionnaires as those responsible for health education. Among the state health centres 60.4% said *all professionals* are

responsible for carrying out health education activities in the health centre. This means that, excluding those who did not answer the question, 37.5% of the health centres gave responsibility for health education to some but not all professionals. Not surprisingly, psychologists and dietitians did not receive any mentions because they are rarely seen at the state health secretariats. In spite of the fact doctors are around 15 times more frequent than nurses in health centres, nurses received 15.8% of the indications as the professional in charge of health education. Doctors received 13.2% of the indications. Dentists, pharmacists and social workers received only one mention each. The other group of professionals seen as in charge of health education is the nurse's assistants or 'those doing this job' (without formal preparation). Auxiliaries, assistants and practical nurses together received 27.6% of the indications. So, health centres believe all professionals have to carry out health education, but more than one third of them suggest that nurse's auxiliaries, nurses and doctors should be in charge. The lack of professionals other than doctors and assistants in the state health centres could explain the preference for these two members of the team. But, the choice of nurses suggests that the nature of their work should be a reason for the preference.

Differently from the health secretariats (as seen in the previous Chapter), health professionals do not overtly choose those in charge of health education according to their 'sensitivity'. However, some believe that the nature of the work of some professions (women's professions more specifically) os more related to health education. This position reveals some similitude to the choice according to 'sensitivity' - educating for health seems to be a 'delicate' task, perhaps a 'feminine' one.

At the municipal level, more than half of the health centres believe that all professionals are responsible by carrying out health education. The other half thinks that nurses and social workers are the most suitable professionals to undertake health education activities. In a second position are doctors, dietitians, and practical nurse assistants. Psychologists and dietitians' assistants were also mentioned.

The preference for nurses and social workers raises a doubt about the status of health education within professionals. Is it the fact that health education should be developed in a constructive ('delicate') way that links it to women's professions? Or is that it does not have the same status of other 'scientific' disciplines? The data collected do not allow any attempt to answer to this issue.

7.9. Health education activities and tools

State health centres have two main ways of doing health education: 79.1% of them use posters as a tool for health education and 77.1% provide information to the patient at the consultation. In 64.6% of the state health centres they also give talks when requested. Only one third of them have group activities or systematic talks at schools, neighbourhood associations or 'Mother's Club'.

In terms of resources health centres look pretty poor. Just one health centre mentioned a video at the waiting room and five mentioned audio-visual/video resources for selected audiences.

There are some other ways to do health education, especially in small towns in the countryside. Three health centres of the same Regional Health Authority use the local radio and/or newspaper to develop some health education. One of the health centres also cited meetings with the local MPs as part of their health education activities.

The data above show that health centres have their own conceptions about what health education is. They are different and distant from the proposals of the federal policies. The gap between the government discourse on health education and the practices at health centres shows two main streams in the construction of health education: progressive discourses on participation and empowerment; traditional practices based on the bio-medical model . The bio-power/knowledge that is exercised by both tendencies has been a continuity for more than a decade and has

changed very little through this period.

At the municipal level the posters, ad hoc talks, and giving information to patients happen at all health centres. The other set of health education activities is the health education groups (focus group and waiting room group). They occur in around 70% of the health centres.

Compared to the state health centres, municipal health centres seem better positioned to develop health education: policy-makers are in contact with health centres, there are possibilities of negotiation to implement policies, and a bigger variety of health education activities with an emphasis on group activities. The presence of a multiprofessional team, the small number of health centres, and the implementation of the *SUS* reform could partially explain this achievement. But the whole set of reasons to explain why some health centres are more committed to health education than others is something this study cannot cover. However, conceptions about what is health education could be of some significance and are explored in the segment below.

7.10. Health education conceptions

As in other questions, the respondents do not reveal a single understanding about health education. When choosing between social and individual reasons to explain health and disease, they take both. Among the 48 state health centres, explanations of the causes of ill-health represent a mixture of theoretical positions, e.g. low wages (43 in favour; 4 against) and bad living conditions (46 in favour; 1 against) are accepted as much as ignorance (45 in favour; 2 against) and bad habits (47 in favour; 0 against). The pattern is choosing both social and individual reasons also in trying to define health education, e.g. health education as a promotion of healthy habits has 39 in favour and 5 against; health education as increasing autonomy has 38 in favour and 7 against. The statement 'to keep health just demands changing some habits' got 9 in favour; 35 against. The other one about 'keeping a

healthy life just demands minimal material conditions' had 38 in favour and 3 against.

The answers of the state health centres, like 9 who think that to be healthy just requires changing of some habits or 7 against the idea of health education as increasing autonomy, show that behind the notion of health education is the believe that human beings have autonomy to change their habits and social factors are not essential in this process. Perhaps this is why 7 health centres disagree with the idea that health education is about improving autonomy. Autonomy is taken for granted by some professionals as an intrinsic condition of their patients' lives. The social aspects are also acknowledge by the health centres when they chose wages and living conditions as reasons to explain health and disease. But they indicated equally bad habits and ignorance without connecting them to social factors. Both ignorance and habits are driven to the sphere of personal power; through autonomy bad habits could be changed.

The municipal health centres answered the questions in a more homogeneous way. 'Wages and living conditions affecting health' had 9 in favour each and none against. 'Ignorance and bad habits' had 8 in favour and 1 against; 'a good health demands few material conditions' had 8 in favour and 1 against; 'change of habits to keep health' 8 against, 1 in favour; 'health education mainly improving autonomy' had 9 in favour, 0 against; and 'promoting healthy habits' was split in 5 in favour 4 against.

The municipal health centres fit partially in the analysis of state health centres, but the 'improvement of autonomy' is fully accepted as an aim to health education and 'health education promoting healthy habits' was a controversial issue because it was the only item that broke the similarity of the answers.

Most of all, these assumptions about health education show that there is a consensus between health centres: they acknowledge both individual responsibility for health and empowerment as a possible result of health education. State health

centres concentrate their activities on individual consultations and talks when required, and selected more assumptions related to individual responsibility. But the discourse of empowerment is also acknowledge in their answers. The municipal health centres develop more participatory activities, provided more answers about empowerment, but also selected those related to individual responsibility for achieving health. These mixed discourses on health education bring together the Ministry discourse on participation and the traditional health education model based on a bio-medical understanding of health. So, there is no single domain in health education that allows the circulation of power without resistance and re-shaping policies; and the micropolitics that take place at the health centres is part of it.

7.11. Conclusion

From health education conceptions to policy implementation, health centres represent a location for the exercise of bio-power/knowledge. Their contact with the population and the power of micropolitics to prevent or promote the implementation of policies make them a special site for the understanding of the construction of health education. Discourses of empowerment and traditional practices reinforce and challenge each other.

Some examples from the data analyzed in this Chapter illustrate the capacity for organization of health professionals and how they exercise power: the community does not participate in the decision-making process at most of the health centres; policy dissemination varies greatly from one health centre to another; implementation depends on doctors' interests, heads' involvement, and "staff disposition"; implementation is always partial in municipal health centres; many activities carried out in the health centres do not correspond exactly to a single policy; some health education practices are created at the health centre. In terms of policy, there are many ruptures and continuities are rare.

However, the issue of governmentality through bio-politics can be

noticed in the gap between the discourse on health education for participation and the 'doctor-assistant' model of the health centre, which mainly offers consultations. Developing policies that do not get implemented and sustaining practices that are not challenged by policy have been continuities in the constitution of health education in the Brazilian national health system. Therefore, health education keeps its prescriptive power, disciplining bodies and normalizing life through healthy behaviours, and the management of the population concentrates on women and children as the main target of policy implementation and health centre consultations.

CONCLUSION OF SECTION I
HEALTH EDUCATION AS BIO-POLITICS

The main argument of this Section was that health education is the aspect of health policy which increases the power of the government to rule individual and collective life. Data from the policy process of federal, state, municipal, and health centre levels were used to examine this argument.

In Chapter 4 the Brazilian national health system was described and analyzed as a site of the management of the poor. In this context, health education policy can be understood as a strategy to regulate a 'dangerous mass'. The regulatory controls proposed in health education policies can vary from the prescription of healthy behaviours to proposals of community participation in the decision-making process at health centres. Both poles were seen here as regulatory controls because it is the rationale of this thesis that education for health does not have the capacity of empowering and liberating people from the inherent processes of disciplining and normalising that lead to docility. They happen at the same time and participation can be conceived as a constructive power exercise to share responsibility with the population for a service that the government should be delivering. It also makes health education a more acceptable practice.

In Chapter 5 the data from the National Division of Health Education provide elements to question the idea that bio-politics is a straight line of power linking the central government to the population. In times of different political tendencies the discourse has been most the same - health education should transform power relations at health centres to improve community participation. The discourse on participation, the other discourses in state and municipal policies, and the practices reported in documents, all presented in Chapter 5, show that health education is composed of many discourses and implementation is not a necessary achievement of every policy formulated. Federal health education policy has been circulating a discourse that is in

consonance with the World Health Organization documents and other international agencies.

The concept of bio-politics apparently loses its power when health education policy is conceived as a site for conflicting discourses, not as an efficient mechanism to circulate power. As in any other power exercise, bio-politics encounters resistance and policies are the result of a tension between different conceptions of health education. The tension is between two exercises of bio-power: one prescriptive, related to a bio-medical model of health, totalizing the collective body by supporting standardised and mainly individual health habits; the other one is participatory, related to a social view of health, which bridges health centres and community through activities planned by both groups and individualizes norms of 'healthy' conduct, making them more acceptable. Thus, health education policy has been a technique of bio-politics but the strategies adopted can vary from a more repressive to a more constructive approach.

Chapter 6 analyzed the making of health education policy in state and municipal governments. The data presented showed many ruptures in this process. Two important features were, first, the differences between the federal government discourse and the propositions of state and municipal policies and, second, the presence of health education in most health policies. The multiple 'bits' of health education everywhere and the lack of implementation of federal policies lead to the maintenance of the 'current way' of doing health education at the level of implementation in health centres. This means that health education policy as bio-politics is ubiquitous in health policy bringing a more complex surveillance into the health area.

At the health centre level policies are re-shaped by the micropolitics that take place there. In Chapter 7 many examples from the political articulation of health professionals illustrated that policy implementation cannot be taken for granted. In general policies were partially implemented and the criteria for deciding which aspect was to be emphasized varied from one place to another. From health centres'

information on their communities, detailed knowledge does not seem to be a vital element to bio-politics as far as the health centres keep their role in disciplining and normalizing life in 'the social'.

Bio-politics, as one of the poles of bio-power, exercises control over the social body by ruling biological processes. Power over life is acknowledged here as a political power. The contribution of this study so far has been to reveal that health education policy is not a single power strategy that is used in the government of the population. Rather, it is a cluster of power relations constituted by alternating conceptions and practices of personal choice for healthy life styles and community empowerment to transform power relations at the national health system. In both conceptions, health education has maintained its basic features of disciplining the poor to consolidate a society of security.

The concept of bio-politics has proved useful to the analysis of health policy. However, due to this theoretical choice many elements of traditional policy analysis which could suggest alternatives to improve the health education policy process have been left out of this study. The confront between Foucault's concept and the data collected here helps in the understanding of the complexity of the notion of bio-politics at the same time that challenges it. The idea of management of the social body through tactics, such as social policy, provides an idea of continuity in the policy process (probably counting on policy implementation) that was not found in this study.

In the next Section the other pole of bio-power, anatomo-politics, will be examined. The daily life of users and professionals of two health centres as well as the health education activities (consultations and focus groups) developed there are explored to develop better understanding of how the mechanisms of disciplining and normalising are related to health education practices.

SECTION II

HEALTH EDUCATION AS ANATOMO-POLITICS

INTRODUCTION

In this section of the thesis the social construction of health education will be investigated in its relationship to the micropolitics that take place at the site where the national health system meets the population: health centres.

The potential that the national health system represents for the management of the population can be only accomplished through the practices carried out at the health centre level. Within the health centre, health education is part of the exercise of power that occurs in the process of governmentality through the national health system.

The examination of practices at the health centre level reveals power mechanisms embedded in daily life that lead to docility and optimization of bodies, but also points to movements of resistance. This Section analyzes the health system's set of routines which organize access to consultations and other procedures, like drug distribution. These practices are commonly taken for granted as the traditional and only possible way of systematizing activities.

This Section also concentrates on specific health education activities developed at health centre level. The two health centres observed provided a good opportunity to explore the practices related to health education because they were among those developing a substantial quantity and quality of health education activities. The activities selected for in-depth study in this Section were consultation and focus group. Information giving, during consultation, is the most common health education activity in health centres, according to the information provided by health centres of Rio Grande do Sul (State 77%, Municipal 100%). Focus group activity is not frequently carried out at the State level (State 27%, Municipal 77%), but when developed it constitutes an entire activity devoted to health education.

In order to understand how health education practices are related to the anatomo-politics of the human body, this Section investigates the processes of creating discipline and normalization of bodies through the contact of the user with the national health system and health education. The main argument of the Section is that health education is mainly a constructive exercise of power to the management of the individual and collective body. The sub-arguments developed are:

- The contact of the user with the national health system represents an experience of disciplining and docilizing individual bodies through a system of surveillance, normalisation, punishment and rewards.
- Health education adds a constructive approach to the consultation. It makes the experience of using the national health system more tolerable and increases the link between the user and the health centre.
- Health education represents both subjugation and empowerment of the patient. Both processes occur simultaneously in health education activities and the power relations that take place between professionals and patients will emphasize one over another, but never eliminate one of them.

Unlike in the previous Section, the specific theoretical framework has been split between the three chapters instead of being presented in the first chapter because many of the concepts used here have already been introduced in Chapter 1 and Section I.

CHAPTER 8

LEARNING TO BE A PATIENT CITIZEN: THE EXPERIENCE OF USING THE NATIONAL HEALTH SYSTEM

8.1. Introduction

Before having access to any health education activity the user of the Brazilian national health system has to experience a set of routines. To gain access to any procedure or activity the person usually has to queue for some time and explain the problem to some two or three professionals before receiving the information or procedure required.

When analyzed as an individual experience, the contact of the user with the national health system does not show the collective dimension of the problem. According to the *Zero Hora* Newspaper (A falência da saúde pública, 1994, p.2), in the capital of Rio Grande do Sul, one of the richest states of Brazil, every dawn, 20,000 people circulate through the 90 health centres of the capital, queuing for hours outside the buildings. There is a whole set of common experiences that the users of the national health system share all over the country. To queue for long hours is just one of them.

This Chapter describes the routines observed in two health centres in the city of Porto Alegre. The details about the health centres already have been provided in Chapter 2 - Methodology. The data used in this Chapter comes from fieldnotes and interviews with patients and health professionals. After an introductory review of literature, this Chapter describes the phases that an ordinary user of the national health system has to undergo in search for health care.

The argument of this Chapter is that the contact of the user with the

national health system represents an experience of disciplining and docilizing individual bodies through a system of surveillance, normalisation, punishment and rewards. Connecting the poles of anatomo-politics to bio-politics it is possible to say that the health centre contributes to the exercise of governmentality establishing norms of behaviour among its users.

In order to investigate this assumption this Chapter is divided into 7 sections as follows: anatomo-politics of the human body, discipline, gaining access to the national health system, preparing for the consultation, after the consultation, other services provided by the health centre, and rewarding the 'patient' and hard working patient.

8.2. Anatomo-politics of the human body

The exercise of bio-power aims at controlling life in its individual and collective processes. Anatomo-politics is concerned with the docilization of individual bodies as Foucault (1990, p.139) explains:

> *(it is) ... centered on the body as a machine: its disciplining, the optimization of its capabilities, the extortion of its forces, the parallel increase of its usefulness and its docility, its integration into systems of efficient and economic controls, all this was ensured by the procedures of power that characterized the* ***disciplines****: an* ***anatomo-politics of the human body****.*

Repressive and constructive approaches have been used throughout the last centuries to achieve the usefulness of bodies. The development of capitalism demanded bodies which fit into the machinery of production (Foucault, 1990, p.141). From physical punishment to training, many techniques have been employed in different sites of social life.

Anatomo-politics became part of daily life, an invisible power, with no exteriority but tangled in the relations of knowledge, surveillance and others which discipline bodies. Ewald (1992, pp.169-175) argues that discipline was transformed from a negative form - like blocking the poor and mad in society - to a mechanism that

targets bodies to train them. Ewald (1992, pp.169-170) points out that:

> *Disciplines are no longer the prerogative of certain institutions ... Disciplines become ubiquitous and liberated, no longer addressing only someone who is to be punished ... they are placed at the service of the good, the good of all, of all socially useful production. Disciplines are addressed to all people, without distinction.*

Foucault (1991, p.170) states that "discipline 'makes' individuals"; individuals are objects and instruments of this specific technique of power. Some of the ways used to construct the 'disciplined person' are investigated below.

8.3. Discipline

The discipline of bodies is based on the vast network of disciplinary experiences each individual encounters through life. Health centres contribute with their own set of techniques. Foucault (1991, pp.215-216) claims that discipline is not a practice of one or some institutions. Rather, it is a modality of power that infiltrates the others, making sense of different experiences and linking them through the social fabric.

Ewald (1992, p.170) corroborates this point saying that disciplines create a "common language between all sorts of institutions". He adds:

> *Disciplinary society is a society of absolute communication: the diffusion of disciplines makes it possible for everything to communicate with everything else according to an interplay of redundant elements and infinite homologies.*

The question that remains is how discipline works. Dreyfus & Rabinow (1982, pp.153-155) mapped Foucault's theory and this is a summary of the process of disciplining: (i) parts of the body are subjected to precise training; (ii) small scale training is generalized on a large scale; (iii) control is constantly applied relating to time, space, and movement - standard operations are created.

The desired outcome of this process is a total docility, which demands minimum but constant surveillance to achieve efficiency. The process of disciplining bodies is also done through the meticulous regulation of the "the smallest fragments of

life" (Foucault, 1991, p.140). In the case of the experiences of the users of the national health system, there are rules and norms to gain access to every little procedure they request. This experience of discipline is re-enforced by mechanisms of minor punishment or reward according to individual 'performances' of the users.

Foucault (1991, pp.177-178) links discipline to punishment of inadequate conduct and reward of correct behaviour. As he explains:

> *At the heart of all disciplinary systems functions a small penal system. ...The disciplines established an 'infra-penalty'; they partitioned an area that the laws had left empty; they defined and repressed a mass of behaviour...*

This system of micro-penalties can be seen in the school, work, family or in the national health system. Foucault (1991, p.178) relates penalties to most areas of human life: use of time (control of absences, lateness); behaviour (disobedience, impoliteness); use of the body (lack of cleanliness); development of activities (lack of zeal, inattention). The solution to these minor 'problems' patients could present is to train them to be patient citizens. The norms and routines have to be learnt and the gratification-punishment system regulates 'misdemeanours' and 'success' in performances. Foucault (1991, p.180) suggests that rewards should be used more frequently than penalties. They construct desirable models and the disciplined person accomplishes these standards with the help of rewards.

Ewald (1992, p.171) cites three major disciplinary instruments in the work of Foucault: surveillance, normalising sanctions, and examination. The first two are discussed next, whilst examination is the focus of the next chapter.

8.3.1. Surveillance

Foucault (1991, p.173) describes the ideal model of surveillance as a single gaze which sees everything all the time. The idea is that there would be a central point from which nothing escapes and to which all the information and gazes converge. This description relates to the Panopticon - a jail designed to have all the inmates under vigilance of a single central tower in an octagonal pavilion.

Studying the Panopticon, Foucault (1991, pp.200-209) suggests that:

> *(It) ... must be understood as a generalizable model of functioning; a way of defining power relations in terms of the everyday life of men. ... it is the diagram of a mechanism of power reduced to its ideal form; ... It is polyvalent in its applications; it serves to reform prisoners, but also to treat patients ... It is a type of location of bodies in space, of distribution of individuals in relation to one another, of hierarchical organization ... which can be implemented in hospitals, workshops, schools, prisons.* (p.205)

The ideal model of the Panopticon and the way health centres work in the surveillance of the population have in common the principle of surveillance. Surveillance becomes part of everyday life. Health professionals work with both sick and healthy people to cure and to promote health - their gaze covers the whole community for 'the good of all'. For example, a series of rituals of hygiene is the basic feature of the 'healthy' people. At the time of using any health service there is always the possibility of health professionals checking whether the patient has been observing the principles of cleanliness. The space where bodies can be observed goes beyond the limit of health centres. From the health centre, as a central point, gazes can cover any location in the community.

The efficiency of the surveillance model is based on the continuous and never-ending possibility of being observed (Dreyfus & Rabinow, 1982, p.189). In the case of the Panopticon the inmate does not know if the guardian is looking at him/her; in the health centre any contact (most of them indispensable) opens up the possibility of being questioned about the observance of the basic principles of 'healthy' people. The other technology of power used in the exercise of anatomo-politics is normalisation.

8.3.2. Normalisation

It is important to differentiate norm and discipline. The process of disciplining bodies is frequently based on norms. Ewald (1992, p.174) makes a clear distinction between them:

> *'Norm' should not be confused with 'discipline'. Disciplines target bodies, with a function of training them; the norm is a measure, a means by which the common measure is produced.*

The process of normalisation happens through comparison, hierarchisation, differentiation, homogenization and exclusion (Foucault, 1991, p.183). It is a measure against which each individual confront her/himself and so it excludes some, but mostly it produces individuals who share the same principle of comparison (Ewald, 1992, pp.171-173). Ewald (1992, p.173) asks:

> *What precisely is the norm? It is the measure which simultaneously individualises, makes ceaseless individualisation possible and creates comparability.*

Foucault (1991, pp.182-183) argues that the articulation between discipline and normalisation generates distinct processes. A norm can be an optimum which people are expected to reach. It can work as an average or it can be the minimum expected from every person. Norms can become the criteria which measure the 'nature' of individuals. Quantity and quality can be checked through them. Normalisation is also a limit that establishes the degree of difference between what is acceptable and what is considered abnormal.

These distinct ways of using norms will be explored in the analysis of the experiences the users of the national health system have when they search for health care. The optimization of bodies and their integration in economic processes depends on their fitness (health) and access to curative care, but their docility is equally important and the national health system also contributes to the disciplining of bodies. The processes involved in the anatomo-politics of the body at the national health system level are described next.

8.4. Gaining access to the national health system

There are two possible ways to gain access to health care in the Brazilian national health system. The population can chose either health centres or hospitals to have consultations. The assistance provided by health centres is constituted by consultations (usually general practitioners, paediatricians and gynaecologists) and procedures (vaccination, checking blood pressure, nebulization, bandages). According

to one of the nurses interviewed, people tend to go to hospitals directly. The referral system does not work and health centres do not make appointments for patients with specialists. The patient has to do it personally. As a nurse explains:

> *We have patients coming from a very distant neighbourhood to collect medication. Some services work, perhaps with fewer than 50% of the necessary resources, but they still manage to do something. Others are completely discredited. Then, everybody goes to the hospital because there it is easier. You stay for two or three days in the queue, but the compensation is that you will have all the exams, x-ray, everything you need is there and, if necessary, you will be admitted as an in-patient.*

The advantages of the health centre are a same-day consultation and proximity to patients' houses. In order to handle this high demand in the context of a lack of human and material resources, health centres try to discipline the users of the national health system. The health centres observed in the present study have different ways of organizing the access to consultations. Health Centre 1 has queues for each doctor at different times of the day. Health Centre 2 has one single queue early in the morning for all consultations.

The issue of gaining access to consultations is complex. There is a set of rules which must be observed. The rules encompass surveillance, control of space, and codes of behaviour, from those queuing and the health professionals in charge of the process. The official information is that the health centre opens at 7 am and there are ten *fichas* (tokens for consultation) for the paediatrician, for instance, which will be distributed to the first to arrive in the queue[1]. Sometimes subjugated knowledge is also provided: the timetable set by queuing patients. As a practical nurse explained to a patient:

> *We issue the tokens at 7, but it is good to be here earlier ... like 5 am, to get a place in the queue.*

Because the receptionist and assistants do not want to be accused of misguiding patients, not all comment on the best time to get a place in the queue. For

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[1] It is not possible to obtain a token by making a telephone call or writing a letter. Somebody has to be there personally to get the token.

instance, no answer or a body movement of raising the shoulders to say 'I don't know' was seen many times during the fieldwork.

> *P. Can you book the next consultation?*
> *A. It's not possible.*
> *P. If I come at 6 I will get it, won't I?*
> *(no answer)*

The reason why Health Centre 2 decided to distribute all tokens in the morning is to allow people to go home and to create space to deal with the morning patients. One of the professionals in charge of the reception explains it:

> *Today at three in the morning we already had a queue for the paediatrician. Now all the tokens are distributed in the morning because people used to wait until 11 am for the afternoon consultations.*

By interviewing patients in the waiting room it is possible to check the length of time they wait for a consultation. Patient A, waiting for the gynaecologist, arrived at 5:40 am and received her token at 7:15. This makes 1:35 minutes of queuing. At 1 pm she is back because her consultation is in the afternoon. She was lucky to get the first token and will not wait long. Patient B arrived in the queue at 6:30 and got her token at 7:30. She is back at 1 pm for her consultation but does not know how many patients there are in front of her. At 14:15 she is still waiting. That makes at least 2:15 hours waiting. During the fieldwork, the only consultation for a new patient with the dentist at Health Centre 2, was taken by a patient who came at 11 pm on Sunday to get a token at 7 am on Monday.

There is a great concern among patients to checking whether places in the queue are properly observed. Before the health centre has opened, they organize the queue according to the number of tokens for each speciality and tell those who exceed the number of tokens available that they have little chance of obtaining a consultation. When the number of consultations has to be changed, the staff leave a note for the next morning's queue. After the tokens have been distributed those who have consultations in the morning wait there. During the morning, some patients go to the reception to check the order of consultations. Others just wait to be called.

Queuing is part of everyday life for the user of the national health system. A scene that was observed at Health Centre 1 (but which occurred many times in both) was of a patient arriving, saying 'good morning', and then asking: "Who is the last one in the queue?" Silently the patient places him/herself at the end of the queue in order to a bandage changed. Another patient came to ask about a consultation with a psychologist. The dialogue between him and the practical nurse was:

Nurse: Token for the psychologist? Come next Thursday at 8.
Patient: Are you sure I don't have to come earlier? What about the queue?

The long hours required to gain access to a consultation are a cause for some complaints. Patients make comments to other patients or address the reception to complaint; comments like this are heard:

I am here since 4 in the morning and I am still waiting for my consultation!
(at 11 am)

To wait for seven hours for a consultation is not unusual. The patients already have an idea of the time required according to the kind of consultation they want.

Patient: Do you have tokens for the dentist?
Receptionist: It looks like there will be five on Monday .
Patient: Five? So I have to start queuing at dawn.

Dentists and psychologists have a different schedule of consultations because they usually have to see the patient many times. So, once a month bookings are made for the dentist, psychologist and other non-emergency cases. The user can come and book a consultation with the gynaecologist, for instance. On the day of the consultation the patient comes back at 8 am or 1 pm, at the same time as all the other patients booked for that day plus those who received a token on the day, and waits to be called. In Health Centre 2 a patient looking for consultation with the psychologist was informed that at the end of May there will be a new booking. The nurse who is there looks at me and says: "She is in need now, not in 26 days." She suggests to the patient to go to some other places, but the options are few.

There is no way to use the national health system and not queue for

hours. Because it is a compulsory experience, the 'outcomes' of this practice can be shocking. Before the health centre is opened, people stand outside the building. In the winter nights in Porto Alegre temperatures can stay as low as 0 to 5°C. In spite of this, women queue for hours with all their children. Because some are single parents or their partners start working very early, they have no other alternative than taking the whole family to the health centre queue. Each adult is limited to one consultation with any specialist. This means that a mother with two sick children has to take another adult with her. If it is the same disease, perhaps she can persuade the person in the reception to give her two consultations. But two or three different consultations will make things really difficult for her. In the health centres observed, they would try to accommodate a consultation for a second child, but a third would mean one more night in the queue.

In Health Centre 1 a young mother asked for contraception and the assistant practical nurse noticed she is breast feeding. They discuss the issue in the reception as follows:

> *Nurse: What is the pill you take?*
> *Patient: I take the 'micro'.*
> *N: Aren't you breast feeding?*
> *P: Ya.*
> *N: Have you come to the check up?*
> *P: I didn't.*
> *N: This will dry the milk.*
> *P: If I will wait to make it here I will never have it.*
> *N: There are always tokens for pregnant and puerperal women.*
> *P: I came here and they didn't give me any. The baby had a fever and I didn't have the consultation because it is not allowed for the two of us to see the doctor in the same day.*

People look for alternatives such as daughters and sons queuing for their old parents; neighbours caring for the children allowing *only* the sick one to queue; and husbands and wives sharing time in the queue. In the case of hospitals, where the queues can last for more than 24 hours, some people also hire a 'queuer' (someone who is paid to queue) to keep their place.

A common problem for poor people living in shanty towns is that when

they spend too many hours out of their homes they feel frightened by the possibility of being broken into. In fact, during the time of the fieldwork at least two patients had their property stolen. One retired man attending the Hypertension Group, for instance, had his electric shower stolen and stopped coming for some time.

Once the token is obtained, the patient will rarely miss the consultation. An example that illustrates this comes from a patient attending the Pregnancy Group who was not pregnant. When asked why she was there, she said that her sister was the pregnant one but, exceptionally, had to work at the time of this first meeting. So, she was there to represent her sister, keep her place and report back to her sister at home the content of the discussion.

After such an effort to get in touch with a doctor, patients still have to deal with the unpredictability of the health service - not so unpredictable because it happens every week. For instance, gynaecologists do not come when they are involved with a delivery in their private practice. Some other doctors also had a day of absence during the fieldwork. A nurse attending a health conference had her patients waiting for her because the secretary did not tell them not to come. Lack of water twice, for almost the whole day, in Health Centre 1, and lack of electricity for a morning in Health Centre 2 also caused cancelation of procedures and consultations. The solution offered in these cases is to automatically transfer the consultations to the next day and not to offer any consultations to the following days patients, leaving a message for the queue.

There are many other details of everyday life in the process of gaining access to consultations and procedures that could be described here. However, these are the main features and they are sufficient to provide a first picture of the routines organized for patients. The national health system establishes a particular relationship with users. The user does not exist for the system unless the person is physically there. The body has to be present for the existence of the person being acknowledged, and for patient status to be given as a reward.

This prerequisite creates the opportunity to make the national health system an experience of disciplining bodies. Foucault mentions the training of every part of the body to achieve discipline. In the national health system, from childhood, the individual body, stands for hours in a queue, bears cold weather or rain, is deprived of sleep, is under surveillance and helps to keep control over other bodies. Haraway (1989, p.10) explains this process saying:

> *Bodies, then, are not born; they are made ... they are constructs of a world-changing kind.*

The importance of these experiences of control and surveillance is related to the fact that they happen continuously and frequently; these are experiences that construct bodies.

The sort of control patients have over the process - organizing the queue, checking whether the sequence has been respected, and complaining - makes it more acceptable and both health centre professionals and users work together because 'waiting' is the way through which the system operates. The docility of the body of the user is essential to her/his adaptation to the system. In terms of body experience a consultation can cost many hours, hunger, physical distress caused by carrying a baby for many hours, and emotional distress. A huge capacity for endurance and docility is necessary to go through this process in a polite way.

The lack of alternatives, as well as the long training the poor are submitted to, are elements in the construction of the patient citizen. Other aspects, such as preparation for the consultation, will be examined below.

8.5. Preparing for the consultation

Before seeing the doctor, every patient has their blood pressure and pulse rate measured; other specific recordings are made depending on the reason for the consultation. This is what in other parts of the thesis was called 'assistants' consultation'. The team of practical nurses and assistant practical nurses shares the same space to talk to patients and carry out the procedures for pre-consultation.

Measuring blood pressure and weighting do not always result in information to the patient. Strong (1979, pp.139-140) comments that in paediatric clinics observed by him the staff just took notice of those patients who presented some abnormality. Patients in normal conditions were not commonly told the results of their physical assessments. The example below illustrates what has been observed during fieldwork:

> *(The assistant practical nurse does not mention the patient's weight)*
> *The patient asks:*
> *P: Sixty two?*
> *APN: Sixty two and a half.*
> *(The assistant assesses the blood pressure)*
> *P: Is it OK?*
> *APN: Good, actually a little low.*

The pre-consultation may be used to provide information.

> *Patient's friend: Miss, my friend wants to know how much she weighs!*
> *Assistant Practical Nurse: It's OK. Are you having a consultation?*
> *PF: No, just her.*
> *APN: No problem at all.*
>
> *(Nurse checks the blood pressure)*
> *N: Are you taking the medicine for your blood pressure?*
> *P: Not always. I don't like medicines, my body will get dependent.*
> *N: The medicine for blood pressure is helping your heart work without making such an effort. If your heart gets some help it will be OK. You won't get addicted. If you don't take the medication you will let your heart down.*

It is the opinion of the professionals interviewed that every moment is an opportunity to develop health education. Nurses expect and acknowledge that many assistant practical nurses undertake health education activities when working in the pre-consultation:

> *They have a more intimate relationship with the patients. They give real advice. For instance, when they are undressing a baby for examination, they assess if there are any skin problems, and they give the proper advice. They also give guidelines regarding breast feeding, checking the baby's weight and development ...*

Before seeing the doctor, the patient is asked several questions about her/his problem. In Health Centre 1, the consultations to the gynaecologist are preceded

by a questionnaire about the reproductive life of the patient. The aim of this procedure is to gather information about the patient, to plan future activities and to give more time to the gynaecologist to exam and give information to the patient. The questions are asked in the reception or in the consultation room when available (which rarely happens). There are 13 questions concerning the partner; work; family income; sexual intercourse; contraception; pregnancy; miscarriage and abortion.

The patient has to explain (justify) the reason for the consultation when taking her token, in the pre-consultation with the assistant practical nurses and, in cases like the one above, to provide many details of her private life. In the consultation, the patient will provide a new description of the case, perhaps in greater depth. Excluding the consultation, all other occasions can be considered public, because the information is provided in front of other patients. The access to private aspects of people's lives in the health centre shows how health constitutes 'the social'; in the name of promoting health and healing, a total access to information is justified.

In all observed cases, patients provided the information requested. In the case of the questionnaire filled out before the gynaecological consultation the patients tried to speak in a very low voice, and some kept their heads down. Embarrassment could be noticed among some of the interviewers and other patients close to the one who was answering the questions. Most of the patients pretended not to hear anything else but their own conversation. Other alternatives were the use of metaphors, showing the patient the written question, and whispering. On a few occasions rooms were available for private interviews. Even so, not all assistant practical nurses opted to interview in private. Two of the interviews shadowed include the following:

Nurse: Partner?
Patient: Yes.
N: Do you work?
P: Yes. I'm a cleaner.
N: Income ... one, two, ...?
P: Two (It means two minimum wages as family income).
...
N: Is it the same husband, I mean, boyfriend?
P: (Patient laughs) Yes, it is.
...

N: Contraceptive method?
P: Pill.
...

The fact that questions about abortion, a practice forbidden by law in Brazil, are asked in public implies that health professionals believe they should have access to every detail of patients' life. Patients have few alternatives: to whisper, to lie about one or two items, to provide additional details to the doctor. At the time of the fieldwork in Health Centre 1 no patient refused to answer or complained formally about the questionnaire.

After being prepared for the consultation, the patient goes back to the waiting room and, standing or sitting, waits to be called. The way patients are called varies from doctor to doctor and also according to the physical space of the health centre. In Health Centre 1 patients waited close to the consultation rooms. So, some doctors went out into the waiting room and called patients by their name; others shouted from inside the room: "Next"; others asked the patient leaving to call the next patient. In Health Centre 2 the receptionist told the next two patients for each doctor that they would go near to the consultation room, while all others waited in a large waiting room. Again, summoning the next patient varied from professional to professional. The patient is supposed to go through these phases of the process of having a consultation in a 'collaborative mood': to call the next patient, to stand because someone older should have a seat or to call a patient who is waiting outside because it is too hot in the waiting room - all this part of the process of being a patient.

The preparation for the consultation results in information being collected from, but not always being provided to the patient. Patients are left without knowing their blood pressure or weight. Some of the questions asked in public before the consultation transform the patient into an object of health care, an object made visible in the best interest of the patient. The process can cause embarrassment to patients and professionals but the aim of promoting health can justify almost any activity. The common element in all these practices is the control of the activities by the

professionals. Decisions are concentrated on the professional side and what is expected from the patient is tolerance and collaboration. The information provided do not change the disciplinary nature of the experience of being prepared for the consultation. They make it more acceptable.

Freund (1982, pp.20-21) calls these practices described above 'civilized social control'. Instead of acceptable, this author presents the forms of control as increasingly 'invisible', relying on personal internalized control embedded in every citizen. Like in this study, Freund sees health as a political arena to construe 'civilized bodies', here called 'patient bodies'.

The consultation will be discussed in the next chapter. Afterwards the patient usually goes to the pharmacy or reception to receive the remedies prescribed by the doctor.

8.6. After the consultation

The patient usually leaves the consultation with a prescription for some drugs. Because remedies are expensive, patients try to get them from the national health system. The examples below illustrate the experiences of patients.

Patient: Iron supplements, please.
Assistant Practical Nurse: Do you have prescription?
P: No, he (the doctor) said to take it constantly.
APN: If he said so he should have written a prescription. Without the prescription I can't give it.

P: I have a prescription for Micrordiol. Do you have it?
APN: Yes.
P: Is this usually available or not?
APN: This one comes frequently.
P: My husband got three Triquilar the other day for me. I haven't used them.
APN: Please bring them to us, I will give to someone else.

Doctor: Do we have Propanolol?
APN: No, doctor. We haven't had it for a long time. I am afraid you'll have to write another prescription.

(Patient with three drugs prescribed)

APN: Instead of one pill, you will take 30 drops of this one. This and this we don't have. Try other health centres.

APN: This is a March prescription (It is end of April). You have to go to the Hospital X.
(Patient murmurs) To go to the hospital ... this is awful! And the doctor? Is there no doctor today?
APN: Today it's all busy (2:30 pm).

Patients usually have to go to more than one health centre to get the whole prescription. However, some drugs are not available anywhere. The only way to get the treatment is to buy it. Many patients cannot afford that. So, after hours of waiting for a consultation they have to start a second phase of the process experienced by the users of the national health system - the search for medication. In both Health Centres 1 and 2, professionals (the cases observed were nurses and social workers) personally paid for bus tickets for the poorest patients to help them to look for medication in bigger health centres.

When the medication is given to the patient, assistant practical nurses or those in charge of the pharmacy repeat what is written in the prescription to make sure that the person understands how to use the drugs. Illiterate patients usually have difficulties because they do not differentiate between the names of different drugs. Professionals try link the colour of the boxes to the sequence of medication. The experiences observed did not always prove successful.

8.7. Other services provided by the health centre

Patients keep in touch with the health centre to receive treatment, to check their blood pressure, to look for medication. There are always great numbers of people coming in to ask for information, remedies and results of examinations. The national health system does not send information to people's home. They have to go to the health centre to keep informed. In these contacts some features can be identified: patient does not control the use of the time, there is a lack of precision in information

and also the staff makes some particular uses of vocabulary.

There was a particular terminology used to address the users of the national health system observed in Health Centre 2. As a researcher, I referred to them as *clientes*, but the receptionist challenged my terminology and asked: "Why do you call them *clientes* if they are *pacientes*?" It was only at that point that the difference became clear. I asked what the difference was for her, and the explanation was:

> *'Cliente' is a person who pays for treatment. If you go to a private doctor you are a 'cliente'. But here everybody is 'paciente' because it is the national health system and everything is free.*

This person working in the reception was not a health professional. She was very surprised when I explained to her that, in technical terms *pacientes* are those who are in hospital and every user not admitted as an in-patient is a *cliente*. In a sense, she was right in her use of the term. The process of gaining access to health care, from obtaining a token to receiving remedies, is so long that the user could be considered as a patient for a day.

Health centres offer services such as vaccination, bandaging, and injections. These are supposed to be available during the whole day. However, to organize and regulate activities, there are times when it is inappropriate to request such procedures. Some health centres establish a timetable. Patients are left waiting for some time when the priority is pre-consultation.

> *Practical Nurse: Yes, please (1:32).*
> *Patient: I am here to get the result of the exam.*
> *PN: Now you have to wait because it is the time of pre-consultation.*
> *(Patient waits around for ten minutes)*
>
> *P: Bandage, please.*
> *PN: I can't do the bandage today because we don't have water. You can come any time tomorrow from 7 am to 5 pm and I will do it for you.*
>
> *P: Can I have a new bandage?*
> *PN: Bandage only at 1:30 (It is 11:25).*

The examples above show that to wait to have a procedure is part of the

process of using the national health system. If the patient comes at the time of pre-consultation it is just a matter of waiting. The use of time in health centres respects the internal dynamics of the service. For instance, according to patients, a discussion about closing later has been going on for years. They mention in a focus group activity that they arrive at home and their children are sick and they have to wait until the next morning. However, no change in the timetable appears to be under discussion in the health centres observed.

The lack of good time keeping forces users to return frequently to the health centre to get the same information. The results of examinations is an example of this.

Patient: The result of my exam, please.
Practical Nurse: When did you have it?
P: 17 of March.
PN: It takes 40 days, sometimes more.

P: ... I don't know the number of my notes.
PN: Name?
P: A.A.F. The exam was made two months ago.
PN: It is always good to bring the number of the notes... Here it is! No, it is not here yet.
P: Oh dear, how long it takes! I have a consultation with the gynaecologist next week ...

In the health centres observed there were also many examples of flexibility and accommodation to help patients in need, such as manifestations of respect for those who are older or illiterate and attempts to maintain privacy in public spaces.

Patient: (2:48) Is there anything you can do for a "damaged" finger without having a consultation?
Practical Nurse: How did you hurt it?
P: I didn't hurt it. It is like that since Wednesday.
PN: Come back at 4, then I will try to fit you in. Did you have a tetanus vaccination?
P: Yes, eleven years ago.
PN: Ah! It is a case for a new dose. So, when you come back, bring your vaccination card.

N: This vaccination has to be done in the bum. Is it all right if I do it or would you prefer one of the colleagues (shows the women who work there)?

P: It can be you, there is no problem.

In the reception of Health Centre 2 patients had to sign after receiving any treatment. One old patient was leaving the health centre after nebulization without signing the book and I asked the receptionist whether he was forgetting. She explained that he was illiterate and since she realised that, she signs the book for him, "not to humiliate him in front of the other patients". In one of the many consultations nurses give in public because there is no consultation room available, a nurse explained all the details about the treatment of scabies without ever mentioning the name of the disease. She did it as follows:

> *This is a skin disease. You and your other children can have it too. It needs treatment. I will take the remedies from the pharmacy and teach you how to use. ...*

But at this same health centre a nurse complained to the head of the health centre that one of the receptionists was never at the counter and always arrived late. There were always patients waiting. The head answered:

No one is bleeding out there. Patients can wait.

In both health centres observed there was a programme of food distribution linked to the service of diet and nourishment. This programme is a good example of how in the national health system the contact with the user aims at 'educating' (or perhaps training bodies). The food programme distributes milk to children, complementary diet to pregnant women and some families. Those included in the programme are the poorest in the community covered by the health centre. However, the process is not simply going to the health centre once a month and collecting food. It is far more complicated. Before every session of food distribution there is a compulsory meeting. The issues discussed there are the ones health professionals consider of importance to those patients.

One meeting which took place during the fieldwork was about a new parasite which was originally from Africa but has been found recently in Brazilian

shanty towns. The community which the health centre covered was already facing the problem. The solution is to tackle it in a collective way and those attending the meeting were taught how to proceed.

Knowing that food distribution was linked to talks and meetings with the dietitian, social worker and nurse, many of those collecting food go one hour later to avoid the meeting and collect the food. They are also expected to keep their children under strict weight control, but not all do so. In some cases, one of the professionals makes a home visit to find out what is happening to the family and to reinforce the importance of the link with the health centre.

The way professionals see these absences is usually as patients' lack of interest. As an assistant dietitian described:

They come late on purpose; they should be here one hour earlier.

In this study, however, the experience of depending on the health centre to provide food for children and having to 'pay' for the food with attendance at meetings and receiving home visits is seen as an example of surveillance and discipline. As with any other power relation, resistance emerges against this mechanism of control. The alternative that patients found is to be just late enough to avoid the meeting.

There are other services offered by the health centre. Those selected and presented in this section represent part of what was observed in the daily life of users and professionals. The way the services are offered to users in its particularities of the use of time, space and body reveals opportunities for disciplinary practices which can be corroborated by the minor experiences of punishment and reward.

8.8. Rewarding the 'patient' and hard working patient

The system of reward and punishment at the health centre involves approval and approval not only of patients' behaviours at the health centre itself but also

of all their attitudes and decisions. Because health relates to all aspects of life, most of the behaviours of patients are under surveillance and those which fit with the discipline of the health centre or represent healthy choices can be rewarded.

Zola (1972, p.490) has studied medicine as a form of social control and points out that patients take some medical prescriptions as a punishment. In this study, however, the notion of punishment and reward relates to the procedures experienced in the daily life of users of the national health system.

The difference between the patient who goes to the queue at 4 am and the one who arrives at 6 am is that the first one will probably have the opportunity to choose between two or three doctors and the second will take a token for anyone who is available. So, the reward to those who come really early is the right to choose. As a patient proudly explained to me:

> *My brother-in-law came at 4:30 to queue for me. The problem is that my boy just has consultations with Dr. X since he was born and lots of people also want her.*

In Health Centre 2 there was a doctor who was reserved by the receptionists for 'employment' cases - sick leave, certificate of good health, etc - when some patients in the queue realized there were only consultations with him, they preferred to leave and come back another day. The punishment for those who 'are not hard working' patients is to get doctors who are 'not so good'.

Those who are 'really idle' would come much later and so for them there will be no consultation left. However, when tokens are no longer available some patients try to bargain for consultations. Any breakdown in the system creates problems because an 'idle' patient will be rewarded, as the example below shows:

> *Patient: (3 pm - already shouting) ... I've been in two other places and they didn't see the baby. It is an emergency ...*
> *Receptionist: As I said, the doctor can't have more consultations because he had 11 today and four were extra cases.*
> ...
> *R: (turning to the researcher) We know that some patients don't come to take*

the token and want privileges.

The patient then entered into the doctor's consultation room where she cried and said she was desperate. The doctor explained that usually all his time is busy, but that day he could make an exception. As soon as the patient enters in to the consultation another patient sitting in the waiting room says:

> *She doesn't want to get up early in the morning. She doesn't work outside home and doesn't come to get a token.*

Situations like that created confusion among the staff. In both health centres observed much of the time in the staff meetings was spent in plans and deals among the team to keep the rules of the health centre. Doctors who make too many exceptions were accused by other colleagues of setting a bad example because all the patients will ask for exceptions. The assistant practical nurses and receptionists complained that their effort of organizing patients looses authority when exceptions are made. The experience of disciplining the users requires coherence in the application of norms and the staff spends long hours planning it.

Good patient behaviour is frequently acknowledged in public. During observation in the reception a boy came to the health centre asking for ointment. He brought a clean glass, with a lid, because he knew that the health centre could not give a whole tube of ointment. So he was expecting to take just enough for his mother's change of bandage. No comment was addressed to him, but the receptionist remarked - and everybody else in the waiting room could hear it - that this was a nice patient; someone who understands the problems of the health centre and thinks about the others.

Another way to reward is to separate those who belong to the health centre originally (geographic region) and those who are there just to collect medication, for instance. The health centre tries to 'protect' its remedies for those who are 'their' patients. At the pharmacy, those looking for contraceptives hear the explanation:

> *We already gave everything we had. Now only to our patients. You should have a consultation and the "cartão da mulher" (woman's notes) with us.*

Those who apparently break the norm are, in fact, constructing it. The public condemnation of a situation differentiates the 'hard working' from the 'lazy' patient. The example of a mother who had her child sent to the hospital for malnutrition and infection explains this. She did not behave as a mother should, feeding her baby. As a result, people heard of it in the waiting room; the nurse was called by two mothers and they discussed the case. The norm of 'caring mothers' was constructed based on the exception. The nurse said she was going to make a home visit and, in case things were really bad, including the other children, she would call the Children's Protection Agency (*Conselho Tutelar*). At the end she added: "This is carelessness, negligence".

The punishment is moral; it attacks the good reputation of the patient. Another example of punishment comes from a consultation. The patient said she has four children. The nurse answered: "FOUR! You are so young. Do you intend to have more?" The patient clearly did not know what to answer. She said: "No, I don't think so." The conversation follows about how expensive life is these days and so on. Conversely, in other consultations patients who took the initiative to say they will just have one or two children encountered support and compliments.

A set of gestures, smiles, head movements, loud or low voice are some of the elements that have to be observed to understand the mechanisms of creating and sustaining norms and discipline. The experiences of users in the health centres are "guided" by those indications of proper behaviour and mistaken conduct.

8.9. Conclusion

The user of the national health system has to experience a series of disciplinary measures in order to have access to health care. Some of them had been described in this Chapter.

The ideal experience described by one nurse interviewed was for the patient be "bombed in a positive way" by health education all the time s/he is using the

health centre. Some health education does happen through the different phases of the process of using the health centre. However, what the observation of daily life of two health centres showed was, most of all, a complex set of disciplinary powers.

The process of surveillance occurs among patients themselves but is been mainly employed by professionals while controlling access to consultations and procedures. Professionals control the process through the distribution of tokens. The use of time is also decided by health professionals. Patients have to wait and be trained to tolerate the administration of their time by others. Also bodies are exercised because the process involves standing for hours, not eating, not using the toilet, etc.

The whole process of using the health centre services is normalized by the 'patient user' pattern. The same explanation has to be provided three times, the time required is not easily predictable, and information about the patient's health is not always provided. The 'patient user' waits for the best time to ask. Those behaving in line with the expected pattern receive signs of approval. A link between the user's life and the health centre is established when the user is included in the selected group of 'our patients'; this means knowing when medication is coming, having access to drugs which are difficult to obtain, etc.

The experience of discipline and docilization of bodies is based on the justification health provides to most practices. In order to promote health care many disciplinary experiences are imposed onto the users. Perhaps it is possible to say that the experience of using the national health system is 'educative' - it constructs patient citizens who have their bodies trained to be under surveillance, to observe the norms and to be rewarded by their code of conduct.

CHAPTER 9

TO TREAT BODIES OR TO TREAT BODIES AND PROMOTE HEALTH? HEALTH EDUCATION IN THE CONSULTATION

9.1. Introduction

By using the national health system, the patient looks for health care, whatever this means. Due to the sophistication of health as a field of expertise, patients do not know precisely what to expect in terms of health care where hospital technology is concerned. However, in the national health system, medicine dominates the scene with consultations. Here patients who have a health problem expect a solution or further investigation after the consultation.

The experiences of the users described in Chapter 8 highlight the importance of the consultation for patient satisfaction. The difficulties they face to talk to the doctor, dentist or psychologist make the moment of the consultation a very precious one. Taking into account that, in many health centres, the consultation is acknowledged as the most frequent site for developing health education, this Chapter concentrates on the consultations which were shadowed in the two health centres observed.

The argument of this Chapter is that health education adds a constructive approach to the consultation. It makes the experience of using the national health system more tolerable and increases the link between the user and the health centre. Health professionals have an option between treating bodies or doing so **and** promoting health through health education during the consultation.

This Chapter is divided in the following sections: the consultation and its history; treating bodies but not always promoting health; and patients' assessment of consultations.

9.2. The consultation and its history

The modern techniques that nowadays constitute the consultation were created at the end of eighteenth century (Foucault, 1973, p.xii). In 'The Birth of the Clinic' Foucault relates the development of a disciplinary society to the emergence of many institutions and practices in society, such as the hospital and modern medicine. The home bed of the sick was replaced by the hospital bed, where individual bodies could be observed.

Throughout the eighteenth century the information collected about sickness was organized in terms of classification of symptoms (Armstrong, 1995, p.2). In Hospital Medicine, symptoms and signs were joined in the search for a pathology in the body of the patient. In order to look for information within the body a set of techniques was created. Even today they constitute the basis of the clinical examination: inspection, auscultation, palpation and percussion (Armstrong, 1995, pp.3-4).

Since the eighteenth century medicine has placed the body at the centre of its scientific scrutiny: anatomy was the base for the location of diseases. Armstrong (1983, p.2) comments that this was also a political process, a 'political anatomy' because:

> *... the changes in the way the body is described are not the consequences of some random effects or progressive enlightment but are based on certain mechanisms of power which, since the eighteenth century, have pervaded the body and continue to hold it in their grasp. From that time the body has been the point on which and from which power has been exercised.*

The body became an object of physical and political examination. Foucault (1990, pp.151-152) points out that life is the objective of many technologies of power. In the health arena, Foucault (1973, pp.29-35) mentions surveillance through the medical gaze and the creation of 'normalities' as examples of these technologies.

The doctor (also nurse, dentist, ...) - patient relationship has been producing normal people, healthy people and also abnormal and sick ones. Changes in the medical model have been reflected in the way the consultation is carried out.

Armstrong (1982, pp.110-111) recognizes a shift in this century in the way the patient was treated. From a passive body fabricated by clinical examination, the consultation turned its focus to a more subjective account of health provided by the patient. Armstrong (1982, pp.111-120) shows that, until the twenties, in medical publications the patient was seen as the carrier of a pathology and aspects of her/his individuality were irrelevant. But, this situation changed, and in the sixties the treatment of the whole person was already under consideration. Armstrong (1982, p.119) adds that

> *... the discourse on the doctor-patient relationship over the last few decades has, like the clinical examination, had an object and an effect. The clinical examination was a device for ordering bodies which, in doing so, constituted them; the medical interview and relationship has become a comparable mechanism for analyzing, and thereby constituting, idiosyncratic patients.*

Health education can be seen as part of this movement of constituting the patients as a subject. In the consultation the professional has the opportunity of adapting the information to the specificity of the patient's life. Calnan et al. (1986, p.184) say that in the eighties general practitioners in the United Kingdom have been recommended to "extend the traditional content of the consultation", incorporating health education into it. This view has been both supported and criticized. The opportunity for prevention of disease and empowerment of the patient through the understanding of the social and political dimensions of health are reasons to include health education in the consultation (Calnan et al., 1986, pp.184-189). Criticisms include the argument that the medical profession is trying to gain dominion over patients' lives through influencing lifestyles (Calnan et al., 1986, p.185).

In the last decade of the century a new kind of patienthood has been experienced by both professionals and patients. Patients expect to be heard, to explain their points of view and most doctors acknowledge these practices as part of the consultation. Consultations with idiosyncratic patients in health centres at the community level, rather than passive bodies in hospital beds, are the focus of the next section. The issues which will be explored are whether or not health education is integrated into the consultation and the repercussions on the consultation.

9.3. The regime of consultation

Some studies (Byrne & Long, 1976; Strong, 1979; Buetow, 1995) have explored the rituals and roles patients and professionals develop during consultations. Strong (1979, pp.38-39) points out that the "ceremonial order of consultations" observed by him in United States and Scotland was very much invariant. He explains that the main characteristic of the consultation is its "bureaucratic format". During the consultation patients and doctors:

> *routinely transcended the mundane particularities of their meeting and invested themselves and their relationship with much of the same ritual form.* (p.38)

In the ritual form of consultation doctors have a systematic and rarely questioned control of the consultation (Strong, 1979, p.129). As a basic rule, everything that does not fit the usual format will be seen as irrelevant (p.39). The focus of the consultation is on physical problems (pp.138-139).

The study of Byrne & Long (quoted in Strong, 1979, pp.199-200) also shows that doctors have almost complete control of the consultation and that consultations are strongly routinized. The control over the consultation derives from professionals' technical knowledge. Strong (1979, p.128) comments that:

> *technical authority given to doctors was matched by an equivalent authority to control almost every aspect of the consultations' shape, sequence and timing.*

The ceremonial order of the consultation involves the control of time, talk, selection of topics, and the suppression of other involvements (Strong, 1979, pp.128-148). The latter refers to the fact that patients should maintain themselves focused on the doctor's requests and questions, assuming a "restricted set of bodily actions" and keeping a "state of permanent alertness" (pp.129-130). These demands just apply to patients.

Crawford (1980, p.373) points out that patients themselves are 'professionalized'. They go to the consultation bearing in mind their previous

experiences as patients and expecting a pre-structured kind of encounter. The contact between professionals and patients, as observed in the fieldwork, follows next.

9.4. Treating bodies but not always promoting health

Health education during the consultation can be carried out in two different ways: (i) problem-related health education which involves helping the patient to understand meaning of the diagnosis, the significance of treatment and prevention, and social or psychological implications of the problem; (ii) non-problem-related health education which means that the professional takes the initiative to cover some other aspects of health knowledge that should be of importance to the patient (Calnan et al, 1986, pp.194-195). This second type of approach is seen as problematic by general practitioners (Williams & Calnan, 1994, pp.372). Among the problems mentioned, doctors cited that: health promotion and prevention is "tedious, dull and boring"; there are constraints of time during the consultation; 'curative' medicine should come first; etc.

The contrast between the consultations observed was big - from the time to the content and examination techniques employed for similar problems. Among those observed, four professionals' consultations were selected to be presented here: two nurses and two medical general practitioner from each of the two health centres observed. One of the shadowed doctors resisted to collaboration with the research for one week. All other professionals accepted immediately. Ten consultations of each professional were shadowed. The examples presented below cover a range of situations which vary from no health education in the consultation to extensive problem-related health education.

On the day when the first doctor was shadowed, seventeen consultations were carried out in one hour ten minutes. At the end of these, an assistant practical nurse called me and asked why it took the doctor so long to complete the consultations that day. The usual time observed on other days was from forty to fifty minutes to finish

some 15 to 20 consultations. When asked about the time available for each patient, one injured worker said in the post-consultation interview:

> *Patient: Hum ... it was a little bit quick.*
> *Researcher: What did you expect from the consultation?*
> *P: I wanted him to give me an injection. There is one that I already used in this case, but I didn't say anything. This injection I used another time and I got better; it was the shoulder then.*

It was not only the time that imposed limits on the way the doctor-patient relationship could be developed. In these consultations the door was constantly open - partially or completely. Only one patient asked to close the door before the consultation started. In all other consultations the information provided by the patient was 'shared' with the patients waiting in the corridor. Whenever auscultation of the lungs took place, the doctor closed the door and opened it afterwards.

In the case of the injured worker, his knowledge of the previous successful treatment was not brought into discussion. The doctor's approach during the consultation did not encourage any contribution from the client. The whole consultation was a sequence of seven questions and one explanation from the doctor and seven answers and one commentary from the client. The patient commented that he was putting alcohol on the injured region and the doctor said to use a hot water bottle or cloth.

Three of the ten patients shadowed had work-related problems. Their consultations illustrate both the passive and docile posture bodies should assume when in touch with the national health system and the repair process to keep their bodies fit for work (in Health Centre 2 this involved the doctor in charge of work-related problems mentioned in the previous Chapter). The approach during the consultations did not involve any health education about how to prevent similar accidents in the future. It was an encounter purely to fix the body.

There was also a trend among patients to request tests. Three patients made clear they would like to have some tests (blood, urine, x-ray, ...). In one of the

interviews before the consultation, the patient explained why she was coming to see the doctor:

> *I came here because I have a pain in the chest and I want to request an authorization from the chap (doctor), to see whether he sends me for an x-ray.*

Another patient brings a relative of her sister, a woman in her seventies, and explains to the doctor the reason for the consultation:

> *Relative: Doctor, she has a very bad flu. She lives with my sister. ... coughing a lot, with pain in her back. We would like to have some tests.*
> *Doctor: Is it hurting?*
> *Patient: I have pain in my lung.*
> *D: What kind of tests would you like to have?*
> *R: A blood test...*
> *D: It is the doctor who knows what tests are necessary and whether they have to be done.*
> *P: No, my sister said so because ...*
> *D: The doctor knows what tests have to be done.*
> *R: I came here to tell you what she told me.*

To the previous patient the doctor said that only people who fallen over badly need x-ray. The desire for tests rather than diagnosis and treatment seems to be a reaction from patients trying to get access to information about their own bodies. The tests provide concrete results about the patient's condition; they are 'independent opinions' which can point out to the doctor what is really happening. Opting for tests looks like an attempt to regain power, bringing arguments to persuade the doctor.

Another element that corroborates this point of view is the reaction of the doctor. To control requests for tests in the laboratory or hospital is a task which belongs to the doctor. He stressed that prescribing tests depends on medical knowledge and the proper conduct for the patient is to wait passively for the doctor to decide if a test is necessary. Commenting on scientific knowledge and AIDS, Patton (1990, p.57) illustrates how scientific knowledge has been considered as "an ideal" and also how it has "successfully claimed itself to be above politics". However, in the micropolitics of the consultation room scientific knowledge justifies the unequal power relations between doctor and patient because the doctor has "the ability to "see" what ordinary people cannot" (Patton, 1990, p.57). Everything that depends on medical knowledge is

supposed to be under the control of the doctor and this includes the patient's body and the patient's will to a better understanding about her/his health. As the quotations illustrate, there is a tension between the use the doctor makes of medical knowledge and the attempt of the patients to use this knowledge to gather information about themselves.

Foucault (1991, p.194) mentions that power relations produce reality and rituals of truth. He argues that power should not be seen as repression. However, the imposition of medical knowledge as the criterion for deciding about people's lives and not taking into account their requests, is an action which generates resistance. Patients do refer to the experience of being offended by the doctor's abuse of power. Baudrillard (1987, p.26), for instance, criticizes Foucault for his argument that "nothing functions with repression, everything functions with production". The examples below demonstrate that repression and resistance can be part of power relations in the consultation.

The patient is a young woman complaining about headaches and she describes herself as a nervous person. Part of the consultation was as follows:

> *Patient: ... but recently I'm having a lot of headache. Today, for instance, is a horrible day; I've got a headache since the morning. I took a pill but it came back.*
> *Doctor: Well, from here (shows the neck with his hand) upwards one cannot guess anything! It's not useful to put my hands in your head, I won't find anything. This thing of pain comes, disappears, comes back, it's nervous or it isn't ... this is pure guessing. And here we don't guess.*
> *P: But I'm not saying you guess things.*
> *D: Right, I don't guess. I will refer you to a specialist, a neurologist, to check if it is a neurological problem. He will asks for tests. I will give you a medication to help with the pain ...*

After the consultation the patient was interviewed and asked if she liked the consultation. She answered:

> *I tolerated it (irritated). This is not the proper way to talk to people - "How can I guess? I am not a wizard". This never happened to me before. If you are a doctor, you have to say what is my problem, but it is not in this way that you'll understand me. He asked me things, that's OK, but look how he asked! No one likes him here.*

The patient's complaints identify the lack of diagnosis and health education in the consultation, as well as of politeness. She wants to be informed, understood, and treated in a polite way. If the previous consultations she had were constructive in creating a disciplined and docile body which depends on medical knowledge, this one was mainly an experience of censorship and exclusion.

As described before, in the beginning of clinical practice, bodies were expected to lie passively to be observed and examined. Nowadays the 'whole person of the patient' already knows what the elements of the consultation are and expects, often in an active way, to have all the phases of the consultation properly developed for her/him. Patients take care of their bodies, resisting the treatment prescribed, when they do not agree with the way the consultation was conducted.

> *Patient: I didn't like the consultation because the doctor didn't examine me. I told him I had pain in my back and my chest and he didn't examine me to check if I have anything on my lung. ... he immediately gave me a 'benzetacil' (antibiotic injection) without asking me if I am allergic. Could you imagine if I take it and I have a shock? Who will take care of my baby?*
> *Researcher: Will you take the injection?*
> *P: No.*
> *R: Yesterday you had a consultation for the same problem, isn't it true?*
> *P: Yes, in the Hospital X. The doctor didn't lay a finger on me and gave another injection.*
> *R: Did you take it?*
> *P: Of course not, he didn't examine me.*

Another patient decided to take the medication prescribed just because "this was too much pain". But she also complained about the consultation and said she will never have another consultation with this doctor. Patients resist against their powerless position - providing information, having their behaviour checked, not receiving information back - using the national health system in different places, not obeying prescriptions, telling others to avoid a certain professional, not telling the doctor they already had a previous consultation, etc. The problem is that many of these practices represent bearing pain and extra work, and circumscribe to the patient's life. The control of knowledge by health professionals and their authority to gather information to produce a diagnosis are not challenged by these manifestations of resistance which were observed.

It is important to contextualize the notions of discipline and surveillance that are embedded in the consultation. The next consultation was carried out by a nurse and a diabetic patient was being trained to self-inject insulin. It provides an example of training in terms of manual skills, use of time and of surveillance over many aspects of the patient's life. However, it is acknowledged here as empowerment of the client through health education for reasons discussed below.

Nurse: Now you should demonstrate where you will inject it.
Patient: It could be in the thigh.
N: Yes, in this part here (shows with her hands), in both of them.
P: They injected me in the arms like that.
N: In the arm?
P: Yes, like this (shows in her arms).
N: Ok, but this part here is very painful you should avoid it.
P: I don't know, I never tried there.

The whole consultation took half an hour and was one in a series where the nurse was training and evaluating the patient to handle her treatment at home. It appeared to be a systematic session, like in the traditional approach to health education where the professional teaches the patient. However, observing the time used by each of them for talking and who was in control of the consultation, reveals that one third of the consultation was led by the patient, talking about her doubts and worries. It is an impressive amount of time, taking into account it was meant to be a training session. The nurse spoke more times, but it was as part of the demonstration and correcting the patient's technique.

This consultation is understood as empowerment of the patient because the knowledge was adapted to a common language but provided the essential technical terms related to the disease. The patient had her life bound to the health centre because she needed an injection every day. She was suffering pain due to injections that had been done in the same region because different assistants were in charge of it and there was not a map of the regions of the body to use. Through the training the patient will develop skills to control her own injections and glycaemia tests, just coming to the health centre for consultations. The training programme was tailored to her needs, including appointments convenient to both nurse and patient. There was no queue and

the time was adapted to the needs of each consultation.

The patient was hoping to start the treatment at home soon, but the nurse was doubtful about ending the training. She wanted to observe the patient more before authorizing her to start at home. As in the previous consultations, the professional knowledge-power is the basis for the consultation, but the patient here exercises her power and resistance with possibility of altering some of the features of the relationship. At the same time it is much more difficult to identify control and surveillance in such a 'caring' atmosphere.

Another nurse carrying out consultations was in charge of smear tests. She organized half hour consultations to have the time to evaluate other aspects of the sexual and reproductive life of the patient. The opportunity of asking questions and discussing health issues in the consultation simultaneously imposed a long waiting time on patients. Patients' bodies should be there, at the health centre, waiting to be empowered. The consultations start at 2 pm and there are six per afternoon. This means that the last patient will seen at 4:30 pm. The consultation starts with apologies for the delay.

(Patient enters the room and stands up)
N: Please sit down, dear. We are a little bit late, aren't we?
P: Yes, a little bit.
N: Is this your first consultation?
P: Yes.
N: Denise already introduced herself, but I didn't. My name is X, I used to work in ... and here I work with women's health.
P: I came here because I already have three children and I never had a smear.
N: We should talk about it. Sometimes people feel scared.
P: And also one has to come a month in advance to get a token.
N: Do you work?
P: No.
N: But we have consultations on the day; it's for emergencies, IUD, ...
P: The IUD is for free?
N: Everything in the health centre is for free.

This initial talk in the consultation expresses the tension between the different 'learnings' that are provided by the experience of being user of the national

health system. When health education is added to the consultation this make it an opportunity to promote a better understanding about the patient's body and choice in matters of health care. However, it does not change the routines the patient has to experience which also promote learning. The consultation follows:

> *Patient: My menstruation used to come on the second day. Now it comes on the third or fourth. Is that all right?*
> *Nurse: How does the pill act inside the body?*
> *P: I don't know.*
> *N: The contraceptive is a hormone that "deceives" the body ... So, it makes no difference on which day the menstruation comes.*
> *P: I didn't go to the doctor, I bought this one from the chemist and I read the information for patients.*
> *N: Do you know any other methods?*
> *P: IUD, but I don't know how it works.*
> *N: Let me show you. This is the IUD. It goes here (showing a picture). This is the applicator..*
> *P: This part here doesn't hurt?*

The conversation covered all the contraceptive methods, concentrating on the preferences of the patient. Before the smear the nurse showed the equipment used and discussed the technique. In all the consultations observed the nurse made clear that the patient can come back just to talk and discuss issues. In other consultations the body was discussed in a political way, in relation to pleasure, safer sex, the man's responsibility for contraception, etc. Patients evaluated the consultations in a similar way:

> *P1: I learnt more about how is my body inside. I'll come back if I have any questions.*

> *P2: I liked the consultation because she talks a lot and I felt free to ask whatever I want. I like the way she is. There are nurses who are rude to the patients.*

Another set of consultations shadowed were carried out by a general practitioner. He doesn't establish a precise time per consultation, but he is referred to by some patients as 'the doctor who takes his time'. The things that were characteristic in his consultations were books on the table and problem-related health education in every consultation. In many consultations he collected the information and stopped for some three minutes to read about the case. He uses both conventional drug prescription and

homeopathy. The patients interviewed were all satisfied with the consultation they had with him. There was one case that was different in terms of the understanding the patient had of the information provided.

The patient came to the consultation with leaflets about contraceptive methods. The assistant practical nurses prepared some to the doctor give for patients to read at home. The consultation started with the doctor asking which method she chose and what questions she had. She decided to try the IUD. They checked the details of the consultation with the gynaecologist and the patient said in the meanwhile she would be using condoms and Billings. The doctor agreed and explained to her the details about the fertile period, use of condoms, etc. After the consultation, in another consulting room, she was interviewed and said she really liked the consultation and that Dr. X was very nice. So, she was asked to explain to me the methods she would be using for the next month or so. She could not because she "did not understand everything". Due to the implications of this situation, I volunteered to explain again and she asked me to do so. It took half an hour to assess her knowledge and fill the gaps until she was able to explain the whole process herself.

The question raised at the end of the conversation was why did she leave the consultation without asking those questions. And the answer was:

> *Patient: Dr. X is so nice, I didn't want to keep asking. He had other patients.*
> *Researcher: And what about a pregnancy?*
> *P: Me and my husband could take more care than ever during this month.*

The consultations shadowed show that health education during the consultation increases the acceptance of the consultation and the patients report greater satisfaction. Health education has been reported to relate to patients' satisfaction in other studies (Buetow, 1995, p.214). The issue that remains is its double capacity for disciplining and empowering. In gratitude to the doctor who spends his time teaching her, the patient prefers to change her sexual life rather than to disturb him. Health education in the consultation is a constructive power that promotes a more refined mechanism of discipline because it is tailor-made for each individual and involves

personal relations of respect and gratitude.

9.5. Patients' assessment of consultations

In December 1994 Weatherall (quoted in Hall, 1994, p.1), Regius Professor of Medicine at Oxford University, said that English doctors are unkind and thoughtless in their dealing with patients. So, said many of the Brazilian patients interviewed in 1993 for this study.

Eyles and Donovan (1990, pp.95-113) say that patients do not have the knowledge to judge the doctor's qualification. They use elements of common sense judgement, like the way the professional talks to them, the expressions used and politeness, to assess the quality of care they are receiving. Buetow (1995, p.215) comments that among Australian patients only 6% identified 'knowledge and skill' as qualities needed by doctors. However, the professional-patient relationship seems to be an important predictor of satisfaction. In the fieldwork it was possible to observe other criteria used by patients. For instance, if the doctor does not physically exam a patient, there is less room for trust in the treatment prescribed. If the doctor does not ask certain questions like "are you allergic to this substance" or "are you pregnant?" when the treatment is being prescribed, some patients will question the professional's technical qualification.

A patient in Health Centre 2 told the nurse that she was going to another place for a new consultation because she knew the doctor was wrong. According to the patient her daughter needed a 'benzetacil' injection and the doctor prescribed a home treatment. The reason for her lack of trust was a previous problem with her other child. This doctor prescribed injections for ten days but when she took her son to hospital that same day they admitted him for treatment. She just had a consultation with this doctor because there was no other token available. It is impossible to know whether the treatment was wrong or underestimated the severity of the case, but patients do challenge opinions and prescriptions. In this case, the nurse provided a second opinion

to the mother. She looked at the child's throat and confirmed the medical diagnosis and treatment, but prescribed additional medicinal teas.

Eyles and Donovan (1990, pp.95-96) argue that patients who complain can be exercising some kind of resistance against the powerless experience of being patient. The authors say:

> *... they may be trying to regain the power and control over their own bodies that they are obliged to devolve to their doctor during the consultation.*

The difficulty in assessing good quality care makes many patients try to develop a link with a specific doctor. If they like the consultation and the patient recovers or understands how to prevent something, they will try to keep "their" doctor - a person they trust to be in charge of their family's health. This is the model of medical care used by the middle and upper class through the system of private consultations. Achieving this model of care justifies the investment done by patients, by coming very early in the morning to queue, as one patient explains:

> *Dr. X is the doctor of my family since he came to the health centre. He is the only doctor who sees my boy. My mum was using lots of medication and he cut them. Now she is much better and just using homeopathic treatments and one pill. ... He explains everything and always examines. He taught me a lot of things I didn't know.*

This patient also said that one advantage of having Jorge as the family doctor was his accessibility. In case something goes wrong with the treatment or a question emerges she can always just pop into the health centre and ask him at the end of his shift. This kind of relationship corroborates the establishment of links between the community and the health centre and is perceived by the patient as another indicator of good quality health care.

9.6. Conclusion

The examples from the consultations shadowed during the fieldwork demonstrate that consultation can be a space for health education, but it does not mean

it is always used for such aim. Health education in the consultation is seen as an exercise of constructive power because there is a basic aspect to those relations that are not touched by health education. The power relations that take place in the consultation cannot be radically transformed because the control professionals have over knowledge and patients bodies is the fulcrum of the activity.

In the search for elements to evaluate the quality of health care received, health education in the consultation seems to be understood by patients as an indicator of good practice. When assessing health care, patients tend to concentrate on aspects of the professional-patient relationship. Health education can promote links and produce 'good' professionals and 'happy' users.

CHAPTER 10

LEARNING TO BE A HEALTHY CITIZEN: EXPERIENCING HEALTH EDUCATION ACTIVITIES

10.1. Introduction

Consultations and procedures are usually the services to which the users of the national health system have access. Pereira (1983, pp.123-124) concludes from her research that on the Brazilian national health system health education is developed in a rudimentary way, not being systematic even in the consultation. In contrast, the documents and interviews analyzed in this thesis show that in Brazil there is a discourse on participation and implementation of health education initiatives to promote a better quality of health care.

In fact, some health centres do carry out health education activities in many of their practices. They are singled out by Secretariats as models for others or successful experiences do be analyzed. Therefore, in order to investigate a 'possible future' for the national health system, this Chapter focus on health education activities carried out in the health centres observed - known for their involvement in health education.

In spite of the general belief that health education is good for patients, the argument developed in this Chapter is that health education represents both subjugation and empowerment of the patient. Both processes occur simultaneously in health education activities. The power relations that take place between professionals and patients will emphasize one over another, but never eliminate one of them.

This chapter is divided in the following parts: a gaze over the community, normal and pathological within the community, and health education activities.

10.2. A gaze over the community

Throughout this century, medicine developed a series of areas of knowledge which cover non-pathological aspects of life. Armstrong (1983, p.101) argues that, for instance, in paediatrics the clinical gaze was turned to the development of the normal child; in psychiatry attention was centred on coping strategies used by ordinary people. He mentions that the normal individual has been under the observation of a web of specialties. By focusing on normality rather than on disease the aim of health care was shifted:

> *Illness, in the post-war years, began to be temporally and spatially distributed, not in a physical domain, but in a community. The community was the term deployed to describe that truly social space that had emerged in the calculated gap between bodies.* (Armstrong, 1983, p.100)

This shift to viewing health as a community issue, rather than concentrating on disease in individual bodies, lies at the basis of Surveillance Medicine, described in Chapter 1. Armstrong (1983, p.102) suggests that, under this new conception, the body is constructed in a particular way:

> *The new body is not a disciplined object constituted by a medical gaze which traverses it, but a body fabricated by a gaze which surrounds it: the new body is one held in constant juxtaposition to other bodies, a body constituted by its relationship and relative mental functioning, a body, of necessity, of a subject rather than an object.*

The creation of subjectivity is part of the work developed in health education. The patient's health is seen as the effect of the patient's mind, spirit, social life, etc. In radical health education, the search for a better quality of life through health presupposes a participatory role for the patient - providing information and changing programmes according to community interest. In the specific case of focus group, patients may co-ordinate the activity themselves. The health education patient, in radical approaches, is a person dealing with health - even when sick - and linking most of the aspects of life to medical knowledge.

The focus group is a strategy to bring together peer members to share their life experiences on issues related to health. In the forties Lewin (1947, pp.197-211)

demonstrated that rather than lectures or individual consultation to convince mothers to drink orange juice it was better to promote group discussion and group decisions. Group members not only persuade themselves to make healthy choices, they also construct healthy individuals. The construction of identity occurs in the relations between participants; it is provisional and achieved in process (Townley, 1993, p.522). The healthy person brings her/his daily life into the discussions and re-creates her/his identity in accordance with the norms and acceptance produced by the group.

The set of participatory activities in health education makes the surveillance of the community a constant experience. Bringing the community into the health centre and giving them elements to persuade each other and to produce truth legitimized by health knowledge is a way to create healthy citizens. They develop self-regulation, they relate their daily experiences to health, and they disseminate medical knowledge within the community.

Health education, in its more developed radical activities, is a refined strategy in the construction of a regime of total health. It pervades community issues - security, local politics, leisure - and it reinforces the link between health centre and the users. The responsibility for health is everybody's responsibility. In this process, health and life are tangled in such a way that the notions of normal and pathological are incorporated into daily lives; they are not a reason for exclusion but for comparison and regulation.

10.3. Normal and pathological within the community

Health education as a constructive exercise of power does not exclude or label patients as normal and pathological. Rather, it spreads a conception of flexible boundaries between them. Health education is applicable to every one - the 'normal' person who tries to keep healthy, the sick who tries to be 'normal' in aspects of life not related to the disease, the 'at risk' person who tries to stabilize in a non-pathological condition.

Rodmell and Watt (1986, pp.4-5) point out that health education creates notions of 'adequacy'. They suggest that this happens through 'lifestylism' or pathologisation of certain conducts, like typical behaviours of social groups. This approach fosters a sense of failure and inadequacy among individual patients or some groups in a community. However, it is the view of this study that health education also creates 'adequacy' by promoting health, encouraging healthy choices, and rewarding the healthy citizen.

It is the possibility of covering the most diverse aspects of life, including disease, that makes health education a better technique of power when compared with disease prevention. Health education can develop any member of the community as a healthy individual because the boundaries of disease are overcame by health. When analyzing the concepts of normal and pathological Canguilhem (1989, pp.181-183) stated that disease is an "inferior norm" because it cannot be transformed into another norm and it is restricted to precise limits. However, normality is a flexible domain. Canguilhem argues that the normal has the capacity of being transformed according to individual conditions and the limits between normal and pathological are vague.

Since the forties, the gaze over the community has been dealing with the notion of imprecise boundaries between normality and pathology. Armstrong (1983, pp.96-97) describes a classic study in hypertension where the authors conclude that the line separating the normal from the pathological is drawn for convenience and any change in its location could make hypertension as rare or as common as they wish.

In health education activities, the construction of normality and healthy standards happens through the transmission and dissemination of knowledge; not exclusively professional knowledge, but many kinds of knowledge. It is not constructive to exclude popular knowledge. As Keenan (1987, p.14) points out,

> *Power does not work simply by imposing constraints or contents on knowledge, just as knowledge does not merely mask, serve, or expose power. ... Thus, where knowledge is concerned, power relations do not simply say "no". On the contrary, ..., they stimulate, excite, incite knowledge.*

The promotion of a better understanding of health issues increases the possibilities of communication between health professionals and users, as well as strengthening the links between ordinary life and health. Normalising the pathological and keeping the issues as a permanent debate at the community level are some of the contributions that health education can bring to the health arena.

10.4. Health education activities

One of the observed focus groups for pregnant women was introduced to the patients as an opportunity to talk, resolve doubts, to discuss issues of interest to the participants. There was no content to be taught. Patients were in charge of the selection of topics. Compared to other health education groups, this approach is more patient-centred.

The dynamic of the group was structured by patients asking questions and professionals answering them. There was an effort to listen to patients' opinions and experiences from previous pregnancies. However, any technical aspect raised (Should a pregnant woman take aspirin? Is there any problem in going to the dentist?) was presented directly to the doctor in the group. The criterion of normality was in his hands. The question concerning what is normal and what is not was raised five times during one hour-long session. The answers were like this one:

> *Patient: Sometimes I sleep and a white substance, its a milk, something very sticky spreads in my clothes. I am not sure if this is normal.*
> *Doctor: It is normal. But it is also normal for it not to happen.*

The two main features of these meetings organized for pregnant women was the control of the 'correct' or final answer by the professionals, especially the doctor, and the reinforcement of the importance of the professional-patient relationship. These are examples from the same meeting:

> *Doctor: Theoretically, all doctors know which drugs you can take or not. So, if the doctor recommends a medication you can take it trustfully ...*
>
> *D: If the baby sucks and the mother goes to the paediatrician periodically, and the baby is putting on weight, for sure the quantity and quality of milk the*

baby is receiving is sufficient. ... if he doesn't put weight properly, the paediatrician will detect that.

If the person needs an x-ray, there is a leaded coat that protects the tummy from radiation, and the doctor will always calculate the risk and the benefit.

The point about the x-ray was raised by a patient who injured a finger and was sent for an x-ray by the doctor. But she told him she was pregnant and they cancelled it. In the answers of the doctor to the group there was reassurance about the trust the patient should have in any doctor. The healthy pregnant citizen is the one who participates and looks for information, but also who is a docile body. Health information should be disseminated among patients, patients have the power to choose the issues they want to discuss, but scientific knowledge entitles professionals to control the boundaries of normality and thus to construct normal bodies.

Patton (1990, p.72) describes professionals doing health education as "para-scientists" who act as translators to the community. She calls attention to the fact that what the patient receives as information is supposed to be the best understanding the professional has about a scientific information. This process depends on the scientific knowledge of the professional and also on the approach s/he uses to explain science in terms of everyday life. An example of the construction of truth done by the 'story telling of scientific facts' is provided by Martin (1990, pp.74-80). She shows that in textbooks menstruation, as part of the reproductive process of women, is described as "degeneration, decline, losing, dying", etc. Confronting these accounts with the description of men's reproductive physiology reveals that metaphors and explanations can add different views to similar processes. Men's physiology is said to be "remarkable, amazing, having sheer magnitude".

Another kind of health education meeting observed was contact between the health centre and specific groups in the community. Five professionals from Health Centre 1 and a community leader went to visit a small shanty town far from the health centre, and with no access to health care. The group was meeting during the monthly activity of checking the weight of children organized by Catholic nuns. The

professionals introduced themselves and spoke about the services that are offered at the health centre. Health education activities were emphasized, as well as the distribution of food to those who are undernourished. This was followed by a dialogue between community and professionals to discuss the problems as perceived by the community:

> *Social Worker: We would like to know what could we do in terms of work together?*
> *Patient: Our community needs a doctor once a month. This shanty town is rejected. If everybody agrees ...*
> *S.W: Everybody?*
> *P1: Everybody who is here wants (others agree).*
> *P2: Another thing we need is a creche. We want to work but there is no place to leave the children.*
> *P3: Here no one helps each other.*
> *Nun: In X (name of the neighbourhood of the health centre) it's different. We help each other, we work together.*
> *P2: But here the community leader does nothing.*
> *S.W: Do you have to wait for the leader?*
> *P2: Well, it's his role.*
> *(discussions about the Neighbourhood Association)*
> *P4: Three years ago the landlord was ready to give part of the land to built a school and creche, but no one did anything. This is not the role of the residents.*
> *S.W: So, what is the role of the residents? Shall we remain immobilized and wait?*

After the discussion, a nurse introduced the issue of cholera and how to prevent it. She spoke for five minutes and half of the people attending the meeting left the room. She realized the issue was not of interest and she asked why. One of the patients answered that they knew everything about it because of the television campaign. The meeting ended with information about the participatory budget of the municipality, how to participate, how to request funding; information about the Local Health Council meetings and information about the health centre itself.

During the next week, part of this population started to use the health centre and some came to the food distribution meeting. Before any food was distributed there was a general discussion about the users' requests and this was followed by a talk about a parasite. In the general discussion the residents of the community visited were introduced and a debate about changes in the health centre took place. Patients wanted to have the health centre opened until 6 or 8 pm and also Saturdays. One of the

professionals explained that a request was sent to the Health Secretariat Administration, but no answer had come back yet.

Explaining that the health centre offers health education activities and that no one has to queue to talk to the social worker and nurse, a health professional said:

> *The health of a human being is a whole. It's holistic. Development is not just physical. Sometimes people complaint that they come to the health centre and spend the day, talking to many professionals. This happens because health is something very complex. ... The health centre is like a part of your home. Everybody can use it. It's accessible.*

The link established between the shanty town and the health centre meant an opportunity of access to health care and help in the organization of the community. These are strategies related to the empowerment of the users. This can be seen in the request sent by the health centre and users asking for the working hours of the health centre to be extended. But it does not mean that this kind of practice is merely empowerment. It also deals with discipline of bodies and surveillance in a constructive way. Health education is involved in the production of a healthier citizen - from the individual home in shanty town to the health centre as everybody's home.

In the hypertension group, the meetings are associated with blood pressure checking and distribution of medication. The contact with the doctor is also used for quick ad hoc consultations. What is particular to this group is the medicalization of daily life and the extension of the concept of health through the notion of risk. In a meeting co-ordinated by a nurse, patients were discussing their condition. The issues discussed related to food, physical activities, work, television programmes, relatives, shopping, etc.

In the following meeting this same group was co-ordinated by the doctor and he brought up the issue of the conditions of the health centre. During the discussion patients revealed some of the codes of conduct that are part of the group.

> *D. Here in the group we are all the same, everybody has the right to speak. Of course, there are personal differences; Mrs. Silva, for*

instance, rarely speaks. We can see that she is a quiet person.
P1.She doesn't have the right to talk because she comes late.(laughs)
P2.But today she came early.
D. Yes, today she came early. It is important to have the right but also to consider yourself equal to the others ...
P3.We should talk when we know, but when we don't know we should stay quiet.

The meeting was very political and patients decided to write a letter and organize an appointment with the mayor of the city to request better material conditions for the health centre and other improvements. The negotiations about who should take responsibility for getting the process started, were initiated as usual, by the doctor.

P1.So, why don't you write a letter, doctor?
D. Why me? The group should do so.
(Comments)
D. How can we do it? To whom should we send it?
P2.To the mayor, of course.
D. Does everybody agree?
(All patients agree)
P1.Wait a minute, who will write the letter?
P3. I volunteer to walk and deliver the letter.(laughs)
P4. ... We want the health centre working day and night.

The experience of writing a letter, organizing the group, meeting the mayor to present a request can be considered as radical health education in a hypertension group. The patients were worried about being 'humble' people and not being received by the mayor, and about writing a letter in good Portuguese. This meeting promoted the empowerment of the users, encouraging the organization of the community. At the same time, this is an experience of medicalization of life - the promotion of health through access to medical care.

The posture of the doctor during the meeting also focused on the relative importance of doctors. He mentioned a member of the group as an expert in medicinal teas, a person to be consulted for information about the right tea for each person. The use of time was decided by participants as much as by him. Often the issues discussed had nothing to do with the main topic suggested for that meeting. When a patient was talking about the price of her medication and private consultation, the doctor said:

> *What I usually say is that the doctor is the less important part of the treatment. In the case hypertension, a chronic disease, what is important is to have a good diet, to live calmly, not to be very tense ... We have people here who control their blood pressure without medication, just taking care of salt intake, exercise, ...*

Another feature of this group was that complaints about the difficulties of being a user of the national health system were not left out, but discussed in the group. Health education, in this case, meant to share solutions and to resist forms of control over individual and collective bodies identified by the patients. The important point is, however, that this approach does not eliminate the disciplinary experience of being a user of the national health system and the intrinsic mechanisms of power that pervade health education activities: surveillance of the community, self-discipline as a positive outcome of health education practice, and the production of healthy citizens who disseminate the health domain over life.

10.5. Conclusion

Health education activities can promote a critical position on the part of the community, promoting an understanding of health as a political and socio-economic experience. The organization of groups within the community, an increased understanding about the body and its processes, and a space for political action within the health centre are some of the results of a radical approach to health education.

The data analyzed in this Chapter also show that the process of empowerment does not happen without disciplining the participants of health education activities. The routines of the use of time and body - control of punctuality, absences, interaction in the group - and the rewards to those who participate - easier access to the doctor, blood pressure checking after the meetings - construct a 'disciplined healthy citizen'.

The construction of the 'healthy citizen' happens in this milieu and what

is added to the process is the context of health. The clinical gaze over the community is carried out not only by health professionals but by all those involved in health education activities; they bring the community into the health centre and they carry the notions of a 'regime of total health' with them. Health becomes synonymous with life.

CONCLUSION OF SECTION II
HEALTH EDUCATION AS ANATOMO-POLITICS

This Section concentrated on the experience which users have when they are using the national health system and receiving health education. The argument pursued was that health education represents a constructive exercise of power to manage individual and collective bodies.

In Chapter 8, the routines of the two health centres observed were described. Anatomo-politics relates to this experience in its many forms of administering the daily life of the health centres: 'discipline' is presented as a useful tool to organize and make efficient the access to consultations and procedures; the surveillance of the conduct of the users is carried out by professionals and users themselves; the 'patient citizen' is the norm against which every user is measured to evaluate the adequacy of her/his conduct; and those who have a link with the health centre and act as 'patient citizens' benefit from small rewards. The experience of using the national health system trains individual bodies and produces docile bodies. Some manifestation of resistance is also often an outcome of the process of using the system.

In Chapter 9, consultations without and with health education are contrasted in order to estimate the effect that health education adds to the treatment of bodies. The consultation is a site for the construction of subjectivity and patients have an expectation of being treated as a whole person; not as passive bodies. The lack of certain elements identified by the patient as essential to the consultation - such as the omission of a physical examination - are regarded as bad practice. Patients who do not develop a good professional-patient relationship tend to resist treatments and campaign against certain professionals at the health centre level. However, the provision of health education during the consultation normally leads to the satisfaction of the patient, who judges s/he has been treated as a whole person, and increases the link between professional and patient. Subsequently, this makes the use of the national health system

a more tolerable experience.

In Chapter 10, health education activities in groups show how health education means both empowerment and subjugation. The aspects related to empowerment are the acceptance of the patient in a group of peer members where her/his position counts; the acquisition of knowledge about biological and emotional processes and strategies to cope with slight variations; the relative autonomy from the national health system that better health knowledge can represent in patients' lives; and political involvement in campaigns and organized groups to struggle for better health care. At the same time, health education activities promote regulatory controls that are part of the process of disciplining and normalising bodies: the achievement of healthier habits is controlled by the whole group and not only by one professional; the patient is expected to talk about (confess) her/his failures and achievements; daily life activities are related to health care and every aspect of life can come subjected to the scrutiny of the health education group; the promotion of self-discipline and a set of disciplinary practices permeate the activities; the clinical gaze is extended to the community and the community comes to regard the health centre as its 'home'. Health education activities produce 'healthy citizens' who increasingly experience many aspects of life as events related to health.

Health education is a constructive exercise of power because it uses refined strategies to discipline bodies. The exercise of anatomo-politics deals with the production of individualities and subjectivity - the healthy person, the disciplined person, the patient citizen. They are not repressive approaches to control users, on the contrary they promote participation and freedom of choice in many cases.

The use the national health system shows that the patient can 'learn' many things from this experience. Perhaps the concept of health education should be extended to cover the 'learning' patients acquire while in contact with the system. This new concept could challenge the notion that health education is intrinsically good - in the ordinary sense of the word. Health education does construct 'good' professionals, those

who carry out health education in the consultation or health education focus group. However, health education as an exercise of power deals with both docilization and empowerment of patients. Thus the expanded concept of health education contributes to the understanding of health education as bio-politics of the population and anatomo-politics of the human body.

CHAPTER 11

CONCLUDING REMARKS ON THE SOCIAL CONSTRUCTION OF HEALTH EDUCATION

11.1. Introduction

The thesis pursued through the whole investigation has been that health education represents a singular contribution to the exercise of bio-power. Its involvement with the prevention of disease and promotion of health, as well as its educational character, enhance the set of power techniques employed in the management of the individual and social body.

After examining health education in both poles of bio-power, which are bio-politics and anatomo-politics, the present Chapter explores the relationship between health education and bio-power. At the end of Sections I and II a conclusion that related specifically to each chapter of the thesis was presented. Therefore, here the discussion concentrates on the main issues which have pervaded the whole thesis.

Throughout this study, the concepts of health education and bio-power have been used according to the formulations of other authors. In this Chapter they will be re-examined in the light of evidence provided by the fieldwork and earlier theorization developed in the chapters of the thesis. The Chapter is divided into five sections: (i) Is health education good for you? (ii) What is health education? (iii) Health education is bio-power; (iv) Health education expanded: governmentality through the regime of total health; (v) Bio-power: the concept.

11.2. Is health education good for you?

Traditionally, health education has been conceived as an asset within

health care because it provides information and suggests alternatives in terms of life-style to prevent disease and promote health. Of course, there are many possible approaches to health education practice.

In this thesis two main approaches have been described: traditional (or prescriptive) and radical (or participatory). In the practices of the traditional approach, the patient is taught how to achieve better health, as defined by professionals. Providing health knowledge occurs in a prescriptive process of transmission from the one who knows (health professional) to the learner (patient). In the participatory approach lay and scientific 'knowledges' are brought together and re-constructed, in an attempt to create equality between professionals' and patients' power/knowledge relations.

It is common sense that health education 'is good for you'. It has been argued in this thesis that the educational character of health education adds a value to it as a health practice, making health education desirable. In a country like Brazil, where educational resources are limited, to be in contact with health professionals and learn about your own body and the health of your family is a good opportunity. In this perspective, health education is indeed a 'healthy' practice, a 'good thing'.

Nevertheless, a more detailed analysis of this issue has revealed that health education covers a large range of practices, from 'good' to 'bad', from 'healthy' to 'unhealthy', from empowerment to subjugation or from liberation to docilization. As the data analyzed in Section II showed, health education is empowerment because the information provided to patients helps them to make informed choices. Based on the knowledge acquired and on their own knowledge, patients can make decisions about their health taking into account scientific, social and personal reasons. This is an opportunity for the exercise of autonomy and self-government. The political dimension of health education also constitutes it as a site for involvement in the micro-politics of the community, as well as a transmission belt for requests to the different levels of government.

Health education is also subjugation. As demonstrated by the data in Sections I and II, many health education practices are an imposition of 'truths' about health, where the patient loses control of her/his own body. Instead of choice, the patient experiences the government of her/his body or family from outside. Relating the data analyzed to the literature reviewed in this thesis, it is possible to say that scientific knowledge legitimizes the power of health professionals to manage what used to be considered 'private'. This is another way in which health education can mean control. It is an expansion of the clinical gaze over the population. Health education covers most of the issues related to life and is put into practice by a network of different professionals, from social workers to psychologists.

What supports this double view of health education is the idea that total autonomy and liberation are not possible for any human being. According to Foucault's theory, no educational process can only liberate because at the same time it disciplines bodies. In this thesis health education is seen as both empowerment and subjugation also because any health education activity keeps a common core of social practices. These practices had been identified by Foucault in other social practices and have been used to develop an understanding of health education in this thesis; they are: confession, achievement of self-discipline, and the professional's right to interpret the information provided by the patient. These are elements in the construction of a normalized and disciplined society.

Health education is normally taken for granted as a good practice. To understand why this happens was, in fact, the first motivation for this study. The practices and policies examined in this study have shown that health education has not been challenged in its constitutive elements (confession, etc) which were described above, but has been reformed or transformed in its general strategies of approach - from prescriptive practices to participatory practices. From the literature comes the notion that a social practice which is taken for granted represents a crystallized cluster of power relations. Health education is taken for granted as a good health practice but, in order to examine the power relations that constitute it, in this thesis health education is

conceived as a constructive practice (and not automatically a 'good' one).

11.3. What is health education?

In this thesis health education was conceived as a socially constructed discipline. Health education is the result of discourses and practices generated in many sites of society, here analyzed with special emphasis on the national health system, where health education is supposed to occur. The investigation of health education in this context raised the following conclusions.

Health education is a social policy which disseminates constructive techniques of power to be employed in the national health system. Federal health education policies in Brazil claim that health education is a means to transform power relations in the national health system. Health education is presented as a strategy to re-balance the power of health professionals and the powerless situation of users. These propositions from the policies have been compared with the data gathered by questionnaires and interviews - lack of implementation, rare monitoring of policies, etc. The conclusion is that health education should be defined as an area of health which is used to circulate ideas about democracy, participation and empowerment; it has been conceptualized as a discourse that is not presented in terms of its achievements - like vaccination policy, for instance - but which disseminates an 'ideal pattern of activities' that should happen at the health centres. The argument of this study was that the 'ideal' activities and relations between professionals and users are the promotion of more refined and constructive power strategies.

Health education is a professional practice developed in the national health system. As the data from the health centres has shown, health education is not a frequent practice; many times it is received by patients as a 'gift'; and health education is a practice that constructs 'good' professionals. What happens depends on the sensibility of professionals, their time and will. What happens is that patients, making comparisons between themselves, see who are the lucky ones who have 'nice'

nurses/doctors/assistants, meaning those who listen and explain health issues to patients. What happens sometimes, is that health education makes the health centre a 'better' place, an extension of the community, a place where people meet to talk and to be listened to.

The development of health education creates identity. It grants knowledge for the construction of norms between professionals and patients, as well as between patients themselves. As seen in Section II, health education patients are expected to ask questions related to the topic of the meeting or consultation; they should manifest opinions. Health education constructs a 'participatory patient' because it goes beyond a repressive exercise of power. Health education creates new identities for professionals and patients. The 'healthy individual' is then the one who, perhaps, is sick but keeps in touch with the health centre preventing complications in her/his ill-health and promoting health in the other areas of life not reached by the disease.

Health education is also an element that helps in the construction of 'the social'. Health education practice transforms elements of the private lives of patients into targets for discussion and analysis by professionals and other patients. In order to promote health, health educators are sent out into the community and details of daily life become of interest to 'good' professionals and 'healthy' patients. This mixed public-private site, 'the social', expands the potentials for intervention in the social body and health education is a tool in the construction of this space.

Health education has been analyzed until this point in accordance with the way it is usually defined - as a set of educative practices utilized to promote health. However, the data collected in this study point to another way to conceive health education. From the perspective of the patient, health education could be defined as the 'learning' of the patient when in contact with the national health system. This contact 'teaches' patients what is expected from them, which behaviours are appreciated and rewarded. It is suggested in this study that the construction of the 'healthy' patient is done through an educative process that could also be called health education. According

to this point of view, this study suggests that the concept of health education should be expanded to: everything that the contact with the health system and professionals 'teaches' to the users. This new conception of health education expands the conventional concept and separates out the concept of 'goodness' traditionally attached to it. When the patient puts together the 'learnings' promoted by experiences such as difficult access, quick consultations, health education groups, queues, free drugs and tests, how can health education be defined?

Health education is thus re-defined here as a form of bio-power; as a form of control over life in its relations to individual bodies and population. Health education in this new conception - learning from experiences of the user of the national health system - shows how much politics is embedded in health education, as described in the next section.

11.4. Health education is bio-power

The management of individual and collective bodies occurs in many sites of society - eg at work, and in the educational and health system. By concentrating on the Brazilian national health system, this study explored the notion that bio-power is bio-politics, anatomo-politics and an intermediary network of power relations among them.

The Brazilian national health system provides many examples of the management of the population itself. However, the focus of this study was how health education, as a field of health promotion, expands the contact between government and population.

As bio-politics, health education policies in Brazil have been disseminating discourses on participation and empowerment. The analysis of federal policies showed that most of these policies were not implemented, but were in consonance with international and national policy and political processes. The proposed

policies also point to a possible direction for the future for the national health system: decentralized, democratic, participatory. It was and is suggested in this thesis that, in terms of bio-politics, this means that from repressive approaches the system is turning to constructive approaches to manage the population.

The concept of bio-politics proved an useful tool for understanding health education policies. However, the analysis of the data produces questions about the ways in which bio-politics, and subsequently bio-power, are presented in the literature. The metaphors of 'capillarity', 'circulation of power', and 'power running through the social body' (Hewitt, 1991, p.231; Foucault, 1990, p.94) are used to explain how bio-politics reaches different sites in the social body. They imply a notion of a continuous and consistent flow through the social fabric. In fact, what the data in Section I showed was a complex process of ruptures and continuities where no 'easy' flow takes place. The examples of information about the population and lack of implementation of policies illustrate the complexity of bio-politics.

According to Foucault, gathering information about the population is part of the process of bio-politics. However, in the Brazilian national health system very little information is sent back to the state and central government. Bio-politics is exercised in spite of the fact that health centres gather information in a non-systematic way. The management of the population occurs through what was called in previous chapters 'the traditional way of doing things'. Considering that health centres manage the mass of poor citizens, why should they be overwhelmed by the job of providing information? The rupture in the circulation of information which, theoretically, empowers the government to more precise management of the social body, gives place to an 'alternative' (non-circulating) way of exercising power.

The lack of implementation of policies also challenges the notion of the capillarity of bio-politics (Hewitt, 1991, p.231). Policies are formulated and the achievement of their goals should be their way of circulating power. However, health education policies are formulated and not implemented; not formally formulated but

policies-in-implementation; and most of the time health centres implement policies partially. This large range of ways of dealing with policies suggests that capillarity is a metaphor that does not provide an adequate image of the complexity of power relations which are involved in bio-politics.

The partial and non-implementation of health education policies also raises the question of the importance of health education in the management of the population. The argument sustained in this thesis has been that the management of the population can be exercised in a more primitive form, with a minimum of health education, but health education enhances this management, adding more refined strategies to the exercise of power.

Anatomo-politics, as the other pole of bio-power, helps to examine health education and its contribution to the establishment of constructive power relations within the national health system. As demonstrated in Section II, health education makes the national health system more acceptable; a 'better' place. Radical and holistic approaches to health education suggest that users should have opportunities to discuss their demands, decide which health education activities they want, and receive interdisciplinary support. Radical and holistic views can improve the quality of health services. Nevertheless, the point sustained in this work is that a better national health system is a constructive way of governing the population.

Anatomo-politics is also exercised in the search for healthy life-styles and in the promotion of health. Whether healthy or sick, the 'healthy citizen' keeps in touch with the national health system because health education activities are for all, preventing disease and promoting health. Health professionals committed to health education visit people at home to inform them about the importance of keeping in touch with the health centre and attending health education activities. Therefore, health education, through its capacity of expanding the limits of health practice into the healthy community, is an exercise of power over life.

According to Foucault, anatomo-politics aims at creating docile and useful bodies. In this conceptual frame, the constructive approach of health education described above is achieved by means of discipline and normalization. However, to limit health education to an understanding of it as a refined form of control of the individual and collective body means to lose the perspective of its potential for empowerment. The concept of anatomo-politics sheds light on the inherent process of discipline embedded in any health education practice, but its quasi-nihilist view of control diminishes the process of empowerment also possible through health education. The analysis of health education practices has shown political and social achievements through health education - patients organized themselves, requests were sent to the government, etc. As argued before, health education is both subjugation and empowerment. To examine it through the concept of anatomo-politics means a risk of over-emphasizing its potential for producing docile bodies and not exploring with the necessary depth its capacity for empowerment.

The expansion of health to regulate many sites of the social body has been observed not only as a consequence of health education. Health promotion and a regime of total health are linked. This is the topic of the next section.

11.5. Health education expanded: governmentality through a 'regime of total health'

In recent years, an emerging trend in the areas of public health and health promotion can be noticed: the justification of changes in society because these changes will promote health. This movement includes 'healthy cities', green policies, healthy social policies, etc. In this thesis, this movement has been associated with the concept of a 'regime of total health'. This is the idea that health is desirable and should be promoted. However, it is important to notice that health reaches almost every space in human life and can justify political and economic changes in society. This makes health a solid argument to be used in the name of the population but also to protect many other interests.

The debate on the notion of risk provides a good example of how health has been creating new domains and constructing a regime of total health. Risk may concern private issues, such as sexual options and particularities of sexual intercourse, for example in the case of HIV/AIDS prevention, as much as the level of mercury and other pollutants from industrial waste in the waters of rivers. Risk is a category that re-focuses health care from disease to health. To be sick is part of a bigger process which is to be healthy. What disease creates is a new range of possible risks for the patient and perhaps her/his family.

At a macro structural level, the new public health movement relates social policies to "health, equity, comprehensiveness and accountability" (Kickbusch, 1990, p.9). Actually, Kickbusch (1990, p.9) says that three international conferences in health promotion between 1985-90 established a framework "articulating a new role for government decision-making in promoting health". She adds that the conferences "offer a vision for the future".

The 'future' seems to be a new approach to the government of the population - a constructive one. The 'regime of total health' is an ultimate expression of the use of bio-power to govern bodies in their political existence. There are examples at all levels of government. The United Nations' Cairo Conference on Population and Development demonstrate how health has been used in an international context to challenge national decisions on issues like population, economy, and ecology. At a national level, the case of Brazil illustrates that the national health system is a site for the government of the population. Health can also justify national policies on food production, environmental changes, and work conditions. At the local level, health education policy has been advocating participation of the users in the national health system and transformation of economic and social reality in order to achieve health for all. The search for health at all these levels constitute paths which circulate power through the social body. The 'regime of total health' constitutes a strategy of governmentality.

11.6. Bio-power: the concept

In the book 'The History of Sexuality - An Introduction', Foucault develops the concept of bio-power based on the idea that the relations of blood (as in sovereignty or death) gave place, in the nineteenth century, to relations linked to sexuality:

> ... *sexuality was on the side of the norm, knowledge, life, meaning, the disciplines, and regulations.* (Foucault, 1990, p.148)

Foucault (1990, pp.37 and 148) describes a shift from repression of sex to its arousal. A debate about the administration of sex has permeated the last two centuries, and Foucault questions whether its aim was not to "constitute a sexuality that is economically useful and politically conservative" (p.37). He answers that this was perhaps not the final goal, but it was certainly a goal. Surveillance over sex included its management via campaigns, religious advice, and fiscal measures, trying to shape people's sexual behaviour in accordance to political and economic norms (Foucault, 1990, p.26). Sex was a permanent issue in social life, according to Foucault (1990, pp.48-49), demonstrating that, more than prohibition, what happened was a proliferation of sexualities - labelled normal or perverted - but sexualities as sites for the optimization of control.

Looking into the category 'sex' itself, Gamarnikow & Reinfelder (1996, pp.1-29) demonstrate how sex became a domain for health. Once sexual behaviour has been conceptualized as reproductive behaviour, health embodied sex (Gamarnikow & Reinfelder, 1996, p.20). Perhaps pornography is the aspect of sex that 'escapes' the domain of health. Therefore, instead of sex, it is possible to talk about pornography and health. One space is regulated by law and the other by medical 'normality'. Foucault (1990, p.48) himself refers to "medicine, psychiatry, prostitution, and pornography" as helping in the extension of power over sexuality. Throughout the century, sex - as sexual intercourse - had been transformed into sexuality - a conception that involves the whole body in its physical, social, and psychological existence. Nowadays any aspect of normal and pathological sexuality is covered by psychology, psychoanalysis,

sexology, urology, gynaecology, forensic psychiatry, child psychiatry, social work, and so on.

Foucault (1990, pp.104-105) raises the issues of pathologization of perverse pleasure and pedagogization of children's sexuality as forms of management of sex. He acknowledges the incorporation of sex by health, but he keeps his attention on the nineteenth century and the shifts which occurred there. Foucault (1990, p.103) describes sexuality as a "dense transfer point for relations of power" and as:

> *useful for the greatest number of maneuvers and capable of serving as a point of support, as a linchpin, for the most varied strategies.*

The potential for the control of the collective body through sex and sexuality is a strong theme in Foucault's theory and has not been challenged by this research. What does seem relevant to question is whether sex is still a central concept for the understanding of bio-power. As discussed in the previous section, the current trends in health and medicine reach many more sites in the social body and do so as a constructive exercise of power.

While Foucault has been investigating sex in Western societies in the last few centuries and places it at the core of the exercise bio-power, the data examined in this thesis - a history of the present - imply that health has been transformed and could be the central linchpin for the exercise of power over life. Health, rather than sex, can cover both sexualized and non-sexualized aspects of life. Foucault explains how sexuality invaded so many domains of life and was used to normalize and discipline individual and collective bodies. Nevertheless, to promote health and prevent risk involves every aspect of life with the constructive contribution of health education, which brings the possibility of educating through participation.

Taking into account that the discourses on sexuality and health constitute identities, one can see the possible benefits that the use of health can bring to the exercise of bio-power. The construction of a 'healthy person' is something more easily acceptable, than the construction of a 'sexualized' one. Health has an intrinsic value

which increases its acceptability[1]. People are already prepared to suffer physical pain in order to maintain or recover health. Health, in contrast to sexuality, has a broader capacity of interference over life, with extended domains from pathology to the so called normal aspects of life within the community.

An example to illustrate changes not observed in Foucault's studies comes from psychiatry. Foucault (1990, p.104) discusses the hysterization of women's body as a form of control over life. It is, no doubt, a way of regulating female bodies. However, psychiatry is nowadays entering in a different era. Increasing attention has been dedicated to drugs, like Prozac (fluoxetine), which can allegedly regulate changes in the mood of the healthy person, making her/him a more productive, integrated and happy individual in society. It is the confrontation of the individual against her/his optimum state that creates the 'normal'. The normalization of individuals without the use of a collective norm is a constructive (more refined and flexible) approach that stresses even more the importance of self-discipline as a power strategy. In this case, health can go beyond the domain of sexuality as a constructive power exercise.

Repressive approaches can also be identified in the domain of health and sex. Compulsory and prescriptive approaches adopted in some health practices generate resistance. So do some strategies used for the management of the population through sexuality. As Baudrillard (1987, p.26) mentioned, "all construction and no repression" seems to be an unlikely event in the employment of power. In any case, health covers sex as a category and, according to the data of this study, has a refined set of strategies in the employment of constructive power.

The extension of the medical gaze through health education, its community participation approach, the promotion of health everywhere through all means in a 'regime of total health', these are all elements that help to sustain the proposition that health, instead of sex, has been establishing itself as the core of bio-

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[1] For instance, in Africa campaigns against genital mutilation have focused on health arguments, rather than on women's rights, in order to make some achievements (Koblinsky, M. et al, 1993).

power at this end of century.

I began this thesis intrigued by the common sense attribution of 'goodness' to health education: the evidence gathered in the fieldwork and its analysis strengthened my sense that health education is not intrinsically bad or good. However, it is a constructive strategy in the exercise of power over life. Health education grants the government access to individual bodies; it determines what is healthy for individual bodies and what should be prevented.

In Foucault's original writings on bio-power, he described the control over sex as the prime example of such a concept. Nineteen years later, it is possible to identify an emerging trend: a shift to health as the preferred strategy to manage the social body and to make docile individual bodies. Access to most aspects of the individual's life is granted through health policies and practices. And health education is a constructive way to achieve control.

Coming back to the initial question 'Is health education good for you?', the answer is: it may well be. However, health education certainly is a contribution to the management of social and individual bodies - a constructive exercise of power.

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APPENDICES

APPENDIX 1

Questionnaires - Health Secretariats and Health Centres

QUESTIONÁRIO PARA AS SECRETARIAS ESTADUAIS DE SAÚDE

Este questionário tem por objetivo diagnosticar o tratamento que a área de educação para a saúde vem recebendo junto às Secretarias Estaduais de Saúde no Brasil. Por favor, responda a cada questão tão precisamente quanto possível.

Observação: o termo "políticas", como é usado neste questionário, significa uma variedade de documentos oficiais tais como: plano, projeto, programa, recomendação, memorando, carta circular, etc.

A.Conceitos

1. Para referir-se à ação educacional que objetiva elevar o conhecimento da população sobre o processo saúde-doença, conseqüentemente promovendo melhores níveis de saúde, sua Secretaria prefere utilizar o termo:

( ) Educação para a saúde

( ) Educação em saúde

( ) Educação e saúde

( ) Todos os três são usados indistintamente

2. Você pode explicar porque esta preferência?

3. Existem outros termos preferidos pela Secretaria?

( ) Sim

( ) Não

4.Se você respondeu sim na Questão 3, por favor especifique quais são estes termos:

5. Qual a definição que sua Secretaria usa para este(s) termo(s) preferido(s)?

6. Escolha dentre os conceitos abaixo o que mais se aproxima da concepção que sua Secretaria tem de educação para a saúde[1].

( ) Educação para a saúde é um processo educacional que visa mudar maus comportamentos em relação à saúde.

( ) Educação para a saúde é um processo educacional que tem por objetivo desenvolver o potencial de cada indivíduo para uma vida em harmonia com seu corpo e meio ambiente.

( ) Educação para a saúde é uma prática social permeada pela estrutura de classes que pode resultar tanto na reprodução destas estruturas, quanto na tomada de consciência, por parte do indivíduo, da sua condição de oprimido.

( ) Educação para a saúde é uma prática social de acentuado caráter regulatório que é constituída pelas relações de poder entre indivíduos e grupos, podendo promover uma autonomia decisória que eleve a qualidade de vida e a saúde.

B.Estrutura do Grupo de Educação para a Saúde

7. Na sua Secretaria há um grupo específico para coordenar o processo de educação para a saúde através de todo o sistema (elaboração de políticas, orientação, avaliação, etc)?

( ) Sim

( ) Não

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[1]Por uma questão de simplicidade, neste questionário adotou-se a expressão "educação para a saúde" para designar todo processo educacional ligado à área da saúde.

8. Se você respondeu sim na Questão 6, escreva o nome do grupo e a sua posição na estrutura administrativa da Secretaria:

9. Se você respondeu sim na Questão 6, complete a tabela abaixo sobre a estrutura do grupo de educação para a saúde.

Número	**Profissão**	**Horas/semana para o grupo**

10. Se você respondeu não na Questão 6, por favor explique como as questões relacionadas à educação para saúde são tratadas na sua Secretaria.

C. História

11. Na sua opinião, qual foi o mais relevante documento sobre educação para a saúde produzido entre as décadas de 80 e 90, excluindo-se as políticas produzidas pela sua Secretaria?

12. O objetivo da tabela abaixo é determinar quando sua Secretaria começou a considerar a possibilidade de trabalho em educação para a saúde.

Atividade	**Ano**
Discussões informais dentro da Secretaria	
Discussões informais fora da Secretaria	
Produção de memorandos ou documentos de circulação interna	
Produção de políticas da Secretaria	

13. Esta questão se refere ao número e ao tipo de políticas produzidas pela sua Secretaria em 1992. Indique:

Total de políticas de saúde produzidas:_____

Total de políticas sobre educação para a saúde:_____

Total de políticas incluindo aspectos de educação para a saúde:_____

14. Dê o nome das políticas de educação para a saúde que sua Secretaria produziu desde 1990:

D. Formulação e Disseminação de Políticas

15. A formulação de políticas em sua Secretaria está baseada em:

( ) Políticas federais

( ) Políticas estaduais

( ) Políticas municipais

( ) Solicitações das Delegacias Regionais da Saúde

( ) Solicitações dos postos de saúde

( ) Solicitações de grupos organizados da sociedade

( ) Nenhuma razão específica

( ) Nao existem políticas de educação para a saúde

( ) Outro (especifique)_____

16. Quais são os documentos que influenciaram sua Secretaria na produção de políticas de educação para a saúde? Por favor dê o nome destes documentos.

17. Qual o impacto dos grupos abaixo listados na formulação de políticas por sua Secretaria?

Grupo		**Impact**	
	Grande	**Algum**	**Nulo**
Especialistas em educação para a saúde			
Profissionais dos postos de saúde			
Comunidade			
Grupos organizados da sociedade			
Outros (especifique)			

18. Por favor descreva o caminho percorrido por uma política da Secretaria até um posto de saúde. Se possível, use o exemplo de uma política de educação para a saúde.

E. Implementação de Políticas

19. Quantos são os postos de saúde sob o seu controle?

20. Quantos destes postos de saúde têm programa(s) de educação para a saúde implementado(s)?

21. A sua Secretaria considera que os postos de saúde precisam sofrer mudanças para atingir os objetivos traçados para a educação para a saúde?

( ) Sim

( ) Não

22. Se você respondeu sim na Questão 20, explique quais são as mudanças que deveriam ser feitas.

23. A sua Secretaria considera que há um profissional específico responsável pelas atividades de educação para a saúde nos postos de saúde?

( ) Sim

( ) Não

24. Se você respondeu sim na Questão 22, indique quem é este profissional:

( ) Agente comunitário de saúde

( ) Atendente de enfermagem

( ) Auxiliar de enfermagem

( ) Técnico de enfermagem

( ) Assistente social

( ) Dentista

( ) Enfermeiro

( ) Médico

( ) Nutricionista

( ) Psicólogo

( )Outro(especifique)_____

25. Quais são os objetivos que sua Secretaria deseja atingir através dos programas de educação para a saúde?

Por favor, anexe a este questionário a última política de educação para a saúde (ou política de saúde relacionada a educação para a saúde) produzida por sua Secretaria. Remeta ambos à pesquisadora, até 16.04.93, através do envelope subscritado, em anexo. Muito obrigada!

QUESTIONNAIRE TO STATE GOVERNMENT HEALTH SECRETARIATS

This questionnaire aims to diagnose the treatment health education area has been recieving within the State Government Health Secretariats in Brazil.

Please answer each question as accurately as possible.

IMPORTANT EXPLANATION: the term "policy" in this questionnaire means a whole set of official documentation such as plans, programmes, recommendations, memoranda, etc.

A. Concepts

1. To refer the educational process that aims to improve the population knowledge about health-illness, consequently promoting better standards of health, your Secretariat prefers to use the term:

( ) Health education (Educacao para a saude)

( ) Education in health (Educacao em saude)

( ) Education and health (Educacao e Saude)

( ) All three are used interchangeably

2. Could you please explain why this preference?

3. Are any other terms preferred by the Secretariat?

( ) Yes

( ) No

4. If you answered yes in Question 3, please specify what are the terms:

5. What is your Secretariat working definition of its preferred term(s)?

6. Choose among the below concepts the one that better represents the concept of health education[2] used by your Secretariat.

( ) Health education is an educational process aiming at changing bad behaviours related to health.

( ) Health education is an educational process aiming at developing the potentiality of the individual towards balance in (his/her) life, body and the environment.

( ) Health education is a social practice permeated by the structure of classes that can result both in the reproduction of these structures, and in the awareness, by the individual, of his/her condition of oppressed.

( ) Health education is a social practice of strong regulation nature. This social practice, constituted by the power relations between individuals and groups, could promote autonomy to improve the quality of life and of health.

B. Structure of the Health Education Team

7. In your Secretariat is there any specific group to coordinate the health education process through the whole system (creation of policies, assessment, orientation, ...)?

( ) Yes

( ) No

8. If you answered yes in Question 7, could you please write the name of the group and its place in the administrative structure of the Secretariat?

---

[2]In order to present the questionnaire in a simple way, the expression that will be used here is "health education"(educaçao para a saúde).

9. If you answered yes in Question 7, please complete the table below about the structure of the health education team.

Number	Profession	Hours/week to the team

10. If you answered no in Question 7, please explain how the issues related to health education are treated in your Secretariat.

C. History

11. In your opinion, what was the most relevant document about health education produced among the 1980s and 1990s excluding the policies produced in your Secretariat?

12. The purpose of the table below is to ascertain when your Secretariat began its thinking on health education.

Activity	Year
Informal discussion inside the Secretariat	

Informal discussion outside the Secretariat	
Production of internal working papers or memoranda	
Production of Secretariat's policies	
Other(please specify)	

13. This question refers to the number and kind of policies produced by your Secretariat in 1992. Please state:

- Total number of **health** policies produced:_____
- Total number of health education policies:_____
- Total number of health policies including health education aspects:_____

14. Could you please write the name of the health policies your Secretariat has produced since 1990?

D. Policy Formulation and Dissemination

15. The policy formulation of your Secretariat is based on:

( ) Federal policies

( ) State policies of other states

( ) Request of the "Delegacias Regionais de Saude"

( ) Request of health centres

( ) Request of organised sectors of the society

( ) No special reason

( ) No policy was already introduced

( ) Other, please specify:_____

16. What are the documents that influenced your secretariat in the production of health education policies? Please give the names of the documents.

17. What is the impact of the below groups in policy formulation in your Secretariat?

	Great	Some	Nil
Specialists in health education			
Health centre staff			
Community			
Pressure groups			
Others(please specify)			

18. Could you describe the way policies run from the Secretariat to the health centres? If possible, take the example of health education policies.

E. Policy Implementation

19. How many are the the health centres under your control?

20. How many of your health centres have a clear programme of health education implemented?

21. Does your Secretariat think the health centres need to be changed in order to achieve the aims you have stated to health education?

( ) Yes

( ) No

22. If you answered yes in Question 21, please explain what are the changes you consider important to be done.

23. Does your Secretariat think that is there a specific professional responsible by health education activities in the health centre?

( ) Yes

( ) No, the head is responsible

( ) No, everybody is responsible

24. If you answered yes in Question 23, please write which is this professional:

25. What are the aims your Secretariat is hoping to achieve through health education programmes?

Please enclose the last health education policy (or health policy including health education) your Secretariat produced. Send it back within the questionnaire to the researcher until 16.04.93. Many Thanks!

QUESTIONÁRIO SOBRE OS POSTOS DE SAÚDE NO RIO GRANDE DO SUL: SUA ESTRUTURA E SUA ATUAÇÃO EM EDUCAÇÃO PARA A SAÚDE

Este questionário tem por objetivo traçar um perfil dos postos de saúde do Estado. Por favor, responda a cada questão tão precisamente quanto possível.

Observação: o termo "políticas", como é usado neste questionário, significa uma variedade de documentos oficiais tais como: planos, projetos, progra - mas, recomendações, etc.

A.Caracterização do Posto de Saúde

1. Total de atendimentos mensais:

( ) 0-500

( ) 501-1500

( ) 1501-5000

( ) + de 5000

2. Número de funcionários (trabalhando no momento):

Número	Cargo
_____	secretário(s)/técnico(s) administrativo(s)
_____	agente(s) comunitário(s) de saúde
_____	atendente(s) de enfermagem
_____	auxiliar(es) de enfermagem
_____	técnico(s) de enfermagem
_____	enfermeiro(s)
_____	assistente(s) social(is)
_____	dentista(s)
_____	médico(s)
_____	nutricionista(s)

_____ psicólogo(s)

_____ outro:_____

_____ outro:_____

_____ outro:_____

3. O posto de saúde é mantido pelo:

( ) Governo Municipal, desde sua criação

( ) Governo Municipal, após a implementação do Sistema Único de Saúde

( ) Governo Estadual

( ) Outro(especifique):_____

4. Escolha a alternativa que melhor se aplica à administração do seu posto:

( ) o posto de saúde é coordenado por um chefe apenas

( ) o posto de saúde é coordenado por um chefe e um vice-chefe

( ) o posto de saúde é coordenado por uma diretoria e um chefe

( ) outro(especifique):_____

5. A "Chefia" ou "Diretoria" é:

( ) indicada pela Secretaria de Saúde do Município

( ) indicada pela Secretaria de Saúde do Estado

( ) eleita por todos os funcionários e representantes da comunidade

( ) eleita por todos os funcionários

( ) eleita pelos funcionários de nível superior

( ) outro(especifique):_____

6. O atual chefe é:

( ) assistente social

( ) dentista

( ) enfermeiro

( ) médico

( ) nutricionista

( ) psicólogo

( ) outro(especifique): _____

7. O posto de saúde é representado no Conselho Municipal de Saúde-CMS?

( ) Sim, por um de seus funcionários

( ) Sim, por um representante da comunidade

( ) Sim, por um representante da CLIS

( ) Sim, por _____

( ) Não, porque não há CMS no município

( ) Não, porque o posto não tem interesse em participar

( ) Não, porque não se prevê a participação do posto

( ) Não, porque _____

8. Assinale quais as informações sobre a comunidade disponíveis no posto de saúde.

Informações disponíveis	SIM	NÃO
Total de habitantes		
Taxa de morbidade		
Taxa de mortalidade		
% de criancas com imunização em dia		
% de mulheres em pré-natal		
% de mulheres em programa de prevenção do câncer de colo uterino		
% de famílias em programa de suplementação alimentar		
% de desempregados		
Padrões de condições sanitárias entre os diversos grupos da comunidade		

9. Existe alguma forma de participação da comunidade no processo de tomada de decisão do posto de saúde?

( ) Sim

( ) Não

10. Se você respondeu sim na Questão 9, especifique quais são as formas de participação.

11. A comunidade possui um representante(s) formal(is) junto ao posto de saúde?

( ) Sim

( ) Não

12. Se você respondeu sim na Questão 11, explique quantos são os representantes e como são escolhidos.

13. Assinale a afirmativa que melhor descreve o seu posto de saúde:

( ) O posto de saúde desconhece qualquer política sobre educação para a saúde e não possui qualquer atividade relacionada à área.

( ) O posto de saúde desconhece qualquer política sobre educação para a saúde mas possui seu próprio grupo de atividades em educação para a saúde.

( ) O posto de saúde possui políticas relacionadas à educação para a saúde, mas ainda não implementou estas políticas.

( ) O posto de saúde possui políticas relacionadas à educação para a saúde e já as implementou/implementou algumas.

B. HISTÓRICO

14. Esta questão se refere ao número e ao tipo de políticas recebidas pelo posto de saúde em 1992. Indique:

Total de políticas recebidas:_____

Total de políticas sobre educação para a saúde:_____

Total de políticas incluindo aspectos de educação para a saúde:_____

15. Na sua opinião, qual foi o mais relevante documento sobre educação para a saúde produzido entre as décadas de 80 e 90?

C. FORMULAÇÃO, DISSEMINAÇÃO E IMPLEMENTAÇÃO DE POLÍTICAS

16. Indique dentre os ítens abaixo aquele que é a maior influência na elaboração de políticas de saúde nos níveis estadual e municipal:

Estado	Município	
( )	( )	Políticas federais
( )	( )	Sugestões e informações das Delegacias Regionais de Saúde
( )	( )	Sugestões e informações dos postos de saúde
( )	( )	Solicitacões de setores organizados da sociedade
( )	( )	Nenhuma razão específica
( )	( )	Outro(especifique):_____

17. Os postos de saúde têm algum papel na formulação de políticas de saúde?

( ) Sim

( ) Não

18. Se você respondeu sim na Questão 17, explique qual o papel dos postos de saúde na formulação de políticas públicas:

19. Assinale os procedimentos habituais pelos quais uma nova política passa ao chegar ao posto de saúde, em distintas fases:

-Fase de Tomada de Conhecimento

( ) a política é examinada pela chefia

( ) a política é afixada em um mural

( ) a política é comunicada aos funcionários por um memorando

( ) a política é apresentada em uma reunião de funcionários

-Fase de Discussão

( ) alguém é escolhido para estudar a política e apresentá-la ao grupo

( ) uma reunião especial é feita para discutir a implementação da política

( ) a comunidade participa na escolha de prioridades para a implementação da política

( ) um grupo é escolhido para estudar a implementação da política

( ) contatos com a Secretaria de Saúde são feitos para elucidar dúvidas

-Fase de Implementação

( ) a implementação é coordenada pelo chefe

( ) a implementação é coordenada por um grupo

( ) nenhuma mudança nas proposições da política é considerada

( ) ajustes da política à realidade do posto de saúde são negociados com a Secretaria de Saúde

( ) ajustes da política à realidade do posto de saúde são feitos sem consulta à Secretaria de Saúde

( ) a implementação é completa, conforme determinado na política

( ) a implementação é parcial, de acordo com as possibilidades do posto de saúde

-Fase de Avaliação

( ) não há avaliação após a implementação

( ) os primeiros resultados são avaliados pelos funcionários do posto

( ) a comunidade participa da avaliação

( ) os resultados da avaliação são mandados para a Secretaria de Saúde

( ) a própria Secretaria de Saúde faz a avaliação

20. Quem decide e como são decididas as prioridades entre as políticas a serem adotadas pelo posto?

21. Há alguma participação da comunidade na identificação destas prioridades?

D. Atividades de Educação para a Saúde

22. Dê três exemplos de atividades bem sucedidas desenvolvidas pelo posto de saúde e baseadas em alguma política de educação para a saúde:

Atividade	Política
_____	_____
_____	_____
_____	_____

23. Dê três exemplos de atividades não bem sucedidas desenvolvidas pelo posto de saúde e baseadas em alguma política de educação para a saúde:

Atividade	Política
_____	_____
_____	_____
_____	_____

24. Quais são as atividades e instrumentos para educação para a saúde existentes no posto de saúde?

( ) poster e outros materiais educacionais

( ) vídeos apresentados na sala de espera

( ) grupos de sala de espera

( ) apresentações de vídeos para grupos específicos

( ) atividades em grupo para prevenção e acompanhamento de tratamentos (ex. grupo de gestantes, grupo de diabéticos, grupo de hipertensos, ...)

( ) palestras sistemáticas na comunidade (especifique em que grupos da comunidade:_____)

( ) palestras na comunidade, por solicitação

( ) orientação ao cliente durante a consulta

( ) outra(s):_____

_____

_____

25. Na sua opinião há algum profissional responsável pelas atividades de educação para a saúde junto ao posto de saúde?

( ) Sim, agente comunitário de saúde

( ) Sim, atendente de enfermagem

( ) Sim, auxiliar de enfermagem

( ) Sim, técnico de enfermagem

( ) Sim, assistente social

( ) Sim, dentista

( ) Sim, enfermeiro

( ) Sim, médico

( ) Sim, nutricionista

( ) Sim, psicólogo

( ) Sim, _____

( ) Não, o chefe é o responsável

( ) Não, todos os profissionais são responsáveis

( ) Não, _____

26. Indique sua concordância ou discordância das afirmativas abaixo escolhendo uma resposta para cada sentença dentre as opções:

CP:Concorda Plenamente

C: Concorda

SO:Sem Opinião

D: Discorda

DP:Discorda Plenamente

	CP	C	SO	D	DP
Má saúde é causada por salários ínfimos					
Má saúde é causada por maus hábitos					
Má saúde é causada por más condições de moradia					
Má saúde é causada por ignorância					
Manter-se saudável exige apenas a troca de alguns hábitos					

Manter-se saudável exige condições materiais mínimas					
A educação para a saúde pretende essencialmente promover hábitos saudáveis					
A educação para a saúde pretende essencialmente promover a autonomia do indivíduo em relação ao seu corpo e ambiente					

QUESTIONNAIRE ABOUT THE STRUCTURE OF HEALTH CENTRES IN RIO GRANDE DO SUL AND THEIR ROLE IN HEALTH EDUCATION

This questionnaire aims to diagnose the profile of the State health centres. Please answer each question as accurately as possible.

IMPORTANT EXPLANATION: The term "policy" in this questionnaire means a whole set of official documentation such as plans, programmes, recommendations, memoranda,etc.

A. Characterization of the health centre

1. Number of consultations per month:

( ) 0-500

( ) 501-1500

( ) 1501-5000

( ) + 5000

2. Staff numbers(staff working presently):

Number	Profession
_____	secretary(ies)/administrative technicians
_____	lay health visitor(s)
_____	nursing auxiliary(ies)
_____	assistant practical nurse(s)
_____	practical nurse(s)
_____	nurse(s)
_____	doctor(s)
_____	dentist(s)
_____	dietician(s)
_____	psychologist(s)
_____	social worker(s)
_____	_____

____ _____

____ _____

3. The health centre is funded by:

( ) the local government, since its creation

( ) the local government, after the implementation of the UHS-Unified Health System

( ) the state government

( ) other sources(please specify):_____

4. Tick the alternatives that apply to the management of your centre:

( ) the health centre is coordinated by only one head

( ) the health centre is coordinated by a head and deputy-head

( ) the health centre is coordinated by a board of directors and head

( ) other(please specify):_____

5. How is the head (or board of directors)'s position filled?

( ) through appointment from the Local Secretariat of Health

( ) through appointment from the State Secretariat of Health

( ) through election by whole staff and community representatives

( ) through election by the whole staff

( ) through election by professionals peer members

( ) other(please specify):_____

6. The present head is:

( ) dentist

( ) dietician

( ) doctor

( ) nurse

( ) psychologist

( ) social worker

( ) other(please specify): _____

7. Is the health centre represented at "CMS" meetings?

( ) Yes, by a staff member

( ) Yes, by a community representative

( ) Yes, by a member of the "CLIS"

( ) Yes, _____

( ) No, because there is no CMS in the municipality

( ) No, because the health centre has no interest in participating

( ) No, because health centres are not expected to participate

( ) No, _____

8. Please tick the available data in the health centre about the community.

Information available	Yes	No
Number of inhabitants		
Morbidity rate		
Mortality rate		
Children with immunization up to date		
Number of pregnant women in ante-natal care		
% of women in preventive breast cancer programme		
% of families recieving nutrition supplement		
% of unemployment		
Standard of sanitary conditions		

9. Is there any form of community participation within the decision-making process in the health centre?

( ) Yes

( ) No

10. If you answered yes in Question 9, please specify what are the forms of this participation:

11. Does the community have a formal representative(s) within the health centre?

( ) Yes

( ) No

12. If you answered yes in Question 11, please explain how many are the representatives and how is the position filled?

13. Which of the following statements is the best description of your health centre?

( ) The health centre is not aware of any policy about health education and has no activity related to it.

( ) The health centre is not aware of any policy about health education but has its own group of health education activities.

( ) The health centre knows policies concerning health education, but had not implemented anyone yet.

( ) The health centre knows policies concerning health education and already implemented (some of) them.

B. History

14. What was the total number of policies recieved by the health centre in 1992? Among them how many were exclusively about health education and how many included health education as one of its topics?

Total number of policies:_____

Health education policies:_____

Health policies including health education aspects:_____

15. In your opinion, what was the most relevant document about health education produced among the 1980s and 1990s?

C. Policy formulation, dissemination and implementation

16. What do you think is the main influence to state and local government police makers to formulate new policies in the health area?

State Local

( ) ( ) Federal policies

( ) ( ) Suggestions and data from the "Delegacias Regionais de Saude"

( ) ( ) Suggestions and data from the health centres

( ) ( ) Request of organized sectors of the society

( ) ( ) No special reason

( ) ( ) Other(please specify)_____

17. Do you see any role to health centres in the formulation of health policies?

( ) Yes

( ) No

18. If you answered yes in Question 17, please explain what is the role of health centres in policy formulation?

19. Tick the common procedures a new policy suffers when it arrives in the health centre:

-Awareness

( ) the policy is examined by the head (or board)

( ) the policy is exhibited in a board

( ) a memoranda is done to communicate the staff

( ) the policy is presented in a staff meeting

-Discussion

( ) somebody is chose to study it and present to the staff

( ) a special meeting is done to discuss the implementation

( ) the community participates in the election of priorities to implementation

( ) a committee is chose to study the implementation

-Implementation

( ) the implementation is coordinated by the head

( ) the implementation is coordinated by a committee

( ) contacts with the Health Secretariat are done to elucidate doubts

( ) no change in the policy is considered

( ) adjustments to the health centre's reality are discussed with the Health Secretariat

( ) adjustments to the health centre's reality are done without any dicussion with the Secretariat

( ) the implementation is partial, according to health centre's possibilities

-Evaluation

( ) there are no evaluations after implementation

( ) the first results of the implementation are evaluated by the staff

( ) the community participates in this evaluation

( ) the results of the implementation are sent back to the Health Secretariat

( ) the Secretariat evaluates the implementation

20. How are made the decisions about what are the priorities among policies to be adopted by the health centre?

21. What is the role of the community in the identification of these priorities?

D. Health education activities

22. Give three successful examples of activities carried out in the health centre based on health education policies:

Activity	Policy
_____	_____
_____	_____
_____	_____

23. Give three unsuccessful examples of activities carried out in the health centre based on health education policies:

Activity	Policy
_____	_____
_____	_____
_____	_____

24. What are the activities and instruments for health education existing in the health centre?

( ) wall poster and other educational materials

( ) video presented in the waiting room

( ) informal discussions in the waiting room

( ) video presentation for specific groups

( ) specific group activities for prevention and follow up for treatment (e.g. group of pregnant women, group of diabetics, ...)

( ) invited talks in the community

( ) talks in the community on regular bases (specify where:_____ _____)

( ) integral part of the professional-patient interaction during the consultation

( ) other:_____

( ) other:_____

25. In your opinion is there a specific professional responsible by health education activities in the health centre?

( ) Yes, the assistant practical nurse

( ) Yes, the dentist

( ) Yes, the dietician

( ) Yes, the doctor

( ) Yes, the lay health visitor

( ) Yes, the nurse

( ) Yes, the nursing auxiliary

( ) Yes, the practical nurse

( ) Yes, the psychologist

( ) Yes, the social worker

( ) Yes, _____

( ) No, the head is responsible

( ) No, everybody is responsible

( ) No, _____

26. Please tick according to your aggreement/disagreement one of the options below to each sentence.

Key:

FA: Strongly agree

A: Agree

NO: No opinion

D: Disagree

SD: Strongly disagree

	SA	A	NO	D	SD
Ill-health is produced by very low wages					
Ill-health is produced by bad habits					
Ill-health is produced by bad housing conditions					
Ill-health is produced by ignorance					
To keep health demands only changing some habits					
To keep helathy demands minimal material conditions					
Health education aims mainly at promoting healthy habits					

Health education aims mainly at promoting the individuals' autonomy in relation to their bodies and environment					

APPENDIX 2

Semi-structured interviews

CONSULTATION: PATIENTS' INTERVIEW

-Before Consultation:

1. Could you please explain me why are you asking this consultation?

2. Do you know the doctor/nurse who will see you? For how long do you see this same doctor?

3. (If answer no) Do you come very frequently to the health centre? Why you did not ask the same professional who saw you last time?

4. (If answer yes) Why did you choose this professional?

5. What is the matter with you?

CONSULTATION

- After Consultation:

1. Could you please explain to me what did the professional explain you during the consultation?

2. Do you intend to do what was recommended?

3. Do you have conditions to follow the professional's recommendations?

4. Did you learn anything in this consultation? What?

5. Do you still have any doubt you would like to ask the doctor/nurse and you did not? (If answer yes) What and why did you not ask?

HEALTH EDUCATION ACTIVITY: PATIENTS' INTERVIEW

-Before Activity:

1. Why are you attending this activity?

2. Do you know the professional who will carry out the activity? For how long have you been attending this activity?

3. Do you know any other people who are coming to the activity today?

4. Why did you choose to come to this activity?

ACTIVITY

-After Activity:

1. Do you think you understood everything that was presented?

2. (If not) What did you not understand?

3. Could you please repeat to me what were the main ideas of the activity?

4. Did you learn anything new in this activity? What?

5. Did the activity give you the information you were expecting?

6. If you were the person in charge of this activity, how will it be organized? (items: contents, language, structure, participation)

7. Do you feel able to explain other people the same things you heard during this activity?

8. How do you explain the low/high participation of the group in this activity?

9. Do you still have any doubt you would like to ask and you did not? (If answer yes) What and why did you not ask?

PROFESSIONAL'S INTERVIEW

- Personal Health Education Practice

1. In your opinion, is there a specific professional responsible by health education activities in the health centre? (If yes) Who?

2. What are the activities you develop that you consider as health education?

3. Do you think your work conditions have any influence in the way you carry out health education activities?

4. Is there any other factor that influences your work as health educator?

- Conceptions on Health Education

5. How is the ideal patient to you?

6. And the ideal health professional?

7. How do you evaluate the understanding of the patient during the consultation?

8. Do you have any criterion to adequate the information you will give to the level of understanding of the patient?

9. Do you think that the consultation is a good time to carry out health education?

10.From your point of view what is the right balance between the time doctors/nurses spend looking for the disease and the time for health education?

11.What do you think is the avarege knowledge about health the patients you see here use to have?

12. What do you think they could know but they don't?

13. What do they understand as health?

- Politics and the National Health System

14.What is out of your control in this setting and you would like to control?

15. What is out of patients' control?

16. Do you see any relation between the way patients are treated in the public health system and the political life of the citizens in this country?

POLICY MAKERS' INTERVIEW

- History

1. Could you give a brief description of the history of the health education area in this Secretariat?

2. What was the first policy to refer to (or about) health education you had here?

3. Do you know how many specific health education policies were created during the 80's and 90's in this Secretariat?

- Health Education Team

4. Who formulates the policies about health education here?

5. How is the composition of the health education team (if it exists)?

- Formulation and Dissemination

6. What are the current documentation you use when preparing a policy about health education?

7. What are the official influences you take into account when preparing policies? Please explain the clash: policy implementation vs. change of government.

8. Is there any other sort of influence in the preparation of policies?
(Ask about specialists, health centres, community, pressure groups)

9. What is the way a policy takes from the preparation until its evaluation?

- Implementation

10. How is the follow up of a policy implementation among so many health centres?

11. What are the main difficulties in this area?(Ask:health centres, professionals)

12. Could you describe a successful experience of implementation of a policy?
What are the reasons of the success?

13. Could you describe an unsuccessful one? What are the reasons to the failure?

14. What are the main objectives the Secretariat aims to achieve when implementing health education policies?

- Concepts

15. Could you please define health education?

16. Do you think that all the people who participate in the policy formulation and implementation share the same opinion?

17. How does it(different concepts) interfere in the final results of health education programmes?

APPENDIX 3

Pictures of the Health Centres' neighbourhood

Health Centre 1

Health Centre 1

Pictures of the Health Centres' neighbourhood

Health Centre 2

Health Centre 2

APPENDIX 4

Pictures of the Health Centres 1 and 2

This Appendix has been removed from the final version of the thesis to protect the identity of professionals and members of the community involved in the study.

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APPENDIX 5

Health Education Guidelines

Brasil. Ministério da Saúde. ***Educação em saúde - diretrizes*** [Health education - guidelines]. Brasília, 1989 a/b, pp.9-10.

Assumptions

"- Health education is a social practice; it is a process that contributes to the development of a critical consciousness about health problems, and promotes the search for solutions in a collective way.

- This practice rejects the conception of education as a simple transmission of knowledge and skills. In a system based on participation, the educational practice is part of the health action itself; it is part of a group of activities which ought to work, in an integrated way, upon all levels and phases of the process of organization and implementation of health services.

- Participation here means that people ought to take what belong to them by right, rather than joining activities decided by others.

- According to a participative methodology, the health practice as an educational practice is no longer a proces of persuasion or of transfer of information, but it si a process which enables individuals or groups to transform the social reality.

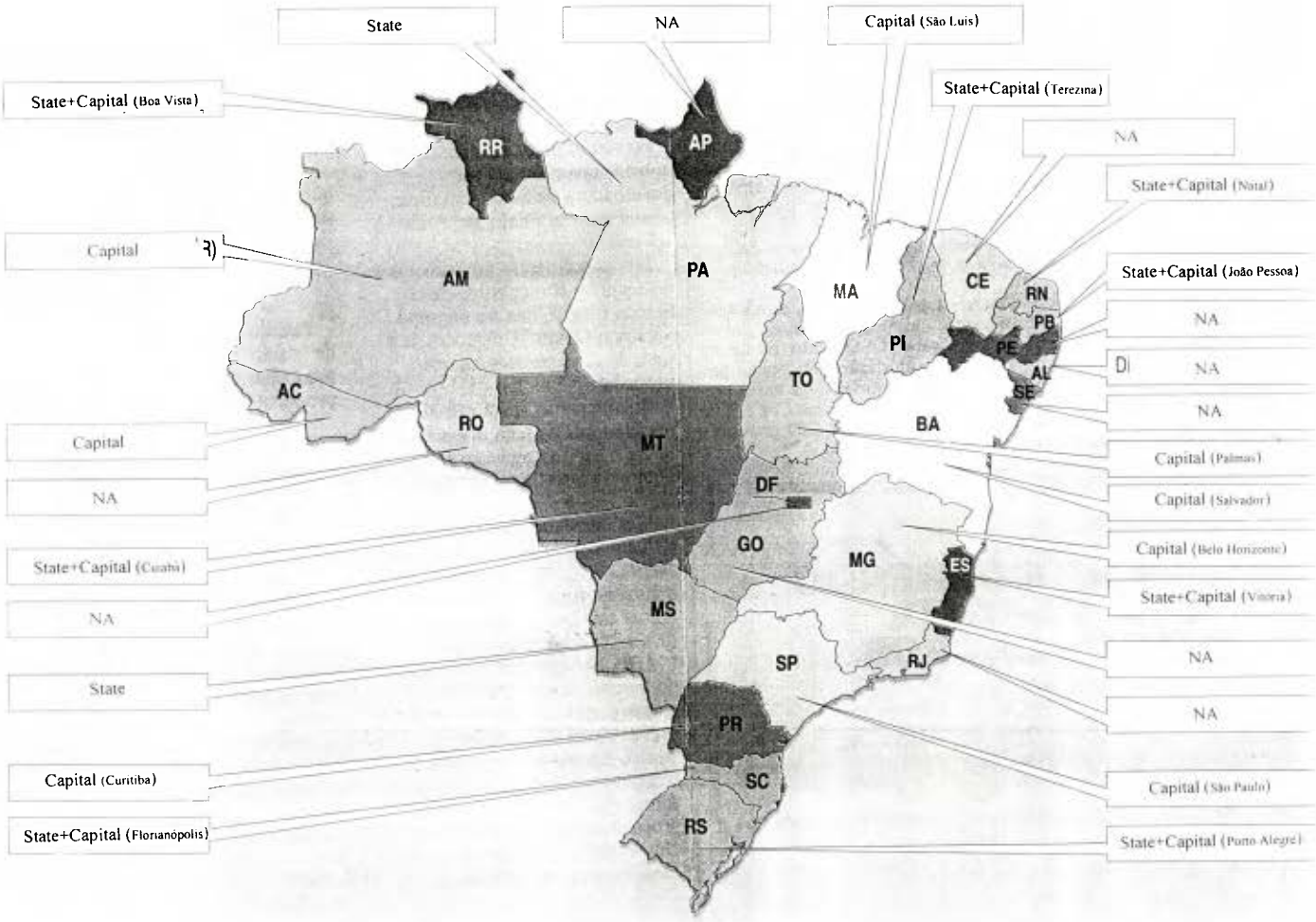
- This process is based on the fact that the reality is dynamic and men, as historical beings, perceive and transform this reality. Every one has, in a particular way, the ability to perceive reality. This ability changes to the extent the individual reflects and acts upon the reality. Everybody has the potential to self-organise and to be an actor in his/her own history; everybody has expectations about possibilities of changing his/her daily life; and s/he accumulates life experiences, values, beliefs and knowledge which constitute a cultural universe that must be respected.

- One of the subjects of this process is the population, when popular participation is mentioned, it means that the population, in an organised way, ought to be able to express their needs and expectations through participation in the decision-making process of health policies and the control of health services. It is the role of the State to manage, plan, implement, supervise and evaluate the health services provided.

- Another subject involved in this process is the health worker, in the direct contact with the patients, in the sphere of the health institution to which s/he belongs (decision, planning and evaluation), and at the different levels of the health system. Commonly, in the interior of the institution the relations take place in an authoritarian way. Health workers, mediators among the national, state and local levels, ususally are merely managers in line who implement decisions about which they were denied right to discuss. In reality, the decentralization process will only happen when health workers, experiencing this educative process, can participate on the production of knowledge and can decide about the ways to deal with the real needs of the population."

APPENDIX 6

Geographical Distribution of the Data Collection: States and States's Capitals Which Answered the Questionnaires



RS Rio Grande do Sul	MT Mato Grosso	PA Pará	PB Paraiba
SC Santa Catarina	GO Goiânia	MA Maranhão	RN Rio Grande do Norte
PR Paraná	MG Minas Gerais	PI Piauí	CE Ceará
SP São Paulo	ES Espírito Santo	SE Sergipe	RR Roraima
MS Mato Grosso do Sul	BA Bahia	AL Alagoas	TO Tocantins
RJ Rio de Janeiro	AM Amazonas	PE Pernambuco	AC Acre
			AP Amapá

NA: No answer

APPENDIX 7

7.1. Geographical Situation of Rio Grande do Sul in South America

7.2. Regional Health Autorities in Rio Grande (regions circled were covered by the questionnaire)

APPENDIX 8

Additional Information on the Characteristics of State and Municipal Health Centres in Rio Grande do Sul

Funding and control:
Health centres in Rio Grande do Sul are funded by the federal, state and municipal governments. The state still plays the most important role in controlling the services of the national health system. In 1990, it controlled 67.4% of all national (non-private) health institutions in the state, in spite of the fact that 125 municipal governments already were implementing the municipalization of health according to the SUS reform. The municipal governments control 25.3% and the federal government 7.3% (RS-SSMA, 1990, p.20 and errata). According to the questionnaires, 83% of the state health centres are totally funded by the state. Only 12.5% are already being funded by their municipalities.

The health centres funding structure is rigid. The state or municipality are the only sources of maintenance for the health centres. Only two state health centres recorded a mixed financial support. In one case both state and municipal government shared the funding and in the other the state was sharing the funding with the *LBA - Legião Brasileira de Assistência*, a charity belonging to the federal sphere.

Decentralization:
According to the questionnaires sent, municipalization is slower than claimed by the state secretariat. The process of decentralization, started in 1988, was not implemented in 83% of all health centres which answered the questionnaire.

In the state capital the municipalization process had hardly begun. The municipal government controls only 11 health centres and the state has around 80. However, in all these years of decentralization the state and municipal governments have not found a way to start the process of decentralization. The explanation is that the municipal government refuses to accept health centres which are not properly equipped and in good material condition. Also the transfer of the money should start immediately and this seems to be a difficult issue for the state.

Number of consultations and staff:
The questionnaires showed that although health centres vary according to the number of consultations per month, at the state level half of them (50%) have from 501 to 1500 consultations; the second largest group 29.1% has between 1501 and 5000 consultations. The extremes of fewer than 500 consultations or more than 5000 occur in 12.5% and 8.4% of health centres respectively. At the municipal level two thirds of the health centres have from 1501 to 5000 consultations per month and the other part of them (one third) have from 501 to 1500 consultations.

There is a direct relationship between number of consultations and number of staff. The state health centres with more than 5000 consultations per month have the largest staff (37, 45, 47 and 73 professionals each). But, there are exceptions. Among the health centres which have from 501 to 1500 consultations per month there two health centres with a large staff: one has 39 and the other 28 members, though all others employ between 4 and 11 professionals.

There are two municipal health centres which have from 501 to 1500 consultations per month. One of them has the smallest staff; only seven people. The other one with the same number of consultations and all the reminding seven municipal health centres have a staff from 21 to 33 people.

Considering the health centres of the three levels of government (RS-SSMA, 1990, p.20), in the national health system in Rio Grande do Sul there are around 15 doctors and 15 assistants to each nurse. However, in a 1993 official document the state health secretariat does not present these figures. Rather, it chose to present the number of professionals in the state as counted by the professional councils, including those professionals who work at hospitals, private clinics, etc. In the State of Rio Grande do Sul as a whole, there is one nurse for every 3.42 doctors and one nurse for 4.91 other nursing personnel. The number of consultations quoted in the same document are around 2 million consultations with doctors and 2.5 million consultations with assistants. The assistants are incorrectly called nursing personnel, thus allowing the state to pretend it works only with formally trained staff (RS-SSMA, 1993, p.15).

Head of the health centre:

There are wo cases of election in state health secretariats. In the first one the electorate is limited to the professionals with a university degree. In this health centre there are seven doctors, a dentist and a nurse and three assistants. The second case of election is held in a big health centre (73 people) where all professionals vote, but the result has to receive the approval of the Regional Health Authority.

In the state health centres not all heads get paid. It depends on availability of funds. For professionals with a university degree the additional salary represents 1/7 of the monthly salary which is about £ 530.00 for 20 hours per week or £ 750.00 for 40 hours per week. So, the heads, when paid, earn between £ 75.00 and £ 105 extra per month for their management duties in the health centre[1].

Municipal Health Council:

In terms of power, the health centres are also under the indirect control of the Municipal Health Council. The heads are not accountable to it directly, but complaints can be raised at that level. Although the Councils were established by Law in 1988, 36.7% of the state health centres are in places were the Councils were not set up

[1] These figures were provided by professionals working in the health centres.

yet.30.6% of health centres do not participate in the councils because, among other reasons, the health centre is not represented as an institution at the Council. 22.5% of health centres have members of staff participating, but at least in one case not because the health centre was invited, but because the staff wanted to participate. In 6% of health centres the head represents it at the Council. However, in the Capital, health centres participate in the Council and are represented by their staff, a member of the local Council or a member of the community. Only one health centre has not started to participate yet because the community is still organizing itself.

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