DOI: http://dx.doi.org/10.18569/tempus.v10i3.1777

Participação da comunidade na gestão e controle social da política de saúde.

Community participation in management and social control of health policy.

La participación comunitaria en la gestión y el control social de las políticas de salud.

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RESUMO: O controle social é a forma pela qual os cidadãos garantem participação nas decisões que interferem nas políticas públicas. Para identificar o conhecimento da comunidade acerca dos órgãos representativos para o controle social em saúde, assim como os indivíduos que os representam nos Conselhos Locais de Saúde (CLS) foi tomado como campo de investigação o território de um Núcleo de Apóio à Saúde da Família do Município de Chapecó – SC. Os domicílios que serviram como amostra foram selecionados aleatoriamente por meio das fichas A dos cadastros dos agentes comunitários de saúde, nos quais era realizado um questionário estruturado com perguntas sobre uso e acesso aos serviços de saúde. Os resultados evidenciaram que a prática do controle social não é utilizada por uma grande parcela da população, sendo esse uma possível forma para busca de melhoria do serviço e do vínculo serviço-comunidade. Por isso, ainda que os Conselhos de Saúde

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sejam espaços em que a população tenha a participação como garantia uma efetividade maior só será alcançada quando houver maior envolvimento dos usuários neste processo.
Palavras-Chave: Conselhos de Saúde. Participação Comunitária. Sistema Único de Saúde. Saúde Pública.

ABSTRACT: Social control is the way in which citizens ensure participation in decisions that affect public policies. To identify the knowledge of the community about the representative institutions for social control in health, as well as individuals representing them in the Local Health Councils (LHC) the territory of a Family Health Support Center of the municipality of Chapeco-SC was taken as a research field. Households that served as sample were randomly selected through the type A record sheets of community health workers, in which it was carried out a structured questionnaire with questions about use of and access to health services. The results showed that the practice of social control is not used by a large portion of the population, although this is a possible way to seek for improvement of the service and the service-community bond. Therefore, although the Health Councils are spaces where the population has guaranteed participation, greater effectiveness will only be achieved when there is greater involvement of users with this process.
Keywords: Health Councils. Consumer Participation. Unified Health System. Public Health.

RESUMEN: El control social es la forma en que los ciudadanos garantizan la participación en las decisiones que afectan a la política pública. Para identificar el conocimiento de la comunidad sobre los órganos de representación para el control social en salud, así como las personas que los representan en los Consejos Locales de Salud (CLS) fue tomada como un campo de investigación en el territorio de un soporte del Centro de Salud Familiar de la Chapecó-SC. Los hogares que sirvieron de muestra fueron seleccionados al azar a través de los registros de los registros de los trabajadores de la salud de la comunidad, en la que se llevó a cabo un cuestionario estructurado con preguntas sobre el uso y el acceso a los servicios de salud. Los resultados mostraron que la práctica de control social no es utilizado por una gran parte de la población, siendo esta una posible manera de buscar para la mejora del servicio y el servicio en la comunidad de bonos. Por lo tanto, a pesar de los consejos de salud son espacios donde la población tiene participación como garantía de una mayor eficacia sólo se logra cuando hay una mayor participación de los usuarios en este proceso.
Palabras clave: Consejos de Salud. Participación Comunitaria. Sistema Único de Salud. Salud Pública.

1 INTRODUCTION

Social control is one of the ways in which citizens ensure their participation in decisions that influence public policies. With the democratization of the country in the 1980s, this participatory feeling was greatly influenced by the movement called Health Reform, which sought changes in the Brazilian health[1].

Social participation, i.e., the involvement of citizens in political decisions was and has been widely discussed in various forums. It should be noted that the Unified and Decentralized Health System (SUDS in Portuguese) was created from the 8th National Health Conference (NHC), held in 1986. Although it had not predicted the centrality of the municipality in managing the system yet, it already had the basic principles of universality, decentralization, regionalization, equity, community participation and hierarquization[2]. In 1988, with the promulgation of the Constitution of the Federative Republic of Brazil, in its articles 196-200, there is a recovery, according to Cotta, Cazal and Martins [3], of the original proposals of the Health Reform through the creation of the Unified Health System (SUS in Portuguese) and the Constitution establishes the basic guidelines of SUS, which are decentralization, comprehensive care and community participation.

The regulation of SUS occurred after two years of its creation, through the Organic Health Laws (OHL) 8080/90 and 8142/90. The first, besides providing for the conditions for promotion, protection and recovery of health, addresses its organization, principles and guidelines[4]. The second provides for community participation and establishes Health Councils at all levels of government, defined as permanent collegiate bodies, with deliberative character [5].

Health Councils must rely on community participation, working in the design, proposal and implementation of public policies [6], but also in the social control exercised through the supervision, monitoring and evaluation of health policies. According to Cotta et al.[7], social control "should be conceived as a result of direct involvement of the population in the public management process, resulting that society appropriates of means and tools to plan, monitor and analyze health actions and services." Its composition as a collegiate body occurs through government representatives, health professionals, users and service providers, by ensuring the following proportionality of members 50% by users, 25% by workers' representatives and the other 25% remaining are filled by government representatives and service providers[8].

It is noteworthy that the Health Councils have their own regiment to set the number of counselors, the number of regular and special meetings, as well as the term of office. This regiment must comply with federal laws, such as the proportionality of the representatives and their deliberative character.

For Kleba *et al.*[9], the functions of these organs can be grouped into five categories that characterize their ability to respond to actions, programs and health policies: deliberating, supervising, regulating or registering, assisting or advising and informing or communicating. This characterizes them as management councils, institutionalized mechanisms of social control, which play a key role as co-responsible partners in health management.

However, for the Ministry of Health, strengthening mobilization and social control in health should be promoted through other channels of communication between government and citizens in order to facilitate the participation of society in the construction of new models of care and

management in health, "ruled by the logic of needs, demands and rights of the entire population"[10]. Such initiatives, as the promotion of popular education, leadership training, professional associations and popular movements, should be based on the principle of equity and favor the inclusion of specificities of different social groups.

In many Brazilian municipalities, in addition to health policy management councils, Local Health Councils were created in order to promote community participation in the construction of health together with the territory covered by the health unit. The Local Health Council differs from institutionalized Health Councils, constituted in the three legislative spheres, because it is a consultative and not decision-making body, which aims to approach the community from the local health unit[1]. In addition to ensuring access to information on the operation of services, as well as on activities of the municipal administration, the Local Health Councils intensify the link between health unit and community by seeking resolution to problems identified by the population, mobilizing and strengthening capabilities[11].

In general, councils are spaces for exercising citizenship, as they include the voice and interests of users, but they are also learning spaces, whether about content as health, functioning of services and public administration[2], or about skills such as how to argue and take responsibilities. Cotta, Cazal and Martins[3] highlight the character of participation as a process that is built by participating; "it is not a content that can be transmitted, neither a skill that we can acquire through mere training, actually, it is a mentality and behavior to be built by critical reflection and citizens' maturity."

Effective democratic practices that can strengthen participation and social control require a new democratic political culture that sets up effective processes of communication between policy managers, directors and the general society. In this sense, several authors point out difficulties related to the exercise of social participation as advocated by the law and the guiding policies of SUS organization.

Among the difficulties there is the reminiscence of paternalism, clientelism and authoritarianism, causing that individuals continue to accept that other people decide for themselves. Oliveira, Ianni and Dallari[12] claim that the restricted social participation is associated with sociocultural factors, such as "lack of participatory tradition and civic culture in the country, the authoritarian tradition of the Brazilian state and the dominant political culture." The lack of political will and the difficulty of managers to share decision-making power on council spaces are highlighted by different authors[3, 7, 12].

Another obstacle that partially explains the low participation of users on councils is the difficulty of understanding the technical language used by professionals and managers during meetings, the low recognition of the community itself in relation to the functions of members of the health council and the voluntary character of this office[10, 3]. This voluntary aspect may discourage participation because, in a capitalist society, the appreciation of a position is associated with the financial benefits

it guarantees; the more important the position, the greater the compensation. Bispo Junior and Martins[13] point out that in our days there is prevalence of immediacy and individualism, in which people often show interest only by activities that bring direct and immediate personal benefits.

Nevertheless, those who are willing to participate face other obstacles such as lack of training to work as adviser and intimidation that health services representatives may exercise. In addition to the issues that may constitute obstacles for the participation of users, Grisotti, Patricio and Silva[14], highlight that in many situations, the management board works only as a legitimating and body of government actions, not deliberative, which discourages public participation.

In an attempt to change this scenario, the National Primary Care Policy defined as one of its principles the social participation and emphasized that this should be encouraged, "enabling addressing health determinants and conditionings in the organization and orientation of health services from methods that are more centered on the user and the exercise of social control"[15]. But for the community to develop its legitimate power of social control, they need to appropriate knowledge. Oliveira, Ianni and Dallari[12] state that "participation will only be possible when the society in its diversity has knowledge to promote not only its effective participation, but mainly satisfaction in participating".

Considering the context presented and recognizing that the participation of users is essential in social control, the aim of this study was to identify the knowledge of the community about the bodies set up for the exercise of community participation and social control in health, taking as a research field the territory of a Family Health Support Center.

2 METHODOLOGY

The study is characterized as exploratory and descriptive, with mixed approach - quantitative and qualitative - developed in the territory of a Family Health Support Center (NASF in Portuguese) of a central municipality in Health area in the Western Region of Santa Catarina State. This territory was defined after dialogue between municipal managers and health researchers.

The data collection instruments were built with the participation of professionals linked to health management, in particular primary care management, seeking to cover issues that could contribute to the qualification of planning and social control of health policies in the Family Health Strategy teams (FHS). The instruments used in this research were tested in a pilot study and widely discussed in a group of researchers and health professionals. Data analysis was under the responsibility of professors of the programs, under the supervision of the research coordinators.

In quantitative terms, it was used a cross-sectional study design, defining as population the families registered by health centers inserted in NASF, a total of 13,866, according to the SIAB data of February 2011. The sample selected it was 1,133 families, with a sampling error of 3% and loss ratio of 10%.

The selection of households (participating families) was random, through the type A record sheets of community health workers (CHW) belonging to the aforementioned health centers. At first, they the records of families according to their micro-area of residence were gathered then grouped in a single pile; then, the eighth family (number drawn by the research team) was selected and from that, the next subsequent families were selected with interval of 12 records, until reaching the sample value determined for each health center. In the third stage, there was confirmation with the CHW responsible for the family, whether they still resided in the registered address and whether there was time restriction for the visit/interview, proceeding, in this case, to drawing a new family. All 1,133 selected families were visited, however, 110 were excluded because they did not agree to join the study or were not found at their homes after three consecutive attempts. Thus, the total sample consisted of 1,023 families.

Data collection was performed by using a structured questionnaire applied by scholars previously trained, at the homes of the randomly selected households. To participate in the survey, respondents had to be 18 years old or more.

For the processing of data researchers used proper techniques for a quantitative descriptive study, which inform about the number and percentage of distribution of a particular event in the study population; in this study presented by simple frequency in Tables 1 and 2. The data were typed in Excel program; then they underwent the quality control process with analysis of coherence and consistency. After correcting typos, authors proceeded to the statistical analysis of data, with the aid of the Statistical Package for Social Science (SPSS).

In qualitative terms, it was used as the data collection technique the Participative Fast Estimate (PFE), which is intended to guide the community situational diagnostic process. According to Kleba et al[16], the PFE technique enables to identify, in a short period of time, troubles and needs considered relevant by social subjects interested in its resolution, and capabilities that require resources and investments for their maintenance or strengthening.

According to the fast estimate proposal, interviews were conducted by following a script of questions with 20 leaders, two by each area referring to the FHS team, these being selected by team indication, with the criteria of representing different organizations and being references in the community. The number of leaders was defined considering the feasibility of access and time available for data collection. Similarly, the script of questions was built after dialoguing with managers and service professionals, by questioning the leaders on the mode of organization of the community, the participation of the population, the knowledge of managers on participation and social control, the difficult situations that have occurred in the last year and the way the community has organized to seek a solution. The interviews were conducted at the residence or other location, as determined by the leader, ensuring privacy and confidentiality of respondents.

The analysis of qualitative data was through the systematic reading of the transcribed interviews.

From this reading, researchers sought to identify in respondents' speeches record units that could express relevant ideas about the guiding research questions. The analytical process followed the precepts proposed by Minayo[17] to conduct a thematic analysis of the research content, from which it was possible to identify three categories, as follows: Health Councils and the community; Participation and community action; The Council's role in the social control of the budget.

Regarding the ethical aspects of research, the project was approved by the Ethics Research Committee of the Community University of Chapeco Region under Opinion 001/2011, based on the National Health Council Resolution of the Ministry of Health.

3 RESULTS AND DISCUSSION

The city of Chapecó has 26 health centers in its health network, with a total of 41 FHS teams, which means over 75% of population coverage. In 2010, this municipality established four Family Health Support Centers (NASF), and the Center selected for this study includes eight FHS teams.

Health councils and the community

In order to identify users' knowledge about the health councils, respondents had to answer the questions found in Tables 1 and 2. The first and the second questions asked whether the respondent had already heard of or knew the City Health Council and the Local Health Council, respectively; the third question asked whether participants knew any counselor. All questions had a higher frequency of the answer "no", highlighting the community's lack of knowledge about these forums and their representatives.

Table 1 – Users' knowledge on City Council and Local Health Council of a reference municipality in health located in the Western region of Santa Catarina state, 2012.

Question/answer	Yes	No	Ignored/No answer	Total
Have you ever heard of/know the Municipal Health Council?	45% (n.459)	53.9% (n.552)	1.1% (n.12)	1023
Have you ever heard of/know the Local Health Council in your neighborhood?	32.5% (n.332)	66.8% (n.683)	0.7% (n.8)	1023
Do you know any counselor?	12.8% (n.131)	86.4% (n.883)	0.8% (n.9)	1023

Regarding the participation of users in the Local Health Council, Table 2 shows that 88.6% of respondents had never attended the Council.

Table 2 – Users' participation in the Local Health Council of a reference municipality in health located in the Western region of Santa Catarina state, 2012.

Question/answer	Yes	No	Total
Have you ever participated in the Local Health Council?	11.5% (n.106)	88.5% (n.811)	917
Among those who participated	As a counselor	As a listener	
	43.4% (n.46)	56.6% (n.60)	106
Total	152	871	1023

Evidence shows that there is little community participation in local health councils. This fact disrupts/destabilizes the proposition that the Local Health Councils are constituted as democratic spaces for social control and for purposing actions for the community. According Busana, Heidemann and Wendhausen[18]:

> Through popular participation in health councils together with the will to achieve political and social changes, this process will constitute an essential tool for the development of individual and collective empowerment, as this process changes the *status quo* by promoting political awareness and raising autonomy for decision-making.

In addition to hearing users of health services, authors also interviewed community leaders (identified by health professionals), who confirmed, in a way, the little involvement of community in councils, since 60% of leaders do not know any counselor in the neighborhood, 40% had never attended the council meetings, 25% reported not knowing the Health Councils and only 20% had already been or is currently a counselor in the Local Health Council. Among those who have participated in any meeting, most stated they have been invited through community health workers, which, according to them, is due to the fact of being part of the neighborhood association or community council. In their opinion, the local council performs a good job, although it can improve.

The visibility of councils within the community is highlighted by Cotta, Cazal and Martins[3] as crucial to the effective exercise of social control. For these authors, the councils are unknown to most citizens, which shows distance not only between representatives and their constituents, but also between councils and the population in general. Democratizing information indicates commitment of counselors, ensuring greater reliability in participatory mechanisms and promoting co-responsibility among the various social segments. In addition, it "plays an educational role among the population, because it shows the possibility of really effectuating the participation of

civil society in the shared management of public policies".

For Oliveira, Ianni and Dallari[12], social participation can be strengthened as there is a political culture that promotes the recognition of the other as a citizen, which is also favored by associative practice that promotes social ties, legitimizing the representation on the councils. In this sense, the National Health Council stresses the importance of dialogue in the coordination and exchange between councils and organizations, popular movements, public and private institutions to promote health[15].

In addition to community participation in Local Health Councils, researcher sought to know, with the leaders, which important groups existed in the community, and these have emphasized the elderly groups and the women's groups, because they promote physical, leisure and cultural activities and nurture the debate on issues of interest to the community. The youth group was highlighted in only one community. However, in the opinion of most leaders, young people are resistant and have not adhered to invitations to attend meetings in the neighborhood. Among the institutionalized entities, the initiatives of churches were cited more often, as their work together with the association of residents. Among the activities, they highlighted the construction of a square and a gym for the community and the social work performed by the church of that community in supporting a self-help group involving drug users. Other initiatives cited in favor of promoting health in the community were: cultural, formative, recreational and educational activities developed with different age groups by a Community Center and by Gaucho Traditions Centers (GTC).

Community mobilization initiatives reported by the leaders are in line with the Primary Care National Policy, because this policy is based and guided by the stimulation of participation and social control as a way to increase the autonomy and capacity of care to their health from activities more focused on the user and on the exercise of social control. The implementation of qualification guidelines of care and management models, such as collective participation in the management processes, valorization, encouragement to autonomy and awareness of different subjects involved in the production of health must be characteristics of the work process of Primary Care teams[8].

Batagello, Benevides and Portillo[19] claim that these community spaces emerge as a possibility to overcome the significant difficulty in promoting the effective participation of the population, by building new meanings for the formal settings of social participation. Lima, Sá and Pinheiro[20] outline as new meanings to "construction of personal and social identity of its residents, the constituent interactions thereof, the feeling of belonging, binding, action and social commitment" so that through the development of people, the same occurs with public policies in their strategies and meanings.

However, Coelho[21] states that policies related to social participation in the SUS only explain about the implementation and strengthening of conferences and health councils. Therefore, other community spaces are very vaguely addressed, which does not guarantee the "strength of these

lines in the effective construction of SUS".

Thus, so that Health Councils can assume and commit to its competencies in the logic of effective participation and social control, Batagello, Benevides and Portillo[19], ensure that it is necessary to understand "that health councils do not replace the social movements and that these are the movements that should guide the actions of councils." Therefore, the expansion of alliances between non-governmental public institutions and social movements should be encouraged in order to qualify the public policies management.

Participation and community action

In seeking to understand the perception of leaders on the capacity of action of the community, they were asked to cite some difficult situation occurred in the last year and how the community got organized to seek a solution. They cited various initiatives to support the improvement of working conditions in health facilities, such as reformations and expansion of physical infrastructure, increase of the number of employees or even the permanence of employees in the unit to reduce turnover. Other major initiatives relate to improvements in the neighborhood claimed in the city council, such as plates with street names and speed bumps, expansion and adjustments in public transport and the resolution of problems relating to sewage. Some leaders cited the movement against the use of drugs and social work initiatives in favor of poor families.

According to the leaders, community organization is given by "*meetings and debates*", or even "*assemblies*", for which "*one calls the other*". Depending on the subject, "*they search knowledge with several people*", whose information and clarifications encourage the development of solutions. The community radio station was cited as relevant mobilization channel and also the *"mouth to mouth"* motivation, involving neighborly relations. Another way to mobilize the community is to promote events or selling raffle tickets to raise funds for solidarity actions. The dialogue with the mayor or responsible sectors was also cited as an initiative of the leaders for the resolution of community problems.

It is worth mentioning the importance of community radio stations as an important device in the mobilization of the population because "the use of community radio station as a space dedicated to health issues can serve as an advocacy tool for human and social rights, as well as a management tool from a perspective of interactivity with the population"[22].

When asked about the participation of people in activities in the community, the opinions of leaders diverge: for some of them, there is little participation of the community because, according to them, "*people are lazy*" and "*show up to complain"* in the meetings. Besides that, "*people need to be motivated to participate; it is always the same people, if you want to bring people, you have to invite them from house to house*". For others, *"people are very committed"*. Especially *"in sports"* participation is good; and participation in *"community organization"* meetings increases every year.

The leaders cited as favorable aspects to the growth of community actions the union, the common interest in the development of the community and also the interest of the population in recreational and pleasurable activities. Access conditions, such as location of the service and infrastructure in the neighborhood, also facilitate participation.

However, with regard to the difficulties of adherence of people to participate in the search for resolutions to community problems, leaders mentioned that the *"schedule of meetings coincides with community residents' work time",* especially concerning the Local Health Council meetings, and that *"the time interval between meetings ends up discouraging people"*. It was also highlighted by leaders that *"the most vulnerable groups (with greater financial difficulties) are the least involved"*, either by shame or fear of speaking. Furthermore, one of the leaders states that "*people are tired of fighting".*

Difficulties surrounding the participation of people in favor of the common good as well as the effectiveness of public policies relate directly to the limit to get hold of knowledge. For Shimizu *et al.*[23] the greatest difficulty that counselor have in developing all their functions is the lack of skills.

In addition, excuses such as lack of time reflect the current economic system, capitalism, "which promotes individual values and encourages society for consumption and accumulation, as well as frustration for not recognizing the importance of political social action", which estalishes important obstacles to social mobilization[21].

Other factors that negatively influence the participatory culture, according to Cotta *et al*.[7], is the absence of political will so that citizenship is truly exercised. This can be modified when there is "accumulation of successful experiences of unity and cooperation between citizens and the State, that strengthen mutual trust actions, aiming at building a truly common good".

About the statement that the most vulnerable groups are the least involved, Oliveira and Pinheiro[24] indicate a strong relationship between political apathy and socioeconomic inequalities, in which there is little participation of the lower classes subjected to degrading conditions, which do not enjoy their fundamental rights. Still, when participating, they "do not dare asking to talk and sometimes are not seen or heard when they dare to such deed.".

Souza *et al.*[2] state the importance of conducting discussions on community participation in social control, thus contributing "to the reflection of the Counselors on the importance of making decisions consistent with the welfare and health of the population." Thus, this makes "possible to trigger a process of popular participation and social control in health, although incipient, in a micro-area of operation, ensuring a more ethical and equitable Unified Health System"[25].

The Health Council's role in the social control of the budget

Health Councils, established as social control mechanisms with deliberative, oversight, normalizing and informative character, have the legal duty to formulate strategies and monitor the implementation of public health policies, including the financial aspect. Thus, Cunha and Magajewski[26] claim that the monitoring and implementation of health plans in relation to expenses and expected results must have the active participation of such institution.

So that councils can act in the planning and control of government acts, it is essential that the public administration render account for its actions. Resolution No. 333/2003 of the National Health Council provides for the content of this accountability, which includes progress of the agreed health agenda; management report; amount, source and method of use of resources; initiated and completed audits in the proper period; supply and production of services in the health care network[8].

Goncalves, Goncalves and Tavares[27] state that "it is through accountability that leaders demonstrate what they did and their planning to transform the reality of the population". Only through this mechanism the society can exercise its function of monitoring public investments and propose actions to improve the adequacy of the budget to the community health needs.

However, the 11th National Health Conference report points out that the accountability mechanisms that councils receive have not allowed the control over the sources of funding, the clarification on the application of public resources and the monitoring of results of implementation of health plans[28].

They have used complex instruments for accountability, making difficult the understanding, evaluation and hence social control. An example, according to Fleury *et al.*[29], is the periodic Budget Report, the most widely used mechanism for accountability of health departments, which has an essentially technical language and therefore represents an obstacle to the advancement of transparency if it is not combined with other forms of accountability as there is difficulty in understanding the provided information.

Thus, there seems to be no interest from internal controlling bodies and the governments themselves to facilitate external control exercised by councils. Still, we must recognize that the Federal Constitution and the policies deriving from it are unknown for a significant portion of the population, which contributes to the low participation of the population in social control processes, as shown in Table 2.

Additionally, authors reported other obstacles faced by councils such as the uncertain periodicity of meetings, the little time for detailed analysis of expenses, insufficient discussion among counselor, lack of prior knowledge of the approved budget, information transmitted concisely and financial dependence of the institution, which can be used as a bargaining chip in approving opinions [23, 14,

[27, 30].

To empower the counselors regarding their duties to inspect, decide on the municipal health budget and use it for the benefit of well-being and community development, there is need of continuous training[27].

However, Kleba *et al.*[9] states that "the realization of these tasks occur only when the counselors understand the implications that their decisions can have on the conformation of model and care practices," since there are no rules that blame the councils and their representatives for the results and impacts of their deliberations[31].

For Leite, Lima and Vasconcelos[32] if the community understands and assumes the regimental competencies that are assigned to the Health Council, this would expand its role, overcoming the assignment of approving routine projects or of solely acquiring funds, becoming more effective in participation and social control, providing transparency, efficiency and equity in the use of public resources.

4 FINAL THOUGHTS

This study makes clear that community participation and social control are still unknown for a significant portion of the population. It is possible to infer that the recent democratic tradition in the country, the low knowledge of Human Rights, the mistaken understanding of citizenship (too focused on the ability to have and consume) and the still conservative way of conducting public management, centralized in power and decision by governments contribute to distancing the population from public health policy management.

The Brazilian law, since the organic laws of different public policies, has incorporated values, concepts and guidelines that seek to strengthen the decentralization of the State, the social participation and the comprehensiveness of health care. This public policy area is complex both in regard to the actions developed in different modalities, in order to meet the demands of individuals and groups, and in relation to public management processes.

The public policy councils, which are social control bodies of the State by society, should encourage social participation, strengthening the relationship between government and society in the management of public actions. It is necessary to develop strategies to qualify counselors, democratize information, and promote the exchange of experiences and discussion of the limits and possibilities of representation. For this purpose, there is need to activate the permanent education process together with the Health Council, by allowing reflection on relevant topics that will contribute to a better understanding of their role and their responsibilities, especially with regard to SUS social control management.

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Paper presented at 18/12/15

Approved on 26/09/16

Published on the system 10/10/16