Original Article

The Community Management Strategies for Primary Health Care Services through Local Governance System

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ABSTRACT

Introduction: Primary Health Care (PHC) is a major health care activity in many developing countries like Nepal, where community participation plays a vital role in sustaining PHC. Nepal has adapted PHC as health policy in 1991. This encouraged for community participation. However, there were no clear strategies to involve them. Hence this study was conducted to provide management strategies for PHC activities through local governance. The logical framework was developed with an objective of participated community people in PHC. The purpose of it is to develop strategies for community participation in PHC program.

Methods: This is a descriptive type of study focusing on qualitative approach. The semi-structured interview and focus group discussions were conducted with key personnel from settlement to district and regional levels. The FGDs were conducted in three groups in Sathighar VDC. Researcher herself participated meetings, and conference. The different frameworks (Environmental Analysis Framework, Weisbord's Six Box Model) were used to analyze the collated data.

Results: Four major strategies were developed. Among them, the Strength-Threat strategy is chosen. It included collaboration with DPHO, NGOs & Community Organizations (COs) for PHC Program; Mobilization of traditional healers and volunteers; bridging gender gap through gender training; promote female education through literacy classes; and improve economy through livelihood project.

Conclusion: The expected results are to establish health networking from settlement to district and to carry out participatory health planning, implementation, monitoring, and evaluation. The activities developed to achieve those results are social preparation; growth monitoring and community based nutrition and safe motherhood program; The community based supervision/monitoring and evaluation system is developed. The Potential Problem Analysis (PPA) shows that there are lack of networking skill of DDC; mistrust of NGOs with DDC and DPHO; and frequent transferring of government staffs. However, there are some enabling forces like willingness of DDC on collaboration; transparency in DDC.

Key words: Community participation, Management strategy, Strength, Weakness, Opportunity, Threat.

INTRODUCTION

Primary Health Care (PHC) has been accepted by many member nations of WHO and NGOs as the basis for their health care.system and have placed community participation in the central part of Primary Health Care. Nepal has adapted PHC as health policy in 1991. This brought health planner to think and understand the way in which community participation developed. The Local Self Governance Act (1991) provided the provision for developing many health related function and authorities to local elected bodies.[1]

As other developing countries, Nepal had many health problems like high IMR (75/1000 live births), high MMR (1500 per 100000 live birth)[2]; 80 percent women

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were anaemic and antenatal visit coverage is very low.[3] As compared to capital city, Kavre district had higher IMR (64 vs. 32 per 1000 live birth)[4]. There is still practice of not giving food during diarrhea; only 16 percent children consulted in the health facility; and rate of fully immunization children is still lower.[5]

Community participation is a social process whereby specific groups with shared needs living in a defined geographic area actively pursue identification of their needs, take decisions and establish mechanisms to meet these needs.[6] It is considered as a central to PHC.[7] DDCs/ VDCs are empowered to implement PHC program in the community.[1]

The finding of this study will provide baseline information to guide policy makers and Development Managers in developing as well as implementing possible strategies for delivering of PHC services. It will also be useful for District Development Managers, Advisors and Donor Agencies for the reviewing and further strengthening of the existing program.

METHODS

The qualitative approach was used for this management study included semi-structured interview, focus group discussions (FGDs), and ocular together with community people. The external environment was analyzed using environmental analysis framework and organization diagnosis was done on the basis of Weisbord's Six Box Model.[8] In this connection interview with a wide range of stakeholders from settlement level to District and Regional level were conducted. FGDs were conducted in three groups in Sathighar VDC. Among that one was carried out at VDC level and two were carried out in community/ settlement level. Researcher herself along with Community people had ocular inspection in the village to obtain quick information and verify some of the information.

The questionnaires were developed for the internal assessment of DDC. Weisbord's Six Box Model (1976) was the basis for the questionnaire, which measures the six variables viz; Purposes, Structure, Relationship, Rewards, Leadership and Helpful Mechanism. The internal assessment of DDc was done by stakeholders who are working together with DDC such as representative from NGOCC, UNICEF, UNDP/PDDP, and Assistant team Leader/PDDP, LDO/GON, PO/DDC, Some political leaders and some VDC chairpersons.

Data analysis techniques: The collated primary and secondary data were analyzed based upon on the above mentioned models.

Interpretation and diagnosis: The obtained data were assessed with the amount of variance for each of the seven variables (1-7). In relation to a score of 4 is the neutral point and above 4 would indicate a problem with organizational functioning. The closer the score to 7 is the more severe the problem would be. Scores below 4 indicate the good functioning and with a score of 1 indicates optimum functioning.

RESULTS

Findings and discussion: The health problem of Kavre district was not different from other parts of Nepal. The high mortality and morbidity is due to prevalence of communicable diseases like diarrhoea, RTI, measles and malnutrition. The hygiene and sanitation condition was poor. Immunization coverage was lower as compared to capital district. More than half portion of children was malnourished. The modern health care services are not easily accessible to majority of people living in rural areas. Most of children did not get treatment when they were sick due to poor economy, lack of knowledge on health care, unaffordable and inaccessibility to medical facilities and services. The overall literacy rate for district was low and female literacy rate was even lower as compared to male in district. The political commitment for primary health care is lacking in action and result. The society is male dominant and there is gender disparity. People believe on traditional healers. The lower caste people are socially and economically deprived and their participation on health care program is very low. Majority of people depends upon agriculture. Despite of those, there were some opportunities. The community organizations, which are the potential outlets for program delivery, are functioning well. Health resources of the district were not properly used. The LSGA has provision for developing many health related function and authorities to local elected bodies. The donors are supporting for the development of whole community and also regarding the children and mother including their health respectively.

Analysing internal environment, the strengths, weaknesses, opportunities and threats were identified which is shown in table 1.

Table 1 : SWOT Matrix

External / Internal	Opportunities	Threats
	Well functioning COs	Higher morbidity of children
	Underutilized health resources	Lack of Proper Health Management
	Conducive Government policy	Gender disparity
	Ongoing implementation of DPCP	Low literacy rate
	Support from donor agencies	Lack of political commitment
		Poor economy
Strengths	**Strength - Opportunity (SO) or Expansion Strategy**	**Strength - Threat (ST) or Networking Strategy**
Good leadership	Enhance participatory planning using Triple A Process in PHC	Collaboration with DPHO, concerned NGOs & COs for PHC Program
Clear purpose	Extension of DPCP	Mobilization of traditional healers and health volunteers involving them in COs
Strong network from grass root level to DDC		Bridging gender gap through gender training
Good relationship with donors		Promote female education through literacy classes
Strong financial resource mobilization and management		Improve economy through livelihood project
Weaknesses	**Weaknesses-Opportunity (WO) or Consolidation Strategy**	**Weaknesses - Threat (WT) or Wait and See Strategy**
Poor coordination with LAs & Local NGOs	Enhance capacities of staffs, local leaders and CO s	Continuation of project delivery services
Low capacity of staffs in monitoring and supervision	Enhance computer technology	
Inappropriate organizational structure	Develop Participatory supervision and monitoring	
Low capacity on technology utilization		
Poor information system		

Recommendation: Based on the SWOT Matrix analysis there are four major areas of strategies viz: SO, ST, WO and WT. Hence, the ST strategy was recommended based on the criteria (Table 2) which, includes like enhance of Triple A; Expansion of DPCP; Joint PHC program, and Mobilization of traditional healers, women's group. This strategy was chosen with the indicators of magnitude, relevance, importance and sustainability. This strategy comprised of following sub-strategies.

Collaboration with DPHO, concerned NGOs and COs for PHC program: The prevalence of simple communicable diseases led to high morbidity among children. DDC needs to collaborate and coordinate for the PHC programs with DPHO, and other concerned NGOs. Looking at it's strengths and weaknesses, following participation mechanism help to enhance it's health program.

Mobilization of traditional healers and health volunteers: Since, Traditional Healers and Health Volunteers are the key stakeholders in the community, they should be mobilized properly. They should be involved in nearest community organization.

Table 2 : Selection criteria for strategic option:

Strategies	Indicators of measurement			
	Magnitude	Relevance	Importance	Sustainability
Strength-Weakness (SO)	×	√	√	×
Strength- Threat (ST)	√	√	√	√
Weakness-Opportunity (WO)	×	√	×	×
Weakness-Threat (WT)	×	√	√	×

Note: Responding (√); Not responding (×)

Bridging gender gap through gender training: Women are needed to be encouraged in participation of health development activities. DDC need to focus on women and emphasis on women led and managed health program. In addition, gender training for women and men together should be given and advocate the value of equity of male and female for the health development.

Promote female education through literacy classes: DDC need to implement programs such as literacy classes focusing on women to improve the educational status of women and health messages should be incorporated in.

Table 3 : Areas of participation for different stakeholders in primary health care activities:

PHC Activities	Participation of different stakeholders			
	DDC	DPHO	NGOCC	COs
Social preparation	Hostage or formal & informal meetings, mobilization of COs, NGOs	Assist DDC to conduct meetings, conduction of orientation,	Participate meetings and orientation, assist in participatory data collection	Participate meetings and orientation, Data collection
Traditional healers and health volunteers training	Financial management Supervision and follow up	Conduction of training Guidance & monitoring Regular follow up	Follow up Facilitation Report keeping	Selection of participants for training Report keeping
Growth monitoring & community nutrition program	Community mobilization	Technical support Human resource Facilitation Report keeping	Technical support Human resource Facilitation	Message delivery Gather of people Weighing of baby Report keeping Group discussion
Community based safer motherhood program				
Immunization	Community mobilization	Human resource Vaccines Report keeping	Health education Facilitation	Message delivery Gather of people Report keeping
Family planning	Community mobilization Financial management	Technical support Provide contraceptives Report Keeping	Human resource Health education Facilitation	Message delivery Gather of people Counsel
ANC/PNC Check up	Advocacy	Technical Service Human resource Medicine supply	Facilitation Health Education	Message delivery Gather of people Check up by TBAs
Safe delivery	Advocacy	Technical Service Human resource Medicine supply Equipments supply	Advocacy Facilitation	Message delivery Gather of people Counsel
Breast Feeding	Advocacy	Advocacy & education	Advocacy & education	Advocacy & education
Community Drug Program	Community management Coordination Financial contribution Monitoring and supervision Feedback	Technical support CDP training Human resource Coordination Monitoring and supervision Feedback	Facilitation Coordination Trainings	Cooperation Information dissemination
Safe drinking water management through community participation	Community mobilization Financial management Follow up	Provide manpower Provide bleaching powder	Technical support Health education	Regular purification of water Safeguarding of water sources
Referral System	Linking network with secondary and tertiary hospitals Providing ambulance facility	Linking network with secondary and tertiary hospitals Developing referral system	Referring complicated cases	Referring complicated cases, keeping records
Health literacy	Community mobilization Financial management Follow up	Trainings as per needed Human resource Coordination Monitoring and supervision Feedback	Trainings as per needed Coordination Monitoring and supervision Feedback	Report keeping Community mobilization Discussion in every meeting

Source: Assessment of original data

Table 4 : Community participation in primary health care: Logical framework
(Proposed project period for four years)

	Intervention Logic	Objectively Variable Indicators	SOV	Assumption
Overall Objective	Participated community people in PHC	Involved DDC, VDCs, COs, local NGOs in PHC during participatory health management including assessment of health needs, analysis, take into action and monitoring & evaluation; % of financial contribution for health program.	Records of DPHO, DDC, VDCs, COs and NGOs	DDC, VDCs, COs, NGOs have known Triple A process
Program Purposes	Developed strategies for community participation in PHC program	Implemented no of various activities	Records of DPHO, DDC, VDCs, COs and NGOs	DDC, VDCs are supportive
Results	Established health networking from settlement to district and carried out participatory health planning, implementation, monitoring, and evaluation.	Established working network from settlement level to district level forming Health Management Committees in each level Signed agreement with DPCP, DPHO for PHC and developed collaborative program by participatory way. Implemented participatory health planning, implementation, monitoring and evaluation	Records of DPHO, DDC, VDCs, COs and NGOs	LSGA 1999 has empowered local govt
Activities	**Social Preparation:**			
	Organizing I/Formal meetings and conference on PHC management through community participation.	No. of formal and informal meetings conducted	Concerned VDCs, COs,	
		No. of conference held	Records of NGOs, DPHO, DDC	
	Formation of Health Management Committees at district & VDC level.	No. of Health Management Committees formed	Records of NGOs, DDC, DPHO, TBAs record, HP and Ilaka Health center	
	Orientation of community participation in PHC in each level from district to down.	No. of orientation held		
		Availability of data/information		
	Collection of data in participatory way using PRA	No. of traditional healers and health volunteers trained such as Dhami/Jhankri, TBAs and FCHVs	Records of COs, SHP, HP, DDC	
	Traditional healer, Health Volunteers training	No. of COs started growth monitoring of under 3 years children and preparation of sarbottom pitho		
	Dhami/Jhankri training			
	TBA Training	No. of COs involved in safe motherhood program		
	FCHVs training			
	Growth Monitoring and community nutrition program	No. of pregnant mothers received antenatal and postnatal service	Records of COs, SHP, HP, DPHO, DDC	
	Community based safe motherhood program	% of children and mother immunized	Concerned HP, PHC Center, DPHO, DDC	
		No. of couples received FP services		
	Antenatal & postnatal check up	Home delivery vs. hospital delivery cases		
	Immunization of children and mothers	No. of mothers breast fed their babies up to 2 years		
	Family planning	% of financial contribution by DDC and VDCs		
	Safe delivery			
	Breast feeding	Formation of Community Drug Management Committee		
	Community Drug Program	Prepared a detail Scheme for Community Drug Program	Records of NGOs, DDC, COs	
	Formation of Community Drug Management Committee	No. of orientation and trainings at different level in CDP		
	Development of detail scheme for Community Drug Program	No. of water resources protected and managed by community people		
	Orientation/training			
	Safe drinking water management through community participation	Agreement with town hospital for referral system	Records of DDC, DPHO, Hospital	
	Development of referral system	No. of health education classes	Records of DPHO, HP, COs, DDC	
	Health Literacy			

Pre Condition: DDC, VDCs &DPHO implements LSGA 1999 & emphasis on participatory planning, implementation, monitoring &evaluation of PHC in the community in collaboration with DPCP.

Improve economy through livelihood project: DDC should promote the income generating activities of those people through giving opportunity of livelihood project.

In order to fulfill the aforesaid strategies, DDC has it's core competencies working in the community, is networking up to the settlement level for community participation. It has already implemented DPCP and applied the participatory process using Triple A, PRA, and growth monitoring tools. This is the right time to develop the capacities of staffs of DDC and DPHO, political leaders as well as CO. However, DDC has poor coordination and linkage with other Line Agencies and Concerned NGOs, which need to be strengthened.

Lastly, the project was designed using Logical Framework assuming to accomplish with in four years (Table 4).

The community based supervision/monitoring and evaluation system was designed. DPHO, PHC center, HP, SHP are solely responsible for technical backstopping and monitoring and supervision in their respective level. Whereas, DDC, VDCs, Ward Committee and COs are responsible for community mobilization, information dissemination as well as administrative management. The health activities report will be reported from COs level and will review and compile in each level. The review meeting will be held every four monthly in DDC. The supervision and monitoring is carried out with checklist from their each level. The review and evaluation takes place in two ways using participatory approach.

Community Based Supervision/ Monitoring and Evaluation System

Supervision and Monitoring System: The DPHO is the key line agency to implement PHC program. District Public Health Officer is solely responsible for effective implementation of the PHC program. DPHO, PHC, HP, and SHP are responsible for technical backstopping and monitoring & supervision. DPHO mobilizes local level health manpower for program implementation. Whereas, DDC, VDC Management Committee, COs are more responsible for administrative management and community mobilization for delivery of PHC services. Hence, monitoring and supervision will be applied from both sides.

District Health Management Committee will also supervise and monitor the program at least below the VDC level during the program launching time and organize the four monthly review meeting. The committee regularly supervises and monitor once a month visiting the site. VDC Health Management Committee also supervise and monitor in each ward in every month especially attention will paid during the program launching time. VDC Health Management Committee also organizes meeting in every month on progress report of all wards and will discuss about the issues on primary health care such as how many children improved in their weight, how many vaccinated, how many suffered from diseases etc in their CO level which they will report to DDC Health Management Committee. Supervision and monitoring will be done with checklist in each level to make it more effective and practical. After which, report will be forwarded from settlement level to DDC in each month via each Health Management Committee.

Evaluation System: The evaluation will take place in every level in participatory way. Monthly meeting will be held in VDC and issues will be discussed in the VDC Health Management Committee. Similarly, review/evaluation meeting at VDC takes place in every four month and recommendation, suggestions and feedback send to COs and District Health Management Committee. Likewise, District Health Management Committee organizes the biannual review/evaluation meeting on progress and will find out strengths, weaknesses and provide feedback to VDC, DDC, LAs and NGOCC respectively. Thus review and evaluation takes place in two ways using participatory approach.

Program Impact on Individual Level: There are several factors, which play an important role to make community participation effective. A more important factor is the preparedness of the target beneficiaries and their knowledge and attitude towards PHC. An effective participation results in increase in immunization coverage, nutritional status, contraceptive prevalence rate, health awareness, female literacy, gender balance, promotion of safe motherhood, improve in hygiene and sanitation, decrease in childhood morbidity and availability of drugs in the health centers. Ultimately, this increases the quality of life of individual, increasing in individual income and lowering health budget of each household. The following diagram will clarify further more in this regard (Fig. 1).

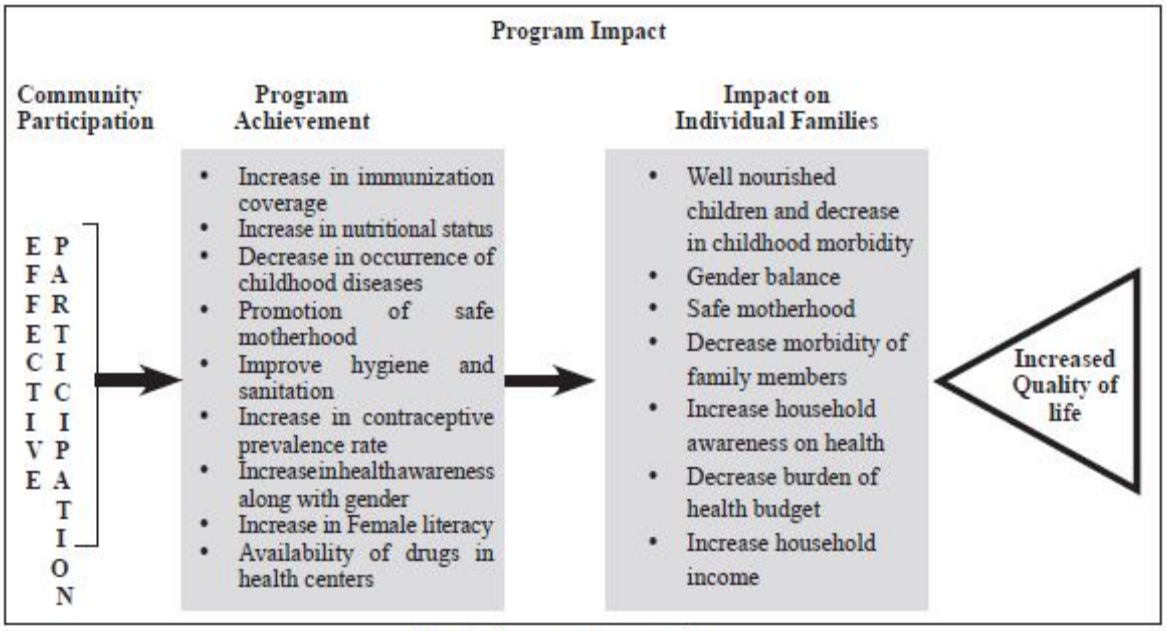
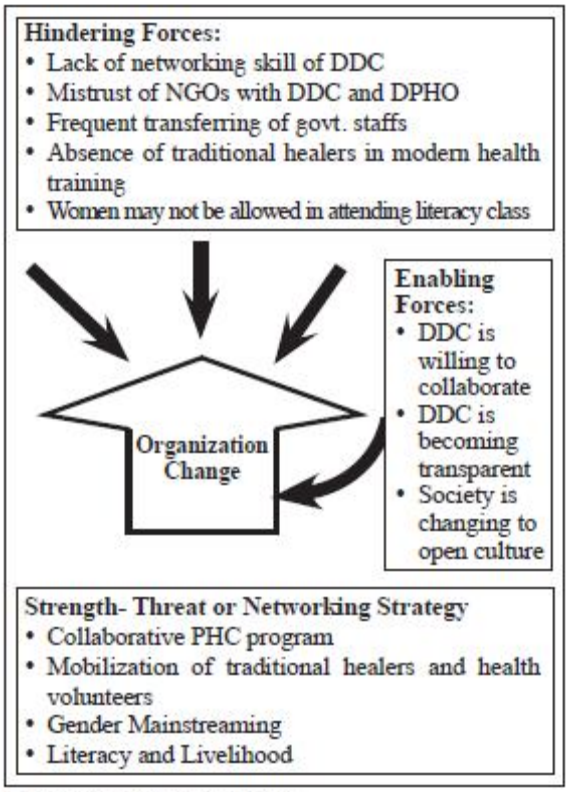


Fig. 1 : Program impact scheme

Hence, an effective participation of each households and individuals has impact on the health of the individuals and their quality of life.

Potential Problem Analysis: Some of the problems could be occurred during implementation of program. Those potential problems could be lack of networking skill of DDC. NGOs might not believe with DDC and DPHO because they lack in commitment and slow in process. Besides, DPHO has problem of frequent transferring of government staffs. Concerning the training for traditional healers in modern health, they might not attend in training because of their culture value. Women may not be allowed to participate in literacy classes. The following diagram further clarified this concept (Fig. 2).

There are enabling factors, which help to overcome the above-mentioned hindering factors. DDC is willing to collaborate program with DPHO, concerned local NGOs and COs. It is developing information system to make transparent. Donor Agencies can negotiate with government to keep staffs stable in the same post at least for three years. Besides, society is changing to open culture. This helps in empowering gender. Some of the solutions to overcome hindering factors and strengthen enabling factors are given below.



Source: Assessed in original data

Fig. 2 : Potential problem analysis

Solutions to overcome hindering factor and strengthen enabling factors

Make DDC coordination Committee strong and capable.

Involvement of male in management committee for literacy classes.

Involvement of male partners in gender training.

Provide traditional healers with First Aid Box with simple modern medicine like Cetamol, Brufen, Rehydration Package same as given to FCHVs.

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