saúde EM DEBATE

ORIGINAL ARTICLE

Judicial governance and intersectoral deliberation in the SUS: A normative evaluation of the Pernambuco State Health Committee

Governança judicial e deliberação intersetorial no SUS: avaliação normativa do Comitê Estadual de Saúde de Pernambuco

Gobernanza judicial y deliberación intersectorial en el SUS: una evaluación normativa del Comité de Salud del Estado de Pernambuco

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ABSTRACT The judicialization of healthcare is a challenge for Brazil's Unified Health System (SUS) and the Judiciary, which led the National Council of Justice to create the Comitês Estaduais de Saúde (CES) (State Health Committees). This study aimed to evaluate the normative compliance of the CES of Pernambuco (CES/PE), analyzing its potential as a governance body. The study used a qualitative-quantitative approach, analyzing 23 meeting minutes, as well as questionnaires from 18 committee members. The quantitative analysis used a 60% compliance criterion, while the qualitative analysis employed content analysis. COREQ criteria were adapted to ensure methodological rigor. The CES/PE achieved an overall compliance rate of 68.2%. Performance was mixed across the following dimensions: structure (77.8%), process (53.8%), and outcome (73.1%). The main advances were inter-institutional coordination and the production of technical notes by the Judiciary's Technical Support Units. Identified weaknesses include the lack of a work program, limited regulatory proposals, and limited proactive action. It is concluded that the CES/PE is a relevant body of judicial governance in health, but its effectiveness depends on strengthening the 'process' dimension and the institutionalization of regulatory mechanisms. This experience can provide insights to improve national guidelines to combat the judicialization of health.
KEYWORDS Health's judicialization. Health evaluation. Right to health. Governance. Unified Health System.

RESUMO *A judicialização da saúde é um desafio para o Sistema Único de Saúde e para o Judiciário, levando o Conselho Nacional de Justiça a criar os Comitês Estaduais de Saúde (CES). Este estudo buscou avaliar a conformidade normativa do CES de Pernambuco (CES/PE), analisando seu potencial como instância de governança. O estudo utilizou abordagem qualiquantitativa, analisando 23 atas e gravações de reuniões do órgão, além de questionário aplicado a 18 membros do comitê. A análise quantitativa usou critério de conformidade de 60%, enquanto a qualitativa empregou análise de conteúdo. Os critérios Coreq foram utilizados para garantir rigor metodológico. O CES/PE alcançou uma conformidade geral de 68,2%. O desempenho foi heterogêneo entre as dimensões: estrutura (77,8%), processo (53,8%) e resultado (73,1%). Os principais avanços foram a articulação interinstitucional e a produção de notas técnicas pelos Núcleos de Apoio Técnico do Poder Judiciário. As fragilidades identificadas incluem falta de programa de trabalho, baixa proposição normativa e limitada atuação propositiva. Conclui-se que o CES/PE se configura como uma instância relevante de governança judicial da saúde, mas sua efetividade depende do fortalecimento da dimensão 'processo' e da institucionalização de mecanismos normativos. A experiência pode fornecer subsídios para aprimorar diretrizes nacionais de enfrentamento à judicialização da saúde.*
PALAVRAS-CHAVE *Judicialização da saúde. Avaliação em saúde. Direito à saúde. Governança. Sistema Único de Saúde.*

RESUMEN *La judicialización de la atención sanitaria desafía al Sistema Único de Salud y al Poder Judicial de Brasil, lo que motivó la creación de Comités Estatales de Salud (CES). Este estudio evaluó el cumplimiento normativo y el potencial de gobernanza del CES de Pernambuco (CES/PE). Mediante un enfoque de métodos mixtos, se analizaron actas y grabaciones de reuniones, aplicando cuestionarios a 18 miembros. Se usó un criterio de cumplimiento del 60% (cuantitativo), análisis de contenido y criterios Coreq (cualitativo). El CES/PE logró un cumplimiento general del 68,2%, con un desempeño heterogéneo: estructura (77,8%), proceso (53,8%) y resultado (73,1%). Los principales avances fueron la articulación interinstitucional y la producción de notas técnicas. Las debilidades detectadas incluyen la carencia de un programa de trabajo, propuestas normativas débiles y acción proactiva limitada. Se concluye que el CES/PE es un ejemplo relevante de gobernanza judicial en salud, pero su efectividad requiere fortalecer la dimensión procesual e institucionalizar mecanismos normativos. Su experiencia es útil para perfeccionar las directrices nacionales sobre la judicialización sanitaria.*
PALABRAS CLAVE *Judicialización de la salud. Evaluación en salud. Derecho a la salud. Gobernanza. Sistema Único de Salud.*

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Introduction

The judicialization of health in Brazil has emerged as one of the main challenges facing the Brazilian Unified Health System (SUS), placing pressure on the constitutional principles of universality and equity in the face of lawsuits that often disregard collective health planning and technical-scientific criteria for resource allocation. Although this event stems from the legitimate exercise of fundamental rights, it has had significant impacts on public administration and revealed profound asymmetries in access to justice and health care[1,2], thereby interfering with the sustainability of the Brazilian health system itself[3,4].

In this context, the National Council of Justice (CNJ), through Resolutions Nº 238/2016[5] and Nº 388/2021[6], established the State Health Committees (CES) as collegiate and multidisciplinary bodies intended to foster dialogue among the agencies and institutions that comprise the justice and health systems, promote the resolution of health-related disputes through litigation prevention, and use evidence-based medicine. These initiatives are aligned with the perspective of deliberative and collaborative governance in health, as proposed by Schulze and Gebran[7], and seek to mitigate the effects of uncoordinated judicialization on the SUS principles.

Recent studies have highlighted that the CES represent one of the main institutional responses to judicialization, albeit with varying degrees of institutionalization and effectiveness[8]. Authors such as Lamarão Neto and Brito Filho[9] analyze the Committees from a legal perspective, highlighting both their innovative potential and the structural and regulatory limitations that continue to shape their work. Likewise, Souza and Ribeiro[10] document experiences of interinstitutional dialogue mediated by collegiate bodies, emphasizing their effects on closer ties between the Judiciary and health management, as well as efforts to rationalize public resources.

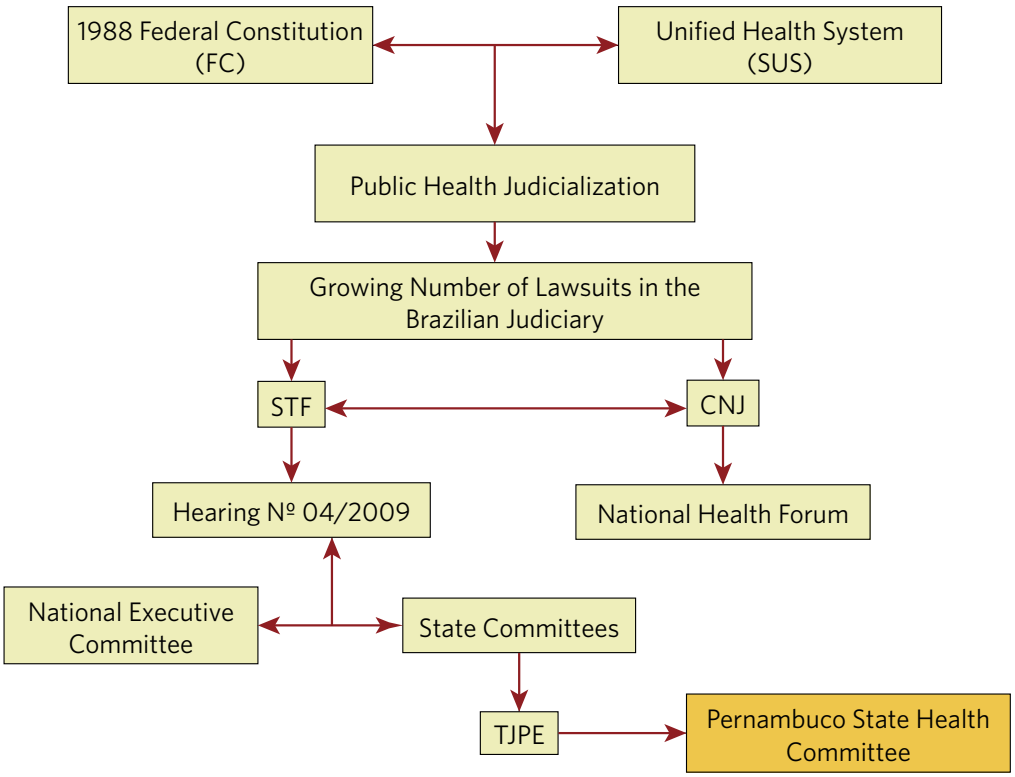
The Pernambuco State Health Committee (CES/PE) was established in 2017 by the Court of Justice of Pernambuco (TJPE) as part of this national strategy based on the understanding that the judicialization of health cannot be addressed solely through action by the Judiciary. Since then, it has served as a forum for coordination among diverse institutional stakeholders, with technical mediation provided by the Technical Support Center for the Judiciary (NatJus) and underpinned by its own ordinances and statutes. However, little is known about the normative and operational effectiveness of these committees, particularly regarding their adherence to national guidelines, their capacity to propose public policies, and their impact on reducing judicialization.

Against this background, this article aims to assess CES/PE's normative compliance level with the regulatory frameworks established by the National Council of Justice (CNJ), analyzing its potential and limitations as a body for judicial governance and intersectoral deliberation at the interface between health and law.

Material and methods

This is an evaluative case study with a qualitative-quantitative approach and an *ex post* design, developed on the basis of normative evaluation[11]. The object of analysis was the CES/PE, a collegiate body created by the TJPE to improve and direct solutions to lawsuits concerning public health in the state (*figure 1*).

Figure 1. Logic model for the creation of the Pernambuco State Health Committee



Source: Prepared by the authors.

The study aimed to analyze the Committee's compliance and adequacy in relation to the rules governing its operation, using as references the CNJ regulatory frameworks (Resolutions Nº 238/2016 and Nº 388/2021, TJPE Act Nº 717/2017, Ordinance Nº 5/2018, and the Committee's own Statute)[5,6,12–14], as set out in *tables 1 and 2*.

Table 1. CNJ regulations concerning State Health Committees

Regulation	Body	Syllabus
1. Regulations mandating the creation of committees in the states of the Federation		
Resolution Nº 107/2010[15]	CNJ	Establishes the National Judiciary Forum for the monitoring and resolution of healthcare assistance claims.
Resolution Nº 238/2016[5]	CNJ	Provides for the creation and maintenance of State Health Committees by State Courts of Justice and Federal Regional Courts, as well as the specialization of courts in judicial districts with more than one Public Treasury court.
Resolution Nº 388/2021[6]	CNJ	Provides for the restructuring of the State Health Committees established by CNJ Resolution Nº 238/2016, and makes other provisions.

Source: Prepared by the authors.

Table 2. TJPE regulations regarding State Health Committees

Regulation	Body	Syllabus
2. Regulations establishing and governing the operation of the Committee within the State of Pernambuco		
Act Nº 717/2017[12]	TJPE	Established the CES within the jurisdiction of the Court of Justice of the State of Pernambuco.
Ordinance Nº 5/2018[13]	TJPE	Provides for the creation and maintenance of the State Committee by the Court of Justice of Pernambuco.
Statute of the Pernambuco State Committee (DJ-e nº 159/19 of 28/8/2019)[14]	TJPE	Provides for the composition and functioning of the State Committee.
3. CES/PE administrative documents		
Minutes/Recordings of CES/PE Meetings	CES/PE	23 sets of minutes and recordings from 2018 to 2022

Source: Prepared by the authors.

The Committee's composition is governed by CNJ Resolution Nº 388/2021[6], Ordinance Nº 5 of January 29, 2018[13], and the CES/PE's own 2019 Statute[14] (*table 3*).

Table 3. Composition of the Pernambuco State Health Committee

	Representative's origin	
Bodies comprising the Committee	**Justice System**	**Health System**
State Judiciary	3	-
Federal Judiciary	1	-
State Public Prosecutor's Office	1	-
Federal Public Prosecutor's Office	1	-
State Public Defender's Office	1	-
Federal Public Defender's Office	1	-
State Attorney General's Office	1	-
Office of the Attorney General of the Union	1	-
Brazilian Bar Association (PE Chapter)	1	-
Municipal Attorney General's Office	1	-
State Health Secretariat	-	1
Municipal Health Secretariat	-	1
Regional Council of Medicine of Pernambuco (CREMEPE)	-	1
Technical Support Center for the Judiciary (NatJus)	-	2
Pernambuco Academy of Medicine	-	1
Pernambuco Medical Association	-	1
Support Team	1	-
Total by System	**13**	**7**
Grand Total	**20**	

Source: Prepared by the authors.

The Logic Models presented below were developed to clarify how the CES/PE was established and to understand how it operates, as per the aforementioned national and state regulations, as well as what the body actually conducted, based on the components of 'structure' (resources used), 'process' (services or goods produced), and 'outcome'.

Data were collected from April 2023 and to 2024 using three strategies: documentary analysis of the minutes and recordings of 23 ordinary and extraordinary meetings; development of the intervention logic model based on the aforementioned regulations; and administration of a structured questionnaire to 18 committee members (90% of its membership).

The systematization and analysis of this documentation enabled the development of the Indicator Matrix for Analysis and Judgment, as well as the questionnaire, which had been previously validated at a CES/PE plenary meeting and comprised 28 items distributed across the three evaluative dimensions ('structure', 'process', and 'outcome'). It included questions answered on a 5-point Likert scale (1 = never; 2 = rarely; 3 = sometimes; 4 = often; 5 = always) and dichotomous questions (yes, no, don't know).

Responses were coded such that compliance was identified when respondents selected 'often/always' (Likert ≥ 4) or 'yes' for dichotomous questions. The compliance rate for each item was calculated as the proportion of positive responses relative to the total number of valid responses. Compliance by dimension corresponded to the simple mean of the rates for its items, and overall compliance was obtained from the unweighted mean of the three dimensions.

The analytical choice of the dimensions 'structure', 'process', and 'outcome' was based on the classic model for assessing quality in health care proposed by Donabedian[16], which is widely used in institutional and normative evaluations because it enables an integrated analysis of available resources, how actions are implemented, and the effects produced. This framework is particularly appropriate for evaluating collegiate governance bodies such as the CES because it allows identifying asymmetries among institutional capacity, operational functioning, and perceived performance.

Within the context of the CES, the 'structure' dimension allows examining the institutional, normative, and technical arrangements that support their work; the 'process' dimension assesses deliberative, decision-making, and interinstitutional coordination mechanisms; and the 'outcome' dimension captures the expected effects of the committee's work, such as improving the quality of judicial decisions, strengthening intersectoral dialogue, and addressing the judicialization of health. This model has been widely adopted in normative evaluations of health policies, programs, and governance bodies because of its analytical robustness and explanatory capacity[11].

The cutoff point adopted to define compliance and adequacy was 60%. This value was chosen for three complementary reasons: first, it constitutes a pragmatic criterion widely used in normative evaluations of services and institutions undergoing consolidation, in which exceeding a simple majority indicates that the minimum expected standard has been met[11]; second, it is consistent with standards-based evaluation, in which this threshold signals intermediate organizational maturity, distinguishing insufficiency (≤ 50%), minimum adequacy (≥ 60%), and consolidation (≥ 70%)[17]; and third, it preserves sensitivity to capture variations across the dimensions of the Donabedian health care quality model[16]. The qualitative analysis was performed using content analysis[18]. The corpus consisted of the committee's minutes/recordings, which allowed triangulation of the findings and strengthened the internal validity of the analysis.

Considering that one of the authors is a member of the CES/PE, measures were adopted to reduce potential analytical biases and strengthen the reliability of the results, as

per the Consolidated Criteria for Reporting Qualitative Research (COREQ) recommendations for qualitative research[19]. The strategies adopted included role separation: the author who was a committee member provided documentary contextualization, while the external coauthor conducted the methodological review, serving as an independent evaluator[20]; and internal validation through prior discussion of the questionnaire in a plenary meeting and member checking to confirm information. These safeguards ensured the transparency and reliability of the findings.

The Research Ethics Committee of the Aggeu Magalhães Institute, Oswaldo Cruz Foundation approved the study through Certificate of Presentation for Ethical Consideration (CAAE Nº 67800423.0.0000.5190 and Opinion Nº 6.124.519) and fully complied with the ethical principles of National Health Council (CNS) Resolution Nº 466/2012, ensuring the participants' confidentiality, anonymity, and informed consent.

Results

When analyzed separately by component and by each indicator in the Analysis and Judgment Matrix developed for the study, responses to the questionnaires administered to CES/PE members yield valuable insights into the committee's work. Most respondents recognized its importance, although they expressed concern about response times and the adequacy of the proposed solutions to the actual needs of health system users. These results were combined with the analysis of the committee's meeting minutes over the study period, from 2017 to 2024.

The analysis of the CES/PE revealed institutional performance with an overall compliance level of 68.2%, exceeding the 60% threshold adopted as a pragmatic criterion of organizational maturity. The results are presented below according to the three evaluation dimensions: 'structure', 'process', and 'outcome' (*table 4*).

Table 4. Summary of findings

Dimension	Compliance (%)	Positive highlights	Key limitations
Structure	77.80%	Intersectoral representation, technical support (NatJus)	Participation asymmetries
Process	53.80%	Regular meeting spaces	Lack of a work plan and low regulatory output
Results	73.10%	Positive perception by members, support for the judicial decision	Difficulty in objectively measuring impact

Source: Prepared by the authors.

Structure Dimension

The 'structure' dimension showed the most consistent performance in the evaluation, with a compliance level of 77.8%. This result reflects robust CES/PE's institutional arrangements and its stable intersectoral composition. The committee is formally linked to the TJPE and includes representatives from the judicial system, the State and Municipal Health

Secretariats, the Public Prosecutor's Office, the Public Defender's Office, and NatJus technical staff, giving it a pluralistic and technical profile.

Among the subcomponents evaluated, high levels of adequacy were found for administrative support infrastructure (100%), human resources (94.4%), material resources (88.9%), and institutional composition (83.4%). These results were corroborated by documentary evidence and by respondents themselves, who reported that meetings were held regularly, formally documented through minutes and recordings, and preceded by open calls to members. The existence of an institutionalized space for joint deliberation was also observed, although some segments participated asymmetrically, such as representatives of users of supplementary health services and social movements.

The composition of the CES/PE is particularly significant and relevant because the variety of representation, encompassing the fields of justice and health as well as executive and community bodies, contributes to the establishment of a broad and multidisciplinary body, which is essential given the demands within its scope.

In this regard, concerning the importance of broader and active participation in out-of-court dispute resolution initiatives, Ventura and Simas[21] state that "this engagement and broader social participation constitute a central determining factor in effective access to rights and justice". When discussing the importance of the mixed composition of the CES, Ribeiro and Vidal[4] state:

> Thus, the eclectic composition of the Committees from these two systems helps facilitate institutional communication, which contributes to the transparency of interinstitutional information.

The work of NatJus was repeatedly valued and stood out as essential technical-scientific support for CES/PE actions to address the judicialization of health in the state. Notably, NatJus is part of the CES, as shown in *table 3*.

On the other hand, the analysis also revealed important weaknesses. Indicators related to internal regulations showed low compliance levels. Only 55.6% of respondents confirmed the existence of internal rules, and 44.4% indicated an available work program. These results directly reflect members' substantial lack of awareness of these regulatory instruments (43.4% and 55.6%, respectively, selected 'don't know'), revealing the need for greater dissemination and internalization of institutional rules among participants.

Process Dimension

The 'process' dimension displayed the weakest performance in the evaluation, with a compliance level of 53.8%, below the 60% cutoff adopted as the adequacy criterion. This result contrasts with the CES/PE's structural robustness and reveals relevant weaknesses in its operational functioning. Although some aspects were positively evaluated, such as streamlined procedural routines (72.2%) and definition of health law strategies (66.7%), several central subcomponents recorded rates below 60%, reflecting important gaps in the committee's capacity to propose initiatives and coordinate stakeholders.

The main obstacles observed included the lack of a formalized work plan and an annual schedule of activities, which hinder planning and strategic action. The production of normative recommendations and binding guidelines is limited, although the CNJ legal framework authorizes committees to undertake this type of initiative. In practice, CES/PE activities remain predominantly reactive and consultative, with few proposals for systemic solutions aimed at preventing litigation.

Another critical aspect concerns the way interinstitutional mediation occurs, which is heavily based on relational capital and informality among members. Although this dynamic may lend some agility to coordination,

it compromises process standardization and the consolidation of institutional practices. Furthermore, turnover among representatives and the lack of updated internal rules were identified by some respondents as factors that hinder the institutionalization of collaborative routines. These findings reinforce the need to strengthen internal processes and expand the committee's proactive and strategic work so as to consolidate it as a body for governance and intersectoral coordination in the field of public health.

Outcome Dimension

The 'outcome' dimension showed satisfactory performance, with a compliance level of 73.1%, indicating positive perceptions of the relevance and effectiveness of the CES/PE as a body for addressing the judicialization of health in the state. Four of the six evaluated indicators met the adequacy criteria, most notably facilitation of interinstitutional dialogue, which achieved 100% compliance, followed by deliberation and proposal of courses of action (88.9%), preparation of technical notes and opinions based on scientific evidence (77.7%), and improvement, monitoring, and resolution of healthcare demands (77.7%). These results point to recognition of the CES/PE as a legitimate forum for technical and institutional coordination between the justice system and public health managers.

As indicated in the questionnaire responses and reinforced by the analysis of meeting minutes, the Committee has helped improve the quality of judicial decisions in Public Health, particularly through the NatJus technical support. This support has been decisive in providing the basis for urgent health-related decisions, as illustrated by the following entry in the meeting minutes: "*The participation of NatJus in the Judiciary's decision-making flow has been decisive in providing a technical basis for decisions involving urgent health demands*".

However, two indicators remain below the compliance criterion: monitoring of lawsuits (44.5%) and reduction of judicialization (50%). The latter, in particular, should be understood as a long-term objective whose measurement is limited within the study timeframe. Furthermore, the lack of statewide systemic indicators on judicialization hampers the longitudinal evaluation of CES/PE effectiveness in this area, revealing an important challenge that must be addressed to consolidate its strategic work and improve public policies related to health and justice.

Discussion

The findings of this normative evaluation of the CES/PE reaffirm the importance of interinstitutional initiatives for addressing the judicialization of health and reveal operational weaknesses that limit its full effectiveness as a governance instrument within the SUS. This issue is consistent with the analysis presented by Torezani[8], who discusses how the committees constitute an institutional response to the increase in judicialization. However, the author also emphasizes that only robust initiatives with adequate regulations and structures can expand institutional governance and reduce litigation in the Health sector.

Although the overall compliance of 68.2% was above the established cutoff point (60%), it reveals asymmetrical performance across the evaluated dimensions. The 'structure' dimension, at 77.8%, highlights institutional adequacy in areas such as infrastructure, human resources, and composition, supporting the argument that the CES/PE's normative and technical foundation is consolidated. Nevertheless, important gaps remain in internal regulations, particularly the lack of a work program, some noncompliance reported by Vasconcelos[22] in collegiate bodies. A study by Lamarão Neto and Brito Filho[9] reinforces that committees frequently face institutional and conceptual limitations that prevent them from fully performing their functions.

The 'process' dimension, with only 53.8% compliance, was the critical point identified. The low frequency of institutional visits, limited production of normative recommendations, and lack of systematic action to implement health policies suggest that the CES/PE operates predominantly in a consultative and reactive rather than propositional and strategic manner. This finding is consistent with Wang's[2] argument that CES, when not effectively institutionalized, tend to occupy a peripheral role in decision-making. The study by Souza and Ribeiro[10], which evaluates the Interagency Committees for Administrative Resolution in Pará, reinforces the need for more structured initiatives so that these collegiate bodies become effective governance instruments and concretely address the challenges posed by the judicialization of health.

Performance was more balanced in the 'outcome' dimension (73.1%), particularly regarding the strengthening of interinstitutional dialogue (100%) and preparation of technical opinions through NatJus (77.7%). These indicators reinforce CES/PE's role as a forum for dialogue between the justice and health systems, aligned with the recommendations of Schulze and Gebran[7], who identify committees as a strategic arena for fostering evidence-based practices and rationalizing the use of SUS resources. Similar evidence was reported by Anjos, Santos, and Morais[23], who, in a systematic review, found that intersectoral dialogue initiatives help reduce repetitive litigation and strengthen shared governance in health. However, as Lamarão Neto and Brito Filho[9] suggest, the CES cannot be limited to consultative arenas; they must advance toward adopting a more propositional and strategic stance in policy formulation and implementation.

However, the indicator for reducing judicialization remained below the expected compliance level (50%), reflecting both the structural nature of the event and the intervention's temporal limits. The literature indicates that the judicialization of health in Brazil is not only a symptom of failures in public policies but also an expression of the selective access to justice and the social inequality that characterizes the country[24,25]. This selectivity means that groups with greater capacity for legal mobilization are often those that benefit most from decisions, thereby widening inequalities. The prevalence of these inequalities reinforces the need for broader interinstitutional actions that combine technical and redistributive dimensions and promote greater equity, as Torezani[8] highlights. Such actions include, for example, expanding access to information and strengthening collective advocacy for the right to health.

The qualitative analysis of the minutes and recordings reinforced these observations. The recurrence of topics such as NatJus operations and dialogue among institutions reveals progress in the 'outcome' component. On the other hand, the limited mention of normative structuring and policy formulation signals the need for more robust institutionalization, similar to the Santa Catarina Committee (COMESC), which has an action plan, thematic committees, and greater institutional diversity. This contrast reflects one of the limitations highlighted by Souza and Ribeiro[10], who note that the lack of structured planning is common in collegiate health governance bodies.

Normative evaluation, therefore, proved to be a powerful methodology for identifying not only adherence to legal and structural criteria but also discrepancies between institutional potential and actual practices. As Brousselle et al.[11] suggest, this approach allows linking the internal logic of the intervention to its actual effects, contributing to strategic adjustments and concrete recommendations for improvement.

Among the study limitations, one author was a member of the CES/PE, which may have influenced the analysis, although this was mitigated by questionnaire validation and methodological triangulation. The qualitative analysis was conducted by a single researcher without cross-coding, which may

have introduced interpretive bias. Even so, the results provide relevant practical contributions to strengthening the CES, particularly by improving the process dimension and ensuring alignment with the guidelines of CNJ Resolution Nº 530/2023[26].

Conclusions

The study evaluated CES/PE activities as a strategy for addressing the judicialization of health, analyzing its compliance and adequacy in relation to CNJ regulations. The study found overall compliance and adequacy of 68.2%, considered good under the defined parameters. The analysis was based on questionnaires administered to members and examination of meeting minutes and revealed that the committee has adequate material and human resources but faces significant challenges in its internal processes, which showed below-ideal compliance. Despite the process-related gaps, the results indicate that the CES/PE has been effective in promoting interinstitutional dialogue and generating deliberations that positively affect health management.

The CES/PE, therefore, constitutes a relevant body for judicial governance in health, but its effectiveness depends on strengthening the 'process' dimension and institutionalizing normative mechanisms. This experience may contribute to the formulation of more robust national guidelines for addressing the judicialization of health.

Authorship contributions

Capela H (0009-0001-3488-4970)* and Oliveira SRA (0000-0002-6349-2917)* equally contributed to the preparation of the manuscript. ■

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