

Negotiating Participation in a Brazilian Health Council

**(NOTE: TITLE CHANGE IN FINAL PUBLICATION – THIS IS
'DEMOCRATISING THE GOVERNANCE OF HEALTH SERVICES')**

Andrea Cornwall

The growing body of work on innovations in participatory governance draws attention to a series of conditions that contribute to making citizen participation meaningful: an overarching political project in which there is explicit ideological commitment to popular participation; legal and constitutional rights to participate; committed bureaucrats; strong and well-organized civil society organizations; and effective institutional designs that include procedures for broad-based civil society representation (Coelho, this volume; Heller 2001; Fung and Wright 2003). This chapter is set in a context where all these factors were in place. It focuses on the municipal health council of Cabo de Santo Agostinho, a small municipality of around 150,000 people in the north-eastern Brazilian state of Pernambuco, and on the motivations, personal histories and experiences of those who were part of Cabo's municipal health council in 2003-5.ⁱ

Drawing on interviews with founding members and those elected to the council for a two-year term in 2003, the council's archives of minutes and participant observation in council meetings over the course of 2003-5, I ask: what brings people to participating in

the health council?ⁱⁱ What visions and versions of participation animate them? What contributions do they see themselves and other participants in the health council making to democratization and the improvement of health services in the municipality? And what challenges do they identify to achieving the potential of the council in democratizing the governance of health services in Cabo?

In doing so, this chapter seeks to address two questions that lie at the heart of debates about the democratizing potential of participatory sphere institutions. The first is whether such spaces can expand and deepen democracy by serving as crucibles for the creation of new political subjects and subjectivities and bring about shifts in identification from clients and beneficiaries of favours to citizens with rights (Tatagiba 2002; Cornwall 2004). And the second is whether these spaces can serve to promote new forms of communication, collaboration and understanding between citizens and the state, that can begin to transform residual political culture and redress inequalities of power (Abers 2001; Heller 2001; Fung and Wright 2003; Gaventa 2004). I begin by setting the context for the analysis that follows, with the story of the institutionalization of Cabo's municipal health council. I go on to examine the narratives of representatives of health service users, health workers and the municipal government and what they have to say about their own participation in the council and what they see as its principal challenges. I conclude by reflecting on what the perspectives of those who participate in it tell us about the challenge of democratizing democracy through participatory sphere institutions.

Spaces for Change?

The ambitious democratic innovation of institutionalizing citizen oversight and engagement in framing health policies in a system of health councils and conferences at each tier of government was a conquest of Brazil's radical health reform movement of the 1970s and 1980s, the *movimento sanitaria*. A key demand of this movement was for *controle social* (literally 'social control'), for a role for citizens and their organizations in holding government to account and in shaping the governance of health services through active engagement in deliberation over policies, plans, programmes and priorities. The ideals embodied in the principle of *controle social* were given shape in the 1988 "Citizens' Constitution" and formalized in the Basic Health Law of 1990, which made the existence of deliberative health councils and their approval of accounts, budgets and health plans a condition for the transfer of federal funds to state and municipal governments (Carvalho 1998). The health councils are designated as deliberative, rather than consultative. It is worth pointing out that the term 'deliberative' - *deliberativo* - carries a different meaning in this context to that used in writings on deliberative democracy in the US and Europe (Bohman and Rehg 1997; Habermas 1996; Fung and Wright 2003): while Habermasian deliberation implies a search for communicative consensus, the Brazilian notion emphasises binding decisions which may be reached without consensus.ⁱⁱⁱ

The health councils are mandated to track the fulfilment of the outcomes of health conferences held every two years at municipal level and every four years at national

level, approve health budgets and plans, shape emergent public policies and monitor expenditure. There are now some 5500 health councils across Brazil's 26 states and 5656 municipalities (Coelho 2004), and the councils and conferences have opened space for several hundred thousand Brazilian citizens to participate in deliberation over health policy. Representation is stipulated by law to follow a principle of parity between governmental and civil society representatives: 50 percent of seats are set aside for user representatives, 25 percent for health workers and the remaining 25 percent for political appointees to posts in health service management in local government and representatives of contracted-out private health services. Beyond this requirement, municipalities and states are advised to enable the representation of particular interest groups, such as disabled people or people living with HIV/AIDS, and those who work with particularly vulnerable groups. Each municipal health council has, however, discretion over how the rules of representation are formulated and over their own internal regulations.

The growing literature on Brazil's health councils paints a mixed picture of the success of these institutions in democratizing the governance of health services (see Coelho, this volume). Set in a context where traces of authoritarian and clientelistic political culture, high levels of bureaucratization, and variable degrees of civic organization complicate the democratizing aspiration of *controle social*, few participatory councils appear to have achieved sufficient independence from established political interests and sufficient citizen competence in relation to the technical, managerial and financial aspects of the

health system to serve as genuinely deliberative spaces. Three principal dilemmas surface from these analyses. The first is that of autonomy, and the extent to which the councils are able to effectively hold to account a state with which its members have multiple and complex linkages (Gonçalves 1999; Hayes 2004). The second is that of representation, and the extent to which the councils genuinely reflect the diversity of social actors and interests (Tatagiba 2002; Galvanezzi 2003; Coelho 2004). And the third is that of embedded inequalities of knowledge and power between citizen representatives and health workers and managers (Rodrigues dos Santos 2000; Del Voz and Pinheiro 1998; Avila Viana 1998). The democratic legitimacy as well as the democratizing potential of the councils depends on addressing these issues. How do these dilemmas for democracy play out in the case of Cabo? And what lessons might be learnt from the perspectives and experiences of its councillors?

Creating Cabo's Municipal Health Council

Cabo is, in many respects, a microcosm of the Brazilian north-east, with a largely urban population, high levels of poverty, violence and unemployment, and a mix of the infectious diseases and malnutrition associated with deprivation and the chronic-degenerative complaints characteristic of modern urban societies. Over the period 1997-2004, striking improvements in health outcomes were achieved in Cabo which can be directly attributed to successful reforms in the health system. Investment by senior bureaucrats and active engagement by health workers and well-organized civil society organizations have contributed to making Cabo's Municipal Health Council one of the

most successful in the region. In what follows, I set the scene for analysing the perspectives of those who participate in the council over the period 2003-5 with a brief account of the council's history.^{iv}

Cabo's *Conselho Municipal de Saúde* (health council, municipal health council) was inaugurated in 1994, as regulations requiring the establishment of councils as a prerequisite for receiving federal health monies came into force. It was born at a time of transition from a progressive municipal government to a right-wing *Partido da Frente Liberal* (PFL) administration with scant interest in popular participation. Over the period 1994-1997, the council functioned in name but was widely perceived as being packed with government appointees and used to rubber stamp the decisions they wanted to see made. Intense pressure from a coalition that brought together progressive elements from the Catholic church, the feminist movement, unions and neighbourhood associations representing the *movimento popular* (popular movement), sought to force the PFL government to hold a health conference and fulfil its statutory obligations to open democratic space for the deliberation of health policy.

It was not until 1998, however, that the council began to gain institutional vitality, with the election in late 1997 of the "post-communist" *Partido Popular Socialista* (PPS), a party with close connections with social movements and a commitment to popular participation, into municipal government. To revitalise Cabo's ailing health system, the new PPS mayor, Elias Gomes, brought in an energetic health reformer, Cláudio Duarte. A radical democrat, one of the founding members of the *Partido dos Trabalhadores* (PT,

Workers' Party) in the region, Duarte brought to Cabo a passionate commitment to enhancing public involvement in health policy so as to create more accountable and responsive local government. Like many medics of his generation, Duarte was a veteran of the radical public health movement, the *movimento sanitarista*. The process of democratizing Cabo's health system that Duarte began was to continue over the years that followed.

At the 3rd Municipal Health Conference, in 1998, a new cohort of health councillors was elected. Among the ten health user representatives was Silvia Cordeiro, the leader of the established Cabo-based feminist NGO, *Centro das Mulheres do Cabo*. A doctor, also with a history in the *movimento sanitarista*, Silvia was to become, in 2000, following the 4th Municipal Health Conference, the health council's first civil society president. The process of constructing a viable democratic space was one that absorbed health council members in intense debate over the months that followed Silvia's election as president. From norms of representation that would permit optimum inclusiveness of the diversity of Cabo's social actors and constituencies, to mechanisms for decision-making, to establishing sub-committees to undertake tasks like inspecting clinics and examining budgets, the task of institution-building was a considerable one. In a context where it is more common for these institutions to be dominated by political interests within local government, rather than actively taken up as political spaces by citizen groups, there were few precedents to draw on.

The 5th Municipal Health Conference in 2003 saw all that had been planned come to fruition. A series of pre-conferences across the municipality expanded participation in deliberation over health policy, gathering locality-specific demands and priorities. From each, delegates were elected to the municipal health conference. Debates raged, propositions and suggestions for reforms were placed on the table, 183 resolutions were passed, and delegates voted new health service user and health worker representatives onto the municipal health council. The twenty health service users elected as title-holders and substitutes represented a diversity of Cabo's poorer citizens; most were lower middle class or working class. Amongst the title-holders, men and women were in equal proportions, with ages ranging from early twenties to late sixties. Three councillors had only primary level education, and only one had studied beyond secondary school. Four of them were unemployed, and a number of others worked part-time or for the organizations represented in the council, which made their attendance at afternoon meetings possible. Those with connections to leftist political parties, principally the PT, were in the majority. Most had no previous experience of engagement with the health sector, and little technical knowledge of the health system, budgeting or planning.

At its inaugural meeting, the council swiftly moved to elect a president. Defeating the Municipal Health Secretary, the president elect, a PT member and representative of the Movement of Christian Workers, Adson da Silva, was, again, a health service user representative. And he epitomised the democratizing potential of these spaces: black,

from a lower-class background and with primary level formal education. Under Sylvia's leadership, the council had achieved some measure of functionality and, through collaboration and consensus-seeking with the municipal health secretariat, had begun to engage in shaping health policy. Adson's mission focused on another dimension of *controle social*, that of *fiscalização*, auditing and ensuring probity in government spending. As leaders, they could not have been more dissimilar; in many respects, as I return to reflect, they manifested the very polarities inherent in the ideal of *controle social*.

The everyday business of the health council ranges from listening to presentations by organizations who deliver services, to being informed about the plans of the municipal health secretariat, to discussing specific incidents that have been reported by members of the public concerning the provision of health services. Meetings last around three hours, and are held monthly. There is little deliberation in the Habermassian sense on matters of health policy; health plans are prepared by the government, without any attempt to engage the participation of health councillors in their formulation, and presented to the council for their approval, along with periodic presentations of the accounts. Minutes of meetings and participant observation revealed heated debates about procedure, and combative exchanges between the more vocal of the health service user and health worker representatives and the Secretary of Health. Over the course of 2004-5, much of the substance of these exchanges concerned the presentation of the municipal accounts.

Participation in Cabo's Health Council

What did “participation” mean to the health councillors who became part of the council in 2003? Why had they got involved? What did being part of the council do for them - as people, as professionals, as political actors? And, from the diversity of backgrounds, passions and positionalities that brought them into the council, what did they make of the council’s potential as a participatory governance institution? In what follows, I consider the perspectives of the three distinctive segments that constitute the council on their and others’ engagement in the health council: health service users, health workers and health managers.

Health service users

A mix of missions, personal as much as political, brought user representatives to the council. Some were seasoned social actors, with backgrounds in social movements, a strong affiliation to leftist parties and experience in community mobilization. It is these kinds of actors who might be expected to extend their attempts to influence local politics and policy into participatory sphere institutions; and they were conspicuously more vocal in the council’s debates. Others were completely new to this arena, having got involved because of personal experiences with the health system that enraged and engaged them, in search of career opportunities and new experiences, a wish to ensure continued financial support for their organizations from the municipal government and a desire to do good for their communities. Others still entered the councils as representatives of organizations who had previously had a representative on the council, stepping into the shoes of a more experienced leader.

Most of the organizations represented on the council had links of some kind with the municipal government.^v Many of the neighbourhood associations were established in the early-mid 1980s, during a progressive administration in the final years of the military dictatorship and received *subvenções* (literally subsidies) from the municipal government for their activities; several of the other organizations, most of whom were established in the late 1990s, had *convenios* (contracts for services) with the government. These connections motivated engagement; they also posed a challenge for the autonomy of these organizations, and the council itself, from the municipal government. As one community activist charged: 'those who don't agree are today those without *subvenções*'.

Health service user representatives' accounts of the purpose of the council varied from those who saw its primary role as that of holding the state to account and enforcing the right to health, to those who saw a broader role for the council in defining public policies, developing projects and engaging communities in improving health services (Cordeiro, Cornwall and Delgado, 2004). These different purposes evoke some of the paradoxes of civil society engagement in participatory sphere institutions, and the tension between the close, collaborative relationship with the authorities that may be needed to facilitate popular participation in shaping health policies and in developing joint projects, and the distance required to elicit accountability. Divergent understandings of the purpose of the council also shape perceptions of what the everyday business of the council should be. For those concerned with accountability, time spent grilling officials over spending is time well spent; for those anxious to see

more discussion about strategic health priorities, there was a certain measure of frustration over the turn the council had come to take in recent times.

What did participating in the council mean to its health service user representatives on a personal level? From activists with years of experience to those completely new to this kind of engagement, their own participation was often described in terms of *crescimento* (growing), gaining experiences that they might otherwise never have had: opportunities to travel beyond the borders of the municipality and the state; to mix with new people, hear how things were being done in other parts of the country, to broaden their horizons; to go on courses, to learn things that they hadn't thought they'd ever understand; to gain knowledge, skills and understanding that they could make use of personally and put to the service of their communities. Yet sceptical views were voiced by some on the participation of some of their fellow health service users. Among the most vocal and the most silent were those perceived by fellow representatives to see the council as a springboard for other opportunities - jobs in the municipal government, seats as elected councillors, and greater prominence, financing and prestige for their own organizations.

Resonating with Castello, Gurza Lavalle and Houtzager's findings in this volume and elsewhere (Houtzager, Gurza Lavalle and Acharya, 2003), many user representatives saw themselves as intermediaries. Their narratives captured a variety of intermediary roles. For one neighbourhood association representative, a librarian who had come to be involved in the politics of health through indignation at the treatment her daughter had

received when she fell sick, user representatives were advocates for those who might know that they have rights but lacked the courage, confidence or knowledge to articulate their demands. She spoke of the fears people have - of not speaking properly and being ignored, of arriving in old and shabby clothes and having the doors barred to them - and of the need for people like herself who can go to the streets to convince them that 'you can lift your head, because you have the same rights as me'.

For a number of other neighbourhood association representatives, being on the council enabled them to be intermediaries for information about new programmes or projects that could benefit their communities and conduits who could bring their communities' experiences and demands for improvements in service delivery to the attention of the authorities. In this intermediary role, health councillors parallel the responsibilities of elected councillors; and they have the potential to actively undermine clientelistic politicians' claims to have personally secured health improvements in the locality and their uses of health as a favour. A representative of the radical Catholic church, with long years of involvement in neighbourhood activism, described how much closer people like him were to communities and the part they could play in changing political culture at the local level by letting people know 'that health is a right, not a favour'. With echoes of Cohen and Sabel's (1997) vision of 'directly-deliberative polyarchy', he also talked of the council as a space for people like him to bring their knowledge of what was being said on the street and experiences of poor health services directly into the ambit of those responsible for provision.

Amongst those with backgrounds in social movement activism, the council was talked of as a space for democracy - a 'school for citizenship', as one put it - that should embody and promote new and different practices from the authoritarianism and clientelism that characterised politics in other spaces. They used the language of *cidadania* (citizenship) to talk about the obligation of the state to deliver on social rights; their vision of the council was as a space for stimulating new expressions of *cidadania* that could extend to society at large - a narrative that has been promoted by Brazilian social movements in the post-dictatorship era (Dagnino 2005). *Cidadania* also framed, for them, a sense of indignation at the lack of respect for their rights by the government. 'We are all citizens', one health service user representative said, 'but the municipal government doesn't respect this. Look at the queues in our clinics, the lack of medicines, the lack of doctors. We deserve more than this'.

The majority of health service user representatives were affiliated to leftist political parties, predominantly the PT.^{vi} Frictions within the council were often attributed to what people called the 'partyization' of debates.^{vii} For party activists, the council was in many respects an extension of other available political spaces. They brought into the council not only political positions - such as the principled opposition to the contracting-out of services (*tercerização*) that united health service users, health workers and managers (Cordeiro, Cornwall and Delgado 2004) - but also political postures and conduct learnt in party meetings. One party activist who had been involved with the council since the outset, alternating between being a representative and speaking from

the floor as a member of the public, spoke of the delight he took in wrestling directly with the government and denounce unfairness and undemocratic practice, using tactics and a style of politics learnt in the party. For him, the council was a more productive political space than those of formal politics: 'I would never want to be a *vereador* [elected local government councillor]', he told me, 'here is where I belong'. Energetic in promoting local health councils, he sketched out a capillary vision of democratic institutions seeded in multiple sites that broadened the scope and reach of politics by creating new and more qualified leaders at the local level, that would create 'didactic' waves that begin at this level and ripple out from there to the municipal, state and federal level, creating a new, more just, political system.

Continuities with the formal political arena emerged in other visions of the council's role. They arose in critiques of those health managers who saw the council simply as an extension of the executive. And these continuities were central to the perspective of the health council president, who described the council as 'an *instancia* [instance] of government.. that exists to contribute to government'. His style of engagement, learnt from hours of watching elected councillors battling in the municipal assembly, was that of insistent questioning, hounding the government representatives for answers on questions of accountability. With repeated recourse to the law, and a taste for formal politics that had led to an unsuccessful attempt at election as a *vereador*, his view of the council was less as somewhere where new norms and policies are deliberated than an institution mandated to ensure accountable implementation. A sheaf of letters

demanding information and follow-up on promised actions in the council's files attest to the seriousness with which he took this duty.

Contrasting visions of the council's purpose and a complex mix of motivations, expectations and understandings of what it meant to be a 'health service user representative' emerge from this account. As Morita (2002) argues, while the category '*usuário*' (health service user) may be seen as an undifferentiated 'them' by health managers, considerable diversity exists within this category; networks, allegiances and identifications span the different segments of the council, creating the potential for conflict as for collaboration. Three preoccupations emerged from health service users' analyses of the shortcomings of the council: the overt politicization of the council; the council's lack of effective independence, a factor both of inadequate resourcing and the dependencies of many of its members on financial support and employment from the municipal government; and the gap between what health managers say about participation and what they actually do. As an NGO leader, with years of grassroots experience, reflected: 'in the space of the council, the government listens and the councillors grow as citizens. But to do this the councillors need to be listened to and respected by the municipal government.' It was this, he felt, that was the biggest brake on the council's role in facilitating *controle social*.

Health Workers

A quarter of the seats in the council are allocated to health workers, who are also selected at the Municipal Health Conference. As a primary care doctor, with years of

experience in Cabo and a political history within the PT pointed out, health workers are a very heterogeneous group; they are difficult to mobilise as a group in part because of the hierarchical nature of the health system and the nature of their contracts. Many are employed on temporary contracts; fearing dismissal for speaking out, they feel keenly the need to be, as one health worker put it, 'diplomatic'.

Health workers occupy positions which many of them recognize as ambiguous. They may be perceived by health bureaucrats and citizens alike as part of the government, to which they are expected to demonstrate loyalty. Yet, as frontline health workers -- doctors in community clinics, auxiliary nurses and community health workers -- they see at first hand some of the deficiencies in the health system, and have other loyalties, to patients and to the communities where they work. And they are, as an auxiliary nurse pointed out, also citizens and able to exercise their own independent judgement: 'As I explained once here in the Council, what everyone thinks in their own minds is theirs, it's not the government who teaches us to think'.

One of the PPS administration's most impressive achievements include a sharp reduction in the infant mortality rate, from 42/1000 to 18/1000 over the course of their two terms of municipal administration. This has been due, in no small part, to the introduction of a national primary health care programme, the *Programa Saúde e Família* (Family Health Programme, now *Saúde em Casa*, 'Health at Home'). This programme led to the recruitment of hundreds of community health workers (*Agentes de Saúde*) who are from the communities they serve, and work to monitor the health of the households in

their area, introducing preventive health measures and referring patients to clinics if sicknesses develop. As Tandler (1997) describes for the nearby state of Ceará, these community health workers bring to their work a commitment to their communities' health, relationships of trust with communities that create internal pressures for accountability and a real sense of pride in their achievements. In Cabo, this sense of pride and the commitment it engenders is palpable.

One young community health worker, recruited as part of the *Programa Família e Saúde*, spoke with animation of how much being involved in the council meant to her. She saw her participation as a way of valuing the role of community health workers. For her, the council was fundamental to effective *controle social*, something to which she was politically committed as a PT activist. It was also a space into which she could bring her passion for politics. She told me

I've been participating like this since I was twelve. I never liked playing with dolls, I wanted to be involved in these kinds of discussions. My daughter, who is five, is just the same. She leaflets with me, she knows what a strike is, she prefers talking with adults to playing with dolls.

For another young community health worker, her involvement began at a pre-conference in her locality: it gave her not only a taste of participation, but the confidence to go forward to the municipal level. What she valued most about the health council is that it provided, as she put it, the opportunity for bringing together 'different worlds'; and for giving health workers, as well as citizens, an idea of what makes health managers tick. It was also the experience of participating at the local level, in one of the

more successful local health councils, that brought another health worker representative, an auxiliary nurse, to the health council. She spoke of the exhilaration of having been part of successful mobilization, together with the community, to make demands on the municipal government for waste removal, and the opportunity she saw for being an intermediary between the community she served and the powers that be. She took great pride in being someone people in her community felt they could count on. For her

We come to learn, to discuss, to grow as people -- not just as a professional, but as a *person* -- and in the case of user representatives, they will pass this onto their community, when someone comes criticizing certain services, they'll know how to explain that service.

Striking in their dedication, never missing a meeting and participating actively in sub-committees, lower-level health workers were often reserved in council meetings. Health service hierarchies quickly reasserted themselves in this space, a factor less of the technical nature of issues under discussion than the inequalities in positional power of representatives from this sector and the insecurity of contractual work. For several of the health workers, like a number of the health service users, one of the main challenges the council faced was the attitudes and behaviour of the health managers. In the analysis of the primary care doctor cited earlier, the root of the problem is that health managers find it hard to see themselves as partners with the council: 'They come there with the stance of the boss, the stance of the manager, and not the stance of the councillor'. What is needed, she argued, is for them to begin sharing problems and working together with councillors to find solutions: 'they treat the council as if they really didn't know

anything'. They are missing a trick, she noted. The council could be a help rather than a hindrance, serving in yet another intermediary role: to defend health managers to communities and to the municipal authorities.

Health workers occupy multiple subject-positions, with identifications as citizens, and as members of communities, churches and political parties, as workers and as professionals. This makes for complexity in terms of their positionality and allegiances. I witnessed several occasions when small groups of health workers and health service users, linked by party affiliation or a shared commitment to an issue of policy or procedure, strategised together outside meetings. Yet as professionals, they were also sometimes frustrated by health service users' complaints and demands, knowing full well just how limited the resources they and their colleagues had at their disposal actually were. Health workers, like health service users, talked of how they had grown through gaining opportunities to acquire new knowledge, broaden their horizons and extend their networks through engagement in the councils. Their roles as intermediaries, and the effects that being in the council have on them as professionals and as people deserves greater attention than it has been given to date.

Managers

Unlike other members of the council, those representing the government occupy seats by virtue of their positions.^{viii} Health service managers are political appointees. They enter office with values shaped by their party political affiliation as well as their medical training. And they are keenly aware of the political fallout that failures to deliver on

health improvements might produce. Representing the municipal government on the health council are those with '*cargos de comando*' (literally 'positions of command') in the health service: the director of the largest municipal hospital, the director of primary care, the director of public health and the municipal health secretary. They are, in effect, the highest officials the municipality has to offer: and the disparities in knowledge and power between them and most, if not all, other councillors are acute.

How do these officials view popular participation in the councils? How do they see their own role in promoting civic engagement and facilitating *controle social*? A number of the senior health managers I interviewed had been student activists in the *movimento sanitaria*. The passion this had given them for popular participation reverberated in their accounts of the council as a political as well as a management space. Their narratives were often more overtly politicised than those of health worker or user representatives, conveying in often eloquent terms their ideological commitment to *controle social*. They saw the presence of senior bureaucrats in the council as essential for its viability; and engagement with social movements as vital for its legitimacy. As the Municipal Health Secretary put it

The orientation of this government is that it's necessary to listen to the population, to listen to social movements, and that they are the fount of orientation as to how health policies should be implanted and implemented... If you don't have the government there to discuss, you don't have decision-making power, influence, deliberation [i.e. decision-making] together with the government.

As I note earlier, the incoming PPS administration of 1997 brought a dynamic health reformer, Cláudio Duarte, to Cabo to revitalise the health system. Reflecting on was

needed to make the councils viable institutions for *controle social*, Duarte identified a number of factors. These included the importance of explicit recognition by the municipal government of the importance of the council, backed with material resources, including the provision of infrastructure; a style of management 'in which information should always be available to councillors even if it is largely technical and they may not fully understand it' and regular meetings attended by senior local government staff who signalled their desire to act on the council's decisions. He deemed essential clear procedures regulating representation and the conduct of meetings. For user representatives to be effective in this space, he argued, they need to be trained so as to avoid simplistic solutions and excessive medicalization.

For Duarte, the council was a space in which '*convivencia constructiva*' -- 'constructive co-existence' -- could be achieved through transparency and commitment on the part of government representatives, which would convince citizens of their seriousness. He was also only too aware of the disabling effects of residual political culture, and tensions between managers and citizens over the scope the council might have for deciding on issues that managers might see as more properly under their jurisdiction. He emphasised the importance of experiential learning, of exchanges of knowledge and experience between councillors, and of municipal health conferences as an 'educative moment'. And he spoke of the need to set the councils in time, as nascent institutions in which new forms of leadership and new democratic practices were emerging through

processes that were beginning to change residual cultures of bureaucratization, clientelism and authoritarianism in local government.

Duarte's successors were described to me by health service users as weaker leaders, who were less effectual in following through on the promise of popular participation. One of them, Rivanildo Santana was, however, described to me as 'inspiring'. I sought him out at the busy Recife maternity hospital that he now directs. Echoing Duarte's sentiments on the importance of popular participation, he emphasised the importance of the council being seen not as part of the government, but as an institution in its own right: a *partner*. To achieve this independence, he argued, the council needs certain institutional conditions that guarantee continuity: secretarial assistance, archives, a computer to register organizations, its own meeting space. It also needs to serve as a space to generate new leaders who, over time, come to secure the council's independence. For this, the municipal health conference is essential: 'I love the conferences because it is there that new leaders arise... new faces'. He recognized the extent to which state reluctance to give up control over decision-making limited the scope of the council:

The council is defined as a consultative institution and as a deliberative institution. In my experience, the council has been not been very deliberative... sometimes it stops being deliberative because decisions have already been made and the institution with power wants to execute them.

For the senior health managers who took up positions in the 2003-5 council, or were called upon to explain themselves at council meetings, *controle social* offered a bridge into the community. One spoke of how the councils are an opportunity for government

to learn from the 'collective intelligence of society' by bringing together different visions of how services might be managed and implemented. 'It's an opportunity', she said, 'for people to grow, to deepen democracy, to create a debate -- in this city, where we have such diversity'. Motivation for citizens to participate came, in the view of another, from the relationship people have with health, as something that 'stirs passions and polemic because it touches people's very skin, sensibility and pain', which helps organize and motivate popular participation, and which in turn creates 'a consciousness that they are citizens'. Difficult as it was to be on the receiving end of demands and complaints, all recognized how vital this was to fulfilling the promise of *controle social* and improving health services.

Issues of representation loomed large in health service managers' narratives. Two concerns predominated: the extent to which the councils create a generation of leaders who begin to behave like elected representatives and seek to maintain their foothold, weakening the broader democratizing effects of constant renovation and capacity building of user representatives; and the fragility of links between those who speak for communities and those they purportedly serve, which translates into a failure to disseminate information about programmes and policies, and to facilitate discussion at community level about priorities and concerns for health. One senior manager reflected:

It preoccupies me, that some people become militants and they are always the representative of the organization and of the community, they come to assume a role, a profile, a personality that seems that they dominate the situation and don't respond to their bases. Then there's the problem of not renewing representation in the council. This is also something that training should address.

The answer for the managers consistently lay in training. Yet this is far from a magic bullet. Training is all very well, one health manager argued, but the council is constantly changing: new people arrive, replacing those whose non-attendance at meetings causes their expulsion, or new association leaders, 'and you're at square one again'. Constrained by available time, as well as finance, densely packed training courses tend to focus on the main priorities: understanding budgets and accounts and gaining an elementary grasp of the health system.

Managers' accounts reveal a tension between their politicized vision of public health and the realities of what health service users have to bring to realizing it. One senior manager noted how disorganized and ill-informed user representatives tended to be, and how their lack of knowledge and parochial preoccupations detracted from the real business at hand: running an effective health service. But there is equally a recognition that the kinds of changes that are needed go much deeper than providing health service users with information about how the health system works. As one senior manager observed

Changing behaviour isn't something simple, easy and linear. It implies processes, that go backwards and forwards... you can't change someone's behaviour just through information, only by raising questions that can change consciousness... and it's not only through conscious processes, educative processes, but in many cases also through processes that can be painful, that affect people's very sensibility.

The challenge of orientating and informing health service users is enormous, she argued: not just on their role in *contrôle social*, but on how to carry it out effectively. It is too easy

to get stuck on the basics, without any discussion of strategic issues that can advance the health system: she gave as an example the extent to which the presentation of the municipal accounts had dominated meetings over the last year.

Amidst a recognition that the council had achieved some measure of maturity, there was also some ambivalence amongst managers about how far it could go. Pressurized by the need to move plans and budgets through the system as quickly as possible, they were only too aware of the tension between efficiency and inclusive deliberation (Warren 2000). And, as several of them observed, if managers were to respond only to health service users' demands, then their agenda for improving health through extending preventive services might well be scuppered. A very real tension arises over where the boundaries of appropriate expertise come to be placed. Yet for citizens, being told that there were complexities that they would not be able to grasp and technical decisions that needed to be made reaffirms suspicions that managers have no desire to cede control. I witnessed one such exchange in a health council meeting. A senior manager commented that the matter at hand was a technical issue that he would not elaborate on as the councillors would not understand it. One councillor piped up: 'try us, you may be surprised... and if we don't understand, we will find someone to teach us so that we will be able to understand'.

The health managers' ideological commitment to *contrôle social* sits awkwardly alongside the defensiveness I witnessed in meetings in the face of irate health service users, and the complaints of health service users and health workers about managers resorting to

technocratic obfuscation, failing to provide adequate information and withholding the resources needed to guarantee the functionality of the council. Even though health managers all emphasized the importance of timely access to information and material support, proposals were often rushed through with little scope for debate, to meet federal deadlines; although, on several occasions, the council demanded extraordinary meetings to discuss them in more depth. And despite the allocation of a budget for the council, the fact that the purse strings were held by the Secretary of Health who could grant or refuse requests for travel or materials and required elaborate bureaucracy to access, limited the council's independence.

Democratizing the governance of health service calls for more than providing the training, resources and support that make popular participation viable, and inviting civil society organizations to participate. As several health managers reflected, the state has a role to play in developing what one described as 'political consciousness, critical consciousness and consciousness of being a citizen' amongst those whom it serves: provoking, in so doing, the cultural changes needed to engage them in *controle social*. Yet, as health service users and workers pointed out, making *controle social* effective also calls for state actors to relinquish some of their power and control, open the black-boxed 'technical' domain to citizen engagement, and recognize that 'constructive co-existence' requires not only ideological commitment, but also real changes in their own attitudes and conduct. For all managers' talk about training, they themselves fail to attend training courses; some training might be in order, health service users and workers

pointed out, to teach them to listen and respect health service users more. The political will was certainly there: it was, perhaps, as a number of health service users and health workers commented, that for all the will in the world bureaucrats used to making decisions and running the show have not yet acquired the skills with which to participate as partners.

Conclusion

At a participatory workshop in April 2004, Silvia Cordeiro posed the question to the health service users and health workers we'd gathered together: had the council succeeded in realizing the promise of *controle social*? Their answer was, resoundingly, that yes, significant strides forward had been made; but that the struggle for *controle social* continues. It is in that process of struggling that new identities and identifications have come to be shaped among those who have entered the arena of municipal policy and politics for the first time, along with new awareness of their rights, new-found confidence and new knowledge. For more experienced activists, the council has offered opportunities for new networks and connections within and beyond the municipality, as well as an arena in which to negotiate demands directly with the government -- whether for better services, or for accountability. As a 'school for citizenship', the health council has taught them many lessons, affirming that citizenship is something actively demanded rather than bestowed (Kabeer 2005). Frustrations abounded in their narratives, but there was a tangible sense that being part of the council was, for many of its health service users and health worker members, a rewarding experience that

enriched them personally and professionally (cf. Baocchi 2001). These findings echo those of Labra and St Aubyn (2002) who talk of the 'virtuous circle' of citizen engagement and the role of the councils in making what Mansbridge (1999) has called 'better citizens'.

The promise of participatory governance lies well beyond the small numbers of people who come to participate in institutions such as health councils. Health service user perspectives on what citizen participation could contribute to democracy signalled some of this promise. The capillary effects of the expansion of democratic spaces at the local level, described by one of the health service users, hold the potential of repopulating politics with new energy, new faces, new practices. That in some parts of the municipality user engagement is reconfiguring representation at the community level, undermining politicians who use health as a favour, and creating new forms of intermediation that work to enhance awareness of rights, suggests that slowly some transformation in political culture is happening, although old ways still retain their hold.

The political dynamics of the council invoke another paradox, captured in the tension between, as Duarte put it, 'constructive co-existence' and the task of *fiscalizar*, that of monitoring the government and holding it to account. Constructive co-existence, like communicative consensus, requires a degree of collaboration and willingness to shift positions that the overt politicization of the council renders difficult. An important dimension of *controle social* is that of accountability; and holding government to account calls for sufficient autonomy for user representatives and health workers to be free to

probe into financial irregularities and bring to the council's attention shortcomings in implementing policies, decisions or programmes. The quest for accountability calls for a style of interaction that is very different from that required for constructing joint projects or deciding together on policy issues: it may demand a more confrontational stance, one that is familiar to the social movement and party activists who bring political practices from other spaces into that of the council. It also lays bare the implications of the relations of power between health service user and worker councillors and the managers who disburse the funds and issue the contracts.

Building a culture of 'constructive co-existence' calls for styles of engagement that are more deliberative, in the Habermasian sense of the word. These sit uneasily with the kind of passionate debates, entrenched positions and political bargains and alliances that animate the everyday politics of participation within the council. It is these debates, positions, bargains and alliances that constitute the life of the council as a political institution; they may be the bane of its existence for some, but they are its lifeblood for others. Continuities with the culture of politics in the formal political arena were more than evident in the council's internal dynamics, from combative styles of exchange, to the use of the vote rather than attempts to arrive at consensus, to notions of representation held and contested by the different actors involved. It is no coincidence that many of those involved in the council have connections with political parties in a context in which participation as a political project is widely subscribed to by the left (cf.

Heller 2001; Gurza Lavalle et al. 2005). The vision of expanding democracy to the grassroots through new democratic spaces and the strategy of seeking close links with social movements are, after all, hallmarks of the two most influential leftist parties in Cabo's politics during this period, the PPS and the PT.

Controle social is inherently political and inevitably politicized. The dimensions and dynamics of participation to which I draw attention here have implications for both the construction of political subjectivities and the creation of new relationships between citizens and the state, with which I began this chapter. These emerge most clearly in perspectives on what needed to change in order for the council to become more effective. For health service users and health workers alike, it was the reluctance of the managers to realize their part of the *controle social* bargain and concede some of their managerial powers to the council that was the brake on further progress. Managers' concerns about gatekeeping and the low rotation of representatives (cf. Cohn 2003) raised other questions: about democratic legitimacy and the extent to which political practices of clientelism and authoritarianism were being reproduced within and by civil society. Civil society emerges in their view less as the motor of democratization than a site in which residual political culture is very much alive; for them, it was a task for the progressive state to democratize its *uncivil* tendencies (cf. Chandoke 2003), educate citizens about their rights and teach them how to participate.

The question then arises: who is democratizing whom? As long as managers see the councils as spaces to which they are doing the 'inviting', the council's democratizing

effects might fail to rub off on *them*, leaving other dimensions of entrenched political culture -- not least the exercise of technical and bureaucratic power -- intact. State actors have an enormously important role in ensuring the viability and legitimacy of participatory sphere institutions (Abers 2001; Coelho, this volume). State support is critical if these institutions are to achieve their promise, whether through provision of resources to guarantee the councils' functionality or training to equip citizens with the capabilities to participate and facilitate the emergence of new grassroots leaders (Daniel 2000; Gohn 2002). And 'champions of change' within state bureaucracies, like Cláudio Duarte, can make a huge difference (Fox 1996). What this chapter suggests is that realizing *controle social* involves more than activating citizens; what is also needed is to explore the reciprocal effects of participatory governance on those who govern in order to address how those on this other 'side of the equation' (Gaventa 2004) might better contribute to achieving its democratizing potential.

Acknowledgements

I am profoundly grateful to Silvia Cordeiro for all that I learnt from her about Cabo and the Municipal Health Council and for all the support she and the *Centro das Mulheres do Cabo* gave me, and Nelson Giordano Delgado, with whom I conducted several of the interviews I draw on here. I owe Surama Lins a huge debt for all her help, as I do

members of the health council. Many thanks too to Lucy Hayes for her research assistance and to Alex Shankland, Mark Robinson, John Gaventa and David Kahane for their comments.

References

Abers, R. (2001) *Inventing Local Democracy: Grassroots Politics in Brazil*, Westview: Boulder.

Ávila Viana, A.L. (1998) 'Desenho, Modo de Operação e Representação de Interesses- do Sistema Municipal de Saude- e os Conselhos de Saúde' in *Ciência e Saúde Coletiva*, Vol. 3 (1): 20-22.

Avritzer, L. (2002) *Democracy and the Public Space in Latin America*, Princeton: Princeton University Press.

Baocchi, G. (2001) 'Participation, Activism, and Politics: The Porto Alegre Experiment and Deliberative Democratic Theory', *Politics and Society*: 29(1):43-72.

Bowman, J. and W. Rehg (1997) *Deliberative Democracy: Essays on Reason and Politics*, Cambridge: MIT Press.

Carvalho, A. I. de (1998) 'Os Conselhos de Saúde, Participação Social e Reforma do Estado' in *Ciência e Saúde Coletiva*, Vol. 3(1): 23-25.

Chandoke, N. (2003) *The Concepts of Civil Society*, Delhi: Oxford University Press.

Coelho, V.S. (2004) 'Brazil's Health Councils: The Challenge of Building Participatory Political Institutions' in *IDS Bulletin*, Vol. 35, No. 2: 33-39.

Coelho, V. S. and J. Veríssimo (2004) 'Considerações sobre o processo de escolha dos representantes da sociedade civil nos conselhos de saúde em São Paulo' in L. Avritzer, *A Participação em São Paulo*, São Paulo: Unesp.

Cohn, A. (2003) 'State and Society and the new configurations of the right to health/ Estado e Sociedade e as reconfigurações do direito á saúde' in *Ciencia e Saúde Coletiva*, Vol. 8, No. 1, 9-18

Cornwall, A. (2004) 'Introduction: New democratic spaces? The politics and dynamics of institutionalised participation', *IDS Bulletin*, 35 (2): 1-10.

Cornwall, A. (2000) *Beneficiary, Consumer, Citizen: Perspectives on Participation for Poverty Reduction*, Stockholm: Sida [free download from www.sida.se]

Dal Poz, M.R., and Pinheiro, R. (1998) 'A participação dos Usuários nos Conselhos Municipais de Saúde e seus Determinantes' in *Ciência e Saúde Coletiva*, Vol. 3, 1, 28-30.

Dagnino, E. (2005) 'We All Have Rights, But... Contesting Concepts of Citizenship in Brazil', in Kabeer, N. (ed.) *Inclusive Citizenship: Meanings and Expressions*, London: Zed Books.

Daniel, Celso (2000) 'Interview: Conselhos, Esfera Pública e Co-Gestão' in M do C. A Carvalho, and A.C.C. Teixeira, (eds.), *Conselhos Gestores de Políticas Públicas*, São Paulo: Polis, 123- 133.

Dryzek, J. S. (1996) 'Political inclusion and the dynamics of democratization', *The American Political Science Review*, 90 (3): 475–487.

Fox, J. (1996) 'How does civil society thicken? the political construction of social capital in Mexico,' *World Development* 24 (1996): 1089-103.

Fung, A. and E. O. Wright (eds.) (2003) *Deepening Democracy: Institutional Innovation in Empowered Participatory Governance*, London: Verso.

Galvanuzzi, C. (2003) 'A Representação Popular nos Conselhos de Saúde: Um Estudo sobre os Conselhos Distritais da Zona Leste e o Conselho Municipal de São Paulo', Research report, CEBRAP, FABESP.

Gaventa, J. (2004) 'Towards participatory governance: assessing the transformative possibilities', in S. Hickey and G. Mohan (eds) *From Tyranny to Transformation*, London: Zed Books.

Gohn, M. da G. (2002) 'Papel dos Conselhos Gestores na Gestão Pública' in INFORMATIVO CEPAM, Conselhos Municipais das Áreas Sociais, São Paulo: Fundação Prefeito Faria Lima, pp 7-16.

Gurza Lavalle, A., Acharya, A. and P. Houtzager (2005) 'Beyond Comparative Anecdotalism: Lessons on Civil Society and Participation from São Paulo, Brazil', *World Development*, 33(6):951-964.

Habermas, J. (1996) "Three Normative Models of Democracy," in *Democracy and Difference: Contesting the Boundaries of the Political*, ed. Seyla Benhabib, Princeton: Princeton University Press, pp. 21-30.

Hayes, L. (2004) *Participation and associational activity in Brazil: The Case of the São Paulo Health Councils*, Masters Dissertation, Institute of Development Studies, University of Sussex.

Houtzager, P., A. Gurza Lavalle and A. Acharya (2003) 'Who participates? Civil society and the new democratic politics in São Paulo, Brazil', IDS Working Paper 210, Sussex: Institute of Development Studies.

Labra, M.E. and St. Aubyn, F.J. (2002) 'Associativismo, participação e cultura cívica, o potencial dos conselhos de saúde' in *Ciencia e Saúde Coletiva*, Vol. 7, 3 537-547.

Mansbridge, J. (1999) 'On the idea that participation makes better citizens', in S. Elkin and K. Soltan (eds) *Citizen Competence and Democratic Institutions*, University Park: Pennsylvania State University Press.

- Mercadente, O. (2002) 'Conselhos Municipais de Saúde' in INFORMATIVO CEPAM, Conselhos Municipais das Áreas Sociais, São Paulo: Fundação Prefeito Faria Lima, 41-44.
- Morita, I. (2002) 'Conselho e Conselheiros Municipais de Saúde: Que trama é esta?' PhD thesis, Anthropology, PUC-São Paulo.
- Rodrigues dos Santos, N. (2000) 'Implantação e funcionamento dos Conselhos de Saúde no Brasil' in Carvalho, M do C. A. and Teixeira, A.C.C. (eds.), *Conselhos Gestores de Políticas Públicas*, São Paulo: Polis, 15-21.
- Tatagiba, L. (2002) 'Os Conselhos Gestores e a Democratização das Políticas Públicas no Brasil' in E. Dagnino, (ed.), *Sociedade Civil e Espaços públicos no Brasil*, Sao Paulo: Paz e Terra.
- Tendler, J. (1997) *Good Governance in the Tropics*. Maryland: Johns Hopkins Press.
- Valla, V.V. (1998) 'Comentários a "Conselhos Municipais de Saúde: A possibilidade dos Usuários Participarem e os Determinantes da Participação"' in Carvalho, A. I. de (1998) 'Os Conselhos de Saúde, Participação Social e Reforma do Estado' in *Ciência e Saúde Coletiva*, Vol. 3, 1, 31-32
- Vargas Cortes, S. M. (1998) 'Conselhos Municipais de Saúde: A Possibilidade dos Usuários Participarem e os Determinantes da Participação' in *Ciência e Saúde Coletiva*, Vol. 3, 1, 5-17

Warren, M. (2000) *Democracy and Association*, Princeton: Princeton University Press.

Notes

ⁱ This chapter owes many insights to a DFID-funded participatory research project conducted with Silvia Cordeiro and Nelson Giordano Delgado in 2003-4 (Cordeiro, Cornwall and Delgado, 2004), which I continued in three further periods of fieldwork over 2004-5.

ⁱⁱ I draw directly here on interviews with six health managers, including two previous Secretaries of Health, five health worker representatives, fifteen people who serve or have served as user representatives, the private sector representative and the executive secretary of the council. My analysis also builds on impressions gained through participant observation at council meetings and interviews with a further twenty people, including civil society leaders, NGO workers and a local politician.

ⁱⁱⁱ I am grateful to Alex Shankland for this point.

^{iv} See Cordeiro, Cornwall and Delgado (2004) for a more detailed account of the process of institutionalizing participation in the health council.

^v This echoes Gurza Lavalle, Acharya and Houtzager's (2005) findings for civil society organizations in São Paulo.

^{vi} This is also observed by Gurza Lavalle et al. (2005).

^{vii} This became acute around the time of the 2004 elections and resulted in the expulsion of the two Communist (PCdoB) party members on the council, instantly reducing the representation of young black men.

viii The private sector have not been particularly active participants in the council. The one private sector representative on the council was an administrator from a local private hospital. He was generally silent in meetings, and spoke of how being on the council allowed him where necessary to defend the interests of his hospital.