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RESEARCH ARTICLE (ORIGINAL)

Analysis of the context components proposed by the World Health Organization in a municipal health council

Análise das dimensões do contexto da Organização Mundial da Saúde num conselho municipal de saúde

Análisis de las dimensiones del contexto de la Organización Mundial de la Salud en un consejo municipal de salud

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Abstract
Background: Studies on social participation point out some limitations in participatory architecture. For this reason, the World Health Organization designed a model with key components for bringing civil society and governments closer together.
Objectives: This study aimed to identify the aspects that influence participation based on the components proposed by the World Health Organization.
Methodology: This case study used a qualitative and cross-sectional approach. Data were collected through document analysis, non-participant observation, and semi-structured interviews in 2020 and 2021 with the municipal health council members of an inland city in the state of São Paulo, Brazil.
Results: Weaknesses were observed in the council's institutional structure, such as excessive bureaucracy, lack of user representativeness, and council members' insecurity regarding the municipality's health-related economic-financial issues.
Conclusion: There is a need to strengthen the culture of participation in this municipal health council, disseminate the activities developed, and reformulate the technical-bureaucratic dynamics that predominate in this environment.

Keywords: social participation; municipal health council; social determinants

Resumo
Enquadramento: Estudos sobre a participação social apontam algumas limitações na arquitetura participativa, razão pela qual a Organização Mundial da Saúde desenhou um modelo que enfatiza as dimensões constitutivas para aproximar a sociedade civil e os governos.
Objetivos: O estudo buscou identificar os elementos que influenciam a participação à luz das dimensões propostas pela Organização Mundial da Saúde.
Metodologia: Trata-se de estudo de caso, com abordagem qualitativa e transversal, que foi realizado por meio de análise documental, observação não participante e entrevistas semiestruturadas nos anos de 2020 e 2021 com os conselheiros do Conselho Municipal de Saúde de uma cidade brasileira do interior do Estado de São Paulo.
Resultados: Foram observadas fragilidades nas arquiteturas institucionais do Conselho estudado, tais como o excesso de burocracia, falta de representatividade dos utilizadores, insegurança por parte dos conselheiros nos assuntos económico-financeiros relacionados à saúde do município.
Conclusão: Conclui-se pela necessidade de fortalecimento da cultura participativa no Conselho Municipal de Saúde estudado, destacando-se a necessidade de divulgação das ações desenvolvidas e reformulação da lógica tecnoburocrática predominante neste ambiente.

Palavras-chave: participação social; conselho municipal de saúde; determinantes sociais

Resumen
Marco contextual: Los estudios sobre participación social señalan algunas limitaciones en la arquitectura participativa, por lo que la Organización Mundial de la Salud ha diseñado un modelo que hace hincapié en las dimensiones constitutivas para acercar a la sociedad civil y a los gobiernos.
Objetivos: El estudio pretendía identificar los elementos que influyen en la participación en función de las dimensiones propuestas por la Organización Mundial de la Salud.
Metodología: Se trata de un estudio de caso, con un enfoque cualitativo y transversal, que se llevó a cabo mediante el análisis documental, la observación no participante y entrevistas semiestructuradas en los años 2020 y 2021 con los consejeros del CMS de una ciudad brasileña del interior del estado de São Paulo.
Resultados: Se observaron deficiencias en las arquitecturas institucionales del consejo estudiado, tales como la excesiva burocracia, la falta de representatividad de los usuarios, la inseguridad de los consejeros en los asuntos económicos y financieros relacionados con la salud del municipio.
Conclusión: Se sugiere la necesidad de fortalecer la cultura participativa en el consejo municipal de salud estudiado, sobre todo la necesidad de difundir las acciones desarrolladas y reformular la lógica tecnoburocrática predominante en este entorno.

Palabras clave: participación social; consejo municipal de salud; determinantes sociales

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Introduction

Over the past 25 years, Brazil has become one of the countries with the largest number of participatory practices among the population (Avritzer, 2008). Examples are the participatory budget and the Health Councils, internationally recognized as suitable democratizing strategies to overcome the limits of representative democracy. Similar to other public policy management organizations, Municipal Health Councils (*Conselhos Municipais de Saúde*, CMS) focus their activity on the participation of civil society in a relatively new institutional architecture that can legitimize and promote social participation in decision-making processes.

In addition to increasing the autonomy of participants in decision-making, thus improving people's dignity, social participation can be instrumental (World Health Organization [WHO], 2011) in valuing people's knowledge and experience for better decisions and health outcomes (Cervia, 2018), in enhancing the representation of underrepresented groups for fewer health inequalities (de Freitas & Martin, 2015), and in overcoming the growing democratic deficit that characterizes health systems (Coulter, 2013).

However, studies on this topic have reported some limitations in this participatory architecture, which carries with it the paradox of having, on the one hand, the power to influence sectoral policies and, on the other hand, a low capacity to balance the forces that make up the political game.

Low social participation in health may be the result of the unwillingness to transfer part of the decision-making power to the communities, giving them autonomy to intervene politically, and the lack of training (Bastos Filho, 2015; Rocha et al., 2020; Ventura et al., 2018).

Therefore, WHO has designed a model to strengthen the culture of participation in policy-making that emphasizes its key components for bringing civil society and governments closer together (WHO, 2011).

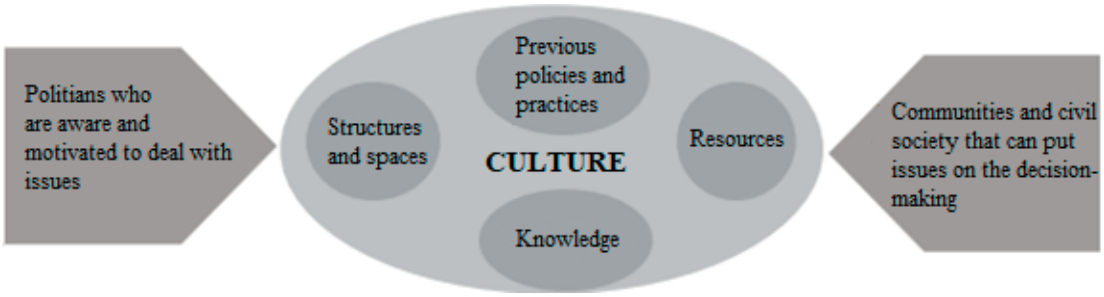
This study aims to describe how social participation is implemented in a Brazilian CMS, with the following research question: What are the aspects that influence social participation in the CMS under study based on the components of WHO's model of culture of participation?

Background

The four dimensions of the culture of participation proposed by WHO are: i) the structures and spaces that allow participation to occur; ii) the resources that stakeholders have to participate; iii) the knowledge necessary to participate; and iv) the impact of previous policies and practices on participation. In this context, government sensitivity to the importance of social participation and civil society organization in defense of collective interests are resources that influence social participation (Ventura et al., 2017). Figure 1 illustrates the proposed components.

Figure 1

The context and resources that influence social participation



Note. Adaptado de "*Diminuindo as diferenças: A prática das políticas sobre determinantes sociais de saúde: Documento de discussão, 2011*" WHO (2011, p. 18). https://dssbr.ensp.fiocruz.br/wp-content/uploads/2020/10/Documento-Tecnico-da-Conferencia-vers%C3%A3o-final.pdf

According to WHO, political, physical, and institutional structures are key indicators of the success of social participation practices, which is ultimately assessed based on how these structures influence policy-making. Therefore, they should be transparent, decentralized, and adopt formal procedures (WHO, 2011). In this context, resources are also a critical element for establishing a culture of participation because policy-making requires time, work (human resources), money, and institutional capacity.

On the other hand, knowledge for participation is also indispensable. Those involved must know the subject matter on which they are expected to make decisions and understand what can be achieved (WHO, 2011). Consequently, the impact of previous experiences strongly influences the perception and ability to actively participate in policy-making. These components require the sensitivity of local governments, which need to identify socially vulnerable groups and ensure that they are actively represented. As a component of WHO's model of culture of participation (WHO, 2011), civil society organizations can monitor commitments and show results in the context of social participation.

Methodology

This case study used a qualitative and cross-sectional approach. Data were collected through document analysis (minutes from 2013 to 2019), non-participant observation, and semi-structured interviews in 2020 and 2021 with the CMS members of an inland city of the state of São Paulo, Brazil.

Before that, it was possible to briefly observe how the CMS worked through non-participant observation, given that, due to the SARS-CoV-2 pandemic, the ordinary and extraordinary meetings of the CMS under study took place in a closed WhatsApp group created for this purpose. In this context, besides the pandemic, a limitation of this study was the mismatch between the number of participants who were official CMS members and the number of those who agreed to participate.

Initially, a documental study was carried out through the systematic analysis of 90 minutes of ordinary and extraordinary meetings of the CMS under study. The main aspects studied in these documents were the dynamics of participation in the meetings (quantity of interventions and involvement of the members of each segment) and the quality of the information provided in the minutes.

Subsequently, semi-structured interviews were conducted online using Google Meet and WhatsApp tools to adopt social distancing measures due to the SARS-CoV-2 pandemic (Schmidt et al., 2020). The interviews aimed to know and further explore the aspects of the representativeness of the CMS and its members, their level of participation, and the opinion of the different CMS members about the limits and potential of these institutional forums.

The CMS members were contacted by email on 3 October 2020 by the CMS secretariat where they received an individual invitation and the informed consent form. Considering that only a few CMS members answered, they were again contacted by phone or on WhatsApp. This new attempt was fruitful, with 16 of the 36 CMS members signing the informed consent form and participating remotely in the interviews. The interviews lasted, on average, 40 minutes, were recorded and later transcribed to ensure content reliability. In this case, the sampling method was theoretical saturation. Data saturation was reached when no more new information was identified to help better understand the phenomenon under study.

The data from the interviews were categorized through content analysis (Bardin, 1995), with the help of the ATLAS.ti software. The minutes were extensively read to obtain quantitative data about the presence of members per segment and participation in the meetings, as well as qualitative data about the quality of the participatory process and the functioning of the analyzed CMS. The analysis was carried out based on the components of social participation (WHO, 2011).

Finally, data triangulation (Patton, 1999) was adopted for data analysis to allow further exploring different aspects of participation in the analyzed CMS.

The study was approved by the Ethics Committee of the College of Nursing at the Ribeirão Preto Campus, under No. 4.307.794/2020.

Results

Of the total number of full and alternate CMS members in 2020, 16 accepted to participate in the study: 8 members from the users' segment, 6 representatives of the workers and providers' segment, and 2 from the managers' segment, equally distributed by gender.

To ensure participants' anonymity, they were identified with an acronym and the respective interview number. The acronyms used were: U for user; T for workers (*trabalhadores*) and providers; and G for managers (*gestores*).

Table 1 shows the thematic units that emerged from the research, whose subcategories were organized according to WHO's four context components that influence the culture of participation.

Table 1

Thematic categories and subcategories resulting from content analysis

Categories	Subcategories
Structures and spaces	CMS bureaucratization Functioning-related institutional difficulties Personal interests versus collective interest
Resources	
Knowledge	Lack of training Learning Lack of representativeness
Impact of previous policies and practices	History of participation Challenges to the influence of the users' segment
Resources that influence social participation	

Structures and spaces

According to WHO, physical, institutional, and political structures, depending on their architecture, can encourage or inhibit social participation. In order to encourage social participation, processes need to be transparent and conducted through stable mechanisms "to institutionalize participation as central to the policy-making process" (WHO, 2011, p. 19).

In the studied CMS, the formal aspects, despite their relevance, were described as an obstacle to free and productive social participation and seemed misunderstood by CMS members from different segments, as shown in the following subcategories.

CMS bureaucratization

The theme of bureaucratization emerged from the participants' statements. For many CMS members, the institutional dynamics were reported as technical-bureaucratic, to the detriment of more effective public policy-making within the CMS.

A CMS member in the users' segment (U7) resented having integrated a space that they reported being merely based on protocol and, based on their experience, admitted not believing that the CMS under study is an institution where those represented have the right to health. This opinion was also shared by other CMS members, including managers.

> The balance of power is disproportionate . . . which makes this space merely based on protocol. People come, we stamp "yes", and they go where they have to go, but the population does not have their demands and rights met . . . I spent two years here and realized that the council merely follows protocol. (U7)

Functioning-related institutional difficulties

The functioning-related institutional difficulties observed include the short duration of meetings and the time spent on formalities and acknowledgments that matter little to the agenda of the day. Data from non-participant observation reveal that most meetings aimed at data presentation by the management.

One CMS member stated that users who attended meetings were not afforded the opportunity to give their opinion or participate in any way in what was being decided: "Anyone there can see that users show up occasionally and don't have a say in what is being voted on. It is a complicated business" (T8).

In this dimension, the lack of structures to hold CMS meetings during the SARS-CoV-2 pandemic was also highlighted.

Personal interests versus collective interest

Some CMS members in the users' segment reported that disputes of interests, although expected in political spheres, occur blatantly on some occasions in the CMS:

> We know that there is a dispute of interests and that this is expected within the democratic system, but it does not mean that things should be the way they have been, at least during the two years that I have been there. (U7)

Another CMS member from the same segment highlighted that the low turnover of its members contributes to defending the interests of only one represented group.

Still on the topic of overlapping personal interests and collective interests, the same CMS member of the users' segment (U7) mentioned that the proposals to be voted on were mostly decided in advance and that the people are allowed to speak by mere formality, without the possibility of a fruitful debate that could change the outcome.

Resources

In this dimension, the minutes revealed that resources are scarce in mental health - an area that requires complementary budgeting to maintain the implemented services – due to the high cost of their monthly maintenance and the "several problems faced by mayors in complying with the budgetary balance as a result of supplemental budgeting for health" (Atas, 2013).

In the interviews, the resources' component was also shared by some council members, who highlighted that public money is poorly spent.

Knowledge

Lack of training

In the interviews, some CMS members reported that training is not a CMS requirement, which can result in a lack of interest in starting any training course.

A CMS member of the health workers' segment (T2) reported that CMS members themselves seek information about how the CMS works, whose knowledge is acquired from their own experience in the CMS.

The minutes showed that, between 2013 and 2015, CMS members requested a training course in analysis and processing of documents related to public accounts. However, during the same period, management board members complained about CMS members' low participation in events on this topic.

The analysis of this period reveals the CMS members' insecurity in economic-financial matters related to the municipality's health, often signing documents without knowing anything about the subject.

Learning

Learning was mentioned by all CMS representative segments. The position of CMS member was recognized as an opportunity for constant learning through one's own experience and the collective construction of health practices.

> You pass on things and you learn things as well. Impact on both directions. You teach and learn a lot from them. But I think it could be better. But yes, there is learning about the laws, the health rules, the organization of the Unified Health System itself, the health laws. There is a learning process, yes. (T4)

Lack of representativeness

As can be seen in one of the health workers' segments (T2), the population is not aware of their power of social

control.

> I believe that the council is very important, but we see that the people do not take ownership of what is rightfully theirs... People don't understand what they have in their hands, the power they have in their hands, the power of voice, and maybe that's why we can't fight so much for health (T2).

The analysis of the CMS website where the minutes are made available revealed that there are no communication channels or organization of documents containing information about project approval and implementation in society.

On the other hand, representativeness sometimes seemed to be misunderstood by the CMS members themselves. The non-participant observation and the analysis of the minutes revealed that many CMS members take the floor very often to compliment or acknowledge during meetings or even to report the attendance to courses that do not contribute to the discussion of public health policy-making.

Impact of previous policies and practices

History of participation

The experience with social participation in health prior to the CMS was a recurring theme in the interviews. CMS members from all segments reported a history of active participation in society and in other deliberative institutions, such as the councils linked to the profession and the Municipal Health Conferences.

Some CMS members of the users' segment had been presidents, members, or founders of Local Health Councils, which are one of the organs where they first started to participate.

In this subcategory, CMS members' motivation also emerged, which led them to start their trajectory of social participation in the CMS. Some believed that participation in the CMS serves as a bridge to start their political career.

Challenges to the influence of the users' segment

In this subcategory, the perceptions of the participants about the influence of the users' representatives in the decision-making processes emerged, as well as whether this segment brings demands to the Council discussions. The quantitative data obtained in the analysis of the minutes indicated a higher number of interventions from the CMS members of the users' segment in meetings between 2013 and 2019, which had a lower mean frequency in that period (Table 2).

Table 2

Distribution of the interventions from the CMS members in the ordinary and extraordinary meetings and the mean frequency by segment, between 2013 and 2019

Segment	Percentage of interventions	Mean frequency
Users	43.4%	46.03
Workers	28.6%	67.69
Managers	27.4%	64.15

When asked about the degree of influence of the users' segment in the decision-making processes, most of the CMS members recognized significant participation, either by the number of representatives or by the proximity to the support base. However, they were unable to mention successful examples of this influence.

On the other hand, the dependence of the CMs members of the users' segment on the President of the Council was another theme that emerged from the interviews. One CMS member identified a type of co-optation of people who, according to them, would support some decisions due to their indication of origin. A similar feeling was shared by another CMS member, who mentioned that it is easy for CMS members of the users' segment to be manipulated by the management.

Resources that influence social participation

In this context, the data obtained made it possible to understand the impact of some resources influencing social participation. Thus, regarding governmental sensitivity, some CMS members from the users' segment and the workers and providers' segment also reported the influence of the political party currently in the local government and the politicization of the interests at stake in the last composition of the CMS.

In addition, one of the participants of the users' segment (U7) reported the regimental maneuvers that they had observed in a group of councilors linked to the President of the Council, who did not approve the new wording of the Internal Regulations, which allowed the reelection of members of the Local Health Council, to prevent a more participatory CMS member - a health worker - from being reelected. In the interviews, a CMS member from the users' segment (U7) highlighted the way certain agendas are written, which end up directing the CMS members' actions, such as what happens with the term "approval of accounts" and other management issues, which are written in a biased way:

> To give you an idea, our consternation with this process of the municipal health council is that they had already written "approval of this and that". This is absurd. Instead of voting, it was written "approval", so it was already subliminal what was to be approved and what was voted on. (U7)

Concerning civil society organizations, a divergence was observed in the CMS members' perspectives on the su-

pport base, with some recognizing the existence of a connection, while others deny it. In this same dimension, low social participation by the local population was also observed. Some CMS members attribute the low engagement, for example, to people's lack of knowledge about their role, lack of interest, or absence of a culture of participation and of fighting for one's rights.

Discussion

Brazil has an important model of participation and social control that, although specific, can serve as a basis for other realities, considering the importance of the debate on participatory culture in the health area. However, studies describe the reduction in civil society participation due to managers who excessively influence representatives' attitudes or weaknesses in the relationship between representatives and institutions (Bispo & Serapioni, 2021; Rocha et al., 2020).

In this context, the institutional, political, and physical structure architecture designed by WHO enables the increase of social participation, bringing civil society and governments closer together. Thus, this study analyzed its four structure and resource components. Concerning structures and spaces, this study found that protocol activities and deliberations are deeply bureaucratic, as occurs with the approval of public accounts, projects, and health plans, seemingly removing from the center of the debates issues of greater relevance to local health, which significantly distances the CMS from the function of a structuring body for public health policies. Thus, technical-bureaucratic issues were often observed in most of the meetings of the analyzed CMS. Most of the meetings were reduced to interventions on management reports and accountability, which reinforces the idea that the Municipal Councils still have a fragmented view of health and that the issues addressed are not structuring aspects of the sector (Jorge, 2013; Stralen, 2010).

In the area of financial resources, which are a crucial aspect of social participation, it became evident that the unequal distribution of resources leads to disadvantages for the portion of the population that participates in social control.

The knowledge dimension is central to this discussion. Studies point out difficulties in social participation linked to the predominance of the managers' technical discourse and the persistence of an authoritarian political culture in municipal councils, which does not promote the participation of individuals without technical training in the area. Some studies report that the specialized knowledge of some categories, particularly workers, service providers, and managers (mostly composed of councilors with higher education), can contribute to the depoliticization of the participation of these segments, masking social interests and bureaucratizing the CMS members' actions (Kezh et al., 2016).

Training is an important tool to overcome the lack of consultation and accountability (Bezerra & Araújo, 2009) and the use of public resources for municipal health, which is essential at the current stage of maturation of Brazilian democracy.

Although the CMS constitutes a non-traditional educational space, many CMS members described learning in the performance of this function, which is corroborated by other studies (Bortoli & Kovaleski, 2019).

In addition to the knowledge dimension, it is recognized that many CMS members lack an understanding of their role. This aspect is also a major weakness as it impacts significantly the attitude they will adopt while working at the CMS. In this debate, Ventura et al. (2018) report that the strengthening of the culture of participation should not be based only on the relationship established with the state entity and the governors/managers, but also involve an analysis of the current context in which citizens are inserted, which implies recognizing the poor access to information and training, as well as considering the frustration arising from innocuous attempts of participation that negatively influence the interest and mobilization of civil society. The relevance of rights education should be highlighted here (Ventura et al., 2017). As for governmental sensitivity about the importance of participation, the interviews also brought to light situations of interference in voting by user representatives, which is widely discussed in the literature (Farias Filho et al., 2014).

Finally, the current context of the SARS-CoV-2 pandemic has negatively influenced social participation within the analyzed CMS, since almost all meetings in 2020 were held via WhatsApp, decreasing discussion quality and hindering the transfer of information and decisions made in the meetings. This context also imposed some limitations on this study, such as the less motivation of the participants for the interviews (many did not called back after being contacted). Another limitation was the literature review due to the lack of reference to this topic in other studies.

Conclusion

This study identified some of the aspects influencing social participation in a CMS based on the context components of WHO's model of culture of participation.

Concerning the meaning of social participation through the lived experience of the CMS members, the participants' statements pointed to the importance of their roles, particularly in representing citizens in the fight for better conditions in the Unified Health System. However, other CMS members, especially from the workers' segment, questioned if that importance was realized, reporting the managers' co-optation of some CMS members of the users' segment.

Many of the participants defined the institutional dynamics as technical-bureaucratic, with meeting time wasted on formalities rather than on policy-making in public health. In this context, the centralized production of information in the technobureaucracy ends up conferring a more prominent role to a single segment, which also occurs in the analysis of public accounts, a matter that requires specific knowledge. This is possibly one of the greatest contributions of this study since these aspects require more technical knowledge that probably almost

no CMS member has and that, given the lack of training offered by the CMS for this job, will further increase previous inequalities among them.

Therefore, the user representatives' role is questioned, namely the influence of this segment in the decision-making processes, described by many CMS members as tools used by the managers to comply with the bureaucracies required by law.

However, despite this perception, the participants reinforced the proximity of the users' segment to the support base (since many are part of Local Health Councils and neighborhood associations, among other civil society organizations), which reveals the strengthening of the component *impact of previous policies and practices*. This aspect was also confirmed by the high number of statements and interventions during the meetings in the analyzed period. The CMS is a space that promotes civic culture and access to health care and can be important to social change. However, this potential depends on CMS members' commitment to publicizing their actions as a way to get closer to the population they represent. Therefore, we emphasize the need to strengthen the culture of participation in the analyzed CMS, highlighting the pressing need to publicize the actions developed in the CMS and conduct more research in this field. This model of social participation has gained international visibility as a democratizing strategy, which currently represents a political urgency for many countries. Finally, the unequal access and use of technologies by many CMS members may have caused deep asymmetries in the decision-making processes of the CMS, which should be addressed in further studies.

Author contributions

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