ORIGINAL ARTICLE

Governance in community based health programmes in I.R of Iran

Katayoun Falahat,[1] Monir Baradaran Eftekhari,[2] Hossein Malekafzali,[3] Ameneh Setareh Forouzan,[4] Masoumeh Dejman[5]

Abstract

Objective: To assess the nature of community-based health programme experience in Iran, and use the results in order to advocate more friendly policies in community, academy and funding organisations.

Methods: The qualitative study was done in 2010-11 at various locations in Iran using semi structural in-depth interviews with the principals and managers of programmes, and focus group discussions with volunteers and service users of 13 Community Based Health Programmes which were active for at least five years. A total of 21 in-depth interviews and 20 focus group discussions were conducted. Data analysis was based on deductive-inductive content analysis approach considering the pre-determined structure in accordance with the study questions. The participants' views were analysed within the main category of governance, including the three sub-categories of leadership, monitoring and evaluation, and resource mobilisation.

Results: According to the participants, governmental programmes have centralised decision-making and management processes and local volunteers have no role in selecting managers at different levels of a programme. Such programmes are funded by the governmental core resources. In non-government organisations, resources available for such purposes mainly come through charitable individuals, service delivery fees and profitable economical activities, financial participation of volunteers and by using other organisations' facilities. In most programmes, there were no systematic process for monitoring and evaluation.

Conclusion: Community-based Health programmes in Iran need to be revised in line with the positive input. There is a need to have community-based units within the Ministry of Health and Medical Education and other relevant organisations.

Keyword: Community-based programmes, Health, Qualitative method. (JPMA 63: 211; 2013)

Introduction

The World Health Organisation giving strategic prominence to its 2008 Alma-Ata declaration has again emphasised the element of participation and has requested all its members to make available a suitable environment for community participation in health-related subjects. As defined by the WHO, participation is a process whereby community members collectively assess their health needs and problems and organise to develop strategies for implementing, maintaining and monitoring solutions.[1] In other words, the working definition of community participation is described as a process by which people are enabled to become actively and genuinely involved in defining the issues that are of concern to them, in making decisions about factors that affect their lives, in formulating and implementing policies, in planning, developing and delivering services and in taking action to achieve change.[2] The rationale for pursuing community participation consists of promoting positive health behavioural change; developing service delivery; mobilising resources for health services; and empowering the community.[3]

There is increasing evidence that consumer and community participation can improve health outcomes, lead to more responsive care, facilitate people's involvement in treatment decisions and improve quality and safety. Besides, it can help to reduce political risk, encourage clinical accountability, identify workforce issues and foster more responsive and equitable services.

In addition, it encourages better utilisation of health services by discouraging health-harming behaviour and changing expectations about the role of health staff and health services.[4]

In the Iranian context, since 1990, different community-based programmes have been implemented by governmental and non-governmental organisations in different fields of health. To the best of our knowledge, few national cross-sectional analyses of these community-based health programmes (CBHP) have been done. The main study sought to ask service users and programmes managers as well as volunteers about their experiences conducting CBHP in Iran. The goal of the

[1,2]Undersecretary for Research and Technology, Ministry of Health and Medical Education, [3]Department of Epidemiology and Biostatistics, School of Public Health , Tehran University of Medical Sciences, [4,5]Social Determinant of Health Research Centre, University of Social Welfare and Rehabilitation Sciences, Tehran, Iran.

Correspondence: Masoumeh Dejman. Email: dejman.masoumeh@gmail.com

overall study was to understand the nature of CBHP practice in Iran and use the data to advocate CBHP-friendly policies in the community, academy and funding organisations. In this article, we present the broad range of experience of those engaged with CBHPs in Iran regarding issues related to governance.

Subjects and Methods

The qualitative study was conducted in 2010-2011. This is a proven method for gaining insight into the participants' experiences.[5] Individual interviews were conducted with principal and executive managers to understand their point of view and experiences.[6] Focus group discussions were conducted with volunteers and service users because of their usefulness in understanding group opinions, concerns, attitudes and experiences.[7]

The study protocol was approved by Ethical Committee of the University of Social Welfare and Rehabilitation Sciences. An advisory committee was formed to supervise the study, comprising CBHP managers, researchers, WHO representatives in Iran and a number of programme managers from the Ministry of Health and Medical Education (MOHME). The members were recruited based on their knowledge and expertise in various areas of CBHP.

A total of 13 CBHPs (Table) were chosen by the advisory committee. The selection of the programmes was based on two-tier inclusion criteria: They needed to be active over the proceeding five years; and to have basic CBHP characteristic. The programmes were selected from both governmental and non-governmental sectors.

Based on their collective experiences and a thorough literature review, three question guides for interviewing programme principals and executive managers, volunteers and service users were developed. Guide questions consisted of five themes, including stewardship; participation; collaboration with other organizations; programme monitoring and evaluation; and resource mobilisation. The applicability of the guide questions were confirmed by the advisory committee and research team through a pilot study. Subsequently, the main phase was initiated.

The participants were purposively (6) selected from each programme with the assistance of key persons who were familiar with and involved in the programme for a long time. For each programme, two interviews with the principal and the executive manger, and two group discussions with volunteers and service recipients (20 group discussion, totally 102 people) were conducted. The focus groups were made up both of men and women, and each group had 5-8 participants. A total of 21 interviews were conducted, while there were 20 focus group discussions (FGDs) involving 102 people.

The research team constituted of six individuals who were completely familiar with qualitative research and interview methods. In a 4-hour session, the study objectives and question guides were explained and probable problems which might be incurred during the implementing phase were described. For each interview, the moderator/interviewer started the interviews by explaining the nature and purpose of the study before obtaining informed written consent. Permission to audiotape the interview session was sought orally prior to the interviews. The participants were also informed about confidentiality, that the participation was voluntary, and they were informed of their right to withdraw from the study at any time during the interview.

After the introduction, the moderator/interviewer gave an explanation about community health participation and then asked about the components of CBHP. The participants were encouraged to talk openly about their experiences relating to the programmes. Probes were used to confirm understanding of the concepts, and to explore areas that the participants did not discuss spontaneously. The researchers took field notes immediately after each interview. Each individual interview lasted 1-1.5 hours and each FGD lasted 1.5-2 hours, and ended when no new issues seemed to arise. The whole process of sampling and collecting data lasted five months, from August to December 2010. Some of the interviews were not fully completed due to the non-cooperation of the respondents.

Data analysis was based on deductive-inductive content analysis approach.[8] The structure of the analysis was based on previous knowledge and the purpose of the study.[9] Analysis started from each interview, which was transcribed and analysed both manually and with the aid of open code 3.4 software. The transcripts were read with the intention of deriving 'meaning units' (covering words, phrases and/or paragraphs).[10] Then the codes and categories were compared in each programme to get a whole picture of the programme. The coding scheme was derived theoretically according to the components of the CBHPs.[11] The inductive codes were sorted into meaningful clusters to describe a CBHP.[12] Then the codes were compared between the programmes to create broader categories that linked codes across interviews. Common classes were merged and conceptual classification was based on leadership and participation concepts. This paper presents the findings related to the concept of leadership.

In order to increase the reliably of data, all codes and classes

were cross-checked by the advisory committee. We shared summarised interview findings with relevant people to address issues of respondent validation.[13] To assess dependability, peer-checking by experienced colleagues to re-analyse some of the data was performed. Consistency checks between colleagues were also performed throughout the coding process for team consistency.[14]

Results

The average age of volunteers who participated in the study was 35±7 years and their range of education varied from simple guidance to above high school diploma. Among the recipients, the average age was 37±10 years and the education ranged from primary school to high school diploma. Interviewing with principals was implemented completely, and with the executive manager only at the level of the Primary Healthcare Network programme. The participants' views were analysed within the main category of governance, including the three subcategories of leadership, monitoring and evaluation, and resource mobilisation.

Leadership mainly focused on selection of project manager and decision-making process. According to the participants, governmental programmes have centralised decision-making and management processes and local volunteers have no role in selecting managers or administrators at different levels of the programme such as executive managers. However, in Healthy City and Healthy Village, Municipality Health Houses and Population Research Station programmes, volunteers actively participated in the selection of the cluster-head and health committee members and participated at the general assembly meetings at district levels. In NGO programmes, the board of trustees is responsible for selecting the board of directors, which, in turn, selects the managing director. All decisions are made by the board of directors and disseminated for implementation throughout the organisations through different forms of directives or information circulars. Most health promotion community-based activities are designed and implemented at the national level and are highly supported by organisations. Community-based interventions are designed at the level of districts (local communities) rarely. Axes of intervention consisted of various spectrum of health problems in individual, environmental and social aspects in the participating programmes. The aim of these interventions was promotion of health community and quality of life at local, provincial and national levels using people participation and inter-sectional cooperation. These interventions caused different degrees of empowering in community and concerned organisations. Totally, all the assessed programmes were community-based. It seems that interventions were institution based, not community-based in most of these programmes.

In governmental organisations such as MOHME, municipalities and social welfare organisations, programmes budget is funded by the governmental core resources. In programmes such as Laborious Health

Table: The selected community-based health programmemes.

Programme Name	Establishment	Affiliation	Scope	Aim of Programme	FGD	Interview
Primary Health Care Net work	1985	MOHME	National	To provide primary health care services in deprived districts and villages	2	1
Population Research Station	2001	MOHME	Sub- National	To empower community for needs assessment and solving health problems	2	2
Safe Society	1994	MOHME	Sub- National	To prevent accidents, minimize its damages and promote safety	0	2
Campaign of Polio Eradication	1993	MOHME	National	Immunization of under 5 year children	2	1
Women Health Volunteers	1989	MOHME	National	To enhance health level among urban communities	2	2
Student's peer education	1995	`	Sub- National	Student health promotion via trained peer volunteers	0	1
Healthy Village	1999	MOHME	Sub - National	Rural community health promotion	2	2
Healthy City	1992	MOHME	Sub - National	Urban community health promotion	0	1
Laborious Health House	1986	MOHME and Industrial Companies	National	To provide Primary Health Care services in industries	2	2
Community Based Rehabilitation	1980	Social Welfare Organization	National	To enhance the quality of life among rural disable people and their families	2	2
Municipality Health House		Tehran Municipality	Local	To provide health services for Tehran citizens	2	1
Addiction control and prevention-(Aftab Population)	1998	NGO	Local	To reduce and control addiction among Tehran citizens	2	2
Disability Empowerment Center (Tavana)	1994	NGO	Local	To empower disable citizens of Qazvin province	2	2

MOHME: Ministry of Health and Medical Education.

Houses, the employer (under whose control these houses are located) is committed to pay salaries and provide services or in-kind benefits. However, the costs for day to day operating or service delivery of such facilities are usually supported by charitable organisations such as the local municipalities or individuals. In non-government organisations, resources available for such purposes are mainly given through charitable individuals, service delivery fees and profitable activities, financial participation of volunteers, and using of other organisations' facilities.

In terms of evaluation and monitoring, some programmes affiliated with MOHME are monitored through field visits with standard checklists and assessment of the monthly reports. Most of this monitoring was without any feedback.

Some programmes such as the Women Health Volunteers and Community-Based Rehabilitation, were evaluated internally, but the results were not published. The Municipality Health Houses programme is the only programme with continuous and organised monitoring, as well as internal and external evaluations system. Also, Safe Society, Healthy Village and Healthy City programmes have been evaluated once. The overall objective of the Healthy Village and Healthy City programmes evaluation was to assess the inputs, the process, outputs and impact of such programmes in Iran, aiming at reviewing the implementation, methodologies and process for further expansion and institutionalisation in the health and development sector. The main objective of Safe Society evaluation where the community was involved, was to determine the degree to which the 'Safe Society' model is effective in reducing injuries in Iran. In most of the CBHPs, there were no systematic process for monitoring and evaluation. In non-government organisations, there is no organised system or process in place to evaluate the programmes, and activities are monitored by assessing the reports by the board of trustees. One of the most important challenges of CBHP articulated by most of the participants was lack of structure for evaluation and feedback from the community.

Discussion

The study showed that most governmental community-based programmes and all non-governmental programmes assessed had no participatory mechanisms in the decision-making processes, and community members were not involved in it. In contrast, literature says participation actively and genuinely in making decisions is a key element in promoting community participation programmes.[15] And lack of such mechanism can be a barrier to achieve community participation.[16] Also, the result indicated that decisions were mainly made in programmes' responsible organisations at the national level (such as MOHME) with the absence of community participators which can be a weak point in programmes' successes and it must be changed to achieve the goals as mentioned by the WHO.[17] In addition, the process of manager selection at all stages of the programmes was not a participatory process, and needs to be evaluated more carefully as pointed by Israel and et al.[15]

All the programmes in the study were without any written instruction for their respective research budgets and allocated resources for each part of a programme' processes which can be one of the first steps to effectively create a strong partnership with the community. The promotion of shared power within partnerships includes ensuring the equitable distribution of resources. If mutual responsibility and shared control are goals of CBHPs, then money, arguably the most powerful resource, also must be shared.[18]

There was no systematic monitoring and evaluation process for CBHPs under study. Some programmes were evaluated once. The overall objectives of these programmes was to assess the inputs, the process, outputs and impact of the programmes, aiming at reviewing the implementation, methodologies and process for further expansion and its institutionalisation in the health and development sector. But the results didn't measure the level of participation. Pointed challenges in most of CBHPs on monitoring and evaluation were ambiguities in the system, unavailability of evaluation results and lack of evaluation of various interventions. There is an analytical framework for measuring the level of community participation provided.[11] The framework consists of qualitative indicators for five factors that influence the process and degree of participation: needs assessment, leadership, organisation, resource mobilization, and management. A five-point ranking scale that measures the degree of participation is prepared for each factor, ranging from 'narrow' participation at one extreme (ranked 1) to 'wide' participation at the other (ranked 5), with three levels in between of 'restricted', 'fair' and 'good' (ranked 2, 3 and 4). This framework will help managers to map the contrasting levels of community participation in different CBHPs in Iran.

Draper et al have also mentioned that it is a challenge to develop a simple valid analytical tool to describe community participation in order to evaluate its relationship with health improvements and other programme outcomes, and one that is equally useful to

planners and managers on the ground.[19] In order to meet the mentioned requirements, the study recommended considering two key issues. Firstly, to define community participation in a way that reflects meanings in different settings; and, secondly, incorporate this definition(s) into an evaluation framework in order to connect the process of participation to defined outcomes and other health impacts in programme settings. Rifkin et al. previously developed a range for participation which had narrow participation at one end and wide participation at the other end. They defined five components of community participation: need assessment; leadership; organisation of the programme; management of the programme; and resource mobilization.[20] Recently, community participation in health programmes have been identified as community leadership and professionals introducing the intervention; planning and management forging partnerships between community and professionals; women's involvement; external support for programme development in terms of finance and programme design; and monitoring and evaluation examining how the intended beneficiaries are involved in programme activities which have been used in this study for assessment.[21-23]

Conclusion

Community-based health programmes in Iran need to be revised based on the positive input from the stakeholders. Expansion of community-based units within the Ministry of Health and Medical Education and other relevant organizations is essential. Appropriate decision-making and distribution of resources are necessary to achieve programmes' goals, especially while working with marginalised communities.

Acknowledgment

We are grateful to all the participants for sharing their experience and knowledge. We also thank the Deputy of the Health Environmental and Occupational Health Centre (Community-based Initiative) at the Ministry of Health and Medical Education in Iran, and the World Health Organisation for funding the project.

References

1. Katz A. The Independence of International civil servants during the neoliberal decades: implications of the work stoppage involving 700 staff of the World Health Organization in November 2005. Int J Health Serv 2008; 38: 161-80.
2. Heritage Z, Dooris M. Community participation and empowerment in Healthy Cities. Health Promot Int 2009; 24(Suppl 1): i45-i55.
3. Jacobs B, Price N. Community participation in externally funded health projects: lessons from Cambodia. Health Policy Plann 2003; 18: 399-410.
4. Laverack G. Health promotion practice: power and empowerment California: Sage Publications Ltd; 2004.
5. Council WC. Municipal Public Health Plan.
6. Dahlgren L, Emmelin M, Winkvist A, Lindhgren M. Qualitative methodology for international public health: Epidemiology and Public Health Sciences, Department of Public Health and Clinical Medicine, Umeå University; 2007.
7. Barbour RS, Kitzinger JE. Developing focus group research: Politics, theory and practice california: Sage Publications Ltd; 1999.
8. Vig EK, Starks H, Taylor JS, Hopley EK, Fryer-Edwards K. Surviving surrogate decision-making: what helps and hampers the experience of making medical decisions for others. J Gen Int Med 2007; 22: 1274-9.
9. Fridh I, Forsberg A, Bergbom I. Doing one's utmost: nurses' descriptions of caring for dying patients in an intensive care environment. Intensive Crit Care Nurs 2009; 25: 233-41.
10. Morse JM, Field PA. Qualitative research methods for health professionals california: Sage Publications, Inc; 1995.
11. Rifkin SB. Lessons from community participation in health programmemes. Health Policy Plann 1986; 1: 240-9.
12. Coffey A, Atkinson P. Making sense of qualitative data: Complementary research strategies California: Sage Publications, Inc; 1996.
13. Barbour RS. Checklists for improving rigour in qualitative research: a case of the tail wagging the dog? BMJ 2001; 322: 1115-7.
14. Rolfe G. Validity, trustworthiness and rigour: quality and the idea of qualitative research. J Adv Nurs 2006; 53: 304-10.
15. Israel BA, Parker EA, Rowe Z, Salvatore A, Minkler M, López J, et al. Community-based participatory research: lessons learned from the Centers for Children's Environmental Health and Disease Prevention Research. Environ Health Perspect 2005; 113: 1463-71.
16. Higgins DL, Metzler M. Implementing community-based participatory research centers in diverse urban settings. J Urban Health 2001; 78: 488-94.
17. Veillard J, Champagne F, Klazinga N, Kazandjian V, Arah O, Guisset AL. A performance assessment framework for hospitals: the WHO regional office for Europe PATH project. Int J Qual Health Care 2005; 17: 487-96.
18. Burhansstipanov L, Christopher S, Schumacher SA. Lessons learned from community-based participatory research in Indian Country. Cancer Control 2005; 12 (Suppl 2): 70-6.
19. Draper AK, Hewitt G, Rifkin S. Chasing the dragon: Developing indicators for the assessment of community participation in health programmemes. Soc Sci Med 2010; 71: 1102-9.
20. Rifkin SB, Muller F, Bichmann W. Primary health care: on measuring participation. Soc Sci Med 1988; 26: 931-40.
21. Prasad B, Muraleedharan V. Community Health Workers: a review of concepts, practice and policy concerns. A review as part of ongoing research of International Consortium for Research on Equitable Health Systems (CREHS) 2007.
22. Murthy RK, Klugman B. Service accountability and community participation in the context of health sector reforms in Asia: implications for sexual and reproductive health services. Health Policy Plann 2004; 19 (Suppl 1): i78-i86.
23. South J, Fairfax P, Green E. Developing an assessment tool for evaluating community involvement. Health Expect 2005; 8: 64-73.