Health Programs carrying on for elderly.

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Introduction

Health Programmes had suffer a transformation show by a denormalizes the traditional cure administration to a proactive implementation (Matus, 1998), these process is, at list in theory, a challenge not only for the objectives and the methodology, need changes in the organization. This work has a proposal to develop theoretical tools that improves the implementation of Health Programs carrying on for elderly.

Methodology for programmes evaluation had a considerable history in Rosario (Argentina). It's possible quote : the Documento del Grupo Estudio Salud Asociación Médica Rosario GESAM (Santhia, et al, 1973), were was made an evaluation of Maternal Child health programme in the city of Rosario relating with the existing health system, pointing the persistent high infant mortality rate in areas were program was carried forward. Years later, after the implementation of the Primary Health Care (PHC), Bloch, Troncoso, and Hachuel Richiger (1987) evaluated the program in the *Area Programática 1* on Rosario city. In his introductory comments, explain most characteristics rules imposed by the provincial health system. The restrictions imposed by these rules, as explained in the work enrolled enormously difficult and the ability to develop planned strategy and hindered further social participation according to the aim of APS.

As a result of ten years of teamwork, we have numerous studies that explore topics related to the implementation of Health Programs in our territory: It's possible mention among them: Tuberculosis. History of a prolonged struggle (Enria, 2000); Representations and practices of TB disease and healing path (Gómez 2006); Strategic Planning in Primary Health Care. Meeting of the sayings, misunderstanding of the facts (Staffolani, 2006); Evaluation of Maternal and Child Nutrition Program (Promin) Rosario (Aronna, 2004); Community Participation in Health Utopia or political compromise? (Enria and Staffolani, 2001); Fragmentation of the community as an obstacle to Primary Care. (Enria and Staffolani, 2003); Social and organizational barriers to strategic planning in the Primary Health Care (PHC) (Enria and Staffolani, 2004); The primary health care and medical specialization. Contradictions of the discourses that impede the transformation of practices of health promotion (Carrera, Enria and D'Ottavio, 2000); Ethos of functionary public health. Obstacles to change (and Staffolani Enria, 2009); The concept of interdisciplinarity in Health Programs (Enria & Staffolani, 2008); Health and Gender Programs. Women with HIV / AIDS (Staffolani & Enria, 2010).

More recently, doomed to the specific Elders field, we can cite a number of works done by this team that contextualizes the present study, discussing implementation of programs for the elderly, which show some difficulties to reaching the achievement of meta, using a qualitative methodology on primary and secondary sources from the analysis of official documents. In Argentina the *Instituto Nacional de Servicios Sociales para Jubilados y Pensionados* (INSSJP) hegemonizes health coverage for this population

group. Questions emerged from this analysis are based in the new meaning of Elderly, meanwhile the maintenance of a social representation of old age peoples mounted a negative value stamped on policy decisions, also the difficulties of access to a programmed activities, are the reasons for the research that gives rise to this work: Care health care in old age in the province of Santa Fe (Staffolani, et al, 2010); Aging. Current status and future prospects (Enria, et al, 2006); Reflections on social care proposal from PAMI (Enria and Staffolani, 2009); Body, new identity and social ties in the Elderly (Enria, et al, 2010); Social Sciences in Health. The health care in the Elderly (Enria et al, 2010); The surge body in the process of ageing. The Elderly narratives of experience in health care programs (Enria et al, 2010); Ageing and body recognition (Enria et al, 2011); Politics and early modern age. Barriers for Human Rights of the elders (Staffolani, 2011), Social exclusion and Aging Policy (Staffolani, 2011), Perspectives on elderly body recognition. (Enria, et al, 2011).

In this paper we address the scope and limitations on the implementation of the proposals to the elderly population, interpreting the knots issue on which it would be possible to deepen the actions to overcome barriers to the achievement of objectives, supported on three different fields : planning policies, policy of human resources and the target population, supported by the assumption that the existing organizational structures constitute a major obstacle to develop ideas that enable transformations to achieve goals in health.

Materials and methods

To monitor the programs management we rely on the results of previous research mentioned above and the information published officially by the INSSJP-PAMI through the internal organ of communication (*Boletín del Instituto*), Laws and internal regulations Resolutions that specify the programs that run within it, through which information flows between actors that are part of the organization (Law 19032, Res. Nº 284-05, Nº 0056/7-DE, Nº 718/7-DE y Nº 040/08-DE y las Disposiciones Nº 1407/GPM/07, Nº 178/GPM-GPS y Nº 070-08). The analysis followed the flow statements and possible implementations as proposed by Mintzberg (1994).

To approach at the human resource field , we worked with the physicians responsible for the Elderly care, through the implementation of focus groups (Taylor and Bogdan, 1987), defining the territory in Santa Fe, Local Management Units Rosario and Santa Fe, researched around knowledge physicians had on the program, describing the role they had to assume in the execution and evaluation of results.

Regarding the target population were collected personal experience stories from elders who had access to and participated in the the Programs activities. For the analysis all information obtained from different sources was triangulated.

RESULTS

On the aim to control diseases international organizations related to health problems (PAHO / WHO / UNICEF / UNDP) had born an intervention proposal generically called "Program". In the early twentieth century the first emerging health programs (tuberculosis and leprosy), were articulated from a normative paradigm, imposing forms of action that both executors as people had to accept, given the scientific strength of their assertions. Always raided from the realization of early diagnosis or a sieve population characteristic of high-risk strategies (Rose, 1985, p. 4) and as second step indicated tried and tested treatment for the specific disease problem. After that time, the evaluations of these interventions have been showing little effectiveness in achieving its objectives: reducing the prevalence of pathologies.

Attempting to transform the initial proposals, programmers had gives life to a new way of planning, showing a shift from restoration of health to strategies of health promotion and disease prevention. These shapes began to occupy a space, at least from the official discourse, increasingly drowning different activities in the large field of Public Health.

Thus, in the last decades of the century, the emergence of problems that can not be defined in traditional terms that have been identified disease problems, with characteristics that are not compatible with Louis Pasteur theory, where a single causative agent is aetiology related causes as the pathology effects, which is described in signs and symptoms universally recognized as a particular pathology, that it possible to be controlled by vaccine immunity and treated with specific drugs.

Health is considered now positively. In any case we speak of health-disease process. (Ferrara et al 1972, p. 7), suggests that "... the concept of health is expressed correctly when the population is struggling to understand and conflicts that the interaction with the physical, mental and social as imposed by the struggle manages to solve the problems ... " more recently André

Contandriopoulos (2000, p. 22) states "Health is a complex, socially constructed, taking into account the perpetual tension between adaptation to life and the environment ...".

Now ageing Health problems are described such as physical inactivity, obesity, loneliness, mental illness, are installed in the community from a broad spectrum of determinants becomes complex analysis and intervention. Thus, the group called elderly becomes a problem may be approached for international organizations who install on the agendas of the countries since Declaration of Cartagena de Indias (1992). This is a group of people who, since the end of World War II, is listed as the largest and most sustained growth. In Argentina represents approximately 14% of the population pyramid (National Census 2010).

Holding a legislative proposal from these statements is difficult, given the complexities of social relations on which it must articulate and negotiate. We must consider the possibility of imposing the health authority for introducing measures. The choice of other methodologies and technologies to address the problems shows the need for other various actors that add specificity to the intervention. There is no identified a causative agent. The theme is improving the quality of life in populations. From printed once known positive results regarding the decline in infant mortality, enabling the deployment of an afterlife that is expressed statistically with increasing life expectancy, which leads to gradual and steady growth of populations, Older Adults, Older Older and very old, extending the range of situations they will realize (Formiga, et al, 2001; Marquez Capote et al, 2001; Vilacorcoles et al 2005; Begiristan Aranzasti et al, 2006).

These social groups with particular histories, cultures and practices mark the need to recognize the complexity of the problem and draws different interventions.

In its on definition, despite the good intentions and sustained theoretical frameworks, we note that the formulated policy programs, designed strategies for action, are well planned. On the implementation process arose so many obstacles related with the organization structure that attempt to achieve the proposals goals.

Following Mario Testa (1989, p. 10), we understand the policies as a proposal for power distribution and strategy as how to implement that policy. From this perspective there is a need for negotiation between the actors, both between different state and with the same people involved, in order to provide a comprehensive framework for such policies, thereby reducing the possibility of creating spaces, which will to inevitable inefficiencies and increased costs both human and financial.

From the assessments made in the management of all programs, one can see the distance between efficacy, effectiveness, efficiency of the proposals. We recognize that the distances are due to the difficulties encountered in implementing the population strategy, which seeks to control the determinants of incidence, reduce the average risk factors and move in a favourable direction throughout the exposure distribution. To address it should cover both environmental actions as forms of behaviour of the population as a whole. (Rose, 1985, p. 5)

Development of the definition of policies

On May 13, 1971 with the signing of facto President Alejandro Agustín Lanusse and Social Security Minister Francisco Manrique, Law 19,032 was enacted that was created by the National Institute for Retirees and Pensioners (INSSJP), which proposed g ... as to confer self-or third-to retires of the National Insurance Scheme and the Integrated Retirement and Pension as their primary family group, health and social benefits, comprehensive, integrated and equitable, geared towards promoting , prevention, protection, recovery and rehabilitation of health, organized in a performance based model based on principles of solidarity, effectiveness and efficiency, to respond to the highest level of quality available to all beneficiaries of the Institute, based on the specificities and idiosyncrasies peculiar to various provincial jurisdictions and regions h. This act constituting the largest Welfare Argentina by the number of beneficiaries, a fact that continues to the present.

Within this proposal is created the *Programa de Atención Médica Integra*l (PAMI) for elderly. In this way the state tries to ensure the care diseased old population from a specific program which cleaves the aging process with pathologies involved in it, being "the cure" as the protagonist of the shares vocation and economic budgets allocated to such end. This ultimately will be the basic pillars of the old building representation old = sick from the concentrated measures almost exclusively in the treatment of the disease, and its consequence: the indication of drugs as a central and almost unique of therapy to the elderly population. Becoming, thus, between institutions, the elderly themselves and the whole population, the social representation means the existential situation of "being old" with "being sick". The old and begin to recognize and introduce the rest of the community that strengthens, as "I am diabetic", "I am hypertensive" generically "I am sick."

This form of distribution of power (political) market consolidates to a new consumer group: the old. Starting, well, a formation of a medical practice that leads to the necessary implementation of consulting specialists, ancillary services of high complexity to the enunciation of a diagnosis, which concludes with the indication of a recipe with poly pharmacy (Enría et al , 2002). Since the State is justified in this way, a high benefit conferred on the medical and pharmaceutical industry, which engulfs the entire budget INSSJP / PAMI, leaving only utterances everything related to health promotion and disease prevention.

In 2005, the authorities of INSSJP reflect on this situation reported by researchers and consumers, defining a new model called *Servicio prestacional Sociocomunitario.* It postulated the break with the sense that old age meant "... as lack of all types: economic, as lack of income, physical, and social disempowerment and, as a lack of roles "highlighting" ... that prevention is the only effective tool against the process of maturity and ageing affecting modern societies, and the increase in chronic diseases and disabilities "(Resolution No. 0585 INSSJP 15/05/2008).

The ageing process becomes the object of study and intervention to affect all societies and should be treated differently than has been used so far.

According to chief INSSJP , "the focus is on the promotion, prevention and non-drug strategies. It all ends in a recipe, it all ends in a prescription and a request for additional diagnostic examination. On more than one occasion that are therapeutic foster movement of knowledge, search the doctor providing the ear and shoulder. " (PAMI Editorial http://www.pami.org.arn 22/07/2011).

This new policy involves opening several fronts, ranging from: the same organization of the health system (better call it disease care), their relationships with the pharmaceutical

industry (not board), the health team, whose practice based on the indication of a poly pharmacy to silence the claims and needs of beneficiaries (your head), and the elderly themselves have learned that for each there is a drug unpleasant sensation, supported by the mass media that promotes them everyday successful new industry of healing.

New definitions would then arise. If the work object is the ageing process, it is necessary to recognize that this is a heterogeneous population, where the diversity of situations, possibilities, cultures, histories, economic access, etc. Propose different population profiles of ageing and health and disease. The individual and collective forms apprehended along life, make adaptations to new maturity and potential to face the difficulties.

In pathological profiles related to the elderly, are classified as chronic diseases, by the time of its development and perpetuation, in a relentless live with them, leading to redefine health Ageing since its pathological profile strongly defined by chronic, leads to understanding health in terms of coping with situations but require monitoring and control, not disabled for social life.

Now to be ill constitute feeling distant categories that characterizes the acute illness. This is mediated processes diagnostic laboratory until the end where catastrophic symptoms that limit life skills are not present or existing perception (Hypertension and Diabetes), enabling a full life. The goal is healthy ageing whose indicator "is the preservation of functional autonomy, ie the ability to properly perceive the particular conditions and environment, produce the necessary adaptations, to obtain and use resources efficiently, make decisions and execute them itself same "(National Socio-Promotion and Prevention, 585-08 Res: 10).

The determinants of disease invite consideration the environment, family relations, food, occupations or jobs deployed, history of participation in civic life or guild, sedentary lifestyle, social interaction opportunities.

The actions involve deploying concepts like changes “habitus” mark distances with the lived and experienced, solitary or shared, in which representations were constructed that expressed in social practices, experience is considered, from science, should be changed, transformed, in pursuit of Health Promotion, Prevention and disease control and appeared (secondary prevention).

In Resolution No. 0585, the Executive Director of INSSJP delegated to the Management of Social Welfare and Community management, approval, evaluation, resource allocation, and the planed acts devices needed for the implementation of the Rules of Procedure in the strategy plan. Thus was born the Sub-National Socio-promotion and prevention to keep growing prevention; posed as an overall program objective: increased opportunities overall health of the members, in terms of functional autonomy, participation in the control of their pathologies, social integration and citizenship, with the intervention in situations of risk to which they are exposed by social vulnerability and fragility staff during the ageing process, through the creation of a space operable regarding these factors risk through participatory relationships, associative and binding. (National Socio-Promotion and prevention 585-08, p. 5). Planning activities through three programs: Community partner promotion and prevention "to prevent further growth," the progressive care program for the elderly and the Screening Program vulnerable populations. Each of them with goals and sub-goals

In his statement from the Social Management and Community Development, the Central office of INSSJP (located in the Autonomous City of Buenos Aires), provides for the participation and integration of older persons within the country, to the actions planned to achieve a maturation process "healthy" in terms of physical, mental and social. The analysis

of these documents the following questions arise: How is it possible that action? What are the channels through ensuring integration, participation and support in time of life habits that are tried institute among older adults?. These questions are, in our view, in real problematic nodes impeding achieve goals.

The description of these nodes could be synthesized in the same bureaucratic organization of the Institute, designed according to the assumptions of the classical theory of administration, with many tight spaces: nine managers, three units of technocrat structure and three support units, all under the command of a single executive authority (Mintzberg, 1994, p. 13).

Following the same author, we look at flows path way of communication and the changes should happen to reach operational units themselves as well that with the Elderly. Stated by the Management of Social and Community Development, the proposal must be communicated to the Management Coordination Local Management (UGL), who shall in turn inform each UGL (territorial offices deployed throughout the Argentina geography in a total of 36), where under a new local administrative structure, from the Office of Health Promotion, will be disseminated to physicians, who are the first contact with the Elderly, a long chain of transmission mandates, which also includes territorial power struggles that make communication difficult and therefore the implementation of schedule.

On the other hand, must be considered to implement actions to be executed from another different bureaucratic office from were there would be organizes and regulates *Médicos de Cabecera* the activity, who are responsible for the health care for Elderly. Thus its activity is reduced to be "reporters" of possibility. We see this in the analysis of flow management, such as playing the traditional legislative proposal where the latter meets effector fundamentally passive role.

The bureaucratic body that is responsible for negotiating with the institutions where they coalesce Older Adults, from which can be bought and run physical activities (Health Promotion and Disease Prevention, HADOb example program) is another program called well-being. The Argentine territory is large and disparate, and regulations not contemplated finding adequate space to carry out planned actions or qualified personnel to implement and monitor such actions, given that the population is growing and it is further necessary continuity and permanent adjustment.

At no time arises Program evaluation of the implementation process of it, let alone the impact on health and disease processes, which by now following Eduardo Menendez (1993) should more appropriately called health-disease-care, given the importance that the health care system in the development of health and disease processes.

Human Resources Policy

The so called *Médicos de Cabecera* are considered the most immediate contact with older adults to access PAMI, who offer their services in the geographic region where they live, "and at the main reference Thus, the link to the articulation of all processes related to health care of members assigned to their standard. " According contract "must fulfill the following functions and requirements: 1. They are the gateway to the income of the beneficiary in the benefit system [...] 4. Conduct activities relating to the promotion, prevention, rehabilitation and health education. 5. Follow up horizontally and vertically to charge people. [...] 11. Make the containment of their patients. 12. Participate in meetings that convene INSSJP as monitoring and evaluating performance based model and its management in particular. 13. Transmitting the information required by the INSSJP in physical format and / or computer and periodicity to be determined "(ANNEX Resolution No. 284-05, p. 42). Based on these regulations, it is important to know how to implement actions.

Through focus groups, involving *médicos de cabecera* in Santa Fe, Entre Rios and northern Buenos Aires (Argentina), in which the sample was delimited cases analysed, we collect the following narratives expressing problems communication between planners and implementers, which pivots on the implementation strategy HADOb program designed to prevent and monitor the aforementioned pathologies in achieving goals.

The first knot problem manifests to ask if they know of the program:

- "Do not know"
- "I listened to the program"
- "Is on page PAMI"
- "... The acronym means" making an effort to decipher

Delving into the discussion, especially in those who have heard about it or read it on the website and were motivated to innovate their practices or just to fulfill the contract, as in the case of younger or newly incorporated into the campus of Family Physicians, lists the following expressions:

- "I went to the Local UGL and asked the program but nobody could tell me something"
- "I applied to the UGL without response"
- "After climbing stairs, I arrived at an office where a social worker told me << this is from here, can not leave the office >>"
- "When I read in the newspapers offices walked one floor to another without finding information"
- "If you come here, to the Local UGL; leaves with the same question"

This exposes causing disorientation territorial disputes between managers, offices that make Local UGLs within the same staff there unknown programs, generating confusion and misunderstanding. We ourselves have travelled requesting offices and planning program without positive results. Nevertheless, all physicians report having been instructed by their actions regarding procurement of notification to be

completed according to the item 13 of his duties (transmitting the information required by the INSSJP in physical format and / or computer and periodicity to be determined):

- "Yes, notify beneficiaries that can move, and we pay a bonus"
- "I paid a premium for notifying the hypertension and diabetes"
- "You pay more if delivered fold providing the PAMI"
- "Management informed us of the Local UGLs to do these forms, if they send you call to see what happens"
- "We sent an instruction for a double entry table had to be done"

After explicit in groups, the importance of actors involved in the process of healthy ageing, its relevance as executors of the transformation of medical practices - from prescriber to manager of a social life and functional Quality, grumbling:

- "But if it is managed by the social worker, we just send you the list with the names of the old and she derives by having quota"
- "We only select beneficiaries indicated that they are able to exercise. And extend the health certificate stating that the person can exercise "
- "In the forms must be rated to beneficiaries for cardiac risk, noting their fitness"
- "We have no interference, is decided at headquarters and are entering the old as the vacancies that count"
- "Yes, we got talking about medication notes"

Asked about his responsibility to "follow up horizontally and vertically to charge people", and talking about the achievements healthy program aims to achieve, who reported reflect:

- "Does not follow, because it ignores those who start exercising, so the quota, when to start, what to do and for how long"
- "As we do not organize, the old have to wait for the summon from the Local UGLs, it is impossible, you can not. When old come to the clinic are on the list with others. If they say no I do not hear anything. "
- "You do not remember who's who, the problems are addressed at that time brings"

Here we see very clearly how care, consisting of mere response to signs or symptoms by claiming the consultant. There is an acceptance of the contractual responsibilities assigned to monitor the ageing process. The normative form seized during the exercise of the profession has become passive executors that respond to demand timely and immediate, without understanding the role that has been assigned. All this reinforced by a clear difficulty in communication flows and coordination of actions.

Other highlights local difficulties not covered from the Local UGLs to implement socio-community activities:

- "There are no places to do more than walking"
- "In this area nutritionists, kinesiology, physical education teachers, are extra, not part of the benefits provided by PAMI"
- "From what I've seen, there is little adhesion"
- "Give quota for 6 months, then switch to another group so that everyone has a chance."

Again we see that in reaching specific territories inhabited Old people has not provided the organization and / or negotiation that makes the viability of operations. When we inquire into some institutions that could provide the possibility of deploying the activities of health promotion involving the rupture with the sedentary lifestyle of its leaders in voice or managers hear the reasons that are not implemented. The answers were conclusive:

- "Old people are dirty"
- "They smell"
- "We urinates the swimming pool"
- "They are slow and take a long time for the changing rooms"

This view reflects a widespread social representation of a negative view of the old, it is also problematic to find knot spaces properly implement activities.

The program is a proposal that needs the to-maturity of all stakeholders and sustainability over time, enabling changes "habitus" so that the results are displayed (Enria et al. 2010, 2011).

With the sole notification by the medical people with possibilities of joining the actions proposed by the program to the Local UGLs, strategically located in communities defined in terms of population density, not enough, you need to achieve implementation. Many elder adults living in distant locations of the sites, where no staff prepared for the practice of calling both the elderly as to develop appropriate strategies for each and every one of the people who require such intervention. Usually found in that features people with little or no specific preparation for this important and central task that would enable the achievement of the objectives of the program, which thus becomes blurred, leaving only the payroll records that show like.

Target population

The message of the need to initiate a way that breaks with a sedentary lifestyle to combat obesity and reduce the risk of hypertension and diabetes, is reported by "*Medicos de Cabecera* and spread by the media broadcast and print. Risk perception is heterogeneous and proclaimed will echo only those who are able to receive it, other problems associated with situations of greater immediacy and vulnerability will be excluded (Douglas, 1996).

Dam these incommunicado is the beneficiary population. As in all the experiences you can find highly motivated groups, with previous experience of participation that engage themselves, from senior citizens, the neighbourhood, invited by friends that are integrated and enthusiasm, wellness and socialization in the spaces where stimulates the movement or in the various workshops that are provided. But a significant number of seniors do not have access to programs, by ignorance, by constraints of distance and / or economic, for socialization problems. These are the most vulnerable, those who do not reach even to learn of the existence of the program and access modes.

The questions would be, those who agreed to participate in the program, how access? What activities do? Do you evaluate the quality of services? What is the effectiveness of actions in terms of achieving the goals set by the program, and beneficiary satisfaction? (Donabedian, 1984).

The description of this process, we can synthesize as follows: Retirement Centers receive offers from various professionals (gerontologist, Occupational Therapists, Physical Education Teachers, Physiotherapists, etc.), that bring their CV together with a proposal of activity to the Elders, it is referred to the Local Management Unit. From there authorizing the contract for six months to carry out the offer to partners.

Work Majors movement requires specialized training: physical education teachers are prepared to work in schools, with children and adolescents up to 18 years to recover the Kinesiology lost skills, occupational therapists to act in situations of disability (though this profession is the one that has addressed the issue of the Elders). In Argentina there until a comprehensive offer specific training for those who should work with almost five million distributed in the spacious old country.

In some cities, gyms hire services in downtown areas, and even paid the transfer of the benefit, but still for a few. The challenge is to train the human resources needed to provide adequate coverage to ensure "Health for everyone".

And for those who do not have access, from where and how to evaluate the strategy? Nor is there any assessment of the effectiveness of the processes implemented or efficiency.

Discussion

A proposal to change the paradigm of ageing sick advocated the dignity of a healthy maturity shares held by non-drug based on the breakdown of a sedentary lifestyle, socialization and recognition of elders as potential citizens to contribute their experience to society, is trapped in the implementation strategy.

The first major hurdle is communication between the various managers areas: central and local. The information reaching the Local Management Units administered from two different units. One is what tells *Medicos de cabecera* notification of potential beneficiaries of the program through the "forms" that should raise the central area, reducing its action to the indication and evaluation of the effects of the program in terms of decrease in blood pressure levels and control of diabetes, as well as the adequacy of weight for height, a situation that occurs only in individual recognition through the indication of what to do.

The other is responsible to organize, negotiate and execute the spaces where the activities carried Major. Both steps are operated by independent channels, it is a central authority, mostly unknown (in both senses) in charge of the execution. This situation does not allow the meeting to make viable monitoring and evaluation processes in terms of participation, relevance of activities, capabilities makers, user satisfaction, effectiveness, efficiency and effectiveness.

Nevertheless, by letter sanctioning family doctors who do not meet the contracted function to develop promotion, prevention, rehabilitation and health education, to track population responsible. And a bonus is awarded per capita only transmit the information required by the INSSJP in physical format and / or computer and determines periodicity.

The obstacle described not dent the good intentions of the "built politics" that has been proposed to transform the "dynamic situation" (Matus, 1984) which identified the renewal proposal INSSJP / PAMI. The difficulty of settling pre-existing structures is still a challenge, and we think that this is the fundamental determinant hindering better deployment and implementation of innovators ideas and availability of financial resources.

The idea of renewed Health Promotion is the key location. From our view it should be understood as an encounter of knowledge: the community and the scientist. Adopting the principles of strategic planning, programs are spaces for negotiation, they need recognition for implementation of the local context (cultural, social representations and practices, structure of institutions, territorial struggles for power).

In the design and implementation of interventions is essential the active participation of the community involved, so it allows the acceptance of innovative activities and staff that runs facilitating and directing actions. Transforming proven effective in controlled situations in population is the challenge faced by program implementers to implement the rules in a territory.

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