Report

Community context of health system development: implications for health sector reform in Pakistan

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SUMMARY To describe local sociopolitical and organizational factors that influence health system development in Karachi, Pakistan, we conducted participant observation while working with health providers and communities in one urban district to reorient services towards a primary health care district health system. We found that the community characteristics, particularly the diverse socialpolitical and cultural make-up and organizational complexity that involved multiple levels of government, influenced efforts towards collaboration and shaped the development of the health system. We conclude that for effective implementation of health sector reform there is a need to comprehend fully the community context and complexity of existing health service provision.

Background

The public sector health system in Pakistan is beset with shortages of funds, ineffective use of available resources and a lack of coordination, both within the public sector and private sectors, as reported in a study from Sindh province [1]. Devolution of power to the district level, integrated curative and preventive care, and the right to participation and effective management are issues that are currently high on the health sector reform agenda with a view to increasing access and quality of care [2,3]. These plans are envisaged within a situation where the public sector accounts for less than a quarter of attendances for health care, and within a context of mushrooming locally or internationally funded nongovernmental organizations, and a decrease in health spending in the public sector. While

this context in itself poses challenges to a coordinated system of care, there are organizational and sociopolitical factors operating at the community level that also need to be understood.

These organizational and sociopolitical factors are more complex in the squatter settlements of the larger metropolitan areas. With rapid urbanization over the last two decades, almost half of Pakistan's 140 million people now live in urban areas. Karachi, with more than 10 million people, presents the most complex situation. In this mega-city, where more than half of the population lives in poverty in squatter settlements, multiple levels of government and nongovernmental organizations and private, for-profit organizations are involved in health care delivery. A fuller understanding of the organizational and sociopolitical context is important for

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health sector reform implementation at the community level.

In one district of Karachi, as part of the Family Health Project of the provincial government, efforts were made to reorient services along the lines of a primary health care (PHC) district health system. Drawing upon discussions at the International Conference on Primary Health Care, Alma Ata, 1978, the World Health Organization and other international health care advisory bodies have promoted PHC as the most relevant philosophy of health care, it brings health care as close as possible to where people live and work [4]. It is considered the key to health for all because the PHC concept includes universal coverage and care according to need; provision of comprehensive services which are affordable, culturally acceptable and effective; community participation; and intersectoral collaboration. Community health services are considered the vehicle for PHC [5]. Within this PHC philosophy, regionalized systems of health care have been promoted as an effective way to deal with the problems brought on by lack of integration and inadequate intersectoral collaboration [6].

Since the early 1990s, there had been a periodic emphasis on health planning at the district level. After 1988, at the end of a 10-year military government, the different levels of government in Pakistan appeared to be inclined towards a policy of local planning and a shift towards the community participation principle of PHC. Within that context, the Family Health Project, funded by the World Bank, was launched. It focused on building district health management teams, fostering interaction with the private sector, enhancing community participation and developing a frontline hospital for non-specialized in-patient care.

An opportunity to identify and analyse factors influencing the health system was made possible during 1993 and 1994 while working to introduce change in the health system in one district of Karachi as part of the Family Health Project. In Pakistan, provision of health services is primarily a responsibility of provincial governments. While the provinces are divided into districts for management and health care provision, essentially, all planning takes place at the provincial level. The project aimed at reorienting the existing services towards a district health system. Karachi is divided into five large administrative districts, each having a population of about 2 million. District South was selected as one of the pilot districts for the Family Health Project, for which a university team provided technical assistance to the government health department.

In describing the factors that influence efforts to bring about change in the health system, this paper reports observations made while attempting to convert separate services into a coordinated PHC system in Karachi. During the implementation of these changes, the sociopolitical and organizational context of health services at the community level were observed. It is important to record those observations at this time when health sector reform agendas are being considered with zeal within the local government devolution plan of the government of Pakistan.

Observations

Karachi: Characteristics of communities in the study site

While the rural areas and small cities in Pakistan suffer from inadequate and poor quality social services, Karachi has its own

problems in terms of inadequate civic facilities, and health and social services particularly, for about 5 million people living in about 500 squatter settlements. The typical population of these squatter settlements is about 8000–10 000. There are, however, a few very large squatter settlements as well. Most clients of public sector health services are from squatter settlements.

A large number of people living in these squatter settlements migrated to Karachi from semi-urban and rural areas across all of Pakistan. Each settlement in the project area is populated by a majority from one ethnic group. Not only do many people in a squatter settlement belong to the same ethnic group, many with a particular trade or occupation also happen to live together. This does not mean that the adjacent areas are ethnically homogenous. A cluster of nearby settlements essentially contains assorted communities, invariably constituted around ethnicity, occupation, or even political affiliation. For example, in a population of about 50 000 from 4 settlements in one part of the project district, there were at least 4 major ethnic groups living together.

Although most in the settlements suffered from poverty, there were a few wealthy people. For example, some inhabitants had a major ownership in Karachi's private transport industry. They made their fortune after migrating to Karachi but preferred to continue living where they had first settled. They became selected or self-declared leaders and had political influence through party politics as well; they made these settlements their power base for provincial or national level party politics.

Many small community-based voluntary groups, representing their own section within the larger geographical community, take responsibility for health and social work. These groups mainly provide small-scale health and welfare services.

At the time of the project, with the bitter political divide of the early 1990s between left and right wing parties in Pakistan, the population of the settlements in the project area was divided, with roughly equal numbers of people on each side. This had implications for community cohesion for development purposes. At the same time, it was not feasible to work on a health and social agenda without getting involved with the local branches of the political parties. Since politicians from the area were inclined to favour their voters rather than their constituency, a large number of community members and service providers were sceptical of the interest of these local politicians in any organizational efforts.

To add to the complexity, different ethnic groups had different political affiliations. Party politics in Pakistan still revolves around feudalism, and voting preferences are based not on what a party has to offer but mainly on the qualifications of the leaders, such as ethnicity, economic status, caste, family/tribe, and religious denomination. Those sub-communities in the project area that had migrated from the North West Frontier and Punjab provinces voted mainly for the political party that had its power base in those areas. On the other hand, the Sindhi and Baluchi migrant communities supported the party which at the time had support from the rural areas of Sindh province. At that time, while one party was in power at the federal level, this area voted heavily in favour of the other party's candidate, who won the provincial assembly seat. The defeated local politician, who had earlier won elections for this seat, was still politically powerful as his party was in power nationally in addition to being part of the provincial coalition government. Local party politics had impli-

cations for local health system development. This point is further elaborated with an example in this paper.

Health services organization

Provision and management of health services in Karachi is complex. While the Karachi Metropolitan Corporation (KMC) is the main public sector health care provider, the federal and provincial governments operate two major tertiary care hospitals, and the provincial government has some of its own primary level outpatient facilities in addition to those operated by the KMC.

Services run by the KMC are split between medical services such as dispensaries and hospitals, and public health services such as control of flies and dogs and collection of vital statistics. At the time of the project, within the curative services provided by the KMC, hospitals with less than 20 beds were overseen by the zonal municipal committees, while hospitals with more than 20 beds were managed directly by the more central and overarching KMC administration. At that time, the KMC had five zonal municipal committees, each responsible for managing the provision of medical services in one district, while the public health division was managed by the KMC itself. Such administrative arrangements have their roots in the overall management patterns of a hierarchical civil service structure, making participatory planning and management for health regions difficult to achieve.

In Karachi, there is a large private sector for health care services. Thus, in the project area there were many private medical practitioners and for-profit maternity homes. There were no formal linkages within the private sector or between the private and public sectors. At the time of the project implementation, only a few charitable organizations provided (mainly) outpatient curative services in the area, in complete isolation from the government or private sector.

Local factors influencing health system development

The following are some examples that helped the project team to understand factors influencing health system development in these Karachi communities.

Politicization of a community facility

A community group was initiated to work on community development initiatives, with members coming from the community at large and local voluntary groups. This group took a lead in using the local KMC dispensary for meetings for the purpose of community development activities. A local politician, who had lost the election in that area but was still powerful because of his party affiliations, perceived the use of the health outpost by the community members as a political activity that could further undermine his position and therefore refused to support the group, despite being approached by them several times. He was able to stop people using the health outpost under the plea that governmental facilities/buildings cannot be used by the public for "political activities".

This conflict at the community level led to a reduction in the interest of community members in development activities. Some members became afraid that it might result in further tension in the community. It would have been much easier to promote participation in development if these tensions had not existed. There is no doubt that health system development and community participation are political in nature. However, because of the peculia-

rities of the locality, these political activities were being seen and labelled as party politics.

Voluntary groups unable to work cooperatively

Each squatter settlement in the area had at least two or three active voluntary groups, which were composed of young people, mainly men, in their teens and early 20s. These groups had a high attrition rate and had little skill in project management.

Most of the community activists belonged to such a group. Each voluntary community group represented one of the sub-communities living in the area. To encourage consolidated effort and the participation of the community at large, it was important that these groups participated in the health and social development activities. With the lack of community cohesiveness however, it turned out to be extremely difficult to motivate these groups to work together. In retrospect, a strategy promoting participation by involving the groups in contributing to separate items of the overall development agenda may have been more effective. The groups did like working together, however, working together on each item within the development process was seen as negatively influencing their identity, which they did not like.

Conflict to control the development of a front-line hospital

The project envisaged a role for a front-line hospital because it was realized that the health system was comprised of either primary care facilities, which saw outpatients only, or tertiary care hospitals which catered to all patients requiring inpatient treatment. What was missing was a front-line hospital that could decrease the load on the tertiary care hospitals. The

central management of the project was the responsibility of the provincial health department. For control and visibility purposes, the management wanted to build a new facility and were unwilling to upgrade an existing KMC facility to a front-line hospital. As might have been expected, given the history of political confrontation between the local and provincial governments in Karachi, achieving the close political working relationship implied by a district health system proved difficult. In the end, no front-line hospital was developed.

Public, private and nongovernmental sectors: reluctance to collaborate

Government staff were reluctant to include private for-profit and not-for-profit organizations in their planning, fearing that they would ask for grants from the project budgets. For example, a senior KMC official remarked that nongovernmental organizations come to a meeting with an empty briefcase and want that briefcase to be filled with government money, particularly when these organizations have learnt that the government has received funding from an international agency. At the same time, the private services had little interest in working closely with the governmental services. The commercial objectives of the private sector diverged from the social objectives of coordinated service provision. These private care providers, particularly general medical practitioners, were the main primary level health care providers for the project area community.

Local staff versus hierarchy

Those in charges of primary care facilities were more aware of the need to interact with the other services and to involve the community in order to make services more

accessible and comprehensive. However, under a traditional hierarchical model, these first-line managers had little scope to plan locally. They were required to act exactly according to directives from their respective departments. Fearing being penalized by their superiors, they were not willing to initiate community participation or interaction with other services. Here again, local characteristics operated. With first-hand knowledge of the community's needs, two first-line managers started taking the initiative. They were politically strong in the local milieu, so were not afraid of taking decisions for which other managers waited for a green light from their superiors.

One such manager who felt strongly about the poor conditions in which the people had to live, wanted to do something for the community, and was willing to risk affecting his career. The spouse of another manager, who volunteered to open her centre for local planning, was a powerful senior officer in a provincial government department. In a situation where job-related fears constrained staff initiative, having such a background helped this manager curtail the threat of retaliation by the hierarchy. The manager herself was a trained obstetrician and had developed a trusting relationship with the local people, but was unable to help them during labour and postnatal care for lack of a functional delivery room and an operating theatre. This situation and the opportunity to take advantage of the project to strengthen the facility motivated her to take the lead.

Discussion

Health system development at the interface between service and community is a political process that becomes more tangible in the face of organizational change [7].

Working for change helped in understanding the local factors influencing health system development in Karachi. While the overall situation in Karachi might be unique, various aspects of that complex situation have been noted elsewhere. For example, the presence of more than one level of government as a key influence on system development is discussed by Cooksey and Krieg, who pointed to political barriers to policy implementation because of a conflict between local government, suburban Cook County, and the state of Illinois in implementing health policy [8].

Another characteristic noted was the behaviour of local politicians depending on whether they viewed the community as "belonging" to them or to the opposition. "Swinging-seat" areas are those where there is no clear majority of people favouring a particular political party. It might be expected that the local politicians and political parties would like to woo people by providing more services and funds to such areas. In contrast, because of its characteristics, configuration and ideology, the community in the project area was "penalized" by the politicians, with delays in, or lack of, development input.

The role of the local politicians in the project area could also be analysed from another perspective. One of the reasons for providing less than optimum space to community participation is that governments believe that the decision-making institutions are already democratic and community needs are represented [9]. The politicians, elected and non-elected, believe in their right to represent, which they fear would be undermined if the community continue to get involved in decision-making beyond voting.

Karachi's community and health services situation points to how health ser-

vices are shaped by the influence of local organizational and sociopolitical factors. A deeper understanding of these issues is required so that people involved with developing policy framework are better informed, and their policy documents take into consideration the role of local factors. Unfortunately, as Leichter points out, the community context for policy development is often ignored [10]. While central (i.e. provincial and national) policy-makers are more concerned with the national and international economic and political context, it is the local need and the local context that influence community organization and involvement. Peterson, while discussing the possibilities for introducing health reforms, defines the structural context as the representational community of organized interests and government institutions by which politics is either thwarted or translated into action [11]. The larger national level political and structural context plays a role in defining national level reforms.

On the other hand, our observations in Karachi suggest that organized interests at the community level determine the fate of any health system change introduced into that area. While decisions about reorientation of health systems are taken mainly under the influence of outside phenomena such as economic rationalist ideologies, adjustments at the local level are shaped by the local sociopolitical and organizational context. Changes are often introduced without actually identifying their compatibility with the local culture and work

ethos, or without looking into their potential to be accepted in the local circumstance as legitimately offering a better balance between local needs and community health development [12].

Difficulties in achieving the objectives of district health system development in Karachi led to reflections upon the shortcomings in the original plans. The aim of the project to reorient the local services towards a system based on the comprehensive primary health care philosophy was not a wrong policy in itself. However, the implementation of the change encountered many obstacles because the policy proposal did not take into account the realities on the ground. In fact, some of the community characteristics which influenced local health system development became visible only in retrospect.

At present, in Pakistan, there is an emphasis on health sector reform through devolution of power and decentralization of services to the district level to improve quality of care. Successfully implementing these reforms will only be possible if stakeholders accept that health system development is a political process, and if they are eager to understand the local dynamics and their potential effect. The community is a dynamic entity that needs to be understood as an ever-changing process, and synthesizing initiatives for change is possible when health professionals seek to understand the community and are understood by the community through respect, humility, and candour [13].

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