State and equity policies in health: participatory democracy?

Estado e políticas de equidade em saúde: democracia participativa?

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ABSTRACT State, equity policies and social participation: participatory management experience in the construction and implementation of public policies. Can health become a space for construction of citizenship that contributes to the reduction of social inequalities? Can the limits of the Brazilian state be prohibitive for the development of a participative management, in which social movements should be able to, in fact, speak about and participate without losing their autonomy? This essay brings elements to this reflection and cites possible advances in such issues, from the implementation of equity policies in health, pointing out, also, potentialities of articulation between the Unified Health System management spheres, as a space, also, of participatory management.

KEYWORDS State. Health. Equity. Public policies.

RESUMO *Estado, políticas de equidade e participação social: experiência de gestão participativa na construção e na implementação de políticas públicas. Pode a saúde tornar-se um espaço de construção de cidadania que contribua com a redução das desigualdades sociais? Os limites do Estado brasileiro podem ser impeditivos para o desenvolvimento de uma gestão participativa, na qual os movimentos sociais deveriam estar aptos, de fato, a opinar e participar sem perder sua autonomia? O presente ensaio traz elementos para essas reflexões e cita possíveis avanços em tais questões, a partir da implantação de políticas de equidade na saúde, apontando, ainda, potencialidades de articulação entre as esferas da gestão do Sistema Único de Saúde, como espaço, também, de gestão participativa.*

PALAVRAS-CHAVE *Estado. Saúde. Equidade. Políticas públicas.*

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Introduction

The challenge of approaching the health equity policies and participatory democracy, considering the role and limits of the State, requires to focus on, in first place, some concepts, contextualizing them in the political field and health.

Far from wanting to impose an absolute truth or to redefine paradigms, it is sought, from a reflexive approach, to bring to the center of the debate, management experiences that understand the limits of the State in the implementation of public policies of equity and recognize the potentialities and the importance of management with social participation.

Considering that the Article 196 of the Federal Constitution (FC) of 1988 states that

> health is the right of everyone and the duty of the State, guaranteed by social and economic policies aimed at reducing the risk of disease and other grievances and equal access to actions and services for its promotion, protection and recovery. (BRAZIL, 1988),

it is possible to infer, from the text quoted, the character of the State policy (the duty of the State) and the principle of universality (the right of all). In addition, it is pertinent to affirm that health is a social and intersectoral policy. In the same Article 196, the FC predicts that health will be guaranteed "through social and economic policies aimed at reducing the risk of diseases and other grievances" (BRAZIL, 1988). Finally, the principles of equity and integrality are clear when the Major Charter deals with "equal access to actions and services for their promotion, protection and recovery (integrality)" (BRAZIL, 1988). Besides these principles/directives (guiding) that seek to guarantee universal health, with equity and integrality, it is important to point out, in the segments highlighted above, the following organizational principles: decentralization, regionalization, hierarchy and community participation.

For the Unified Health System (SUS) to be universal, it is necessary to ensure that all have access to health services. For this purpose, it is necessary to overcome social inequalities and regional differences. The concept of equity is fundamental to ensuring the universality of health.

How do the policies for promoting equity effectively contribute to the citizenship of the social segments to which they are directed, and what do they represent? Is it possible to state that social participation in the elaboration, implementation and monitoring of policies expresses or implies participatory democracy?

The present article proposes to make this reflection, based on the experiences of deployment and implementing policies to promote equity in SUS, from 2003 to 2015.

State, equity and participatory democracy

What model of State is necessary to ensure universality with equity in health? And what concept of equity is being approached? In the last years, some theoretical debates have brought critical reflection on the several and different concepts.

> A distinction often found in the literature is that between horizontal equity – which would correspond to the treatment of equals – and vertical equity – which would correspond to unequal treatment of unequals. (SILVA; ALMEIDA FILHO, 2009, P. 217).

What will permeate the analysis of this article, comes from the question: Which model of State is able to guarantee social rights and generate citizenship? To talk about it, it is important that Marx be rescued (1845, P. 8), when he states: "From each, according to his ability; to each, according to his needs" and each according to his potentialities. Equity will be within the scope of this concept. It is mentioned, in addition:

Equity corresponds to [...] an intervention of social agents, when they assume the role of judges, on the situation of conflict. In the specific case of health, the exercise of equity can be materialized in the process of formulating health policies and intersectoral policies, which may have an impact on the social determinants of health. (SILVA; ALMEIDA FILHO, 2009, P. 217).

How can a health services system contribute to overcoming social inequalities? How the redistribution of the offer of actions and services, and the redefinition of the profile of this offer, in the dimension of the social groups that will be contemplated in it, besides the capacity of the network of attention to attend and to welcome, in a universal and integral way to all, can, in fact, contribute to reduce social inequalities? It is worthy, here, to highlight the deployment and implementation of health equity policies aimed at the needs of the most vulnerable segments of the population, that are at greater risk of becoming ill or dying due to economic, social, cultural and historical characteristics, such as blacks and quilombolas; people in street situation; lesbians, gays, bisexuals, transvestites and transsexuals (LGBT); gypsies; population of the fields, the forest and the waters (riverside dwellers, fishermen, shell fishermen, peasants, rural workers, landless, etc.).

The policies to promote health equity aim to guarantee access to quality health for these populations. These policies are based on the 'equity principle', which

[...] shows that, to overcome differences, it is necessary to treat unequally those who are socioeconomically unequal (affirmative action or positive discrimination). A homogeneous offer to attend to heterogeneous situations can only result in the maintenance of the original differences. This offer will correspond to the needs of a certain subset of the population and will not be adequate for others, either for cultural or socioeconomic reasons. (COHEN; FRANCO, 2007, P. 50-51).

In the last years, organized social movements, representative of these social segments, have presented demands for health, from their identities and social exclusions, seeking policies that recognize their demands and their specificities, in the perspective that the concept of equity articulates with the principles of universality and integrality, considering the expanded concept of health as citizenship and quality of life.

Carmem Teixeira (2011), in a text supporting the municipal and state health conferences, states:

The issue of equity has generated, also, some controversy, by virtual of, on the one hand, questioning the 'relevance' of specific policies to certain groups, seen as a form of 'neo-corporatism' or 'clientelism', as they meet pressures of social movements better organized, or that can establish lobbies, or 'techno-bureaucratic' rings with sectors of policy-making institutions. On the other hand, the relevance of these policies is defended, not only as a response to specific pressures, but as a form of expression of the 4th generation of rights. (TEIXEIRA, 2011, P. 9).

How to work this contradiction? What is the role of the State, after all? What are the limits of public policies?

The study of equity or its inclusion in the State agenda, as a field of social intervention and as public policy, gives it a responsibility to reduce social inequalities, as opposed to the conception of the Minimal State.

Through social policies, the State should take up the challenge of correcting existing inequalities, without doing any rupture with classical liberal principles, such as guaranteeing property. Equity, in this perspective, would contribute to the expanded reproduction of the new order of capitalism [...]. (RIZZOTTO; BORTOLOTO, 2011, P. 794).

From the Lula administration, equity

enters the public policy agenda, including the creation of secretariats with the status of ministries, such as the Secretariat of Policy for the Promotion of Racial Equality (Seppir), the Secretariat for Human Rights (SDH), the Secretariat of Policies for Women (SPM) and the National Secretariat for Youth (SNJ). With this new configuration, Brazil gains social expression in its role of State. A concrete expression of this change is the increase in investments in public policies, including education and health, as well as in policies to promote equity, which aim to recognize and rescue social debts of the brazilian State with segments historically excluded from public policies. It is articulated, therefore, from this period, the concept of equity with social justice, establishing policies that favor the most vulnerable in society, the socially and economically excluded.

The health has been, since then, one of the most expressive spaces of this social rescue and the implementation of affirmative actions and policies of social inclusion, generating citizenship. The brazilian health policy underwent profound changes in the last 26 years, from the institution of the SUS, in the years 1990, to the present day. For a better understanding of the role of the brazilian State in this period and the strategic role of health in the construction of citizenship and social rights in Brazil, it is necessary to understand the brazilian health model, that is, the SUS.

This agenda comes from the Brazilian Sanitary Reformation Movement, which started the debate about the type of State that would be necessary to implement the SUS, guaranteeing health as a universal and integral right for all.

> The implementation of SUS reveals efforts to strengthen a national policy in a federative and democratic scenario, expressed in the institutional configuration of the system and in the regulation of the process of political-administrative decentralization. (MACHADO; VIANA, 2009, P. 23).

The entire health struggle has passed, and passes, by the indispensable role of social participation. The mechanisms of social control of the SUS – such as health conferences and health councils – as well as negotiation and agreement forums among managers – such as bipartite interagency commissions (CIB), which bring together municipal and state health secretaries, and tripartite interagency commissions (CIT), which bring together the Union, states and municipalities – are spaces consolidated in the internal democracy of the SUS. They are instruments for participatory democracy, legitimized by the Organic Laws of the SUS, such as Law nº 8.080/1990 and Law nº 8.142/1990, which, respectively, deal with the organization of the SUS network and its social control and financing.

Undoubtedly, popular participation was decisive for the implementation of policies that placed equity and social inequalities at the center of the debate, claiming full citizenship. Equity in health is a concept that aggregates that of universality, providing, thus, the dimension of building social equality, or, at least, working on the concept of equity with social justice. That said, health presents, establishes and implements policies to promote equity with a perspective to reduce social inequalities and increase the rights and autonomy of these populations, in relation to universal and integral access to health. In addition, it articulates with other social policies, with popular participation as a structuring element of the demands and responses of the Brazilian State.

Equity policies, or affirmative, has grounding in the Brazilian law, including in the Federal Constitution, in its Article 3, subsection III, as noted by jurists:

> Finally, if, on the one hand, the constitutional text confers the statute of formal equality to individuals and groups whose differences it recognizes in the name of plurality and the absence of prejudices, on the other, it

determines the fight against exclusion in the context of material inequalities, in the name of equality and justice. It is, therefore, legitimate for social groups with specific characteristics and subject to inequalities to be subject to differentiated legal protection, which, through non-homogenizing public policies, guarantees their social inclusion and, at the same time, respects their local knowledge. (MIRANDA; LACERDA, 2009, P. 219).

Thus, it can be affirmed that, considering the limits of the State to meet all the demands of the populations in conditions of social and economic inequalities, equity policies contribute to the effective conquest of the rights of these segments, strengthening citizenship and social inclusion.

In addition to health councils and conferences, the ombudsman of the SUS and the equity promotion policy committees have gained expression with citizen participation, both individual and collective. The decrees that institute the National Policy of Strategic and Participatory Management of the SUS (*ParticipaSUS*) promote mobilization mechanisms of the different social segments that relate to this system.

In 2006, with the objective of bringing together the various structures responsible for the functions of support to the strategic and participatory management of the SUS, the Secretariat of Participative Management, created in 2003, was restructured by Decree nº 5.841, of july 13, 2006, now called Strategic and Participatory Management Secretariat (SGEP). In that opportunity, the National Audit Department of SUS (Denasus) was incorporated into SGEP, the Monitoring and Management Evaluation Department of SUS (Demags) was established, the Health Reform Monitoring Department became the Participatory Management Support Department (Dagep) and, finally, the General Ombudsman Department of SUS (Doges) was expanded. In 2011, the Secretariat underwent a new reorganization, maintaining

Denasus, Doges, Dagep and, instead of Demags, the new Interfederal Articulation Department (DAI) and the Information Technology Department of SUS (Datasus) became part of SGEP. In 2013, in accordance with Article 34 of the Decree nº 8.065, of august 7, 2013, which approved a new regimental structure of the Ministry of Health (MH), were defined, among others, the following SGEP competencies:

I. Formulating and implementing the SUS democratic and participatory management policy and strengthening social participation;

II. Articulating the actions of the Ministry of Health, regarding strategic and participatory management, with the various sectors, governmental and non-governmental, related to the constraints and determinants of health;

III. Supporting the process of social control of the SUS, to strengthen the action of the Health Councils;

IV. Promoting, in partnership with the National Health Council, the accomplishment of the Health Conferences and Plenaries of the Health Councils, with the support of the other organs of the Ministry of Health;

V. Encouraging and supporting, including financial and technical aspects, the state, municipal and district levels, in the process of elaboration and execution of the policy of permanent education for social control in the SUS;

VI. Supporting strategies for social mobilization, for the right to health and in defense of the SUS, promoting popular participation in the formulation and evaluation of public health policies;

VII. Contributing to equity, by supporting and articulating social groups that demand specific health policies;

VIII. Promoting the effective participation of managers, workers and users in the election of priorities and in the decision-making process in SUS management;

IX. Formulating and coordinating the Ombudsman Policy for the SUS, implementing its decentralization and cooperation with entities that defend the rights of the citizens;

XII. Promoting, in partnership with the Executive Secretariat of the National Health Council, the articulation of the organs of the Ministry of Health with the National Health Council. (BRAZIL, 2013, ART. 34, FREE TRANSLATION).

It highlights, therefore, participatory management, reaffirming and valuing the role of social participation in the SUS, in different spaces, also recognizing the iniquities in health of specific populations and expanding the spaces of auscultation of society.

The participatory management is anchored in participatory democracy, and the spaces of dialogue and common construction presuppose the adoption of practices and mechanisms that effect the social participation, of users, workers and managers of the SUS. In this context, committees for the promotion of equity policies (chart 1), working groups and management councils are created, and the role of the SUS ombudsman, at all three levels of government, is also expanded.

Chart 1. Technical Committees of Equity Promotion Policies distributed according to the profile and the year of implementation

	2012	2013	2014	2015
Health Technical Committees of the LGBT Population	GO, PE, PB, PR	MS, SP, RS	BA, RJ, PA	-
Health Technical Committees of the Black Population	AC, PB, RJ, RS	MG, DF	PE, RN	-
Health Technical Committees of the Population in Street Situation	-	Goiânia	GO, BA, Curitiba	PR
Health Technical Committees of the Populations of the Field, the Forest and the Waters	RJ (Working group)	-	RS	-
Expanded Committees for Equity Promotion Policies**	-	RN, PI, ES, MA, SE*	MT	-

* The Expanded Committee of Sergipe includes Policies for the Promotion of Equity and Popular Education in Health.

**Expanded Equity Promotion Policies Committees are Committees that work with more than one of the following policies: National Policy for the Integral Health of the Black Population; National Policy for the Integral Health of the LGBT Population; National Policy for the Integral Health of the Populations of the Field, the Forest and the Waters; National Policy for the Population in Street Situation.

The equity promotion committees are spaces for dialogue between management and social movements, and have been spaces for the elaboration and monitoring of policies to promote equity, to strengthen social control and to listen to social movements and their demands, that is, they are participatory instances.

The participatory instances are the spaces whose purpose is to allow subjects to act together and, with that, to potentiate their participatory efforts and the achievement of their goals. (ESCOREL; MOREIRA, 2012, P. 856).

Policies of equity in health

Health has been a pioneer and an entrance door to welcome the most vulnerable

populations, recognizing social inequalities as determinants that generate the process of becoming ill and dying differently in different social segments. The equity promotion policies, in particular, that recognize political individuals who suffer prejudice and discrimination due to their social condition, of race/ethnicity, sexual orientation or culture, such as the black and quilombola population, riverside people, shell fishermen and fishermen, lesbians, gays, bisexuals, transvestites and transsexuals, people in street situation, gypsies etc., are expressions of rights and citizenship, based on health. It can be mentioned:

> When considering health policy as a social policy, one of the immediate consequences is to assume that health is one of the rights inherent to the condition of citizenship, since the full participation of individuals in the political society takes place from their insertion as citizens. (FLEURY; OUVERNEY, 2012, P. 25).

In order to implement social advances in the health area, were instituted: the National Policy for the Integral Health of the Black Population (BRAZIL, 2009B); the National Policy for the Integral Health of the Populations of the Field, the Forest and Waters (BRAZIL, 2011A); and the National Policy for the Integral Health of the Lesbian, Gay, Bisexual, Transvestite and Transgender (BRAZIL, 2011B). As a strategy for the implementation of the new policies, the Committees for Equity Promotion Policies were created in the states and municipalities, contemplating the participation and representation of the social movements of the mentioned policies in the state and municipal spheres.

These health policies promote citizenship, by recognizing, for example, the social name of transsexual people in the SUS and by deploying specialized services to serve them; by recognizing the regional differences of mainland Brazil and implementing the More Doctors and More Health programs,

leading health professionals, in particular, to regions abandoned by public policies; by increasing funding for basic care in the Legal Amazon, implementing Basic Fluvial and/or Riverside Health Units; by implanting Mobile Units of Oral Health to serve the field, the forest and the water populations; by implanting the Offices in the Streets to attend people in street situation, among other services and health actions.

Health of the black population

Racism is one of the strongest expressions of inequality and affects a large portion of the brazilian population. It places people of particular racial or ethnic groups at a disadvantage in accessing the benefits generated by the action of institutions and organizations. In health, inequalities are reflected in epidemiological data, which evidence the differences in access and quality of health care, and in the life expectancy of the black population, both due to the high rates of maternal and neonatal death as well as to the violence experienced in a more intense way by this population group, especially by young black men.

Health indicators, when crossed with socioeconomic characteristics, reveal the important relationship between health, its social determinants and the organization of the health system. The understanding of this set is fundamental provide the required tools to the elaboration of policies and programs focused on the fight against inequalities, mainly in health, where it seeks to build an equitable SUS in access and based on the integrality of health.

The National Health Survey (PNS) of 2013 has brought data showing that the black population still has less access to health, if compared to the white population. It is necessary, therefore, to establish strategies and actions that contribute to the effective citizenship

of the black population. In health, some affirmative actions were developed that could contribute to this citizen perspective.

The National Policy for the Integral Health of the Black Population (PNSIPN) marks the recognition of the black population as a subject of rights and seeks to guarantee equity in the realization of the human right to health of the black population in its aspects of promotion, prevention, care, treatment and recovery of communicable and non-communicable aggrievances and diseases, including those of higher prevalence in this population segment, such, for example, sickle cell disease.

The chart below highlights some advances conquered with the implementation of the PNSIPN (chart 2).

Chart 2. Objectives, strategies and advances of the National Policy for the Integral Health of the Black Population

Objectives	Strategies/Actions	Advances
Recognition of institutional and social racism, broadly promoting the debate among managers, health professionals and society.	Launch of the Campaigns Racial Equality is for Real 2012, and the SUS without Racism - 2014 (posters, folders, tunnel in MH, social networks and media).	Inter-sectoral articulation, raising the visibility of the racism in institutions and in society, and adopting educational measures to combat racism in the SUS.
Recognition of racism as a social determinant of sickness and death of the black population and the need for training in the SUS.	Distance Learning Course about the Health of the Black Population (2014), through Provab (Program of Valorization of the Basic Attention Professional) in the Open University System of the SUS (UNA-SUS).	Training of managers and health professionals for better reception in the SUS network.
Qualification of care for people with sickle cell disease in the SUS.	Ordinance nº 1391, from august 16, 2005, which establishes in the SUS scope the guidelines for the National Policy for the Integral Attention to People with Sickle Cell Disease and other Hemoglobinopathies, and Ordinance nº 30, from june 30, 2015, which deals with the Incorporation of the Bone Marrow Transplantation for the treatment of the sickle cell disease.	Inclusion of the diagnosis of sickle cell disease in the Neonatal Screening Program (Guthrie's Test) in all the states and the examination of hemoglobin electrophoresis in primary care, in the Stork Network and in the donation of blood.
Production of knowledge and indicators about the health of the black population considering racism as a social determinant.	Launching of a research edit about the health of the black population in partnership with the National Council for Scientific and Technological Development (CNPq).	Inclusion in the research agenda of racism as a social determinant of sickness of the black population and its health specificities.

Health of the field, the forest and the water populations

Populations of the field, the forest and the waters are formed by people and communities that have their livelihoods predominantly related to the field, forest and aquatic environments. These include peasants, family farmers, settled, camped, salaried and temporary farm workers, whether or not they live in the countryside; communities remaining quilombos; populations that inhabit or use extractive reserves; riverside populations; populations affected by barrages; and other traditional communities. Together, these populations represent approximately 30 million people living in rural areas of the Country, or 15,65% of the brazilian population, according

to the National Household Sample Survey (IBGE, 2010).

Brazil is a country characterized by the presence of socioeconomic inequality, both among individuals and between regions. In rural areas, it is observed the difficult of access to health actions and services, and the use of outpatient care. These difficulties are some of the great challenges to be overcome by SUS, which, for the most part, cannot reach the field, the forest and the water in its complexity, breadth and geographical extent.

The National Policy for the Integral Health of the Populations of the Field, the Forest and the Water (PNSIPCFA), elaborated with the participation of the social movements, through the Earth Group, instituted in 2005, has the objective of improving the health level of these populations through access to health services; the reduction of health risks arising from work processes and agricultural technologies; and the improvement of health indicators and quality of life. Therefore, it is necessary to consider, in SUS management, the diversity and dynamics of non-urban spaces, population mobility, different social subjects, their modes of production, their forms of community organization, their natural resource needs – including access to land – and a range of cultural and environmental aspects that impact the health, quality of life and sustainable development of these people. The *chart 3* highlights the advances achieved with the implementation of the Policy.

Chart 3. Objectives, strategies and advances of the National Policy for the Integral Health of the Populations of the Field, the Forest and the Waters

Objectives	Strategies/Actions	Advances
Visibility of the policy and implementation of the knowledge and practices of researchers, social leaders, managers/workers of the SUS.	Creation of the Observatory of the National Policy for the Integral Health of the Populations of the Field, the Forest and the Waters (Obteia), in partnership with the University of Brasilia.	Articulation of the SUS management and monitoring of actions and implementation strategies of the PNSIPCFA.
Recognition of social determinants, such as the ways of life and production of the field, forest and water, cause disease in the rural, forest and water populations.	Distance Learning Course about the National Policy for the Populations of the Field, Forest and Waters, by means of the Provab (Program of Valorization of the Professional of Primary Care) in the Open University System of the SUS (UNA-SUS).	Formation of managers and health professionals for better ability to identify signs and symptoms from recognizing how processes of production mode interfere in the health of the CFA populations (pesticides, venomous animals etc.)
Guarantee of access with quality and equity to the services and actions of health of the SUS for the field, forest and water populations.	Ordinance nº 1.591, of July 23, 2012. It establishes criteria for the qualification of Basic Fluvial Health Units (UBSF) for receiving the monthly cost incentive referred to in art. 4º of the Ordinance nº 2.490/GM/MS of october 21, 2011.	Enlargement of access to the SUS to riverine populations, extractivists, quilombolas, rural workers, dwellers etc.
	Ordinance nº 290, of February 02, 2013. It establishes the Construction Component of Basic Fluvial Health Units within the scope of the Requalification Program of Basic Health Units (UBS) to the states and municipalities of the Legal Amazon and the southern Pantanal of Mato Grosso.	
	Ordinance nº 837, of May 09, 2014. It redefines the organizational arrangement of the Riverside Family Health Teams (ESFR) and Fluvial Family Health Teams (ESFF) of the Legal Amazon and the southern Pantanal of Mato Grosso.	
	Ordinance nº 1.229, of June 06, 2014. It defines the values of the monthly costing financial incentive of the Riverside Family Health Teams (ESFR), the Fluvial Family Health Teams (ESFF) and the Basic Fluvial Health Units (UBSF).	

Health of the LGBT population – lesbians, gays, bisexuals, transvestites and transsexuals

The National Policy for the Integral Health of the LGBT has as its goal and objective the reduction of inequalities due to sexual orientation and gender identity, as well as the fight against homophobia, lesbophobia and transphobia, and discrimination of this population in the SUS.

The chart below highlights the advances achieved with the implementation of the LGBT Policy (*chart 4*):

Chart 4. Objectives, strategies and advances of the National Policy for the Integral Health of the LGBT

Objectives	Strategies/Actions	Advances
Respect for gender identity in the SUS, using the social name.	Ordinance MS nº 1820/2009, which provides for the rights and duties of health users, among them the right to use the name.	Inclusion of the social name of transvestites and transsexuals in the Card of the Unified Health System (SUS Card) promoting access to the network with respect and without discrimination.
Visibility of homo/lesbo/transphobic violence recognizing that discrimination based on gender identity and sexual orientation produces violence and death, causing damages to the physical and mental health of the LGBT.	Change of the notification instrument to interpersonal and self-harm violence of the Notification of Injury Information System (Sinan) by the Department of Disease Surveillance and Non-Transmissible Diseases and Health Promotion/Health Surveillance Secretariat (SVS).	Enlargement of the notification object when incorporating homophobic/lesbo/transphobic motivations, as well as information about the gender identity and sexual orientation of the assisted person and the inclusion of a field for the social name of the victim of violence.
Enlargement of health care to transsexuals and transvestites in the SUS, considering actions of primary care to high complexity with respect and humanized reception.	Ordinance nº 457 of August 2008 and Ordinance nº 2.803 of November 19, 2013, that defines the Sex-assignment Process in the Unified Health System, establishing guidelines for assistance to the user with demand for the Sex-assignment Process, considering the integrality of the health care, with reception and care for transsexuals and transvestites in SUS.	Implantation and enlargement of referral services for transsexual and transvestite people in the SUS (outpatient services and referral hospital services in the states).
Recognition of discrimination and prejudice of sexual orientation and gender identity as a social determinant of illness and death of the LGBT population.	Distance Education Course (EaD) about the National Policy for the LGBT Integral Health for health professionals by means of the Program of Valorization of Primary Care Professionals (Provab) in the Open University System of the SUS (UNA-SUS).	Formation of managers and health professionals for better reception in the SUS network without prejudice and discrimination to the LGBT people.
Visibility of LGBT people in the SUS and in the society, with a view to recognizing the prejudices due to sexual orientation and gender identity, building respect and rights to an integral and humanized health with equity.	Campaigns like To Take Good Care of One's Health. It Does Good for Lesbian and Bisexual Women. It Does Good for Brazil (2015); To Take Good Care of Each One's Health. It Does Good for Everyone. It Does Good for Brazil, for transsexuals and transvestites (January/2016); and for gay and bisexual men (April, 2016).	Awareness of society and health managers and professionals of the SUS for the best reception in the SUS network, without prejudice and without discrimination.

Health of the population in street situation

The population in street situation (PSS) is concentrated in large brazilian cities and metropolitan regions. This population makes public places and degraded areas a place for housing and livelihood, and can use temporary shelter units to overnight stay or as temporary housing.

Among the grievances and diseases of major incidence on the segment, are highlighted: alcoholism and dependence on other drugs; mental illnesses and various forms of psychic suffering, often generated by the loss or deterioration of family and social ties, and of social identity itself; Sexually Transmitted Infections (STIs); the Acquired Immunodeficiency Syndrome (Aids); the tuberculosis; and dermatological diseases.

The Presidential Decree nº 7.053, of december 23, 2009, established the National Policy for the Population in Street Situation, and its work plan contains actions for the health of this population (BRAZIL, 2009A). Aiming to reduce health inequities and considering the unfavorable health conditions of this population, the work of the interdisciplinary teams of the offices in the streets, in order to serve it, emphasizes the promotion of health, prevention and basic and specialized attention, including actions of urgency and emergency. Among the advances in health for this population, can be highlighted *(chart 5)*:

Chart 5. Objectives, strategies and advances of the National Policy for the Population in Street Situation

Objectives	Strategies/Actions	Advances
Expansion of primary care to attend the people in street situation.	Offices in the Street by means of specific teams for the PSS.	Humanized and qualified care in the SUS to the PSS, and articulation with other policies, in particular, social assistance.
Formation and capacitation of mental health services teams.	Workshops for SUS primary care teams and social assistance in the nine municipalities with the highest number of PSS.	Qualification of primary health care professionals to host with respect and without discrimination in the SUS.
Visibility of the people in the street situation, rescuing them as citizens of rights.	Social media campaigns, posters and booklet about the health of the PSS focus on professionals/health managers, and the population to host with respect and without discrimination the PSS.	Assistance with humanization in the SUS network, especially in the basic attention and visibility of the PSS with human respect in society.

The actions outlined above, related to each policy, always counted on the space of the committees of equity policies as a center for formulating and monitoring these policies, including defining the priorities to be implemented, the content and approach of the campaigns, articulation with other government sectors, the training of social leaders and managers, the development of distance learning modules, the implementation of observatories of the policies, and the review of regulations and norms. In all these spaces, the committees defined the participation of representatives to follow the management in the deployment process and/or implementation. That is, participatory democracy was also intrinsic to the committee itself and contributed effectively to participatory management.

Final considerations

The policies for equity promotion are citizenship milestones in the SUS and have also contributed in order to other social policies can be able to have the same references, to establish actions and strategies to address social inequalities, considering discrimination based on sexual orientation and identity of gender, racism, LGBT-phobia, iniquities against the populations that live and produce in the field, in the forest and in the waters, and against the people in the street.

The advances achieved are the result of participatory processes, in the different management and social participation spaces. The recognition and respect for the role of social movements, in all trajectory of construction and monitoring of policies, was supported by different initiatives, such: as the formation of social leaderships, to develop actions to monitoring of the implementation of policies in federal, state and municipal managements; the articulation of different partnerships, both governmental and non-governmental, recognizing that the social and cultural inequalities to which these populations are subjected are not limited to the health sector; the organization and structuring of the brazilian State, so that it enlarged its role in the perspective of becoming a Social State.

The participation of social representatives in the spaces of equity committees demonstrated the commitment of management to participatory democracy as a structuring element in the elaboration and monitoring of the actions of policies to promote health equity.

The campaigns developed by the MH, and widely disseminated in social networks, contributed, also, to deconstruct discriminatory stereotypes of these social segments, making society, health professionals and health managers able to look under a new perspective for these populations, understanding the dimension of prejudice and discrimination still present in society as a whole.

In dealing with the concept of equity, bringing together the concept of equality and justice, it is resized the understanding of the role of the State and public policies and, in particular, the role of health, based on the concept of promotion and quality of life, of rights and citizenship. This dimension presents the challenges for social movements in consolidating and affirming spaces of social participation as important mechanisms for securing progress and strengthening participatory democracy. Although in times of democratic turmoil in the Country, it is expected that social participation in these instances – health councils, conferences, committees of policies to promote equity etc. – be that of affirming these achievements and of fighting against setbacks. Normative instruments are, ultimately, legal tools of citizenship. ∎

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