National Agenda of Priorities in Health Research (NAPHR): focus on agenda 18 – Health Promotion[1]

Agenda Nacional de Prioridades na Pesquisa em Saúde no Brasil (ANPPS): foco na subagenda 18 – Promoção da Saúde

Marco Akerman
Lecturer, Public Health School, Universidade de São Paulo. Professor in Collective Health, Medical School, ABC.
Address: Av. Príncipe de Gales, 821, CEP 09060-650, Santo André, SP, Brazil.
E-mail: marco.akerman@gmail.com

André Fischer
Medical undergraduate student, Medical School, ABC.
Address: Av. Príncipe de Gales, 821, CEP 09060-650, Santo André, SP, Brazil.
E-mail: andrefischers@yahoo.com.br

1 This article was the result of a process supported and financed by the Ministry of Health/SCITIE/DECIT.

Abstract

One of the aims of the National Agenda of Priorities in Health Research (NAPHR) is "to respect national and regional health needs and increase the selective induction for producing knowledge ...". The NAPHR is composed of 24 sub-agendas for health research. This article shows the process developed in 2010 to review the ANPPS published in 2006 regarding sub-agenda 18 - Health Promotion. The results of the prioritization process are narrated incrementally in order to show the steps taken by reporting the facts, events and dialogues that took place between researchers and managers. A total of 86 people were invited to take part, 34 of whom did not respond and 52 accepted the invitation and participated fully. We developed 10 steps in the process of prioritizing, with five priority themes, 34 lines of research and ten priorities defined. The consequences in the short-, medium- and long term of this prioritizing process are analyzed.

Keywords: Health Promotion; Research Priorities; National Research Agenda.

Resumo

A Agenda Nacional de Prioridades de Pesquisa em Saúde tem como pressuposto "respeitar as necessidades nacionais e regionais de saúde e aumentar a indução seletiva para a produção de conhecimentos..." A ANPPS está composta por 24 subagendas de pesquisa em saúde. O presente artigo narra o processo desenvolvido em 2010 para revisar a ANPPS publicada em 2006 no que concerne à subagenda 18 – Promoção da Saúde. Os resultados do processo de priorização são narrados de maneira incremental, buscando mostrar os passos trilhados por meio do relato dos fatos, acontecimentos e diálogos efetuados entre pesquisadores e gestores. Oitenta e seis pessoas foram convidadas a participar, das quais 34 pessoas não responderam e 52 aceitaram o convite e participaram. Foram desenvolvidos dez passos para o processo de priorização, sendo definidos cinco eixos temáticos e 34 linhas de pesquisa e 10 prioridades foram definidas. São analisadas as consequências em curto, médio e longo prazo desse processo de priorização.

Palavras chaves: Promoção da saúde; Prioridades em pesquisa; Agenda nacional de pesquisas.

Introduction

The first round of the National Agenda of Priorities in Health Research (NAPHR) took place in Brazil between 2003 and 2004 and was published in 2006; it was revised in 2010. This article shows the exercise of revision, focusing on sub-agenda 18 – Health Promotion, one of the 24 sub-agendas that were revised (Brasil, 2006). This agenda was the first such exercise in defining health care research priorities in Brazil.

The NAPHR is composed of 24 health research sub-agendas (Ministry of Health, 2008): (1) health of indigenous populations; (2) mental health; (3) violence, accidents and trauma; (4) health of the black population; (5) non-communicable diseases; (6) elderly health; (7) children's and adolescent's health; (8) women's health; (9) health of individuals with special needs; (10) diet and nutrition; (11) bioethics and ethics in research; (12) clinical research; (13) health production complex; (14) evaluating health care technologies and economies; (15) epidemiology; (16) demographics and health; (17) oral health; (18) health promotion; (19) communicable diseases (20) communication and information in health care; (21) health care education and administration; (22) health care systems and policies; (23) health, environment, work and bio-security; (24) pharmaceutical care.

There are few studies covering prioritization of research topics in health promotion (Guedes and Ferreira Júnior, 2010; Lira et al., 2009; Silva et al., 2007), which shows the need to conduct wider inquiries into research into this field.

The glossary contained in "Selecting priorities in health care research – PPSSUS Guide" (Brasil, 2008) has the following definition of health promotion which supports the process of prioritizing the lines of research followed in sub-agenda 18:

> Promoting health care consists in providing the population with the means to improve their health and to exercise greater control over it. To reach an adequate state of physical, mental and social health, the individual or group needs to be capable of identifying and achieving their aspirations, to satisfy their needs and to positively change the environment. Health should not be perceived as an

> aim in itself, but rather as a source of enrichment in everyday life. Thus, promoting health is not the exclusive responsibility of the health care sector, and goes beyond a healthy lifestyle, striving for global well-being (PAHO, 1987, p. 1).

The results of the prioritization process are narrated incrementally, seeking to show the steps taken through reporting the facts, events and dialogues that took place.

The researcher – in this case, "the prioritizer" – operates more as a collector of experiences, inspired by the desire to collectively prioritize, rather than as an analyst in search of explanations (Dutra, 2002; Lira et al., 2003).

Context for prioritizing in research

Prioritizing is about making choices. Every choice implies renunciations, consequences and responsibilities. Choices can be developed, exclusively, within a techno-bureaucratic framework imposed by economically rational criteria or be guided by a set of ethical and social values of public interest clearly committed to improving the lives of significant segments of the population (Santos, 2008; Fleury, 2011). In this sense, research agendas need to reflect questions on which policies or procedures would be more efficacious and effective in a specific context, faced with specific problems, and for certain populations (Guimarães et al., 2006; Santos et al., 2010).

However, when observing "real life", it seems that this is not what happens. A report published by the World Health Organization shows the dissonance between financing destined for health care research and the disease loads which affect the global population. This "imbalance is known as the 10/90 gap, meaning that fewer than 10% of financial resources intended for health care research, of public or private origin, are targeted towards studying the diseases and health care problems which make up 90% of the health care problems affecting the global population. The 10/90 gap has high economic and social costs and is aggravated by the fact that even the 10% available is not always used in areas which would have the most impact on health. The expression 10/90 gap has become an international symbol which aims to qualify the profound inequalities which exist in the area of health care research, due to the imbalance in distributing financial resources for scientific and technological developments in health care" (Global Forum for Health Research, 1999, p. 29).

In Brazil, the 1988 Federal Constitution covers the competencies of the Public Healthcare System (SUS) in the Health Section and provides, in Article 200, Paragraph V, that this includes the increment of scientific and technological development in the area of healthcare. In 2000, the Ministry of Health (MH) established the Department of Science and Technology (DECIT) and, in 2003, created the Secretariat of Science, Technology and Strategic Input (SCTIE). These institutional paths provided political, operation and financial support for the discussion of a National Policy of Science, Technology and Innovation in Health Care (PNCTIS), supporting calls to construct a National Agenda of Priorities in Health Research. The policy and the agenda are characterized as administration instruments for SCTIE and serve to support activities promoting research conducted by the MH (Brasil, 2006, 2008; Santos et al., 2010; Santos, 2008).

The principles and values of the PNCTIS proclaim their ethical-political commitment to meet the social needs and in inverting the 10/90 gap in Brazil: (1) ethical and social compromise to improve the Brazilian population's health conditions; (2) to contribute to overcoming all forms of inequality and discrimination (including regional, social, ethnic and gender); (3) respecting the life and dignity of the individual; (4) ensuring the development and implementation of high ethical standards in health research; (5) strengthening the principle of plurality through philosophical approaches and methodologies appropriate for advancing knowledge; (6) including the citizens in the knowledge society, through scientific, technological and cultural education; and (7) stimulate social control (Global Forum for Health Research, 2004, 2005).

Starting points

The first priorities on the "promoting health" agenda were set in 2003 and 2004, ratified in the 2nd National Science and Technology Conference. In 2003 and 2004, our sub-agenda, now known as

Health Promotion, was known as "Risk factors", and we believe that this term set the tone for the lines of research prioritized, which are marked by the "concept of risk". One of the authors of this article (Marco Akerman) participated in the first edition of the ANPPS, in 2003, as a member of the "risk factors" group.

The National Agenda of Priorities in Health Research, published by the Ministry of Health in 2006, shows that sub-agenda 18 - Health Promotion, with four priority themes and 20 lines of research (Brasil, 2006).

The Department of Science and Technology (DECIT), a Ministry of Health body, leading the process of prioritizing, understood that, three years after the NAPHR was approved, it was necessary to evaluate to what extent this encouragement actually adjusted to the sub-agendas of which it was composed and to review opportunities for drawing up a new agenda. The review began with internal exercises, eliminating redundancies; eliminating mentions of specific health problems; simplifying topics; eliminating unclear aspects or mentions of methodological proceedings specific to conducting research. But, bearing in mind the broadly participative process through which the NAPHR was drawn up and approved, DECIT respected and kept the research topics indicated. It merely sought to reduce duplications and to identify the theme of each of the proposals, eliminating mention of specific types of research, approaches, principles already contained in the national policy of science, technology and innovation in health care and other additions that were not directly related to the themes of the research. This proceeding, as well as giving a more appropriate vision of the scope of the coverage of the sub-agendas, was deemed essential to enabling the projects to be classified according to each of the items on the sub-agenda.

Table 1 shows this review, which resulted in the following research lines for sub-agenda 18.

In the NAPHR review conducted in 2010, Marco Akerman was invited by Leonor Maria Pacheco Santos, DECIT director at that time, to coordinate sub-agenda 18, emphasizing the role of the agenda as a "technical and political tool for prioritizing topics in health care research, which first appeared in 2003 and was ratified by the 2nd National Science and Technology Conference, in 2004. It involved contributions from over 1,000 individuals, including researchers, administrators and service user representatives. Seven years after the creation of the NAPHR, it became necessary to update this tool and to define priorities in health care research for the coming years" [2] (Santos et al., 2010).

The second step was to define the reference group for the prioritization. Initially, the following were contacted: (1) 17 participants of the "risk factor" group that set the priorities in the first edition of the agenda in 2003 (10 researchers, 7 administrators); (2) researchers who coordinated health promotion projects financed by DECIT; (3) members of the work group for Health Promotion and Local, Integrated and Sustained Development, from the Brazilian Collective Health Association (Abrasco); (4) authors of articles with the keyword "health promotion" in the title, located using the Virtual Health Library, reference years 2000-2010; and (5) health care service administrators.

This process resulted in 86 individuals being identified (46 in the South and Southeast, 40 in other regions of Brazil; 37 from the Abrasco work group, 39 from outside of the work group; 24 administrators) and invited to participate in the prioritization exercise, through an invitation issued by DECIT in October 2010. Of the 86 invitees, 34 did not respond and 52 agreed to participate.

Finish lines

These 52 individuals received the first instructions, by E-mail, contextualizing the task and suggesting a three-week schedule for the task.

- Week one (ending 26th October): to analyze the current proposed lines of research and suggest others, not covered in the current agenda, to be included;
- Week two (ending 2nd November): propose modifications, or not, to the form in which the current

2 Personal communication from correspondence between Leonor Maria Pacheco Santos and Marco Akerman, sent in 2010.

Table 1 - Themes and lines of research in Sub-Agenda 18, in 2006

18.1. MAGNITUDE, DYNAMICS AND UNDERSTANDING OF HEALTH PROBLEMS AND EVENTS
18.1.1 Concept of health, quality of life, policies and practices of health promotion and protection and risk factors.
18.1.2 Psychosocial and cultural determinants of health and risk allocation, social networks, social support, regional inequality, discrimination.
18.1.3 Validation and synthesis of knowledge and health promotion technologies produced in the country and abroad.
18.1.4 Differentiated exposure to situations of risk (noise, being sedentary, unemployment, drug addiction, obesity, pollution, among others), according to living conditions and lifestyle of specific population groups.
18.1.5 Influences of social reproduction processes as a risk factor to health
18.1.6 Social and environmental exclusion and vulnerability.
18.1.7 Users' perception of risks regarding side effects and contraindications of drugs.
18.1.8 Schooling and health risks for the Brazilian population.
18.1.9 Socio-anthropological studies of the health-disease process and health care.
18.2 ORGANIZATION AND EVALUATION OF POLICIES, PROGRAMS AND SERVICES
18.2.1 Adverse effects of practices to prevent and control risks developed by the health system (iatrogenic).
18.2.2 New forms of state management and public policy, intersectoriality and redefining the role of the state and society in promoting health and quality of life.
18.2.3 Public policies, improving quality of life and promoting health.
18.2.4 Policies regulating the production, sale and consumption of food, medicines, blood products and other products and technologies with effects on health.
18.2.5 Assessment practices of health promotion and risk prevention in health programs.
18.2.6 Evaluation of the role of community health workers in developing autonomy of collective subjects.
18.2.7 Studies on the interrelation of health promotion policies with other policies being placed within national and international scope to improve quality of life.
18.3. EVALUATION, DEVELOPMENT AND APPLICATION OF TECHNOLOGIES
18.3.1 Evaluation of the development of technologies used in the practice of education and health.
18.3.2 Development of strategies for health promotion and disease prevention responsible for higher rates of morbidity and mortality.
18.4. INFORMATION AND COMMUNICATION IN HEALTHCARE/INFORMATION SYSTEMS
18.4.1 Evaluation of information disseminated to the public in health promotinon activities.
18.4.2 Development of methodologies and instruments of social communication for dissemination of information, knowledge and practices of health promotion in all media.

sub-agenda is structured, subdivided as follows: 18.1. magnitude, dynamic and understanding of health problems and events; 18.2. organization and evaluation of policies, programs and services; 18.3. evaluation, development and application of technology; 18.4. information and communication in health care/information systems and excluding, or not, the previously established lines.

• Week three (ending 10th November): circulate the products of the first two weeks among all participants for suggestions and confirmation of the proposal for the sub-agenda.

Of the 52 individuals who agreed to take part, 44 participated effectively (30 from the South and Southeast, 14 from other regions). The Delphi method, in which experts participate in successive rounds of analysis and re-analysis of the themes in question, was used as the methodological framework of the consultation.

The Delphi method is a strictly prospective methodological procedure, aiming to analyze ideas about the future consulting a group of experts in that field, with the aim of reaching a consensus of opinion. It was used at the beginning of the 1950s by Olaf Helmer and Theodore Gordon J, in a research center in the US Rand Corporation, when the Cold War started, initially to investigate the impact of technology in the war and later as a tool to make predictions of nuclear disaster. Delphi begins by selecting a group of experts, who are then invited to opine on issues concerned with future events. The experts' estimates are made in successive rounds, with the aim of reaching a consensus, but with maximum autonomy for the participants. The predictive power of Delphi, then, is based on systematic use of intuitive vision, given by a panel of experts. It essentially develops through the experts' dialogue, with the help of successive questionnaires (Rodríguez Perón et al., 2010, p. 215).

The participation of these individuals (using E-mail and a Gmail group) resulted in 39 responses. Some individuals formed groups and sent joint contributions: Health Surveillance Department/MH, Fiocruz, Midwest Nucleus of the Working Group for Health Promotion and Local, Integrated and Sustained Development (HP and LISD) from the Brazilian Collective Health Association (ABRASCO), Healthy Cities Document Center (CEPEDOC), National Cancer Institute MH-INCA/ Framework agreement for Tobacco Control. In the final prioritization stage, 26/44 "voted" to select the ten priorities.

The steps involved in developing the first and second rounds of the prioritization exercise are presented below, with selected statements of participants showing the dialogue character of the exercise highlighted.

Synthesizing the contributions made by the participants in the first and second rounds

Step 1: the 20 lines of research are collated, defined as a revision exercise and led by Rita Barradas Barata, in 2007 – 12 lines of research were subdivided into three thematic groups.

Step 2: adopting a new thematic group as suggested in the participants' contributions in the current, 2010, rounds: METHODOLOGICAL THEORETICAL APPROACHES

Observing the design of other sub-agendas, various work with the methodological theoretical approach item. As we have already received suggestions for lines within this area, we can add this item to the overall structure. In this aspect, I prefer a plural formulation: "methodological theoretical approaches", recognizing the diversity, with occasionally conflicting facets, of the area. This topic will include both more conceptual studies as well as historical studies as the concepts intersect and are even constituted of a historical and institutional materiality (contribution from João Leite Ferreira Neto, member of the sub-agenda 18 discussion group).

In this, more than any other sub-agenda, this issue is a priority and has been guided by suggestions in the collective construction process since 2009. We are going to break with the fragmentation of disciplines and fare to use an approach aimed at contemporary challenges. Anything complex cannot be viewed from a fragmented point of view. It is based on a complex/systematic approach that health promotion should be examined. It should also be emphasized that it is not enough to triangulate methods, but to go beyond this to the epidemiological issue, who is doing it and why. Thus, in addition to distributive/quantitative, qualitative/structural and dialectic/participative approaches/methods we also have to work with dialogical, recursion, uncertainty, and autopoiesis (self-creation), as Villasante says, with a "socio-practical participatory evaluation" going beyond method, embracing the necessary creativity, giving rise to the paradoxes of everyday praxis of networks involved – a second degree investigation. Therefore, a paradigm shift in research, in which field work and analysis need to be open – reflective actions of the paradoxes and the reflexivity of the tetrapraxis (Contribution from Joselma Cordeiro, member of the sub-agenda 18 discussion group).

Step 3: replacing in the second thematic group MAGNITUDE, DYNAMIC AND UNDERSTANDING OF HEALTH PROBLEMS AND EVENTS, the expression "health problems and events" by "social, political, economic and environmental determinants of health".

I agree with the idea of grouping together the dimensions related to theoretical-methodological foci, and even more with the need to use the issue of social determinants as the guiding dimension of the agenda (contribution from Fátima Pivetta, member of the sub-agenda 18 discussion group).

Step 4: including the expression "developing new technologies" and the words "effectiveness", "networks", "practices" and the expression "capacity to promote equity" in the third thematic group ORGANIZATION AND EVALUATION OF POLICIES, PROGRAMS AND SERVICES.

Since our process of formulating and implementing a health promotion policy is not yet hegemonic, the emphasis on evaluation needs to be a joint process with the issue of a paradigm shift in research methodology and not the focus of an evaluation of effectiveness, when efficiency and efficacy of policies which have not yet been implemented, that is, in practice, fell far short of expectations (another contribution from Joselma Cordeiro).

Step 5: changes to the fourth thematic group INFORMATION AND COMMUNICATION IN HEALTH CARE/INFORMATION SYSTEMS to "methodologies and technologies in producing, communicating and appropriating knowledge and information for health promotion".

Step 6: inclusion of a new thematic group IMPLEMENTING THE WHO FRAMEWORK AGREEMENT FOR TOBACCO CONTROL IN BRAZIL, suggested by current, 2010 participants.

Our proposal is to include a topic aimed at research which supports implementing the WHO Framework Agreement for Tobacco Control in Brazil in the National Agenda of Priorities in Health Research. Brazil's compliance with the Tobacco Agreement [...] was ratified by the 2005 National Congress and approved by the President in 2006. Thus, in Brazil, internalization of the intersectoral measures envisaged in this public health treaty makes the National Tobacco Control Policy a legal obligation for the State. Some of the articles in this Agreement (20 and 21) refer to research to support the implementation of this treaty. I took the liberty of attaching a document on the Agreement and on the importance of research in implementing it (contribution from Tânia Cavalcanti, MH, Liz Almeida, Head of the Epidemiology Division and Valeria Cunha, head of the Tobacco Control Division of Inca, members of the sub-agenda 18 discussion group).

Step 7: inclusion of the new lines of research suggested by participants in 2010 according to criteria of affinity with the thematic groups.

Step 8: to eliminate redundancies, eliminate unnecessary mentions of specific health problems, simplify topics and eliminate unclear aspects and mentions of methodological procedures specific to conducting research.

Table 2 shows the agenda after these rounds of consultation, including 5 priority themes and 34 lines of research.

Step 9: participants received instructions for the process of prioritizing 10 lines of research from the 34 established in the previous rounds, number 1 having the highest and number 10 the lowest priority.

The priorities were selected based on the choices of 26 participants, and each voted for ten priorities of their preference, classifying them according to the number of votes.

1st priority – 18.3.5. Mapping, monitoring and evaluation of health promotion interventions in different settings (municipalities, schools, universities, business, health services, housing, markets, borders, etc.).

2nd priority – 18.4.3. Mapping and evaluating training processes and educational issues in health promotion in Primary and High School education, in vocational and technical training, in undergraduate and graduate courses in the field of health and in healthcare services.

3rd priority – 18.3.10. Organization and work process in health promotion initiatives in the context of primary health care and reorienting healthcare services (matrix support in health promotion in health teams; interface with other policies such as HumanizaSUS).

4th priority – 18.3.4. Evaluation of effectiveness, cost-effectiveness and ability to promote equity in health promotion programs (physical activity, prevention of violence, accidents and alcohol and drug abuse, healthy eating, among others).

Table 2 - Themes and lines of research in Sub-Agenda 18 resulting from the consultation process, 2010

18.1 THEORETICAL-METHODOLOGICAL APPROACHES
18.1.1. Socio-anthropological and historical studies of the relation between health and society, health and illness, quality of life, health care, comprehensiveness.
18.1.2. Methodological studies and modes of producing knowledge, policy and practice (choices) in health promotion.
18.1.3. Empirical and conceptual studies of the categories of autonomy, leadership, empowerment, territory, social control and participation, intersectoral, interdisciplinary policy and practice in health promotion.
18.1.4. Studies on the impact of public policies in general, and of large scale projects in particular, on health equity, especially in vulnerable urban areas
18.1.5. Studies of the connections between health and development (environment, urbanization, climate change, saturation of ecosystems, biodiversity, organic food, etc.).
18.1.6. Studies on local development, community empowerment and social capital
18.1.7. Validation and synthesis of knowledge and health promotion technologies produced in the country and abroad.
18.2. MAGNITUDE, DYNAMICS AND UNDERSTANDING OF SOCIAL, POLITICAL, ECONOMIC AND ENVIRONMENTAL DETERMINANTS OF HEALTH
18.2.1. Developing methods of measuring which encourage the identification of health inequalities between and within territories, in SUS regional spaces, between population groups, in ethnic groups, in traditional communities (quilombolas, communities in the countryside and forest etc.), gender, etc., to influence policies promoting equity.
18.2.2. Economic, bio-psychosocial and cultural determinants of health problems and risk distribution, social networks, social support, regional inequalities, discrimination
18.2.3. Urbanization as a determinant of health (urban governance, urban mobilization; vulnerable urban areas, etc.).
18.2.4. Health, human rights, social inclusion, social and environmental justice.
18.2.5. Lifestyle and collective itineraries.
18.3. ORGANIZATION AND DEVELOPMENT OF NEW TECHNOLOGIES AND EVALUATION OF EFFECTIVENESS OF NETWORKS, POLICIES, PROGRAMS, SERVICES AND PRACTICES AND THEIR ABILITY TO PROMOTE EQUALITY
18.3.1. New ways of financing, managing and budgeting public health promotion policies; redefining the role of the state and of society in promoting health and quality of life.
18.3.2. Evaluation and monitoring the National Health Promotion Policy and its networks.
18.3.3. Constructing indicators, committees and observatories for promoting equity in health care.
18.3.4. Evaluation of effectiveness, cost-effectiveness and ability to promote equity in health promotion programs (physical activity, prevention of violence, accidents and alcohol and drug abuse, and healthy eating, among others).
18.3.5. Mapping, monitoring and evaluation of health promotion interventions in different settings (municipalities, schools, universities, business, health services, housing, markets, borders, etc.).
18.3.6. Developing/validating tools to equip managers and workers to promote health.
18.3.7. Evaluation of new technologies in health promotion and new trials in health promotion in the territories (governance and horizontal practices in health promotion; technologies for fostering health promotion in vulnerable and socially excluded groups).
18.3.8. - Health promotion and new ergonomics (changes in the relations between work and leisure with new technologies, services and the workers regarding mental activity versus physical activity, mental health and behavior in work and family life relationships).
18.3.9. Evaluating cooperative health promotion programs in private companies and the impact of social responsibility initiatives in business on community projects.
18.3.10. Organization and work process in health promotion initiatives in the context of primary healthcare and reorienting healthcare services (matrix support in health promotion in health teams; interface with other policies such as HumanizaSUS).

(continues)

Table 2 - Themes and lines of research in Sub-Agenda 18 resulting from the consultation process, 2010 (continued)

18.4. METHODOLOGIES AND PRODUCTION TECHNOLOGIES, COMMUNICATION AND APPROPRIATION OF KNOWLEDGE AND INFORMATION FOR HEALTH PROMOTION
18.4.1. Methods and languages for the production/distribution/acquisition of knowledge and information on health, lifestyles and socio-environmental vulnerabilities.
18.4.2. Evaluation of information disseminated to the public in health promotion activities.
18.4.3. Training processes and educational issues in health promotion in Primary and High School education, in vocational and technical training, in undergraduate and graduate courses in the field of health and in healthcare services.
18.4.4. Identification and analysis of issues related to theories, approaches and settings in health promotion in teaching, research and intervention activities.
18.4.5. Development of methodologies and instruments of social communication for dissemination of information, knowledge and practices of health promotion in all media.
18.4.6. Ethics in health promotion (limits of behavior regulation).
18.5. IMPLEMENTING THE WHO FRAMEWORK AGREEMENT FOR TOBACCO CONTROL IN BRAZIL
18.5.1. Profile of smoking in Brazil and its impact on health.
18.5.2. Studies on the impact of smoking in Brazil.
18.5.3. Studies on the determinants of smoking in Brazil.
18.5.4. Exposure to environmental tobacco smoke.
18.5.5. Studies on health, environmental and economic damages related to tobacco production in Brazil.
18.5.6. Evaluating the impact of the Framework Agreement for Tobacco Control Measures.

5th priority - 18.3.7. Evaluation of new technologies in health promotion and new trials in health promotion in the territories (governance and horizontal practices in health promotion; technologies for fostering health promotion in vulnerable and socially excluded groups).

6th priority - 18.1.3. Empirical and conceptual studies on the categories of autonomy, leadership, empowerment, territory, social control and participation, intersectoriality, interdisciplinary approach on health promotion policy and practice.

7th priority - 18.2.3. Urbanization as a determinant of health (urban governance, urban mobilization; vulnerable urban areas etc.).

8th priority - 18.1.4. Studies on the impact of public policies in general, and of large scale projects in particular, on health equity, especially in vulnerable urban areas.

9th priority - 18.3.2. Evaluating and monitoring the National Health Promotion Policy and its networks.

10th priority - 18.3.1. New forms of financing, managing and budgeting public health promotion policies; redefining the role of the State and of society in promoting health and quality of life.

In conclusion: some comments on the consultation process and the priorities listed

So, the choices have been made! Making a choice always implies renunciation or seeking a better alternative. And every choice involves short-, medium- and long-term consequences.

We will have to wait to see the medium- and long--term consequences. Will these choices be financed? Will they encourage the creation of lines of research in graduate programs? Will they lead to a better life?

In the very short term, some administrators who participated in the process have already voiced certain dissatisfaction with the order of the list: "I would prefer the list to be inverted", said one such administrator, showing that for him, priorities 10,

9 and 8 from the final list, respectively, financing, evaluation and impact of large scale projects involving healthcare, appear more fitting to occupy the first three places, as these are of much greater concern to administrators than the actual 1st, 2nd and 3rd priorities, respectively, mapping and evaluating the training process and educational issues in health promotion; and organization of the work process in health promotion initiatives.

It seems to us that the first three priorities are more in the "diagnostic" (academic?) field and that the final three are in the "therapeutic" (administration?) field, which perhaps reflects that in the final "vote" more professionals working at universities were involved than those working in administration.

We recognize that this "bias" does not invalidate the process, but merely explains interests and trends. It appears that prioritizing is also a political activity. It is, above all, making a necessary decision.

And, as pointed out so well by Funtowicz and Ravetz in their seminal article *Uncertainty, complexity and post-normal science,* "no group or discipline, however successful it has been in the past, will make definitive or single decisions, the facts are uncertain, values are disputed, risks are high, but the decisions are urgent" (Funtowicz and Ravetz, 1994, p. 1883).

We wish, therefore, to highlight that the exercise presented was inter-disciplinary, there being no quantitative hegemony of any profession, although everyone worked in the field of health promotion and had a technical bias. Future exercises may require the participation of a wider range of sectors of civil society, as the facts continue to be uncertain and the values continue to be disputed. And, as the decisions are urgent, we present this set of priorities for health promotion research which is in no way absolute or definitive. The "risks" of them being contested are high, and this is desirable.

Acknowledgements

This project would not have been possible without the solidarity, collaboration and hard work of 52 individuals working in healthcare services and universities who agreed to participate in the prioritizing exercise in Health Promotion Research.

References

BRASIL. Ministério da Saúde. *Agenda nacional de prioridades de pesquisa em saúde*: Brasil. Brasília, DF, 2006.

BRASIL. Ministério da Saúde. Secretaria de Ciência, Tecnologia e Insumos Estratégicos. Departamento de Ciência e Tecnologia. *Seleção de prioridades de pesquisa em saúde*: guia PPSUS. Brasília, DF, 2008. (Série A. Normas e Manuais Técnicos). Disponível em: <http://iah.iec.pa.gov.br/iah/fulltext/pc/monografias/ms/selecao_prioridades_pesquisa_saude_ppsus.pdf>. Acesso em: set. 2011.

DUTRA, E. A narrativa como uma técnica de pesquisa fenomenológica. *Estudos de Psicologia,* Natal, v. 7, n. 2, p. 371-378, 2002.

FLEURY, S. Direitos sociais e restrições financeiras: escolhas trágicas sobre universalização. *Ciência & Saúde Coletiva*, Rio de Janeiro, v. 16, n. 6, p. 2686-2688, 2011.

FUNTOWICZ, S. O.; RAVETZ, J. R. Uncertainty, complexity and post-normal science. *Environmental Toxicology and Chemistry*, New York, v. 13, n. 12, p. 1881-1885, 1994.

GUEDES, L.; FERREIRA JUNIOR, M. Relações disciplinares em um centro de ensino e pesquisa em práticas de promoção da saúde e prevenção de doenças. *Saúde e Sociedade*, São Paulo, v. 19, n. 2, p. 260-272, 2010.

GUIMARÃES, R. et al. Defining and implementing a national policy for science, technology, and innovation in health: lessons from the Brazilian experience. *Cadernos de Saúde Pública*, Rio de Janeiro, v. 22, n. 9, p. 1775-1785, 2006.

GLOBAL FORUM FOR HEALTH RESEARCH. The 10/90 report on health research 99: promoting research to improve the health of poor people. Geneva, 1999.

GLOBAL FORUM FOR HEALTH RESEARCH. Monitoring financial flows for health research, Geneva, 2004.

GLOBAL FORUM FOR HEALTH RESEARCH. Poverty, equity e health research: a report on Forum 9, Mumbai. Geneva, 2005.

LIRA, G. V.; CATRIB, A. M. F.; NATIONS, M. K. A narrativa na pesquisa social em saúde: perspectiva e método. *Revista Brasileira de Promoção em Saúde*, Fortaleza, v. 16, n. 1-2, p. 59-66, 2003.

LIRA, S. V. G. et al. Produção científica sobre promoção da saúde nos cursos de pós-graduação brasileiros. *Saúde e Sociedade*, São Paulo, v. 18, n. 3, p. 437-445, 2009.

OPAS - ORGANIZAÇÃO PAN-AMERICANA DA SAÚDE. *Carta de Ottawa para promoção de saúde*. Washington, DC, 1987. Disponível em: <http://http://www1.paho.org/Spanish/hpp/ottawacharterSp.pdf>. Acesso em: 21 out. 2013.

RODRIGUEZ PERON, J. M.; ALDANA VILAS, L.; VILLALOBOS HEVIA, N. Método Delphi para la identificación de prioridades de ciencia e innovación tecnológica. *Revista Cubana de Medicina Militar,* Havana, v. 39, n. 3-4, p. 214-226, 2010.

SANTOS, N. R. Política pública de saúde no Brasil: encruzilhada, buscas e escolhas de rumos. *Ciência & Saúde Coletiva*, Rio de Janeiro, v. 13, n. 2, p. 2009-2018, 2008.

SANTOS, L. M. P. et al. O papel da pesquisa na consolidação do Sistema Único de Saúde (SUS). *Cadernos de Saúde Pública*, Rio de Janeiro, v. 26, n. 9, p. 1666-1667, 2010.

SILVA, M. A. et al. Agenda de prioridades da vigilância e prevenção de acidentes e violências. *Epidemiologia de Serviços de Saúde*, Brasília, DF, v. 16, n. 1, p. 57-64, 2007.

Received: 06/25/2012
Approved: 03/08/2013