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Are People willing to Participate in Solving their own Health-related Problems? (Case Study of Kermanshah, Iran)

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ABSTRACT

Community participation has been suggested to achieve a healthier life. The aim of our research was to encourage popular participation in the population research station project in Kermanshah, Iran, and to subsequently survey the viewpoint of the community. In this project, we first interviewed policymakers, researchers, public representatives, stakeholders, members of nongovernment organizations (NGOs), and clerical authorities in order to gain their participation. We then identified the existing capacities of human and physical resources of the district, and we organized community participation. In the second part of the project, we surveyed the viewpoint of people on participation. We identified social, political, economic, cultural, and organizational factors that required mandatory intersectional participation in order to be resolved. In our study, 64.8% of people were satisfied with their participatory activities as moderate to high. This study demonstrates that enabling people, leading them, and encouraging social participation are available solutions to many health-related problems.

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Introduction

Community participation has been suggested for achieving a healthier life and well-being[1] and for reducing socioeconomic inequalities in health. It is widely accepted that people should have a say in decisions that are likely to affect them and be given the opportunity, where possible, to participate in the process of development[2,3]. The organized participation of people in health related activities dates back to the Second World War, along with the development of nongovernmental organizations (NGOs)[4]. Since the 1970s, its importance has been increasingly revealed and has found its way into different economic, social, political, cultural, and environmental areas as a novel approach[5]. A report of 30 national public health institutes showed that popular participation and the empowerment of people were main tools for development, and the report estimated this participation to be more than 65% in this case[6]. In 2001, Iran's Ministry of Health and Medical Education established population research centers (PRCs) based on community participation toward the promotion of health as part of the research/education sector of medical universities. In this research, our aim was to encourage popular participation and the participation of local NGOs in the population research station project in Kermanshah, Iran, and then survey the viewpoint of the community in this regard.

Materials and Methods

In 2002, Kermanshah University of Medical Sciences (Iran) established a PRC and named it as social development and health promotion (SDHP) research center in a healthcare center in a region ("Abadani-Maskan") in Kermanshah with a population of 36,000 households (more than 100,000 individuals). The first part of this study used a qualitative design to establish a participatory project; this part of the study was initiated in June 2006 and completed in August 2010. At first, we interviewed policymakers, researchers, public representatives and local influential persons, managers and other stakeholders in the health sector, city council, municipality, and NGOs, as well as clerical authorities, in order to explain the project, draw their participation and commitment, make policies, supervise the activities, and describe the influential factors and their outcomes. Then, we prepared the population profile of the district and identified the existing capacities of human and physical resources. Next, the population was geographically divided into 24 parts, and two representatives (a male and a female) from each part, who were organized into a voluntary group named the "Council of Trustees," were selected. We encouraged popular participation for compiling interventions to solve the problems of "Abadani-Maskan," by communicating with the lay public and organizations. All problems mentioned by the people were followed up and acted upon by the members of the Council of Trustees.

We started the second part of study 2 years later to ensure completion of some of the projects people followed, with the aim of surveying the viewpoint of people on participatory actions done in their areas in cross-sectional research from May 2012 through June 2012. We selected a convenience sample of urban people (325 cases). Our tool for this part of the study was a researcher-built questionnaire with 67 questions. Content validity of this tool was approved by five researchers who were experts in this field and, with regard to its reliability, Cronbach's alpha was 0.958. The data were analyzed by SPSS18 software and analysis of variance, and *t*-test and were expressed as mean ± standard of deviation. Differences were considered to be statistically significant when $p < 0.05$.

Results

In this study, over 100 residents of the region participated in the program and held more than 200 regular weekly sessions with the Council of Trustees in order to follow the problems. The main product of this study was the voluntary and deliberate participation of people.

The other capacities that we built in the community were as follows: employing a variety of communication channels that suited the public culture, changing the views on the role of the people in the decision-making process, and cultivating a culture of research in the community, determining quantitative and qualitative needs and setting needs priorities, partnering a wide range of stakeholders in participatory projects, allowing an interchange and application of experiences, and finally laying the groundwork for a new approach to research. Our findings indicate that in the region studied, people's interventions were aimed at the issues mentioned hereunder in Table 1. In the second part of this study, our sample was 141 males and 184 females. They

were 17-87 years old and their mean age was 41.83 ± 13.79. One hundred and sixteen cases (36.65%) were high school, 124 cases (39.1%) were diploma, and 77 cases (24.3%) were graduates. Forty-four cases (14%) were unemployed, 90 cases (28.6%) were employed, 65 cases (20.6%) were retired, and 116 (36.5%) were housewives.

The viewpoint of people about participatory actions done in their area regarding health-related problems is shown in Table 2 and, also in this regard, total viewpoint is shown respectively in Table 2.

Table 1. Actions conducted in the region by active community participation

Objective	(Participatory Interventions) Study Interventions
Medical Health care	Providing free medical service for sick children and newborns of poor families; Free nutritional consultation for low-weight children by physicians in the center; Distributing health pamphlets in the region; Providing family consultation for residents with the aim of prevention of divorce and for mental health; Starting educational classes for people with the aim of care of themselves.
Prevention of crimes	Resolving the trouble caused by hooligans, purse snatchers and thieves through the police force; Reporting companies with suspicious activities to the police; Reporting notorious criminals and drug dealers to the police; Preventing the accumulation of drug addicts in residential areas; Establishing a police kiosk in the commercial area increasing police beats in crowded areas; Assigning night watch and volunteer night beats; Providing and repairing lighting.
Reducing unemployment	Establishing “Business Planning” educational classes including: home business and small business (SMEs); Classes for the graduate and undergraduate youth.
Reducing poverty	Starting carpet classes for family-supporting women; Identifying poor families and reporting them to responsible authorities and supporting organizations; Identifying charity activists; Identifying the children requiring educational aids in poor families.
Improvement of physical status on streets and paths	Asphalting main roads and alleys; Pitching road signs; Repairing paving of the curbs; Pitching shades and seats in bus stops; Covering sewage ditches along the streets; Fencing off deserted lands and half-completed buildings.
Establishment of new spaces (cultural, sports, green spaces, etc.)	Following the establishment of cultural centers for the youth; Establishing new parks; Installing exercise facilities in the parks.
Improvement of nutrition and food hygiene	Dealing with unhealthy provision of meat in butcher shops; Supervising the conditions of bread baking in baker shops; Preventing illegal livestock slaughtering in the region; Preventing the sale of unpacked foods; Increasing the flour rations of some baker shops to meet the need.
Improvement of green spaces	Improving green space, tidying trees and preventing tree cuttings; Establishing prayer rooms and restrooms in parks; Improvement of tourism in TAG-E-BOSTAN (an ancient area).
Improvement of environment hygiene	Reducing water cuts, replacing and repairing faulty plumbing; Following the problem of garbage collection and transportation; Preventing the conversion of house yards to grocery stores.
Improving transportation system	Providing speed bumps in some crowded streets; Providing traffic signs; Following the traffic problems of crossroads; Reporting the high-risk streets to the authorities.

Table 2. Total viewpoints of people about the participatory actions done in their area in health related problems

	Not efficacy , or Have no Idea	Low efficacy	Moderate efficacy	High efficacy
Societal Security[1]	2.8%	34.5%	47.7%	15.1%
Medical Health Care[2]	5.2%	32.9%	48%	13.8%
Environmental Sanitation[3]	1.5%	28.9%	55.4%	14.2%
Total	3.1%	32.1%	50.4%	14.4%

1- Include numbers 2, 3 and 4 from table 1.
2- Include numbers 1 and 7 from table 1.
3- Include numbers 5, 6, 8, 9 and 10 from table 1.

Discussion

In our study, the rate of participation was very large at the beginning, and then it started to decline with a gentle slope and eventually reached a constant level. This because there were factors influencing participation and in this regard, a number of issues must be considered as a main problem. We concluded that more time is needed to empower the public and other partners of the participation process and our center did not adequately distribute power to all involved parties. It must not be ignored that community participation in health matters is a multifactorial and complicated issue and should be considered as a repeated learning process with reasonable expectations[7]. In this regard, the results of studies done from Morocco showed that the national trachoma control program was successful but the tuberculosis control program failed, although they were structured in one country with the same capacity, but with different strategies[8].

Our study showed that organizing people enables them to communicate their requests to the authorities and provides the groundwork for their responsibility for following the solution to a specific problem. In addition, it reflected the people's concerns to authorities and vice versa, according to what Friend (1998) defined[9]. It is known that the highest level of participation occurs when an organization requires a community to identify the problems and adopt the key decisions for achieving the solution[10].

The most, mainly health issues, with regard to SDH priority done in Iran in the field of societal security in our study, were unemployment, drug abuse, road accidents, empowerment of women in their life skills, development of prevention of child abuse[11-13], structuring women's neighborhood groups toward a CBPR to eradication of unemployment in Tehran, and structuring them as an available legal resource, and so on[14].

CBPR has also been successful in many projects in the line of environmental sanitation in Iran[15]. In our study, 64.8% of people were satisfied with their participatory activities as being moderate to high; this has been mentioned in other studies[2,3,16]. Successful CBPR projects that have been reported around the world demonstrate numerous strategies for health promotion[17-20], although there is need for more investigation in this regard.

Conclusion

This study demonstrates that enabling people, leading them, and encouraging social participation are available solutions for solving many health-related problems.

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