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Subject: Impacts and Outcomes of Participatory Processes in Brazil and Canada

To add to our previous memo, I am including additional information here about the indicators and the variables related to each. These are taken from **Participation and Health Policy in the City of São Paulo** (a draft, not yet for circulation) prepared by Vera S. P. Coelho with a number of colleagues: Alexandre Ferraz, Meire de Paula, Fabiola Fanti, Mariana Thibes, and Ligia Rubega Daniel and adapted to accommodate the Public Health Agency Case Study.

The procedural features - What is desirable?

a) Inclusion

What enables us to describe, compare and evaluate the participatory process in terms of the inclusion that is being promoted? There is no simple answer since there is considerable debate as to what type of inclusion is considered necessary.

The regulations of the Brazilian Health Councils talk of guaranteeing adequate representation of organized civil society; thus, greater inclusion occurs when more civil society organizations are represented. Those arguing for random selection suggest that the more the socio-demographic profile of the participants mirrors that of the population the more inclusive the process.¹ And finally, for those who argue for the need to include the most marginalized, greater inclusion takes place when the neediest are "over represented".

¹ While not the purpose of this discussion, it is important to note, that questions are increasingly being raised about how random "random selection" can be as well as about how randomness is assessed.

When dealing with the inclusiveness of the councils we refer to variations in the socio-demographic, the associative, as well as the political profiles of the councillors. From this starting point we defined 4 sub-variables set out below. The fifth variable relates to the procedures used in the process of selecting councillors.

The PHAC consultations were designed to randomly recruit ordinary citizens that reflected the population of that part of the country and that, overall, reflected a broad range of Canadian citizens. And, particularly in First Nations communities, used some word-of-mouth recruitment.

The socio-demographic variables were the most relevant. At the same time, some attention was given to associational variables which were assessed following the consultations.

Variables	Instruments - Health Councils	Instruments - PHAC
(1) Variation in the socio-demographic profile of the participants	Questionnaire Information about the population's socio-economic profile	Pre-recruitment questionnaire Information about the population's socio-economic profile Participant questionnaire
(2) Party political variation	Questionnaire Information about the party ideological spectrum	Not applicable
(3) "Associationalist" profile of the participants	Questionnaire	Participant questionnaire
(4) Variation in the coverage of the network - organisations mentioned by participants	Questionnaire	Not applicable
(5) Degree of transparency and accountability in the procedures for selection of participants	Rules/ Questionnaires/ Minutes/ participant Observation	Pre-recruitment criteria Post-process evaluation

The **first variable** provides information about the socio-economic profile of participants and consists of four variables - gender, skin colour, income and education. In the case of these variables the indicator aims to measure the distance between the distribution observed in the council and the PHAC dialogues and the "normal" distribution observed in the population. The indicator should allow

us to determine if the profile of participants is closer to that of the relevant population, or if it's above or below the mean.

The **second variable** provides information about the political orientation of the councillors who declared that they were affiliated to or sympathetic towards a political party. The indicator should allow us to identify if the political preferences of the councillors cover the whole political spectrum (from right to left), only the right wing, only the left wing, only centrist parties or a combination of centrist and right or leftist parties. We consider that the greater the spectrum covered the more inclusive the forum.

The **third variable** provides information about the range of associations represented in the councils. We identified 8 types of organization: Neighborhood Association, Community or Philanthropic Association, Participatory Forums, Social Movements, Religious Groups, Civil Rights Groups, Stakeholders Associations and Foundations. Based on previous work we defined that more than 3 of these types of associations included in participatory forum would indicate a more inclusive pattern. We also included non affiliated participants as a category. In the PHAC case, we were not looking at associations represented; rather, we were assessing the extent to which participation in the dialogue process stimulated interest in: talking with friends, colleagues about the dialogues; monitoring media; changing behaviour related to public health; greater community involvement; participating in other public policy related processes.

The **fourth variable** refers to the size of the network of civil society associations connected to the council through the councillors; the greater the number of associations cited by the councillors the more inclusive the forum.

The **fifth variable** refers to the use of strategies to recruit less well-organised groups and how the selection process of the councillors is organized; the more transparent, inclusive and reproducible the procedures adopted the more inclusive the forum.

These variables can be combined in such a way as to produce a single indicator which reflects the degree of inclusion in a specific forum.

From our perspective what is important is to allow further empirical testing concerning how the variables interact. In this sense it is always worth remembering that the values attributed depend on the criteria adopted. A researcher could, for example, construct the indicator in such a way that the value reflects a greater degree of heterogeneity of the participants, while another may attribute this value to situations where there is over-representation of groups traditionally marginalized from politics.

b) Participation

There are many ways to think about the nature of participation and its challenges. These can include:

- Asymmetries in power relationships between the state and participants;
- Potential domination by party political groups
- Adversarial relationships among stakeholders
- Lack of transparency in decision-making (including how public input is used)

We tended to focus on a small number of basic norms of deliberation.² From our perspective what is most important is to allow further empirical testing concerning the ability of specific design features, expressed in terms of rules and procedures, in affecting the dynamics. Do facilitators, well structured meetings, availability of information, mechanisms for displaying and publicizing of the decisions made, etc all contribute to the quality of deliberation?

From this starting point we defined 8 variables set out below.

Variables	Instruments- Health Councils	Instruments - PHAC
(1) Facilitation	Field observation	Questionnaire, overall evaluation
(2) Information	Minutes, discussion analysis	Presentations, participant questionnaire, overall evaluation
(3) Agenda	Minutes, discussion analysis	Participant questionnaire, overall evaluation
(4) Issues in discussion	Minutes, discussion	Notes, discussion analysis
(5) Who speaks?	Minutes, discussion analysis, field observation	Notes, questionnaire, overall evaluation
(6) Environment	Field observation, questionnaires	Notes, questionnaire, overall evaluation

² There are many ways to characterize key characteristics of deliberation: norms of deliberation (Mansbridge et al); ground rules for dialogue (One World, Inc); process integrity (Wyman, Amar and Dale); Public Engagement Principles (NCDD), and many others.

(7) Decision making method	Minutes	Structured deliberation process for coming to common ground, identifying differences, identifying priorities Notes, evaluation, overall evaluation, post-process evaluation
(8) Transparency	Minutes, field observation	Initial presentations, notes, questionnaire, overall evaluation, follow-up communication
(9) Participant satisfaction	Questionnaires	Questionnaires, end of session focus groups, follow-up survey

The **first variable** provides information about strategies used for counteracting asymmetries (or "levelling the playing field"). The indicator shows the presence or absence of a skilled facilitator conducting the sessions. The presence of a skilled facilitator is expected to increase the opportunities for deliberation.

The **second variable** provides information about strategies used for counteracting asymmetries. The indicator allows us to identify if participants have access to good and balanced information that comes from expert and lay sources and if they receive training for capacity development. More diversified sources of information and access to training are expected to be conducive to deliberative processes.

The **third variable** provides information about who sets the agenda. For the health councils, this indicator allows us to identify if it was set by the government representative, the users representatives, union representatives or by a combination of different representatives. For the PHAC consultations, the agenda was set by the convening agency; however, it was designed to allow for participant input and ongoing interaction with experts. A set of more diversified representatives acting in the definition of the agenda is expected to be more conducive to deliberative processes.

The **fourth variable** provides information about the issues under discussion. The indicator allows us to identify the kind of issue being discussed: policy alternatives, specific problems linked to the provision of services, regional problems or procedures linked to the running of the forums. A more balanced combination of specific and local demands with policy debates is expected to better reflect the public interest.

The **fifth variable** provides information about who speaks. The indicator allows us to identify if there is a balance between or clear predominance of the government representatives, the users representatives, the union representatives. A more balanced participation of the various representatives is expected to be conducive to deliberation.

The **sixth variable** provides information about the environment. The indicator allows us to understand if the environment is one of dialogue, apathy or confrontation. It is expected that a greater exchange of arguments coming from different representatives will favour deliberation.

The **seventh variable** provides information about the decision making method. The indicator allows us to identify if quantitative procedures or consensus agreement were used. Consensus agreements are expected to minimize the risk of oppression of the minority by the majority and in this way are considered to favour deliberation.

The **eighth variable** provides information about the transparency of the process. The indicator allows us to identify if the participants inform the population about what is going on and how decisions are made. It is expected that the more transparent and accountable the process the more conducive to deliberation.

The **ninth variable** provides information about participants' satisfaction with the participatory process. It is expected that more satisfied participants reflect a more effective process.

These variables can be combined so as to produce an overall value that provides information about the presence or absence of features that favour participation in a particular forum.

c. Connections

What enables us to describe, compare and evaluate the participatory process in terms of its links with the policy process? Here again there is no simple answer. For some participants, it is important to have an impact on the decision making process, for others it is important to be involved in the decision making process, yet, for others what counts is that the decisions be converted into tangible gains for the participants. For policy makers, there are many influences on decision making and it can be difficult to know - and to articulate - how input from citizens is assessed alongside the many inputs that may be needed.

We believe it is important to guarantee a process of checks and balances between the participatory process and the policy process.

When we talk about connections in relation to the health councils, we are referring to existing connections between the health councils and the policy process that take place in the executive branch and the parliament as well as at the municipal, the state and the national level. We also refer to the connections with other participatory forums, with the health system and with other public and private

organisations. For the PHAC consultations, we are taking a similar approach to connections. In this case, advice from citizens was being considered along with information provided by scientific, legal, economic and ethical experts, technical and logistics experts, as well as advice by stakeholders and international bodies. From this starting point we defined 5 variables set out below.

Variables	Instruments - Health Councils	Instruments - PHAC
(1) Hierarchy: legal structure connection with other arenas- vertical and horizontal delegation	Legislation, in deep interviews	Federal/provincial-territorial agreements, Post-process evaluation
(2) Variation in the range of the network - connections with managers	Legislation, minutes	Post-process evaluation
(3) Variation in the range of the network - connections with politicians	Legislation, minutes	Not applicable
(4) Variation in the range of the network - connections with participatory forums	Legislation, minutes	Not applicable
(5) Variation in the range of the network - connections with other organisations and government bodies	Legislation, minutes and questionnaires	Not applicable

The **first variable** aims to show the degree of institutionalization of the participative arena with respect to its connection with the three spheres of government. The better the role of the forum is defined in the decision making process the greater the chances it will have an impact on policy.

The **following four variables** aim to reveal the degree of connection between the forum and managers, politicians, government bodies, other participatory forums and organizations. It is held that the wider the network the greater the chances the forum will have an impact on policy.

These five variables can be combined to produce an overall value reflecting the degree of connectivity of a specific forum; with respect to the decision making process about policies and the context where it operates.

Finally, the three indicators - inclusiveness, deliberativeness, connections - can be combined to produce a fourth indicator.

For each dimension considered we have $D_i = [\sum^n Q_j] \% N$

D_i = Dimension

Q_j = Questions considered

N = Number of Q_j in D_i

Since each question, Q_j , that enters into the calculation of D_i has specific scale or value, we standardized each question to vary between 0-1.

In the three dimensions we have $D_{total} = [\sum^n D_i] \% 3$

From this point we can analyze the 3 dimensions and related variables and test whether they "act" in the same direction or not.

Research Process

For the health councils, the assumption being assessed is: the simultaneous presence in a given council of 1) a higher degree of pluralism in the forum, 2) a higher degree of citizens participation in council activities, 3) and a higher degree of coordination with other participatory forums and the health policy process - favours a greater circulation of information and deliberation thereby increasing the chances of improving the quality of health services and of innovation with respect to debates about health policies.

For the PHAC consultations, the assumption was: the simultaneous presence over all the consultations of 1) a higher degree of heterogeneity in the sessions, 2) an opportunity to be fully involved in the session (to participate equally, to offer ideas, ask questions, share perspectives), 3) and assurance that input would be seriously considered, with feedback to participants about how it was considered and its impact on the ultimate recommendation - favours greater deliberation and ultimately influences not only the recommendation on the use of antivirals for prevention during an influenza pandemic but also the willingness of government agencies to involve citizens in public policy deliberations.

The research basically consisted of finding means to recognize the different degrees of inclusion, participation and connectivity and relating these features to the ongoing debates and initiatives in the local health system in Port Alegre and in the public policy deliberations in Canada.

The numerical analysis described above was applied to health council data; it has not been assessed in the same way for the PHAC consultations.

Once these dimensions are well described and "captured" it will be possible to see if there is a systematic relation between these variables (ex: more heterogeneity, more information?) and also between them and different "outcomes" (ex. more deliberation and the achievement of decisions that receive more support from the general public).

For further information about the findings, please contact:

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Materials related to the PHAC consultation process can be found online at <http://www.phac-aspc.gc.ca/influenza/antiviralprev-eng.php>