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Research Article

Cross-Country Study of Institutionalizing Social Participation in Health Policymaking: A Realist Analysis

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Strong evidence suggests that interventions based on community participation have a positive effect on a range of health outcomes in different settings. Community participation contributes significantly to the promotion of health at the local level, especially among the more disadvantaged groups of the society. The main goal of social participation mechanisms is to fill the gap between the views of the policymakers and the experiences and needs of the communities. An important point is that institutionalization of social participation in the development of health policies and its continuity over time are essential requirements. The question here is how participation should be institutionalized in the systems that have started this process. We conducted a realistic evaluation of a multicase study of public participation in health system policymaking. Countries including France, Chile, Iran, Thailand, and Tunisia were selected. The study objective was to determine interventions and mechanisms used by these countries for community participation in health policymaking and institutionalizing it. The data were extracted via a literature review for each country using a realistic approach analysis also known as context, intervention, mechanism, and outcome (CIMO) configurations. Thailand and France, which have applied a set of interventions such as supportive legislations, evidence production structures for informed decision making and interactions, accountability and transparency, and providing a context for development of civil society organizations, have succeeded in institutionalizing community participation in health policymaking. Iran, Tunisia, and Chile have been successful in this regard, but they are still far from institutionalizing community participation. Success in the institutionalization of participatory health governance requires a political will and commitment at the highest level in order to minimize the conflicts between economic and political interests of different stakeholders and to implement a set of interventions to maximize social participation in health policymaking.

1. Introduction

One of the principles of primary health care as proposed at the Alma-Ata Conference in 1978 is to focus on community participation in improving health [1, 2]. Since then, effective measures have been taken to develop and improve the participation of people and communities [3], although some documented experiences indicate that community participation in the health sector has not always been successful [3]. Strong evidence suggests that interventions based on community participation have a positive effect on a range of health outcomes in different settings [4]. Rifkin believes that community participation contributes significantly to the promotion of health at the local level, especially among the more disadvantaged groups of society [5]. One of the subfunctions of governance in the health system is to know the "beneficiary demand" [6], i.e., ensuring that the views, experiences, and needs of the beneficiaries are heard and considered in the decision-making process. Beneficiary demand determines the importance of the interaction of different groups of society with each other and with decision makers to steer them toward more responsive policies [7].

The phrase "social participation" is the most comprehensive/inclusive form of participation. The word "social"

refers to individuals, populations, and local communities, but it can also relate to civil society [8]. One type of participation is the involvement of communities in decisions that affect their health, which requires involvement and influence in the policy cycle components, including decisions affecting health, implementation of such decisions, evaluating and monitoring, and most importantly, definition of the problem [9]. Considering the increasing demand from the health systems around the world, it is reasonable to invest in community participation, which would help them increase the productivity of their resources [3]. Good governance exists where people have legally obtained authority and the voices of those whose interests are affected by decisions are properly heard [10]. One of the vital but challenging aspects of strengthening good health governance is the systematic participation of people in the policy- and decision-making cycles in the health sector [11]. The main goal of social participation mechanisms is to fill the gap between the views of the policymakers and the experiences and needs of the communities [12]. Filling this gap requires the introduction of public views in health, which are clearly beyond the biomedical and technical views that are the dominant face of specialized and governmental circles [13].

An important point is that institutionalization of social participation in the development of health policies and its sustainability over time are essential requirements [8]. Ledford and Edward identified several synonyms for the institutionalization of programs in host organizations, including frozen, established, accepted, stable, durable, sustained, and survived [14]. Glaser used the term sustainability and defined it as continuous or sustained use [15]; however, the concept of institutionalization indicates much more. Miles defined institutionalization as composition [16], and Yin emphasized that once a program was institutionalized, that program became part of the organization's standard operations and was no longer a new plan [17]. According to Goodman et al., institutionalization occurs when a program becomes an integral part of an organization [18]. Today, governments have recognized the importance of community participation in health [8]. The question here is how participation should be institutionalized in the systems that have started this process. In order to find factors and interventions affecting social participation in the health policymaking and its institutionalization, the experiences of countries that undertook measures in this regard were reviewed in a comparative study.

2. Materials and Methods

We conducted a realist evaluation of a multicase study of social participation in health system policymaking. Purposeful sampling was used in this study. Based on a literature review and experts' opinions, the countries that implemented community-based participatory programs in the field of health were identified and categorized by continent.

(i) African countries: Madagascar, Burkina Faso, and Tunisia.

(ii) Western European countries: France, Portugal, United Kingdom, and Germany.

(iii) North, Central, and Latin American countries: USA, Canada, Chile, Mexico, Brazil, and Guatemala.

(iv) Asian countries: Iran, Thailand, Cambodia, India, and China.

In the next step, 5 countries that implemented public participation in the health system policymaking based on the WHO Handbook (https://www.who.int/publications-detail-redirect/9789240027794) on Social Participation for Universal Health Coverage and experts' opinion were selected according to the following background information: human development index (HDI) of 0.7 and above, a population of more than 10 million people, a share of population urbanization above 50% or urbanization growth rate of above 1%, and life expectancy above 75 years.

In fact, the "HDI" indicates the status of health, education, and economy of each country. The "urban population growth" shows the status of urbanization, which is an important factor in citizen participation, and "life expectancy" is a good indicator of the health system function.

In addition, to create diversity between selected countries, a diverse set of cultural, social, economic, political, and health system contexts was considered. The Gini coefficient is a measure of the income distribution inequality in a population. Higher values indicate higher levels of inequality. The political systems of the selected countries were republic in France, Islamic Republic in Iran, monarchy in Thailand, republic with a history of military rule in Chile, and republic in Tunisia after the Arab Spring.

The study data were extracted from a review of the literature published between 1990 and 2021 in English language including articles, published reports, and documents introduced by key informants or presented in at the World Health Organization meetings by the representatives of some participating countries, including Tunisia, Thailand, and France.

A literature search was conducted in Google Scholar and PubMed using the following search strategy: "Participation" OR "engagement" AND "Community" OR "Social" OR "Public" AND "Health System" OR "Health decision making" OR "Health policy-making" AND the name of each country. The source standardized tool for assessing each country is shown in Table 1.

The literature review was continued until data saturation was obtained. The study team answered the following questions in the selected countries:

(i) What was the origin and history of community participation in the health system?

(ii) What interventions and mechanisms did these countries use to institutionalize social participation in the development of health policies?

(iii) What were the strengthening, inhibiting, and sustainability factors of participatory health governance?

A thematic framework analysis was used for synthetizing the results. The collected data were sifted, charted, and sorted in accordance with key issues and themes in five steps

Table 1: Source standardization tool for assessing each country.

Document standardization	Thailand	Iran	Chile	France	Tunisia
Finding supporting laws or acts for public participation in health	*	*	*	*	*
Health system reform history and finding signs of public participation starting point (how and why)	*	*	*	*	*
Finding mechanisms and interventions used to initiate public participation in health	*	*	*	*	*
Finding barriers and facilitators of initiating public participation in health	*	*	*	*	*

Type of documents: manuscript, WHO report, OECD report, World Bank report, health ministry website, and key informant's presentations in formal meetings of the WHO. *: Necessary information is obtained from the available sources.

including familiarization, identifying a thematic framework, indexing, charting, and mapping and interpretation.

A realistic approach was adopted for data analysis. According to this approach, an intervention produces results in certain contexts through the triggering of mechanisms. This is called generative causation [19]. In realistic evaluation research, the goal is to provide a theoretical explanation of how an intervention produces results in specific contexts through the triggering of one or more mechanisms.

The researchers sought to identify regular, but not necessarily systematic, interactions between an intervention, mechanism, outcome, and context. These interactions are also known as context, mechanism, and outcome (CMO) configurations.

3. Results

3.1. Profiles of Countries. Table 2 shows the general characteristics of the selected countries and their socioeconomic contexts.

3.2. Community Participation in the Health Systems of Selected Countries. Inequality in access to health services and demand for the right to health by the public and civil society organizations together with government's support and will resulting in cooperation between the governments and health actors, including the civil society, were extracted as the key factors for participatory health decision making in the selected countries (Table 3).

According to Table 4, among the selected countries, Thailand and France, which have an institutionalized structure at the regional and national levels to attract community participation, used the well-known mechanisms of NHA (National Health Assembly) and PHA (Province Health Assembly) and CNS (Conférence Nationale de Santé) and CRSA (Conférence Régionale de Santé et de l'autonomie) at national and local levels, respectively. These countries used the assistance of the local governments and civil societies to identify public health issues.

Chile is planning to establish a dedicated mechanism for community participation in the development of national health policies. Currently, public voices are heard in health through citizen councils and citizen dialogue.

In Tunisia, in accordance with the "Societal Dialogue for Health System Reform," it is decided that the public voice in the health sector will be heard through local organizations and regional and interregional meetings, and the citizens' opinions presented in national conferences will be applied in the health policymaking.

In Iran, the history of public participation in Primary Health Care (PHC) was institutionalized over 40 years ago. Recently, measures have been taken for community participation in health policymaking, including the establishment of the Social Department at the Ministry of Health and Medical Education, establishment of House of Public Participation for Health (HPPH), and formation of Provincial and National Health Assemblies. In the Health Transformation Plan of the Islamic Republic of Iran, strengthening the health care network and attracting public participation in providing health services and monitoring the services provided to patients and clients are considered.

Table 5 shows the CMIO for each selected country.

According to Table 6, in Thailand and France, a set of interventions has been established for public participation in health policymaking, including supportive legislations, structures providing data and evidence for informed decision making and interactions, accountability and transparency, and providing an environment for growth and development of civil society organizations. These interventions along with political support and will of the higher governmental authorities and the health ministry helped to institutionalize social participation in health. In Chile, Iran, and Tunisia, despite the recognition of the right to health for all by the law, the essential structures to produce the required evidence and data are not developed. Lack of political stability and trust between citizens and health workers in Tunisia is an example of the critical challenges for interaction and dialogue in the health sector. In Iran, community participation in health is recognized by the constitution and general health policies. The Social Department, which was established with the aim of opening the health sector to the public, was dissolved following the change of the Minister of Health, and

Table 2: Characteristics of selected countries[×].

Indicators	Thailand	Iran	Chile	France	Tunisia
Population (millions)	69.8	83.99	19.1	67.4	11.8
Urban population (% of total population)	51	76	88	81	70
HDI[†]	0.77	0.78	0.85	0.90	0.74
Life expectancy at birth, total (years)	77	77	80	83	77
Urban population growth (annual %)	1.7	1.9	1	0.5	1.5
Country income group[††]	UMI	LMI	HI	HI	LMI
Gini index	35	40.9[3]	44.9	32.4[1]	32.8[2]
Poverty headcount ratio at national poverty lines (% of population)	6.8	N/A	10.8	13.8[3]	15.2[2]
Individuals using the Internet (% of population)	77.8	84.1	82.3	83.3	66.7

[×]Source: World Development Indicators database (most of the data belong to 2020, except those noted in the following). [†]Data belong to 2019. [††]Data belong to 2022. UMI: upper middle income; HI: high income; LMI: low middle income. [1]Data belong to 2018. [2]Data belong to 2015. [3]Data belong to 2019.

the duties and responsibilities of this department were transferred to a general department under the direct supervision of the minister.

4. Discussion

The main objective of the present study was to evaluate the factors affecting the institutionalization of social participation in health policymaking.

The case study of the countries showed that each of them applied one or more sets of the interventions. These measures included passing of supportive laws, creating support structures for accountability, transparency, producing knowledge and evidence needed for participatory discussions and dialogues, strengthening civil organizations active in the field of health, and encouraging the presence of the representatives of patients and people in decision-making committees in the health sector. The common element in the experiences of all countries was recognition of the right to health for all at the beginning of the path to public participation.

According to a handbook published by the World Health Organization, these countries had the best practices in social participation in health. The result of the present study showed that a set of interventions was established for public participation in health policymaking in Thailand and France. These interventions along with political will and support of the higher governmental authorities helped to institutionalize social participation in health. Three countries including Iran, Tunisia, and Chile were far from the desired outcome, which is the institutionalization of this approach in health policymaking. It seems that according to the theory of change, more time is required for better judgment. The theory of change specifies how a program brings certain long-term outcomes through a logical sequence of intermediate results [55, 56]. Accordingly, it might be claimed that if a supporting platform is created in these countries, they could be expected to achieve the ultimate goal of social participation in health policymaking in the future. According to the present study, political will and commitment play a vital role in providing interventions and a facilitating platform for the initiation and continuation of social participation in the health policymaking system of the countries. It can be argued that there are no means for quantitative measurement or grading of political will; however, this is merely a claim and it is recommended that further studies be designed and implemented to prove such claims.

Thailand and France have systematic and organized mechanisms to attract community participation in their health systems [8, 20, 41, 45, 57]. In France, two mechanisms, including the National Health Conference (CNS) and its regional counterpart (CRSA), provide the opportunity for the public voice to be heard in the service delivery system. In recent years, by attracting more social groups, there is an opportunity for public participation in health policy development; however, the voice of all is not still equally and fully heard in policymaking. Of course, Rajan et al. conducted a number of studies and found that the COVID-19 pandemic exposed health democracy in France to challenges and doubts [44, 57, 58] so that despite the continuous recommendations of the National Health Conference, the participation of this conference was not sought for the management of COVID-19 crisis. According to Alla, we witness a paradox that the mechanism born from one pandemic (AIDS) in France died during the second pandemic (COVID-19) [57].

In Thailand, "the triangle that moves the mountain" in the form of the National Health Assembly (NHA) and its provincial equivalent (PHA) has created the opportunity for the voice of the public to be heard in the stages of needs assessment and formulation of health policies by the government [8, 20]. Nonetheless, the non-participation of all groups and the louder voice of some groups are considered as the important challenges of the policymaking system of this country [8, 20].

In Iran, the House of Public Participation for Health has been established in most cities. During the COVID-19 outbreak, some of them took measures to attract public participation to deal with the pandemic. Meetings of the Provincial and National Health Assemblies were not held during the pandemic.

In Chile, some participation-based measures have been carried out in the domains of monitoring, implementation of the health policies of the ministry of health, or membership in council bodies [59], but they have not yet turned into a coherent and structured program and are far from the interaction of patients and their representatives in the health system of Chile, including public health issues [60].

Table 3: Origin of demand for public participation and contextual factors in selected countries.

Theme	Subtheme				
	Thailand [8, 11, 20]	Iran [8, 21–26]	Chile [27–39]	France [8, 40–45]	Tunisia [8, 46–54]
Origin of demand for participation	(i) Right to health (ii) Health inequality	(i) Health inequality (ii) Health transformation plan	(i) Democratization and rights agenda (ii) Health and social inequality	(i) HIV/AIDS crisis and the right to health (ii) Health inequality	(i) Health inequality
Contextual conditions	(i) Dialogue space based on health reform movement in 1990 (ii) Political will and commitment (iii) Trust and public demand for more participation in policymaking (iv) Paradigm shift in health definition	(i) Political will and commitment (ii) Dialogue space based on socialization of health	(i) Mobilization of popular classes prior to the 1973 military coup (ii) Established biopsychosocial approach in primary healthcare	(i) Civil society activism (ii) Political will and commitment (iii) Dialogue space based on trust and respect	(i) Dialogue space after 2011 revolution (ii) Societal dialogue for health system reform

Table 4: Mechanisms and interventions in selected countries.

Theme		Thailand [8, 11, 20]	Iran [8, 21–26]	Chile [27–39]	France [8, 40–45]	Tunisia [8, 46–54]
	Level	Subtheme				
Mechanism	Local	(i) Civil society (ii) Local government	(i) Civil society (ii) House of Public Participation for Health (HPPH)	(i) Civil society (ii) Citizen councils (iii) Physical and online offices	(i) NGOs (ii) Local government	(i) Civil society
	Regional	(i) Province Health Assembly (PHA)	(i) Province Health Assembly (PHA)	(i) Citizen consultation and dialogue (ii) Physical and online offices	(i) Regional conference on health and autonomy (CRSA)	(i) Regional meetings
	National	(i) National Health Assembly (NHA)	(i) National Health Assembly (NHA)	(i) Consultative council of the ministry of health (ii) Civil society council Planning for more efficient mechanism	(i) National Health Conference (CNS)	(i) National conference
Interventions		(i) Supportive legislation: (a) Health promotion foundation act (b) National health act	(i) Supportive legislation: (a) Right to health and participation in constitution law (b) Right to health and participation in general health policies	(i) Supportive legislation: (a) The law 20.500 (b) Law on the rights and duties of patients	(i) Supportive legislation: (a) "Kouchner law" (b) Anti-discrimination law	(i) Supportive legislation: (a) Right to health in constitution law
		(ii) Establishing evidence-generating, monitoring, observatory, transparency, and accountability structures	(ii) Strengthening of civil society	(ii) Strengthening of civil society	(ii) Organizational structures	(ii) Citizen juries
		(iii) Government support from civil society networking	(iii) Establishing the deputy for social affairs in MoHME		(iii) Patients' representatives in HAS commission on public health and health economics	
		(iv) Expanding CSO networks active in health and primary health care				

HAS: Haute Autorité de Santé (High Authority of Health); MoHME: Ministry of Health and Medical Education; CNS: Conférence Nationale de Santé; CRSA: Conférence Régionale de Santé et de l'autonomie; HPPH: House of Public Participation for Health.

Table 5: CMIO of selected countries.

Country	CMIO
Thailand [8, 11, 20]	Raising public voice in health policy (O) paradigm shift in health definition, dialogue space, political will & commitment, trust (C) PHA & NHA (M) supportive legislation, expanding CSOs networks, developing required structures, public representatives in decision-making committees (I)
Iran [8, 21–26]	Creating socialization of health dialogue in policymaking space(O) health inequality, health transformation plan, political will (C) PHA & NHA (M) establishing deputy for social affairs in MoHME (I)
Chile [27–39]	Raising patient voice in health service &strengthening monitoring of implementation of health policies (O) mobilization of popular classes, biopsychosocial approach in primary healthcare (C) civil society & citizen councils, campaigns, physical and online offices(M) legislation on the rights and duties of patients, strengthening of civil society (I)
France [8, 40–45]	Raising patient (recently: public) voice in health service (O) civil society activism, dialogue space, political will & commitment, trust (C) CRSA & CNS (M) supportive legislation, creating required structures, patient representatives in decision- making committees (I)
Tunisia [8, 46–54]	White book for better health in Tunisia (O): social dialogue space (C) regional meetings & national conference (M)right to health in constitution, citizen juries (I)

MoHME: Ministry of Health and Medical Education. CMIO: context, mechanisms, interventions, outcome, PHA: province health assembly, NHA: National Health Assembly, CRSA: conférence régionale de Santé et de l'autonomie, CNS: conférence nationale de Santé, MoHME: Ministry of Health and Medical Education, CSO: civil society organization.

Despite the fact that the model designed for Tunisia is based on the successful model of Thailand, the "Societal Dialogue for Health System Reform" program is still far from realization of its goals for reasons including lack of political and managerial stability, lack of trust, and tension between citizens and health professionals [54].

The results of the study showed that adoption of similar interventions to attract social participation in different contexts can help governments and societies in their efforts for achieving participatory policymaking through creating an atmosphere of interaction and dialogue, establishing a balance of power, and raising the public awareness of their right to health and the importance of participation in decisions affecting their health. This approach can be continued and institutionalized in the presence of a supportive context.

The experiences of the selected countries showed that public demands along with the government's desire and will to interact and participate would determine the onset of the movement for social participation in health. In the next step, the political will and commitment at the highest level and socioeconomic and political stability will determine the continuation of this process. The WHO has recognized the political will as one of the factors for sustainability of the "National Health Assembly" of Thailand and the political and managerial instability, lack of public interest, and lack of interest of the ministry of health as the challenges in the Tunisian experience [8]. Haldane et al. believe that the selection of appropriate interventions according to the underlying factors is the key for success in participatory approaches to achieve positive health outcomes [61].

In addition, according to the present study, despite the institutionalization of social participation in the health system of Thailand and France, the enactments of institutionalized structural mechanisms in these two countries are not binding to influence the developed health policies, and both are considered consultative arms to the Ministry of Health and Cabinet [8, 20, 45]. Rajan et al. believe that countries have not yet prioritized provision of the resources needed to institutionalize the participatory health governance approach [11], which can be explained by political economy. The analysis of political economy is the analysis of the interactions of political and economic processes in a society, the distribution of power and wealth between different groups and individuals, and the processes that create, maintain, and change these relationships over time [62]. Due to the presence of multiple factors, structures, and laws in the health policy space and the efforts of pharmaceutical and insurance companies, physicians, and policymakers to maximize their economic and political interests, it is necessary to resolve the conflicts of interest of actors in the health sector to ensure the impact of the people's will in health policies.

5. Limitation

In the present study, 5 countries were selected for in-depth examination. Since they were not English speaking countries, the number of documents published in peer-reviewed journals for these countries was limited. However, fortunately, in addition to articles, the documents and reports

Table 6: Challenges and facilitators in selected countries.

Theme	Subtheme				
	Thailand [8, 11, 20]	Iran [8, 21–26]	Chile [27–39]	France [8, 40–45]	Tunisia [8, 46–54]
Barriers	(i) Weak influence on policies (ii) Difficulties with diversity of approaches and beliefs of constituencies (iii) Ensuring proper representation (iv) Making the role of science and university smarter (v) Establishing better links between national and provincial levels (vi) Non-participation of some populations (vii) Lack of awareness about NHA (viii) Weak capacity of some constituencies for data analysis	(i) Lack of data generation structures for health dialogue space (ii) Changing policies with managerial change (iii) Insufficient performance of existing mechanisms	(i) Lack of data generation structures for health dialogue space (ii) Lack of specific mechanisms	(i) Weak influence on policies	(i) Lack of data generation structures for health dialogue space (ii) Political and managerial instability (iii) Socioeconomic instability (iv) Lack of trust
Facilitator	(i) Political will and commitment (ii) Resources (structure, money, and manpower) (iii) Dialogue space and skills	(i) General health policy (ii) PHC structure	N/A	(i) Political will and commitment (ii) Dialogue space and skills	N/A

N/A: not available.

from international organizations such as the World Health Organization and OECD, which had deep expert reviews, were used in the present study. In the case of Iran, the authors of this article are aware of the process of community participation in Iran's health system.

6. Conclusions

To successfully implement social participation in health policymaking, a variety of interventions are necessary. These interventions include 1) providing the necessary resources such as financial, structural, human, and information resources, 2) establishing good governance by creating supportive regulations and ensuring accountability and transparency, generating public demand for participation, and 3) having the political will to support and implement these interventions. In summary, all of these factors must coexist for social participation in health policymaking to be successful. On the other hand, based on the principles of political economy and due to the presence of important stakeholders such as pharmaceutical and medical equipment companies and insurance companies, some laws and regulations lead to potential conflicts of interests in the big health market, which affects the interaction between the society and the government in the development of policies in the health sector.

The success of the institutionalization of the participatory health governance requires a political will and commitment at the highest level in order to minimize the conflicts between economic and political interests of different stakeholders and to maximize social participation in health policymaking.

Abbreviations

(NHA): National Health Assembly
(PHA): Province Health Assembly
(CRSA): Conférence Régionale de Santé et de l'autonomie
(CNS): Conférence Nationale de Santé
(PHC): Primary Health Care
(HAS): Haute Autorité de Santé (High Authority of Health)
(MoHME): Ministry of Health and Medical Education
(HPPH): House of Public Participation for Health.

Data Availability

The data used to support this study are included within the article.

Additional Points

What Is Known about This Topic? (i) Community participation in health policymaking is important for reducing health inequalities and positive health outcomes. (ii) Institutionalized social participation leads to the realization of health programs goals. *What This Paper Adds?* (i) Participatory health governance is unsustainable in countries that cannot take a coherent, context-specific and systematic package of interventions. (ii) Political will is more important than democracy for institutionalizing social participation in health policymaking.

Conflicts of Interest

The authors declare that they have no conflicts of interest.

Authors' Contributions

RM, FR, and MR conceptualized the study design. MR drafted the manuscript and was responsible for data acquisition and analysis. All authors approved the final manuscript.

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