Short Notes

Community participation & their concepts about decentralization of health programs, in Shendi locality-River Nile State, Sudan

Suleiman Elkamil Ahmed **Hamid**[*]**;** Abdel Ghaffar Ali **Adam**[*]

[*] Public Health, department of health education, faculty of public health, Shendi university, Sudan – E.mail: slmanlma@hotmail.com – Mobile: 0122006418

Abstract

This observational cross-sectional study was carried out in Shendi locality-River Nile State, Sudan. A sample of 653 individuals of different classes from the community, health managers, and health workers in facilities of primary health care (PHC) in the locality were selected to asses the community participation and to know their concepts about decentralization of health programs. The sample was selected using stratified sampling, then random simple sampling was used for each class. Structured questionnaires, & focus groups discussion, were used for collection of the data. (27.3%) of the community participated in health programs. In addition, there is statistical significant association between community participation in health programs and the age of the users of the health facilities. (23.3%) of the community participation is in the planning. Most of the community leaders define decentralization as delegation & distribution of responsibilities. (33.3%) of the health managers define decentralization in health system as delegation of authority. The current study shows that there is partial community participation in health programs. Health managers have to encourage this participation to be holistic and establish health programs on scientific way according to the community needs.

Keywords: ***Community Participation, Concepts, Decentralization, Health Programs***

Introduction

Community is a group of people sharing common values, interests or identity, which distinguishes them from other communities, [(1)]. In addition to the health sector, families and communities need to get actively involved in taking care of their own health. Communities should participate in the following:

- Creating and preserving a healthy environment

- maintaining preventive and promotive health activities
- Sharing information about their needs and wants with higher authorities
- Implementing health care priorities and managing clinics and hospitals, [2].

Development of community participation has many concepts as community involvement, community participation, and community based initiatives (CBI). (CBI) aim to achieve all aspects of development through an integrated approach that utilizes social mobilization and empowerment to guarantee sustainable development for health. CBI strategies introduced include basic development needs (BDN), healthy villages program (HVP), healthy cities program (HCP) and women in health and development (WHD). These CBI strategies all pivot around communities playing an active role in improving the quality of life and health of the people, thus ensuring self-sufficiency and subsequently sustainable development, [3]. All that concepts go with the objectives of the millennium development goals (MDGs), which are eight international development goals that all 193 United nation member states and at least 23 international organizations have agreed to achieve by the year 2015. They include eradicating extreme poverty and hunger, achieve universal primary education, promote gender equality and empower women, reduce child mortality rates, improve maternal health, combat HIV/AIDS, malaria, and other diseases, ensure environmental sustainability, and develop a global partnership for development, [4]. The aim of the Millennium Development Goals (MDGs) is to encourage development by improving social and economic conditions in the world's poorest countries, [5]. However, the overall responsibility of the central and state Governments, the involvement of individuals, families and communities in promotion of their own health and welfare, is an essential ingredient of primary health care. Countries are now conscious of the fact that universal coverage by primary health care can't be achieved without the involvement of the local community. There must be continuing effort to secure meaningful involvement of the community in the planning. Implementation and maintenance of health services, besides maxim reliance local resources such as manpower, money and materials. In short primary health care must be built on the principle of community participation (or involvement), [6]. The promotion of primary health care, health education, immunization and environmental improvement cannot be successful unless the community participates, [7]. Community participation simply means people have to be active with the health workers and health programs, [8].

The aim of health system is health development and to achieve health for all, [9]. In

the other side to improve health status & health facilities to be accessible, decentralization in health system is needed to give more power to the local health system and to cover people by the health services. The majority of the literature define decentralization as being the process that transfers both authority and responsibility from the central government to subordinate governments, [10]. Sudan is the largest country in Africa, the large distance and continuous increasing in population need suitable means to develop and aware the community for promoting public health and improving the available health services. In addition, health system in Sudan needs decentralization to allow good coverage by primary health care.

Health in the developing world presented a gloomy picture of health, [11]. Sudan has many problems which were faced the health systems. To overcome the above obstacles, come sound of the primary health care (PHC) system adoption. In addition a new strategy came, to covered people by the health services of (PHC).

Sudan participated in WHO general assembly in 1973, and committed the strategy of PHC program in 1976, [12], [10]. Sudan health ministry suggests starting the application of the district health system in Harare in august 1987, [10], to achieve the decentralization in the health system.

Shendi locality is one of the localities of the River Nile state, which was implemented the PHC strategy and adopted the health area system, [13]. Therefore, this study done to assess the community participation & to know their concepts about decentralization of health programs.

Methodology

This study is observational cross-sectional study. It was conducted in Shendi locality in September 2007 - April 2010, to asses the community participation and to know their concepts about decentralization of health programs. Shendi locality is one of the localities of the River Nile State. It is 173 km north of Khartoum, the capital of Sudan. The total area of the locality is about 14596 Km2, [14].

The total population of Shendi 'Mahalia' is estimated at about 245000, [15], most of them are farmers. The total number of the families are about 43340, (48.7%) of them are male and (51.3%) are female , [16]. The sample size of 653 individuals was selected of different classes from the community and health workers in the facilities of PHC in the locality by using stratified sampling then random simple sampling was used for each class of the community study as in the following:

- Total coverage of the health workers, (209).
- (30) of the health programs managers of health in ministry of health of River Nile state and in Shendi locality.
- (3o) of the community leaders.

- (384) of the users of the health facilities from the community.

Stratified sampling technique was used to select suitable sample size then a simple random sampling was run to take (384) person of the users of the health facilities from Shendi population, (245000), as a representative sample to fill the questionnaires.

A sample 384 persons were selected. This sample size was sufficient to provide 95 % assurance that the margin of error did not exceed .05 assuming that the population of Shendi locality is (245000) person. The formula used is: n = NZ2 S2 / Nd2 + Z2 S2, [8], [17].

Data was collected by the following means:

– Structured questionnaires to be filled with: Health managers, Health workers, & Users of the health facilities.

– Focus group discussion was done for: the community leaders**.**

The interviewing & groups discussion were done by the researcher him self or his trained assistants.

The collected data from the questionnaires was analyzed by entering it into computer and analyzed using the statistical package for social sciences programs (spss), and then results were presented in tables and figures. Chi-square test was used for testing the associations. The level of statistical significance was set at P-value equal to or less than 0.05 for all tests.

Results

Quantitative results

Table (1): shows the status of community participation in health programs, according to the health managers.

N=30

Variables	Frequency	Percentage
Participated	17	56.7
Not participated	13	43.3
Total	30	100

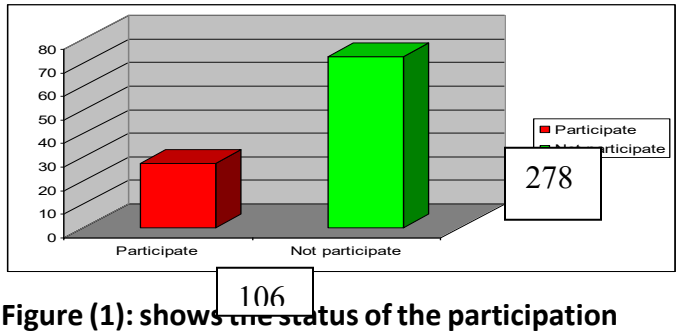


Figure (1): shows the status of the participation of users in health programs. N=384

(27.7%) of the users participated in health programs, and (72.3%) not participated, as in the above figure.

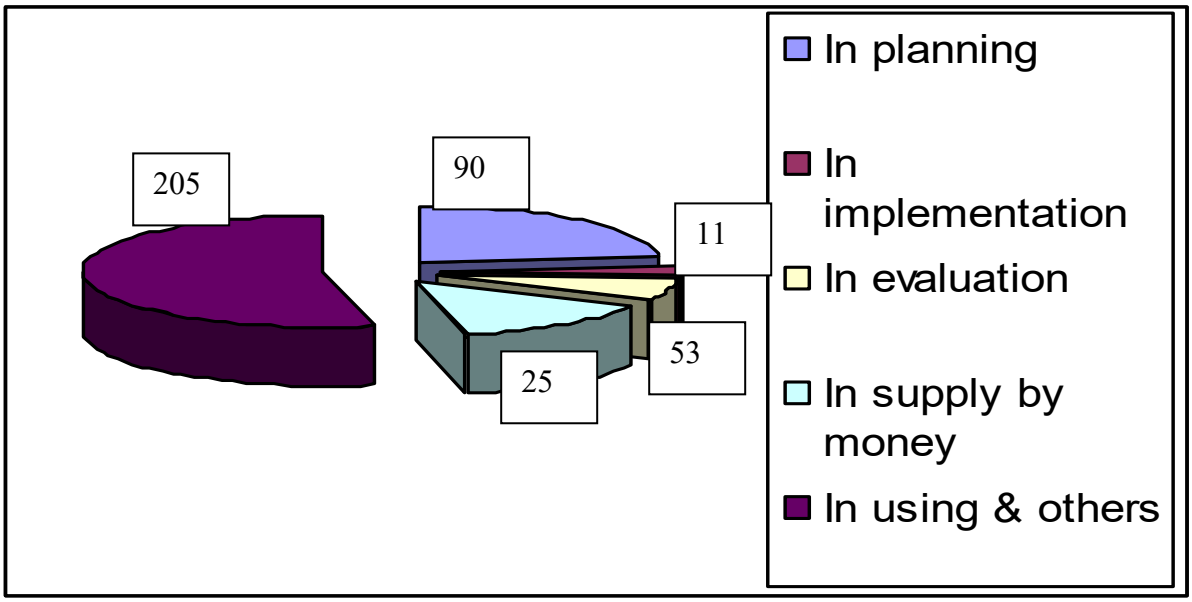


Figure (2): shows the types of the community participation in health programs, according to the users. N=384

(23.4%) of the community participated in planning, (3%) in implementation, (6.5%) in evaluation, (13.8%) in supply by money, (53.3%) in using of health facilities and others, as in the above figure.

Table (2): Shows the status of the community participation according to the sex. N=384

Status of participation	Sex		Total	**P-value**
	Male	Female		
Yes	62	41	103	0.053
No	137	144	281	
Total	199	185	384	

P-value equal or less than 0.05

No statistical significant association between community participation and the sex of the users of the health facilities, because p-value is more than 0.05.

Table (3): shows the status of the community participation according to the age.

N=384

Status of participation	Age				Total	**P-value**
	Less than 15 years	15-30 years	30-45 years	More than 45 years		
Yes	8	52	27	16	103	0.000
No	2	114	112	53	281	
Total	10	166	139	69	384	

P-value equal or less than 0.05

There is statistical significant association between community participation and the age of the users of the health facilities, because p-value is less than 0.05.

Table (4): shows the status of the community participation according to the education. N=384

Participated	Education						total	P-value
	Illiterate	khaloh	Primary	secondary	University	Above university		
Yes	**14**	**7**	**26**	**23**	**32**	**1**	**103**	**0.193**
No	**42**	**14**	**70**	**94**	**59**	**2**	**281**	
Total	**56**	**21**	**96**	**117**	**91**	**3**	**384**	

P-value equal or less than 0.05

No statistical significant association between community participation and the education of the users of the health facilities, because p-value is more than 0.05.

Table (5): shows the status of the community participation according to the social status. N=384

Status of participation	Social status				Total	**P-value**
	Single	Married	divorce	widowed		
Yes	35	64	2	2	103	0.309
No	79	177	17	8	281	
Total	114	241	19	10	379	

P-value equal or less than 0.05

No statistical significant association between community participation and the social status of the users of the health facilities, because p-value is more than 0.05.

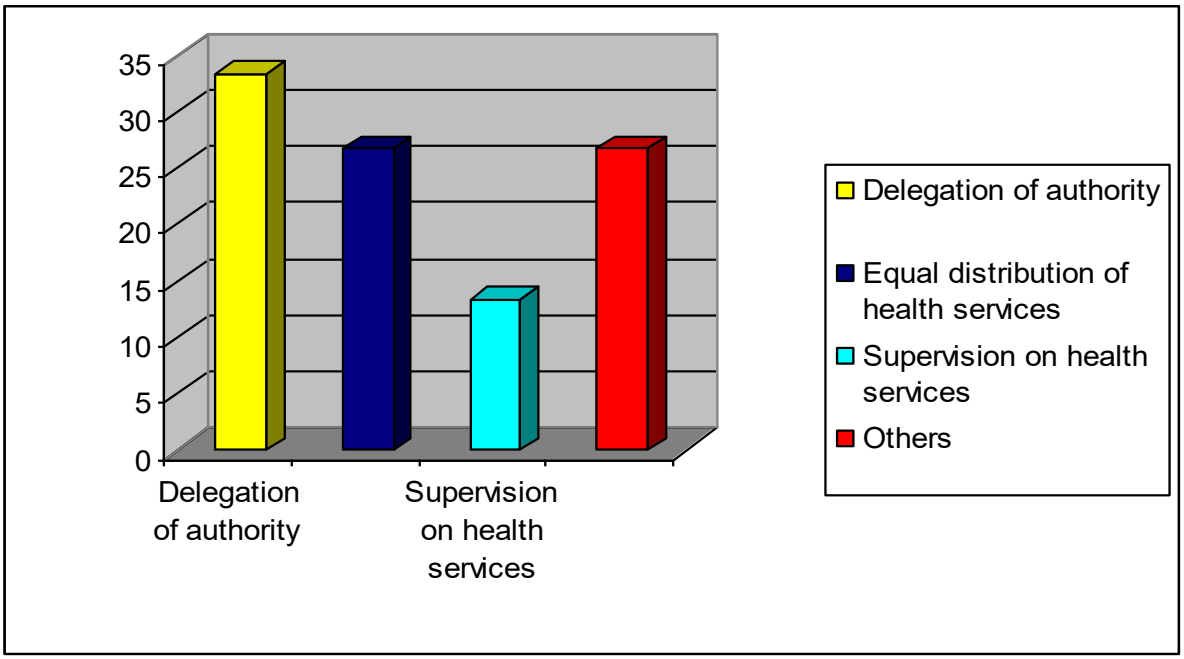


Figure (3): shows the concepts of the health managers about decentralization - N=30

Health leaders define decentralization in health system as, (33.3%) delegation of authority, (26.7%) equal distribution of the health services, (13.3%) supervision on health services, and (26.7%) others, as in the above figure.

Qualitative results

Results of focus group discussion of the community leaders

- Most of the community leaders define decentralization, as a distribution of responsibilities.
- Health authority delegates responsibilities from up level to lower one.
- Community leaders are organizing community by dividing it to committees.
- Health programs and health problems solution come from the community.
- Health managers participate with community leaders in, planning, implementation and evaluation of the health programs.
- Their assessment of public support of the health facilities is poor.

Discussion

Although (23.3%) of the community participated in health programs, figure (2), (72.7%) of them are not, figure (1), this result disagrees with, [6], [18], [19], & [20], "in addition to the health sector, families and communities need to get actively involved in taking care of their own health. There must be continuous effort to secure meaningful involvement of the

community in the planning, implementation and maintenance of health services. In short primary health care must be built on the principle of community participation or involvement".

No statistical significant relation between community participation and sex, education & social status of the users of the health facilities, because P-value is more than 0.05, tables (2), (4), and (5). However, the study found statistical significant relation between community participation and the age, because P-value is less than 0.05, table (3).

The concept about decentralization of the community leaders & health leaders is agreed with, [10], (the process that transfers both authority and responsibility from the central government to subordinate governments).

Conclusion

An observational cross-sectional study was carried out in Shendi locality-River Nile State, Sudan in September 2007 - April 2010, to asses the community participation & to know their concepts about decentralization of health programs. Finally, the conclusions of this study are the following:

- (27.3%) of the users of the health facility participate in health programs.
- There is statistical significant association between community participation & age of the users of the health facilities.
- (23.3%) of the community participation is in planning.
- Most of the community leaders define decentralization as delegation & distribution of responsibilities.
- (33.3%) of the health managers define decentralization in health system as delegation of authority.

Recommendations

Managers of health system to distribute equitably, cover people in the locality by the health facilities, & health facilities to be accessible, they have establish health programs on scientific way and on real studies according to the community needs & the size of the population they have to encourage participation of people in health programs, so to improve the health of the community.

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