Community participation – with provider collaboration
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A pilot project testing the feasibility of the administrative decentralization of primary care in Sheikhupura District, Punjab Province, Pakistan, has demonstrated that in addition to motivating users to participate it is necessary for providers and communities to work closely together and for an environment to be created in which this can occur.

A pilot project in the Province of Punjab, Pakistan, aims to provide improved primary care by reorganizing and decentralizing decision-making so as to give increased authority to district and subdistrict officials for the management and administration of government health facilities. It is also hoped to heighten the sense of ownership of the health service among local people, to raise their awareness of its significance, and thus to improve the quality, appropriateness and efficiency of resource utilization, through the establishment of village health committees. For the purposes of the project, community participation is defined as a social process in which everybody living in an area should be involved, working together with public sector staff and operating within systems that provide mechanisms for identifying needs and taking decisions.

The project was implemented in three tehsils of Sheikhupura District, while a tehsil in Kasur District served as a control. The total population in the four tehsils was approximately 2.6 million. A baseline survey indicated that 68% of medical officers were absent from their places of duty, and that there was an almost complete failure to provide outreach services other than immunization. Only 5% of community members visited basic health units in case of need, and 40% were unaware of their existence.

Situations identified for improvement

Some examples of obstacles to progress are given below, and the underlying structural problems are outlined.
**Intersectoral collaboration**

- A village community had been organized by the project management team, and a village health committee was functioning well. However, when the committee restricted the price of meat sold by local butchers, other butchers from outside the community continued to sell meat at comparatively high prices. The medical officer and the sanitary inspector were asked by the committee to take action against these butchers but argued that they lacked the power to do so. In response, the committee stopped its usual activities and ceased collaborating with the basic health unit.

Primary care requires the involvement of non-health sectors in the maintenance and promotion of health. It should never be assumed that health needs can be met exclusively within the boundaries of the health sector.

**Strategic vision**

- When the project management team was explaining the participatory approach to a community, members of the audience asked what would follow the selection of traditional birth attendants and village health workers for training. The reply was that there would be improved health services and that the health status of the population would improve. "How?" was the next question. The people wanted to know precisely what the immediate tangible results would be.

Health development requires a long-term vision. Primary care may not have an immediate tangible impact. Success requires the pursuit of long-term objectives and great perseverance by all participants in the collaborative process. Understandably, however, people are often impatient to have their health needs fulfilled.

**Health promotion**

- The project management team was asked by a district authority to monitor social development programmes. While the project interventions were being discussed the team was further asked to explain measures for improving the district hospital. When it was pointed out that the project aimed at strengthening primary care in rural areas, the representatives of the authority walked out of the meeting.

In Pakistan, curative care is foremost in people’s minds. Many regard health care as being a matter of providing drugs, doctors, ambulances and hospitals, while preventive and promotive measures are less appreciated.

**Local culture and traditions**

- Female members of the Syeds, a religious group, do not leave their houses except in special circumstances, when a veil is used. A male Syed member of a village health committee requested a home visit by the local medical officer for his ailing mother. The medical officer insisted that she be brought to the basic health unit. When the man later visited the unit he shook hands with all the personnel except the medical officer.

Particularly in villages it is necessary for the activities of health personnel to harmonize with the local culture. People are unlikely to participate in health measures
if their traditions are not respected by public sector staff.

**Involvement of staff in the participatory process**

- A village community was effectively organized and its health committee was interacting well with the basic health unit’s staff, who, however, felt threatened, and three of them were given transfers.

All operational and supervisory staff should be involved in the process of community participation. Among other things they should be ready to share power with the people they serve. Community participation leads to community empowerment. Unfortunately, health personnel are often not prepared to involve themselves in the participatory process, because their education and training are not conducive to doing so. Little orientation is given in medical schools and other educational institutions on primary care and community participation. Consequently, staff feel threatened on being consulted and asked to participate.

Clearly, operational staff are unlikely to demonstrate a strong inclination to adopt the participatory approach if their supervisors have not done so. They may perceive community participation as impracticable. Even the authorities may be unsupportive and may consider the approach to have little value.

**Local decision-making**

- A member of the project management team allocated money for the repair of a village access road and asked the health committee to make a contribution and carry out the work. However, the committee returned the money with thanks and remarked that a local official ought to attend to the matter. A year later the repairs had still not been done.

A high degree of centralization tends to give support to providers but to leave communities helpless. Power relationships are uneven. Communities have become passive recipients of patronage with little encouragement or incentive to participate.

**Lessons learnt**

Clearly, it is necessary to deal with systemic and cultural constraints before progress can be made in community participation. Where it is intended to incorporate community participation into a public health care system it is not acceptable to concentrate on a specific group living in a defined geographical area: all the inhabitants should be involved. Furthermore, health personnel should play a part. It cannot be assumed that providers are always ready to participate and that only communities have to be motivated. Both providers and users need an environment conducive to participation, the constraints on which may be political, bureaucratic, social and cultural in nature.

Community participation in primary care should be seen as part of a comprehensive...
strategy, not as a discrete objective. Other factors that contribute to the creation of services responsive to the needs of populations are investment in human resource development for management, and the management structures that emerge through the formation of decentralized interdisciplinary teams.

Community participation has to fit in with other elements of primary care strategy in order to achieve the broad objectives. Primary care requires that the overall deployment and utilization of resources be given special attention. Management and planning should be rigorous but not subject to excessive central control. Health needs have to be identified and resources have to be deployed where they can influence people’s health. Communities and providers can come together only if the health system so permits. A long-term strategy, addressing the many issues involved, is necessary to bring about the right circumstances. The decentralization of decision-making is vital in the development of community participation and in providing a starting point for making services more responsive to local needs. An improved understanding of the determinants of ill-health and of the role of health services can be expected to enable communities to see beyond pressing short-term needs. Communities should be in a position to influence the deployment of resources and the adoption of promotive and preventive strategies in the interest of maximizing health gains.

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