A Qualitative Study of Community-based Health Programs in Iran: An Experience of Participation in I.R. Iran

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ABSTRACT

Background: Community-based health programs (CBHPs) with participatory approaches has been recognized as an important tool in health promotion. The goal of this study was to understand the nature of participation practice in CBHP and to use the data to advocate for more participation-friendly policies in the community, academy and funding organizations.

Methods: In this qualitative study, 13 CBHPs, which were active for last 5 years have been assessed using semi-structural in-depth interviews with programs principal and managers and focus group discussions with volunteers and service users. Data analysis was based on the deductive-inductive content analysis considering the participatory approaches in these programs.

Results: The results show that, the main category of participation was divided to community participation and intersectional collaboration. The community participation level was very different from "main," "advisory" or "supporting" level. The process of recruitment of volunteers by the governmental organization was centralized and in non-governmental organizations was quite different. According to respondents opinion, financial and spiritual incentives especially tangible rewards, e.g., learning skills or capacity building were useful for engaging and maintaining volunteers' participation. For intersectional collaboration, strong and dedicated partners, supportive policy environment are critical.

Conclusions: It seems that maintaining partnership in CBHP takes considerable time, financial support, knowledge development and capacity building.

Keywords: Community-based health programs, content analysis, Iran, participation

INTRODUCTION

Achieving "health for all" is a major challenge of the third millennium. Developing a healthy community and overcoming complex problems requires participatory approaches and solutions that bring the community together with governmental and

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non-governmental organizations (NGO) in order to empower them and utilize resources for better health. The World Health Organization (WHO) giving strategic prominence to its Alma-Ata declaration has again emphasized on participation and underscored the need to work between sectors to realize health gains.[1] The rationale for pursuing participation includes promoting positive health behavioral change; improving service delivery; mobilizing human, financial and other material (including in-kind) resources for health services; and empowering the community.[2]

Participation is defined as a process whereby community members collectively assess their health needs and problems and organize to develop strategies for implementing, maintaining and monitoring solutions to those problems.[3] In other word, 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 of concern, 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.[4,5] By definition intersectional collaboration is a strategy used to deal with complex policy problems that cannot be solved by a single department or sector. The literature also indicates that intersectional collaboration has been used to bolster health promotion, health protection, primary care and public health.[6]

There is increasing evidence from effectiveness studies that other sector and community participation can improve health outcomes, lead to more responsive care, facilitate people's involvement in treatment decisions and improve quality and safety. In addition to better health outcomes community and other sector participation can help to reduce political risk, encourage clinical accountability, identify workforce issues and foster more responsive and equitable services.[7]

In the Iranian context, since 1990, different community-based health programs (CBHPs) have been implemented by governmental and NGO in different fields of health. To the best of our knowledge, few national cross-sectional analysis of the participation process among mentioned CBHPs has been done. The present study is part of the comprehensive investigation on the experiences of different partners involved in CBHP projects. In the present paper, we sought to explore the experiences of partners regarding participation in CBHP in Iran. The goal was to understand the nature of participation practice and to use the data to advocate for more participation-friendly policies in the community, academy and funding organizations.

METHODS

This investigation was a qualitative study. This is a proven method for gaining insight into the participants' experiences.[8] Individual interviews were conducted with principal and executive manager's to understand their point of view and experiences.[9] Focus group discussions (FGDs) were conducted with volunteers and service users due to its usefulness for understanding group opinions, concerns, attitudes and experiences.[10]

Realization of the research

An advisory committee was formed to supervise the process of the study. This committee comprised of CBHP's managers, researchers, WHO representatives in Iran and number of program managers from Ministry of Health and Medical Education. The advisory committee members were recruited based on their knowledge and expertise in the areas of CBHP.

A total of 13 programs [Table 1] were chosen by the advisory committee, selection of the programs was based on two inclusion criteria: (1) Being active programs in recent 5 years (2) having the community based program characters. The programs have been selected from governmental and NGO.

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

Table 1: The situation of selected community-based health programs

Name	Beginning time	Affiliation	Scope	Aim of program	In-depth interview
Primary Health Care Network	1971	Affiliated to the Ministry of Health and Medical Education	National	To provide primary health care services in deprived districts and villages	Two FGDs and one in-depth interview
Population Research Station	2001	Affiliated to the Ministry of Health and Medical Education	Sub-national	To empower community for needs assessment and solving health problems	Two FGDs and two in-depth interview
Safe Society program	1994	Affiliated to the Ministry of Health and Medical Education	Sub-national	To prevent accidents, minimize its damages and promote safety	One in-depth interview
Polio Eradication Campaign program	1993	Affiliated to the Ministry of Health and Medical Education	National	Immunization of under 5 year children	Two FGDs and one in-depth interview
Women Health Volunteers program	1989	Affiliated to the Ministry of Health and Medical Education	National	To enhance health level among urban communities	Two FGDs and two in-depth interview
Student's peer education	1995	Affiliated to the Ministry of Health and Medical Education	Sub-national	Student health promotion via trained peer volunteers	One in-depth interview
Healthy Village program	1999	Affiliated to the Ministry of Health and Medical Education	Sub-national	Rural community health promotion	Two FGDs and two in-depth interview
Healthy City program	1992	Affiliated to the Ministry of Health and Medical Education	Sub-national	Urban community health promotion	One in-depth interview
Laborious Health House program	1986	Affiliated to both Ministry of Health and Medical Education and Industrial Companies	National	To provide Primary Health Care Services in Industries	Two FGDs and two in-depth interviews
Community Based Rehabilitation	1980	Affiliated to the Social Welfare Organization	National	To enhance the quality of life among rural disable people and their families	Two FGDs and two in-depth interviews
Municipality Health House program		Affiliated to Tehran Municipality	Local	To provide health services for Tehran citizens	Two FGDs and two in-depth interview
Addiction control and prevention-(Aftab population)	1998	Affiliated to NGO	Local	To reduce and control addiction among Tehran citizens	Two FGDs and two in-depth interviews
Disability Empowerment Center (Tavana)	1994	Affiliated to NGO	Local	To empower disable citizens of Qazvin province	Two FGDs and two in-depth interviews

NGO=Non-governmental organizations, FGDs=Focus group discussions

Study participants and sampling process

Participants were purposively[9] selected from each program with the assistance of key persons, who were deeply familiar and involved in the program for a long time. For each program, two interviews with program principal and executive mangers (21 interviews) 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 each consisting of 5-8 participants.

The process of conducting interviews

The research team constituted of six researchers who were completely familiar with qualitative research and interview methods. In a 4 h 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 moderators/interviewer started the interviews by explaining the nature and purpose of this study before participants' consent, which was confirmed by a signature. Permission to audiotape the interview session was sought orally prior to the interviews.

After the introduction, the moderator/interviewer gave an explanation about community health participation and then asked about the components of CHBP. The participants were encouraged to talk openly about their experiences relating to programs. Probes were used to confirm concepts mentioned and to explore areas that the participants did not discuss spontaneously. The researchers took field notes immediately after each interview and discussed these. Each individual interview lasted 1-1.5 h and each FGD lasted 1.5-2 h and ended when no new issues seemed to arise.

It should be mentioned that some of the interviews weren't implemented completely. This was due to non-cooperation of the number of respondents.

Data analysis

Data analysis was based on deductive-inductive content analysis approach.[11] The structure of the analysis was based on previous knowledge and the purpose of the study.[12] Analysis started from each interview. The interviews were transcribed and analyzed both manually and with the aid of open code 3.4. The transcripts were read carefully.[13] Then the codes and categories were compared in each program to get a whole picture of the programs. The coding scheme was derived theoretically according to the components of the CBHPs.[3] The inductive codes were sorted into meaningful clusters to describe a CBHP.[14] Then, the codes were compared between the programs to create broader categories, which linked codes across interviews among programs. Common

classes were merged and conceptual classification was based on leadership and participation concepts. In this paper, we present the findings related to partnership concept.

In order to increase the reliably of data, all codes and classes were cross-checked by research advisory committee. To address conformability, we shared summarized interview findings with the key informants at the end of the group discussion (respondent validation) to get participants' recognition of the finding.[15] To assess dependability peer checking by an experienced colleague to re-analyze some of the data was performed. Team consistency checks between colleagues were also performed throughout the coding process.[16]

Ethical consideration

The participants were also informed about confidentiality, that participation was voluntary and informed of their right to withdraw from the study at any time during the interviews.

RESULTS

According to results, the main category of participation was formed, which was divided to; (1) community participation (2) intersectional collaboration.

Community participation

The category of community participation includes three subcategories named; engaging and maintaining participation, capacity building and participation level.

Engaging and maintaining participation

The volunteers' recruitment process in programs implemented by governmental organizations – whether affiliated to the Ministry of Health or not – was discussed under this category. There was a difference between governmental and NGO. The process in governmental organizations was mainly centralized and done through wide-spread public announcement as revealed by study participants. As expressed by primary health-care (PHC) program principal manager: "Recruitment of all of the volunteers was based on specific selection criteria such as minimum literacy level, previous history of involvement in participatory activities, being native and having a reliable status in the community."

Among CBHP projects implemented by governmental organizations, there were some projects in which criteria for volunteer selection completely depends on the community opinions, requirements and decisions. Healthy Village program was an example of these projects. Although it should be noted that according to the reports of respondents, the above mentioned selection process has not been followed during recent years. Healthy Village volunteers revealed that: "During past 5 years volunteers have been chosen according to the village council members' opinion. The council members are mostly from the village's empowered individuals."

The process of recruitment of volunteers for programs implemented by NGO was quite different, volunteers were usually chosen from the service users group. In addition volunteer, participation was appreciated and highly respected in NGO.

Besides mentioned differences, there were some commonalities in partnership engagement. Almost all respondents expressed that dialogue with community leaders and residents and financial and spiritual incentives especially tangible rewards (e.g., learning skills) were useful for engaging and maintaining volunteers' participation. Incentives includes; holding pilgrimage tours, attending entertaining events or specific contests, free use facilities such as libraries as well as receiving complimentary medical and physical examinations and acquired trainings. Participation of community health workers (Behvarz) in PHC network program was based on receiving salary packages/benefits. Although in almost all programs incentives were considered as a mean for maintaining participation lack of financial resources to support volunteers was reported by the number of respondents. In addition, lack of appreciation of volunteer efforts was also expressed by respondents from programs managed by government. Altruistic motivations were also reported to be useful for initiating and maintaining community participation. Laborious health house program was the only sample that supports were provided by hosted company from the beginning of the program, informants from this program expressed that volunteers working with this program received salary from their company.

Capacity building

Enabling and training courses for participants were implemented at the beginning phase of all governmental and non-governmental community based programs. This was based on each project needs and objectives. As an example, in PHC network program, a volunteer worker from the community has received a training course and also participates in continuous refreshing courses. However, in some programs such as laborious health house program and Healthy Village program, volunteers have explained that refreshing training courses are not held regularly. Number of volunteers from mentioned programs expressed that, lack of training programs in some provinces was due to financial constraints. In Population Research Stations, the educational programs were more comprehensive and consist of research methodology, data gathering and conducting the interventional projects for problem solving.

Participation level

Study participants revealed that volunteers of assessed programs were invited to participate at different levels including: "main," "advisory" or "supporting" partners.

Respondents defined supporting participation as working voluntarily for the project based on predefined manual, with limited rights for taking part in decision making. Samples of participation as a supporting partner were seen in most of the programs. Some reported examples were: Community health education, participating in community needs assessment, participating in community development projects, follows-up health-care as well as rehabilitation services and participating in family planning education programs.

Advisory partnership level as defined by respondents was more than volunteer support of programs. At this level participants had some input on decision making process. Community health workers in PHC program and Women Health Volunteers were samples of this level of participation. Monthly team meetings with program managers were performed and volunteers shared their feed backs about the program with peers and managers. In addition, other means for establishing dynamic feedback system such as routine reporting system was held in these programs.

There were few examples of community participation as main partner. Healthy city program was one of these examples. The mentioned

program principal manager revealed that: "Community volunteers from different sectors and various levels of the community were engaged in conducting baseline household and community needs assessment and priority setting surveys. This activity was supported by an advisory team. Following needs assessment and selecting priorities for intervention volunteers assist and facilitate families to find solutions for their problems and participate in implementing these interventions through facilitating intersectional collaboration."

Intersectional collaboration

Intersectional collaboration was used as a strategy for addressing health problems in the majority of studied programs. This category includes three subcategories named; engage key partners' collaboration, focus on concrete objectives, ensure political support.

Engage key partners collaboration

The way in which a program is framed often determines which government sector and other organizations will participate to address the issue. Strong, dedicated partners are critical to the success of intersectional collaboration. The manager of PHC program expressed that: "Involving the right persons and institutions and reaching beyond government to involve civil society and the NGO are vital steps."

Number of respondents revealed that some challenges in achieving collaboration between health and other sectors included: Funding; diversity of paradigms and views; competing priorities and decision-making processes; and complex processes of engagement. The manager of Population Research Station program reveals that: "Effective collaboration between the sectors could only be achieved if the partners are able to see mutually beneficial outcomes, feasible implementation strategies and compatible monitoring and evaluation methods."

Focus on concrete objectives

Establishing very specific health goals has performed little to promote intersectional collaboration. Some programs such as Population Research Station have chosen to set goals beyond the health sector. The executive manager of this program expressed that: "Majority of this research stations focused on social and environmental determinants of health instead of very specific health issues."

At early stages of the program establishing short-term gains was highly motivating, as notified by volunteers working with a number of studied programs. Volunteers working with Population Research Station program expressed that: "All partners in community based programs must be able to perceive that the process is mutually beneficial and that the objectives of the programs are appropriately related to their mandates and responsibilities."

Ensure political support

Almost all participants emphasized that a supportive policy environment is desirable in fostering a sense of solidarity, facilitating collective action and providing financial support for intersectional collaboration. Strong connections with political leaders, parliament and administrators were expressed as key to securing the program support by PHC program managers. The executive manager of Polio Eradication Campaign program expressed that: "When you are planning for a participatory intervention with national scope, policymakers need to have sufficient information and serious intent to support the program otherwise you will fail."

DISCUSSION

This review of experiences in CBHPs reveals a range of approaches, mechanisms and strategies for supporting participation. The adopted approaches by the program founders lie between two extremes. Top down approaches with a community organization process were used initially and as orientation towards a community development approach increased bottom down approaches were expanded. Older programs were designed based on the idea that professionals should develop and deliver the programs for the community. In these samples same as the experience of similar programs.[17]

Planning has been initiated by professionals who have the relevant training, the selection of participants was based on professional view and participation was limited to supporting tasks. This approach was different from community development, which was the basic idea behind the former programs. Among these programs community participation was considered as a significant component therefore the community

members identified their own health needs and priorities and developed the interventions.

Several mechanisms were adopted for initiating and maintain community as well as other sector participation. One of these mechanisms as discussed in this study was funding. Lack of ongoing funding for community based initiatives can weaken participation.[18] Maintaining partnership in community based initiative (CBI) programs takes considerable time and financial support and when resources diminish maintaining partnership becomes more difficult and challenging.[14] Another mechanism for maintaining partnerships among CBHP is knowledge development and capacity building.[19] Community based research centers experience was a good example regarding benefits of community enabling and its positive effect on maintaining partnership. Although there were very few cases in which programs have been sustained with internal support provided by the organization hosting the program Worker Health Houses program was an example of such initiatives. Consistent with similar studies selecting a single problem for which there is evidence that it is a significant priority seems to be an advantage for community-based public health programs.[20] This may not necessarily be the priority for the health sector, but it can provide a manageable focus for tangible activity and is more likely to lead to some identifiable outcomes.

Intersectional collaboration is considered as a strategy used to deal with complex policy problems that cannot be solved by a single sector.[21] Health equity, as one important indicator, offers an entry point that may hold promise in better intersectional collaboration. This shift requires a health sector that pays sufficient attention to social determinants of health. In addition, we can conclude that developing a well-planned, systematic approach to intersectional collaboration that covers both health and broader socio-economic issues requires considerable political support.

LIMITATIONS

The present study illustrates the opinion of the people in FGDs and individual interviews and should for methodological reasons (qualitative approach) not be generalized to other condition. Furthermore, lack of participation of male volunteers and service users in FGDs was another limitation in this project.

Strength points

In this study, the qualitative approach has been used. Using individual interviews and FGDs could be useful in understanding individual and group opinions, concerns, attitudes and experiences. In fact, this method investigates different concepts deeply and this is one of the most important of strength points.

CONCLUSIONS

CBHPs in Iran need to be revised based on stakeholders` opinion. Using the results of this study could be useful to present an appropriate model to program evaluation. Involvement the community and other sectors in different steps of study can create the ownership and this is one the most important ways of dissemination and participation maintenance.

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