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HEALTH ADVOCACY POST GRADUATE EDUCATION IN BRAZIL: A RESPONSE TO NEW CONSTITUTIONAL RIGHTS[1]

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INTRODUCTION

The philosophical goals and political and economic realities of any country influence the development of a given system for health care delivery and determine to some extent the role of community, professional and private groups within the health sector (*1*). Some authors describe the role of such groups as assisting in defining needs and determining potential medical solutions to health problems, a description that suggests the traditional medical model. Others define the role more broadly to include involvement in the formulation of health delivery systems and policies aimed at improvement of health status. This approach suggests a more action-oriented advocacy model (*2–4*). Many community, professional, and private organizations view themselves as speaking or acting on behalf of constituent groups (*5*).

Although often ignored, frequently misunderstood, and difficult to secure, community participation has been a major principle of public health since the 1920s (*6*). The Declaration of Alma Ata in 1978 states that "health is a human right" and signals the importance and need for community participation in planning and carrying out health programs (*7*).

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The World Health Organization (WHO) has developed an approach to foster health promotion policy and to "advocate" for changes in public policy that promote health across public sectors (*8*). However, advocacy in public health is not a recent concept. Indeed, advocacy activities were an integral part of social programs in the 1960s and are well documented in epidemiology, nursing, and the media (*9–12*).

This article describes the process of developing a curriculum in public health advocacy based on the dispositions (provisions) of the Brazilian Constitution promulgated in 1988.

SOCIAL MOVEMENTS AND POLITICS IN BRAZIL

Community organizations have played a major role in health policy development. With the advent of the military dictatorship in 1964, the role of the State was redefined and its intervention in the economy expanded into all spheres of life in the society. Movimentos Populares de Saúde (Popular Health Movements) formed during this period attempted to equilibrate forces between the society and the State (*13–15*).

By the late 1970s, a movement was formed to reorganize Brazilian society and break from the dictatorship's authoritarianism. A new social consciousness evolved through efforts of the new leadership in the Catholic Church (the most organized effort nationwide), women's groups, worker unions, and human rights organizations. The Brazilian public began to identify its rights and press for public recognition of them. Social movements and other groups, through the national campaign of "Diretas Ja" (direct vote), sought to force the military government to hold direct elections. These groups established a new structure which enabled participation of the general public in the debate over social rights. During this period, a number of groups, including the academic community, elements of the Ministry of Health and State Secretariats of Health, the Catholic Church, worker unions and "Movimentos Populares de Saúde," moved toward the development of a new health policy framework at the Eighth Health Conference in 1986 (*16*).

At the same time that political and social factors contributed to a decline in Brazil's economic status and a stagnation of the development process leading to a deterioration of health status and of the health system, a Constitutional Assembly was convened in 1986 to prepare a new constitutional document. At that time, no one believed that the process or the final product would be democratic (*17–19*). While the model was still guided by a small group of intellectual elites, the people won an important victory with the promulgation of the Constitution.

THE RIGHT TO HEALTH AND THE BRAZILIAN CONSTITUTION

The new Brazilian Constitution guarantees the right to health as a social right for all the people (Article 196). The three spheres of political power in the Brazilian State (Union, States and Municipalities) are required to make provisions for health services (Article 23, II). Since the citizenry can now introduce legislative proposals directly (Article 14), participate in public hearings (Article 58, Paragraph 2, II), hold public referenda, and declare its will in plebiscites (Article 49, XV), legislation related to health can be enacted by the people.

Public participation, along with Executive Power, is explicitly mandated in the Constitution, not only because it is required in the Health Section (Article 198), but also because it is required for all planning at the municipal level (Article 29, X). It is important to note that the health system is constitutionally decentralized. This means that the priorities must be defined at the municipal level.

Health services and actions (health promotion and surveillance activities) are considered to be of "public relevance." This means that the Brazilian government, in all three spheres, must give priority to the health sector.[4] Taking into account these provisions and the fact that the Constitution now clearly mandates public disclosure of the proposed budget and actual allocations for each health priority, the avenues for public intervention in the decision-making processes are extraordinary (Article 74, Paragraph 2). Moreover, any action of Heads of the Executive Power at the three spheres of government against the exercise of social, individual, and political rights is considered a crime of "responsibility" subject to impeachment (Article 85, III).

Several new instruments were created to guarantee rights mandated in the Constitution. These instruments should be examined, keeping in mind that the associations (community, professionals, unions, etc.) were legitimized in Article 5. This means that such associations can now legally intervene in judicial processes on behalf of the rights of their members and the interests of their constituencies (Article 5, LXX, B). Specifically, the instruments of significance to this discussion are as follows: the "Mandado de Injunção" (Writ of Injunction), which protects one's right against the failure of public powers which do not enact the laws or administrative procedures necessary to enforce the provision (Article 5, LXXI); "Ação

[4] This was the conclusion of the Workshop on the Concept of Public Relevance in the 1988 Constitution held by CEPEDISA under the auspices of the Pan American Health Organization, with the participation of constitutional scholars, state and federal judges and state and federal district attorneys, São Paulo, October 4, 1991.

Direta de Inconstitucionalidade" (Direct Action of Inconstitutionality), through which even the associations can demand that the Supreme Court declare a law unconstitutional (Article 103, VII, VIII, IX).

For the first time in Brazilian constitutional history, the functions of the attorney general are clearly defined at the Union and State levels. These functions are very broad and include, among other things, the protection of Indians, the environment, and public goods (buildings, monuments, etc.). Especially as they relate to health, these functions include responsibility for the protection of all individual rights and for assuring that the health sector (including health services and actions) respect the rights of individuals. This implies the right of access to health services as well as the right to health.

NEED FOR TRAINING AND RESEARCH

The provisions of the new Constitution offer several avenues for discussion, debate, and advocacy in the resolution of social conflicts in health policy and politics, unknown heretofore at the community, municipal, state, and federal levels. This will require not only an understanding of the legal mechanisms created by the Constitution to resolve such issues, but also the study and analysis of the application of these mechanisms if they are to become operational and useful to health professionals, community organizations, and the society at large. While it is clear that the mechanisms for change are now in place, there appears to be a gap between what individuals and associations know about them and their actual application. Similarly, there is a void in research and training in this area.

PROGRAM GOALS AND OBJECTIVES

The overall goal of the Public Health Advocacy Program is to develop a theoretical and practical model for public health advocacy based on the new provisions of the Constitution and the experience of advocacy in Brazil to date. The program was developed by the Centro de Estudos e Pesquisas em Direito Sanitario (CEPEDISA), part of the Faculty of Public Health of the University of São Paulo (USP), in collaboration with the Maternal and Child Health Program of the Center for Population and Family Health, Columbia University School of Public Health. This was made possible through a collaborative agreement between the two institutions which provides a mechanism for faculty/student exchange and for joint teaching and research in the area of public health advocacy. The

objectives are to:

- develop a model curriculum in public health advocacy for students at the masters and doctoral levels from both schools of public health;
- undertake applied and policy-related research projects in administrative, legislative, and judicial advocacy;
- provide technical assistance in administrative, legislative, and judicial advocacy to grassroots community organizations and to governmental and non-governmental organizations;
- disseminate information about the concept of public health advocacy and strategies that work.

CONCEPTUAL FRAMEWORK

For the purpose of this program, public health advocacy is based on the efforts of individuals and organized groups who seek to influence governments, corporations, and bureaucracies to be more responsive to the needs of voters, investors, consumers, the poor, and other disenfranchised groups (*20, 21*). The basic assumption of advocacy is that individuals have basic rights which are enforceable by statutory, administrative or judicial procedures. Strategies used in advocacy focus on institutional or bureaucratic failures are inherently political (*22, 23*).

Four basic processes are used in advocacy:

- the identification of a particular problem and documentation of relevant facts. This often involves the analysis of existing demographic and epidemiological data or the collection of primary data using both quantitative and qualitative information;
- assessment of the political situation surrounding the problem to determine strategy development;
- development of strategies to intervene in the policy and decision-making processes of the executive, legislative, and judicial powers;
- ongoing monitoring of the situation in an attempt to assure that the target sector is socially responsible.

The literature describes several advocacy strategies (as outlined below) which have been proved effective in changing health policy (*1, 12, 21*). The new Constitution provides opportunities to apply these strategies more creatively. These include but are not limited to:

- social action, such as petitions and public demonstrations;
- case advocacy, involving citizen advocacy and ombudsmanship;

class action litigation, which invokes the courts as a mechanism for change;
- legislative advocacy, which involves efforts to ensure that statutory provisions serve the needs of and protect the basic rights, including health rights, of individuals and groups, and
- administrative advocacy, which is directed toward those who work in governmental agencies, public institutions, corporations, and other bureaucracies.

CURRICULUM DEVELOPMENT

The curriculum was developed at CEPEDISA by faculty from USP and Columbia University over a period of four years. It consists of two components: a formal six-week course and an internship, also of six weeks' duration, in which students carry out field work under faculty supervision.

Course development

Beginning in 1987, a six-credit graduate course entitled "Planning and Development of Health Policy: The Role of Private, Community and Professional Organizations" was team-taught at USP. Twenty masters and doctoral students participated in this course and carried out four short-term field projects under faculty supervision.

In 1989, a new six-credit course entitled "Special Studies in Public Health Advocacy" was offered, and an internship component was developed. Six USP and two Columbia students enrolled in the course. They carried out a pilot administrative advocacy project under faculty supervision. The following year, 20 USP students and two Columbia students enrolled in a graduate level course entitled "Planning and Development of Health Policy: The Role of Private, Community, and Professional Organizations." In 1991, public health advocacy became a formal (permanent) track in the Faculty of Public Health's graduate program. This permitted the integration of public health advocacy material in the health law track and vice versa. The track requires 330 hours of formal classes and field work. The topics covered in formal classes are outlined in Table 1.

Student selection

Professionals in the fields of public health medicine, nursing, social work, health education, psychology, and pharmacy who are enrolled

TABLE 1. Public health advocacy course topics.

Course	Course contents
Brazilian constitution	Health as a right Direct democracy
Health policy development	Establishment of national objectives National budget planning process
Public health advocacy	Principles Assumptions Basic processes Advocacy strategies
Use of research methods in advocacy	Quantitative Methods Qualitative Methods
Role of community organizations	Advocacy objectives Strategies, successes
Professional organizations	Role of worker unions Health professionals Illustrative examples
Administrative advocacy	Role of health councils Illustrative examples
Legislative advocacy	Use of lobby Preparation of proposals
Media and advocacy	Role of public relations Use of newsletters/TV/radio
Judicial advocacy	Class action Role of the Public Ministry

at USP's Faculty of Public Health or Columbia University's School of Public Health are eligible to participate in the program. Students are invited to informational meetings in which the course and fieldwork requirements are discussed. Each student is interviewed to determine the extent to which his career goals and interests are in concert with program goals. In general, 35% to 50% of the students who express an interest are selected. In 1990, for example, 30 students expressed an interest, and only 17 were chosen. Due to the limited resources for supervision of field work and the nature of the projects, the ideal number of students is deemed to be 7 to 10.

Since the program was initiated in 1987, 44 students from USP and 6 from Columbia University have participated in it. They have represented eight disciplines, as shown in Table 2. Forty-three were from Brazil, one from Egypt, one from the Dominican Republic, four from the United States, and one from Haiti.

TABLE 2. Public health advocacy students by discipline.

Discipline	University	
	USP[a]	Columbia
Psychology	2	—
Medicine	10	1
Public Health Education	2	1
Nursing	2	1
Pharmacy	1	—
Law	2	—
Health Administration	—	2
Sociology	—	1
Occupational Therapy	1	—
Home Economics	1	—
Geography	1	—
Biology	1	—
Audiology	1	—
Total	24	6

[a]University of São Paulo.

Public Health Advocacy Internship

Each student who enrolls in the six-credit course is required to complete a field work project. Due to the nature and complexity of advocacy projects, the faculty develops plans during the semester prior to the course. The projects are selected from among requests received by CEPEDISA for technical assistance in mounting advocacy projects in the City of São Paulo. The interns are assigned to work in small groups (2–4) on selected projects under faculty supervision. They work jointly with faculty to develop instruments for data collection and participate in the data collection and analysis and preparation of project reports.

The projects undertaken by the faculty and interns are designed to develop baseline data and information about existing advocacy efforts in São Paulo and to provide technical assistance when requested by community, governmental, and non-governmental organizations. The projects are both applied and policy-related and involve administrative and legislative advocacy. They are intended to have a positive impact on existing programs and to stimulate new policy and program development. In the future, we plan to develop a judicial advocacy focus as well. Since 1989, five projects have been completed and one is currently in progress.

DISSEMINATION OF INFORMATION

The dissemination of the findings of each project has both pedagogic and practical value. First, report writing and formal presentations

provide an opportunity for interns, faculty, and collaborators who often work in isolated conditions to present and publish together. In addition, the results of the public health advocacy projects have considerable value for the practitioner in Brazil and internationally. Our dissemination strategy emphasizes the lessons learned from each project, the practical use of qualitative and quantitative methods, implications for new program and policy development, and potentially over the long term, new directions in public health advocacy.

Seven papers have been presented at scientific conferences in the United States of America jointly by USP and Columbia faculty and interns, and two papers were published by referred journals.

PROGRAM EVALUATION

Thus far, the evaluation has involved three areas: the extent to which the formal six-credit course met proposed objectives, had professional application, presented topics important to advocacy, and amplified the theoretical lectures; the appropriateness and usefulness of the public health advocacy field projects, as carried out by the interns; and the current or potential impact of the public health advocacy program on the health services system.

Seventy-five percent of the 19 interns who participated in the program in 1990 (the first year we began to collect data) indicated that the curriculum increased their understanding and skills in carrying out public health advocacy activities. Eighty-two percent found the courses highly applicable to their professional work. Seventy percent indicated that public health issues and advocacy strategies were appropriately linked. The interns' assessments of course topics are summarized in Table 3. With regard to field work, 82% reported that the field work complemented the theory presented in the lectures. Half (50%) indicated that the project enabled them to understand the practice of public health advocacy, while some (12%) indicated that they did not understand the objectives of the project.

Based on a preliminary analysis of the reports of four intern projects (1989 and 1990), several observations were made. First, despite limitations in time and resources, interns, faculty, and health department staff were able to carry out a community survey and group interviews in the first full year of the program (1989) and to prepare a final report in less than one year. In 1990, interns were able to gather and analyze information and prepare an inventory of community organizations, as well as analyze documents related to the status of women and make pertinent recommendations.

With regard to the usefulness and appropriateness of the projects to collaborating agencies, we received feedback from the Municipal

TABLE 3. Course topics that received extremely high or very high ratings from 1990 interns.

Topic	Interns (%)
New Constitution and the history of health policy development in Brazil	47
Public health advocacy theory, practice strategies, impact on health policy	64
Use of qualitative and quantitative methods in defining problems and developing advocacy objectives	50
Role of professional and community organizations in public health advocacy	50
Role of legislative advocacy	81

$n = 19$.

Health Department indicating that a number of the recommendations made in our report were either being implemented or explored to determine the manner in which they might be carried out. We have since embarked on an initiative to assess the extent to which community organizations in Vila Romana have the capacity to promote health services within the community and serve as a conduit for the exchange of information between the latter and the health post.

Based on the report of assessment of the needs of community-based organizations in the North Zone, presented to the local organization in that area by the interns, we received a request for technical assistance. In 1991, interns and faculty embarked on a joint project with this group to determine the reasons for resident participation or non-participation in the popular health movement in that part of the city. Outcomes of these projects in terms of their short and long-term impact will have to be more carefully evaluated in the future.

CONCLUSIONS

Public health advocacy is still in its embryonic stage in Brazil. The analysis of the needs of community organizations shows that these organizations are fragile and that they require technical assistance at various levels of advocacy, particularly in the areas of organizational structure, identification of objectives, and development of advocacy strategies using the new mechanisms mandated in the Constitution. The Public Health Advocacy Program has thus far enabled the development of a systematic theoretical and practical model. The program will have to be evaluated to determine the impact of the training component on professional perform-

ance in the area of advocacy, and of the applied research projects on program and policy development.

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