International Health Trends and Perspectives

Health promotion in primary care across Brazil: Genealogic-inspired qualitative study

Research Paper

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ABSTRACT

Objective: To describe and analyze Health Promotion practices in Primary Health Care. **Method**: Genealogic-inspired qualitative, descriptive, and exploratory research conducted in a PHC service in Porto Alegre, Rio Grande do Sul, Brazil. Twenty-three semi-structured interviews were held with the service staff from February to May 2020. The data were qualitatively analyzed using genealogically inspired techniques, which allowed us to identify tensions, disputes, discourses, practices, and power relationships. **Results**: We established eight sets of Health Promotion practices: 1) Educational activities focused on behavioral/habit changes and development of personal abilities; 2) Intersectoral practices and community social networks involving other community equipment; 3) Practices that encourage community organization and participation; 4) Integrative and Complementary Health practices; 5) Practices that stimulate meeting people, sociability, art, and creativity; 6) Practices that encourage environmental and food sustainability; 7) Practices that stimulate income generation; 8) Community communication practices. **Conclusion**: We identified a heterogeneous field of practices to promote health established through the circulation of different types of knowledge and powers. The practices are permeated by discourses linked to neoliberal governability and practices that position themselves against such discourse.

KEYWORDS

Health Practice; Health Promotion; Knowledge; Primary Health Care; Qualitative Methods

BACKGROUND

Health Promotion (HP) is a polysemic concept permeated by different epistemological perspectives and established by different discourses. This argument translates Foucault's (2014) genealogical approach, according to which the discourses and practices are established in a field of knowledge-power relationships. Discourses and hegemonic practices will emerge from its correlation of forces, which we can also call "regimes of truth". However, the discourses and practices that shape the regimes of truth do not disappear. They continue in the field, occupying spaces of resistance and counter-conduct (Foucault, 2008a), even if on the margins.

Individual and population control and regulation mechanisms have been created throughout the modern era to allow the development of capitalism in its different phases. Since the 18th century, the need to reduce mortality, increase life expectancy, and have people offer their workforce was more explicit. Biopolitics appeared in this context. It is a set of strategies enacted to make the population live. The population regulating method since the 18th century is called "governmentality" by Foucault. It consists of a group of techniques operated by different (technical, legal, and institutional) devices to guide people's behavior and facilitate homogeneous individual and collective behavior (Foucault, 2008a).

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The governmentality practices are part of neoliberal rationality, characterized as a socioeconomic design in which market relationships should be as accessible as possible, and the actions of the State are, to a certain extent, limited to regulating such relationships. Besides this, governments should invest as minimum as possible in the social area, barely enough to keep social balance, so that the population can continue to be productive and consume the goods and services offered by the market. Resistance and counter-conducts emerge before these neoliberal governmentality practices. Counter-conduct is the "struggle against the processes implemented for conducting others" (Foucault, 2008b, p.266). In other words, the use of different conduct than the one expected by a governmentality practice.

The governmentality strategy has been shifting during the phases of capitalism, depending on economic and social changes. In this sense, Health Promotion can be understood as a biopolitical strategy of governmentality since it operates discourses and practices that aim to shape the conduct/behavior of individuals and communities. The HP concept was created at the First International Conference on Health Promotion in Ottawa, Canada, and sees health as a resource for life and not as a goal of living. Thus, health is a positive concept emphasizing social and personal resources and physical capabilities. HP is not just the health sector's responsibility and exceeds a healthy lifestyle while also providing the conditions for building a healthy lifestyle (World Health Organization, 1986).

The contemporary concept of Health Promotion relates to several values: quality of life, solidarity, equity, democracy, citizenship, development, participation, and partnership. It is also associated with adopting different articulately enacted strategies: from the State (health public policies), the community (reinforcing community action), the individuals (developing personal abilities), the health system (reorienting strategies), and intersectoral partnerships. Health Promotion provides for multiple responsibilities for problems and solutions towards the Social Determinants of Health, seen as the conditions in which life takes place, encompassing individual factors and the country's macroeconomic situation (Buss et al., 2020). Health Promotion (HP) permeates the different mechanisms to face the Social Determinants of Health (SDH). Therefore, it can be understood as an expansion and a conceptual and operational requalification of the health issue in its growing complexity, embracing new policies and practices of intervention in the health-disease process and for an improved quality of life in general (Carvalho et al., 2004). Different practices prevail in the PHC context, ranging from educational activities to practices that stimulate community participation and organization to claim better living conditions as a right to health.

In Brazil, HP is officially systematized by the legislation and technical documents of the Brazilian Unified Health System (SUS). The 1988 Brazilian Constitution (Brasil, 1988) and the founding documents of the health system – Law N° 8.080 (Brasil, 1990a) and Law N° 8.142 (Brasil, 1990b) – highlight Health Promotion as a priority action in their texts. All health policies are established in the care tripod (assistance/care/rehabilitation), disease prevention, and Health Promotion. HP also advanced slowly in the 1990s, a period marked by neoliberal governments.

Over the years, HP and PHC have been built and updated per the possible conditions of each country in a specific historical period. In Brazil, the Health Movement established in the 1970s amidst military dictatorship was a crucial for building the Unified Health System (SUS). Through intense social mobilization, built on grassroots work with communities, the Brazilian Health Movement legitimized health as a social right in the 1988 Federal Constitution (Brasil, 1988).

The 1990s were fundamental for the construction and implementation of public policies in the country, in a process marked by disputes over a societal project, and the influence of neoliberal rationality in this process is notorious. Gallo (2017) argues that, in this period and the following decade, a State rationale anchored in neoliberal democratic governmentality prevailed in the country, which combined the neoliberal economic agenda with representative participation of society, capable of legitimizing the social policies built. In the field of health, Fleury (2009) assessed that the context in which the

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neoliberal project exercised broad control of Brazilian society hampered the construction of the SUS in convergence with the proposals formulated by the Health Reform Movement, pointing out a paradox in the Movement's history: when it was established as public policy, under adverse and partial conditions, it lost its transformative force and its libertarian nature as an instituting movement. In this context, the same author believes that our chances of reclaiming the struggle to overcome the structural inequality that characterizes Brazilian society go through the permanent construction of the subject so that we can again put the established in its place.

The tensions between rationalities and society projects have greatly influenced the structuring of Brazil's SUS, PHC, and Health Promotion. The plural rationalities in the field of health policies represents an arena in which the different pieces of knowledge constitute tensions and power relationships that will be translated into health practices. This situation can be identified in the technical-legal documents that refer to health policies and the practices effectively carried out in SUS health services.

The discussions escalated in Brazil only in the 2000s, following the establishment of the National Health Promotion Policy (PNPS) in 2006. In this document, HP is understood as one of the strategies to promote health, a way of thinking and acting by articulating other policies and technologies developed by the Brazilian health system, which can build actions to meet health social needs (Brasil, 2006). A new PNS was updated and published in 2014 (Brasil, 2014), broadening the scope of the practices. However, it is challenging to implement the guidelines established by this policy in the current context of lack of investment in social policies and public health expenses.

AIM

According to the PNPS and the National Primary Care Policy (PNAB) (Brasil, 2017), the Brazilian Primary Health Care (APS) is a privileged space to enact Health Promotion practices, as the personnel resides within the territories in which people live. Furthermore, one of the principles of APS, longitudinality, provides for the follow-up through the years and the connection with the community, favoring the different possibilities of HP practices. This article aims to describe and analyze HP practices held in Primary Health Care setting.

METHODS

We performed genealogically inspired qualitative field, descriptive and exploratory research in the context of APS in Porto Alegre, in Rio Grande do Sul, Brazil. The genealogically inspired qualitative research allows identifying tensions, disputes, practices, and power relationships (Foucault, 2014).

The research is being developed in the Unified Health System (SUS) context. Brazilian public health services are free and universal to every Brazilian or foreign citizen and are a constitutional right. They are organized hierarchically in a network and must have coordinated action. Thus, SUS first level of care is characterized by PHC, also referred to as Primary Care in Brazil. The secondary level is intended for medical specialties, and the tertiary level consists of a hospital network and high technological density procedures.

Currently, PHC is organized in the country through health facilities installed near the territories of local communities. Such establishments are staffed with health teams that can be characterized as Family Health Strategy (ESF) teams or not. ESF teams are generally the most complete, with a greater diversity of professional cores, and receive more significant funding. This way, such teams are expected to provide different health practices, offering quality care to the population served (Brasil 2017).

The research is being developed in the Health Units (HU) of the Community Health Service (CHS) of the Conceição Hospital Group (GHC), one of the largest Brazilian hospital institutions. The CHS is a PHC reference for people of the municipality's northern zone (about 100 thousand inhabitants). This service was established in the late 1970s in Brazil's popular mobilization for democracy and social rights. The Health Movement of intellectuals and civil society built the basis for what the Unified Health System would become in the following decade. Currently, it consists of twelve Health Facilities, 39 Family Health Strategy teams (ESF), four Family Health Support Centers (NASF), a Street Clinic team, three Psychosocial Care Centers (CAPS), with one Children

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CAPS (CAPSi), one Alcohol and Drugs III CAPS (CAPS AD III), and one CAPS intended for the care of users, adults, and patients with severe mental disorders (CAPS II).

The research data was produced through semi-structured interviews with the personnel in charge of leading Health Promotion practices in 12 Primary Health Care centers. These centers are responsible for attending to approximately 100,000 people. The professionals interviewed (and their respective numbers) were Social Service workers (6), Nurses (5), Psychologists (4), Community Health Workers (3), Physicians (2), Dentists (2), and a Nutritionist (1), totaling 23 participants. The inclusion criteria of the participants were to be a worker of the researched service, responsible for carrying out Health Promotion practices. Workers who did not perform such practices were excluded. The interviews were conducted from February to May 2020. Most were held in person, and those held in April and May were through video calls, due to the social distancing protocols to avoid the spread of coronavirus.

The respondents were chosen by the snowball technique, thus a non-probabilistic sample, using chains of reference. We started by contacting key informants, called seeds, to locate others with the profiled need for the research within the participant staff (Vinuto, 2012) to map the workers directly involved with the Health Promotion practices. The key informants (or seeds) participated in the research as respondents and provided us with the contact of possible participants. We discontinued the interviews when noticing that the HP practices and narratives were repeating themselves, indicating a saturation point, as provided for by the snowball strategy (Vinuto, 2012).

The interviews were recorded in audio and transcribed. Besides this, we used field notes to document the researcher/interviewer's impressions.

The qualitative analysis data was carried out by the main researcher (first author of this article) and revised by the researchers who composed the authorship of the text. The analysis consisted of the following steps: careful reading of the transcribed interviews; characterization and description of Health Promotion practices, grouping them into sets (similar themes, which were repeated in the interviews, grouped together); analysis of the sets of practices based on the theoretical-methodological framework of HP and Foucauldian concepts-tools. Its characteristics were analyzed from the description of each practice, identifying whether its effect was intended only for the modulation of behaviors or if it had a broader scope.

Thus, it was possible to activate Foucauldian concepts, according to which actions aimed at modulating ways of living can be characterized as biopolitics, within which neoliberal governmentality is the mechanism of action that can be observed in contemporary times. Health Promotion practices with an expanded scope, which exceed just trying to modulate behaviors, can be understood as resistance and counter-conducts, in the Foucauldian sense of these two concepts.

Ethics Consideration

The ethical procedures provided for in Resolution N° 466/12, which regulates Brazilian human research, were observed throughout the study (Brasil, 2012). Data confidentiality and anonymity of the participants were assured, along with the possibility of withdrawing from the study at any time. Before conducting the interviews, the Informed Consent Term (ICT) was read and signed in two copies, one copy for the researcher and the other for the study participant.

The collected data were used solely for academic purposes and will be kept under the custody of the researcher for five years, when they will be destroyed. The research was approved by the Research Committee of the School of Nursing of the Federal University of Rio Grande do Sul (Compesq/UFRGS), Primary Health Care Research Center of the Conceição Hospital Group (CEPAPS/GHC), and the Research Ethics Committees of the Federal University of Rio Grande do Sul (Annex A) and the Conceição Hospital Group, under protocol numbers CAAE 16078319.7.0000.5347 and CAAE 16078319.7.3001.5530, respectively.

RESULTS

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The Health Promotion practices reported by the respondents were grouped into eight thematic groups (presented below). Practices were grouped in one or more sets. The number indicated in parentheses represents the number of Health Centers that offer such practices. Below each group of themes/practices, we present the participants' statements that characterize or detail the practices included in it.

1)Educational activities focused on behavioral/habit changes and development of personal abilities:

Hypertension and Diabetes Group (12); School Health Program-*Saúde na Escola* (12); *Saúde no Prato*/Healthy Eating Group (12); Smoking Group (12); Walking Group (06); Women's Group (05); Sociability and Mental health Group (05); Children's Group (05); Pregnant Group (04); Teenage Group (04); Children's parents and caretakers (02); Collective activities of the Bolsa Família (Family Aid) (01); Men's Group (01); Use of digital media for communication, health education, and mobilize the community (02); Radio program (01); Family planning (01); and, Children's group on oral health (01).

We have many patients that come many times for the same things. We'd like them to have some empowerment in their care, so they don't need to demand so much. Our main objective, of course, is that the patient is well and that their health is okay (Painting).

To advise them on the guidelines, what needs to be translated to people, their everyday lives, and their conditions. Of course, we also want people to lose weight to control their diabetes (Music).

2)Intersectoral practices and community social networks, involving other community equipment:

School Health Program-*Saúde na Escola* (PSE) (12); Gardening group (04); Collective activities of *Bolsa Família* (01); *Chico Pão* Bakery (01); and, Social Assistance Network meetings (01).

Work on prevention issues, Health Promotion, and diagnosis with the children, the teachers, and the health team (Cinema).

3)Practices that stimulate community organization and participation:

Local Health Council (12); Participative Planning (05); Community Assemblies (02); Use of digital media for communication, health education, and mobilize the community (02); Collective activities of *Bolsa Família* (01); and, Immigrant women's group (01).

We have micro and macro-objectives: organizing the access and individual demands in collective demands to stimulate within the community the idea of health as a social right, a citizen's right (Capoeira).

To prioritize actions agreed upon by the staff and users (Theater).

4) Integrative and complementary practices to health:

Meditation group (05); Reiki (02); Auriculotherapy (02); Tai Chi Group (01); and Bio dance (01).

To have spaces in which we could have meditation experiences. To have spaces for self-knowledge. However, mainly to have a space for practice (Hummingbird).

5)Practices that stimulate meeting people, sociability, art, and creativity:

Sociability Group (08); Walking Group (06); Handcraft/manual workgroup (05); Women's Group (05); Sociability and Mental health Group (05); Children's Group (05); Pregnant Group (04); Teenage Group (04); Gardening group (04); Culture points (03); Elderly sociability group (03); Creative Writing group (01); Immigrant women's group (01); Dance at school group (01); Workgroup *Não Pire* (Mental health for the staff faced with the COVID-19 pandemic) (01); Men's group (01); and Happy visits (clowns) (01).

To do some activity that was not about health, to talk (…) on how one gets pregnant, women's body, having to go to the dentist, high pressure is terrible for…no "We don't talk about these things. In this group you come, and you don't talk about diseases. We have depressed people, then [instead of saying] "what are you feeling?", (…) you propose: "let's do

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something and you'll forget what you're feeling" in a playful way (Vegetable).

(...) because someone with diabetes cannot eat cake (…) Everyone knows what you can and cannot eat, it is not in this group that I'll tell you what you can and cannot eat. I work that with my colleagues as well. You cannot supervise (Travel).
To see the body differently. In the health service, one sees the organic body. To see a body that dances (Dance).

6) Practices that stimulate environmental and food sustainability:

Gardening group (04); *Chico Pão* Bakery (01); and Recycling shed (01).

The vegetable garden idea started in partnership with the Mother's Club. (…) An idea started to refer people from the center to the garden, mainly people with mental health issues (…) They work on the land, and after the harvest, they can take it home. They harvest lettuce and arugula (Vegetable).

7) Practices that stimulate income generation:

Handcraft/manual workgroup (05); *Univens*/clothes making-women cooperative (01); and *Chico Pão* Bakery (01).

The aim is to produce handicrafts to sell and generate income to fund the tour the group wants to do (Creative Art).

The Health Center joins the educational work of the Chico Pão bakery, which is a partnership between the Mother's club and the social assistance policy. The teenagers take part in these activities on Monday, Wednesday, and Friday afternoon, and, systematically, we are called to do workshops with the teenagers [with themes decided by them]: theater, violence, sexuality, gender…so it is a powerful space. There is a group of workers in the recycling shed that, sometimes, the team also does some workshops with them (Capoeira).

8) Communication practices with the community:

Use of digital media for communication, health education, and mobilizing the community (02); and Radio Program (01).

With social distancing due to the Covid pandemic (…), I knew that the ACS communicated through messages, but I had never imagined its level. When I sat down with them to send information, I found out they have a 'transmission line' with 200 people, no, [with] 200 families. This is very powerful! We are now trying to send all this to the messaging app of the Health center (Theater).

Besides the in-person group, we created a group to exchange messages and put the immigrant women in touch in a network. In the pandemic period, they continue to communicate through this group. They question the vaccination and the Health center's work. They also use the space to ask for information from one another. Sometimes, they ask for help to care for each other's children (Flower).

Concerning its duration, we had old practices, some from the time the Health Centers were created (the 1980s), until more recent ones, established in the last five years. The oldest one is Participative Planning, which started 27 years ago in the Health Center. The most recent is the Medication Group, which started two years ago. The oldest practices are those regarding sociability and participation groups. The most recent ones are the Integrative and Complementary practices to Health, which encompass the so-called Traditional and Complementary/Alternative Medicine (MT/MCA), whose policy was approved in Brazil in 2006 (Brasil, 2006).

The Health Promotion activities are mostly held weekly, and some, every fortnight. The COVID-19 pandemic has suspended some group activities, as they depend on gatherings. The staff started to use Health Education Practices through digital platforms.

The participation of different professionals was described in all practices, giving them a multidisciplinary nature. We highlight the participation of Community Health Workers (ACS) present in many activities.

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(...) many professions participate, ACS, Odontology, Nursing (…) many professionals participate in the group (Mandala).

The ACS are essential. They are always very involved in participative planning (Theater).

Another important feature was the participation of residents from the Multidisciplinary Residency in Family and Community Health and the Residency in Family and Community Medicine, who were often also involved in the creation of HP practices:

We had the participation of residents from Social Service and Psychology. We also had the participation of a resident in Nutrition that was well engaged with the group (Bacurau).

The idea for a group of immigrant women came from a Social Service resident who was already familiarity with the language. She identified the need to help these women articulate themselves into a network. That is where the idea for the group started (Flor).

The profile of participants is heterogeneous, corresponding to the characteristics of each practice (children, teenagers, older adults, and women). However, the staff confirmed that women use the health services more and tend to participate more in the HP activities:

It is well distributed between men and women but tends to have more women because women traditionally seek care more and have more connections with the Health Center (Van Gogh).

Regarding the methodologies used, we highlight the workers' creativity in creating the proposed activities. The HP practices often use methodologies that stimulate involvement and participation. Many workers use playful resources and workshops to enact the practices. The materials used are low-cost, mainly office and handcraft supplies, old magazines and newspapers, sound system, and food. The institution responsible for managing the teams provides part of the material, mainly office ones. The workers and users of the system also mobilize themselves to get the resources and implement the practices:

The management gives us the material for the activities: paper, cardboard, crayons, paint, and scissors. The staff team also brings old newspapers and magazines…everyone helps out (Happiness).

We seek donations in the markets and sell takeaway meals to raise funds to build the community vegetable garden (Vegetable)

According to the interviews, in all HP practices, the central element of the activities is the meeting between workers and users and among users. To do so, all that is required is available space. Some Health Centers have with physical structure problems. Thus, they partner with other community equipment (such as community associations, church spaces, schools, and others) to facilitate these meetings. Even so, in some circumstances, respondents reported that the lack of physical space made it impossible to carry out some practices.

DISCUSSION

We should highlight some points in the data presented. The time when the practices started can be related to the historical moments of each period: the 1980s witnessed a strong popular movement to defend the SUS; PICS in the context of SUS and Primary Health care have earned legitimacy in the last years, which can explain why HP practices, such as participative planning and sociability groups, are around 30 years old, while PICS, for instance, have primarily been created in the past five years.

The multidisciplinary composition identified in the HP practices has been productive in broadening its reach and impacting the actions. The circulation of different types of knowledge allows a complementary action and increases the capillarity and power around the fields of HP and Primary Care. Silva et al. (2014) points out the power of multidisciplinary work. Health practices held jointly by different professionals are more likely to carry more comprehensive approaches to Primary Health Care users.

The Multidisciplinary Residency in Family and Community Health and the Residency in Family and Community Medicine programs, whose study field is professional training, fulfill an essential role in the

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preservation, extension, and qualification of HP practices in Primary care. This situation is apparent in the studied setting, as all reported practices had the participation of residents from different professional areas. Besides this, because they are constantly participating in debates on their training fields, the residents stress the inclusion of other discourses in the field of HP, often proposing approaches closer to equity and full care, approximating the approaches proposed by HP to the broad concept of health and social determinants of health.

The work of Residency in the field of HP practices in Primary Care is one of counter-conduct when proposing practices that attempt to offer alternatives to neoliberal rationality (Foucault, 2008b). Thus, it is closer to reaching changes in the process and the organization of the work and the routine team practices. It establishes itself as an action and an educational process, broadening the scope of the work to allow changes in the relationships, processes, and answers to the population's health needs (Silva et al., 2019).

Concerning the profile of participants in HP practices, we know that women historically use Primary Care services proportionally more. This tendency was confirmed in a study (Guibu et al., 2017) that researched the main characteristics of Primary Care users in Brazil, where 75.8% of the 8,676 research participants were women.

However, in this research, we identified only one activity exclusively focused on the male public: the men's group. Considering the morbidity and mortality profile in this population segment, the creation of activities focused on this public is a gap and a possibility for Health Promotion. An article on the theme (Trilico et al., 2015) pointed out the need to support more research to understand the real needs of these groups better and create more effective interventions to promote health. We also highlight the importance of thinking about spaces that move away from an approach solely based on risky behavior towards a more comprehensive approach to men's health.

We should underscore the use of participative methodologies in the HP practices described and the technologies often used. Soft, soft-hard, and hard technologies are employed in health routine work. Soft technologies do not imply the use of instruments in health care. Soft-hard technologies presuppose using simple instruments, while hard technologies use highly technological equipment to perform tests and specialized procedures (Merhy, 2007).

Thus, the cost-effectiveness relationship of the care strategies, such as HP practices, which use soft technologies, are stressed (Merhy, 2007), as health is built from the meeting and the production of subjectivities. However, as a tendency, based on how political, technical, and managerial rationales operate in contemporary society, these types of knowledge connected to hard and soft-hard technologies gain favorable arguments and impose themselves over others, leading to an unbalance of power relationships when faced by other care possibilities. This situation even happens when there is no way to prove that this care strategy, focused on medicalization and the use of much technology, could have good results, as the decision to use technological designs is given by economic, cultural, social, and political interests that, nowadays, are considered more adequate, timely, and legitimate than others (Merhy, 2007).

This tension becomes stronger as technological development allows new procedures in the biomedical and pharmaceutical sectors, opening possibilities to anticipate the care or healing of an increasing number of diseases. Moreover, they announce projects of human improvement using specific drugs and robotic innovations. Such aspects can seem futuristic. However, the wish to control, as much as possible, all risk factors still linger in the imagination of people and health services. They are hyper preventive (or pre-emptive) constructions in which one searches for intervention even before action. However, the indication of specific practices seems quite cynical in an unequal setting – often of extreme poverty – faced by the communities, in which the prescription of a medicine or a therapy is often entirely out of reach (Castiel et al., 2016).

Confronted by hyper prevention, the HP practices stimulate meeting moments, using light technologies to create reflexive spaces (such as participative planning, community assemblies, and Local Health Councils) or even spaces to share their presence and

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joy (such as sociability, art, creativity groups, for example). They are counter-conduct actions against the perspective of extreme risk control, improvement of humans, and behavior modulation. The hyper preventive logic is inscribed in contemporary biopolitics to make people more productive so that the capitalist system can exploit their bodies and brains to the maximum. Thus, the effort to legitimate discourses in synch with hyper prevention is aligned with the neoliberal governmentality that shapes behaviors towards super production in the workplace, and reinforces the health market that, increasingly, offers specialized procedures, which people are led to believe they need (Carvalho, 2020; Rose, 2011).

The educational practices, targeting the behavioral/habit changes, and the development of personal abilities are central in the respondents' reports. The group activities, which use Health Education, are sedimented in Primary Care and are even legitimized in legal documents. Moreover, such activities join and sometimes are entangled with those on sociability, art, and creativity. These data follow the results identified in a literature review (Mattioni et al., 2021), which pointed out a predominance of HP educational practices focused on habit and behavioral changes and the development of personal abilities. This review showed that many educational practices are still held in isolation, in a vertical perspective of Health Education, dismissing life contexts and not followed by public policies that favor the adoption of healthy habits by individuals and communities. On the other hand, this same study shows that HP practices that target sociability, art, and creativity also find space in the practice setting, holding a counter-conduct place against the rationale of vertical (and blaming) Health Education used by social groups strongly permeated by neoliberal rationality. Less condemning approaches tend to be more effective in Health Promotion, as they consider the limitations imposed by the quick pace of contemporary life when establishing healthy habits (Nabarro et al., 2020).

Thus, we identified the presence of coexisting different practices in the field of HP in the researched setting, sometimes working cooperatively or in opposition. In the reported practices, we could perceive neoliberal discourses aligned with the accountability of individuals and the community and the control of risk factors. On the other hand, other discourses represent counter-conducts against the hegemonic approach of Health Promotion that inscribes itself in the neoliberal governmentality perspective. The latter characterize practices that are less capable of producing bodies apt to work and consume and more towards producing subjectivities that enjoy life. Such counter-conducts are strengthened by practices that promote reflexive processes among (and with) the community, under a broader concept of health, the Social Determination of Health, the Commercial Determination of Health (strategies and approaches used by the private sector to promote products and choices that are harmful to health (Kickbusch et al., 2016), a need for healthy public policies, and the responsibility of the State to provide decent living standards for its population.

Social policies must be consistent, promote work conditions with acceptable hours, adequate payment to provide for the necessities of life, social protection during hard times, education, health, leisure, culture, sustainable food, urban mobility, among other aspects encompassed by the Social Determinants of Health (Buss et al., 2020) to broaden their coverage and impact amidst a whirlwind of individual accountability and State abandonment.

CONCLUSION

Beyond binary oppositions or cause-effect relationships, we have attempted to analyze the practice field of HP in a Primary Care setting from a broader perspective, in which the historical conditions of society influence the shaping of practices in a health system. The narratives of the interviewed workers show a heterogeneous field of HP practices, established through the circulation of different discourses, knowledge, and powers. At the same time, the correlation of forces in this setting, or even how such knowledge-power relationships are organized, produced, and produce the field of HP practices in Primary Care. On the one hand, discourses reinforce and align with the neoliberal governmentality; on the other, we find those that represent counter-conducts to the dominant perspective in the field of HP, mainly established as a biopolitical strategy, inscribed in the neoliberal rationality.

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According to the Foucauldian perspective, we highlight this study's transience as historical events, which led to the emergence of the identified setting, are ongoing. They build new conformations as they change discourses and the correlations of forces in the health field and society. Thus, the power of the results presented here is the identification of current discourses, unveiling some tensions, possibilities, and limitations to the Health Promotion of individuals and communities attended to by Primary Care services.

We can conclude that the HP services held in Primary care depend on intersectoral dimensions and actions taken in the macrostructure of the country and globally. The principles of HP's technical-political framework are more necessary than ever: the reaffirmation of health as a right; the repudiation of social inequalities; the need for a new international economic order; the responsibility of governments for the health of their citizens; and the right of the population to participate in health decisions.

We also highlight that, even with limitations arising from the socioeconomic structure and the lack of healthy public policies, the Health Promotion practices held in the Primary Care services in our research represent a significant dimension of care in their communities. Besides this, we should note the creativity and commitment of workers who, despite lacking resources and personnel, build receptive, powerful, and productive spaces for Health Promotion in Primary Care Services.

SO, WHAT NOW?

Health Promotion is a polysemic concept, whose theoretical-methodological and practical approach may vary with the rationality in which it is inscribed. We could say that the main approaches to operating HP focus mainly on changing behaviors and lifestyles and, to a lesser extent, the Social Determinants of Health. This paper presents the HP field with analyses of a specific PHC scenario, in which Health Promotion practices are implemented. Through analyses based on Michel Foucault's post-structuralist framework, we could affirm that in the hegemony of its practices, HP establishes itself as a biopolitical strategy of control over bodies and, consequently, population control. In opposition, but in a limited way, some HP practices assume the character of resistance and counter-conduct to HP practices aligned with neoliberal governmentality. Thus, our paper shows that the field of HP consists of an arena in which knowledge and power are continuously activated through health practices. Although HP practices aligned with neoliberal governmentality are hegemonic and have greater legitimacy, we demonstrated how some of these practices may be less potent to produce health from an expanded perspective. On the other hand, HP practices that are marginal in this field of power-knowledge may represent more capacity to produce an improvement in people's lives, so they could be stimulated and gain more prominence in the context of health policies.

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