

0682

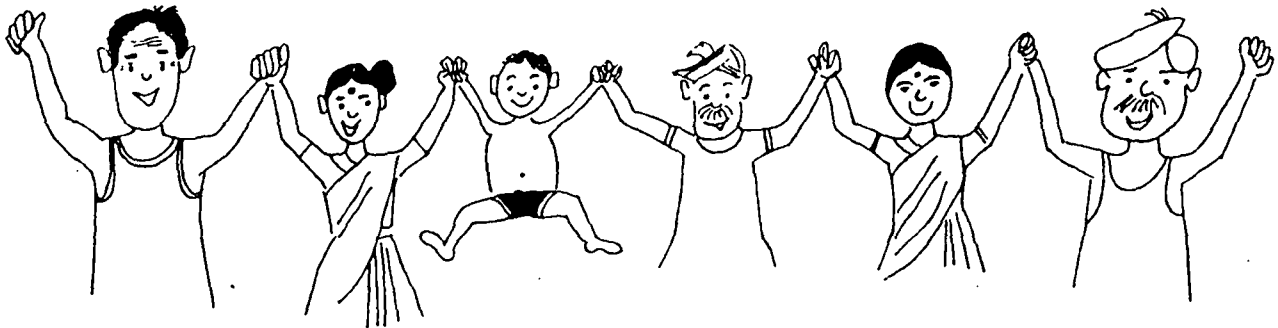
144 9800

Cover  
Story



# Community Participation Theory and Practice in Health Education

Dr John Hubley



## Introduction

Community participation is a very fashionable phrase. It often appears in documents from international agencies such as WHO and UNICEF. But it is a term that is not understood very well. Some persons feel that it is given too much emphasis and that it is the "mythology of the decade". Although everyone talks about it, community participation is often not put into practice.

What is community participation? What does the word community really mean and what do we mean by community becoming involved and participating in improvement of health?

The word community can be used to describe

- 1 a locality or small geographical area
- 2 a group of people sharing some interest

3 a network of relationship at a local level.

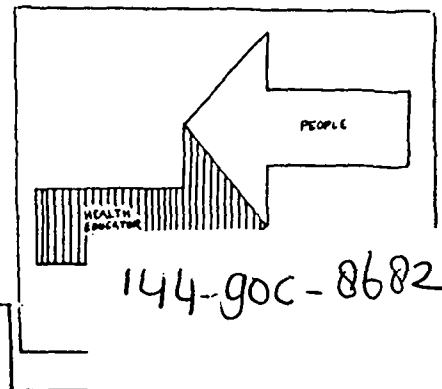
So "Community" means more than just people who live close together, it refers to sharing and working together in some way.

The word community participation is used to cover a whole range of very different actions. At one extreme there are actions which are really forms of manipulation where people are controlled like puppets though there is a pretense of letting them make decisions. At the opposite extreme there is total participation or complete control of their affairs by the community.

Community participation means the involvement of communities in decisions about their own future. Much health education is with individuals — for eg when advice is given at a clinic or when home visits

are made. In community participation programmes the emphasis is not with individuals but with the **WHOLE COMMUNITY**.

Health workers cannot know as much about a community as the people who live there themselves. It makes sense to involve communities in making plans because they know local conditions and the possibilities for change. A common approach is to try and involve the community in helping to carry out initial surveys so you can draw on their detailed local knowledge.



\*We thank Dr John Hubley, Senior Lecturer in Health Education at Leeds Polytechnic U.K., for graciously consenting to let us reproduce a shortened version of his handbook on

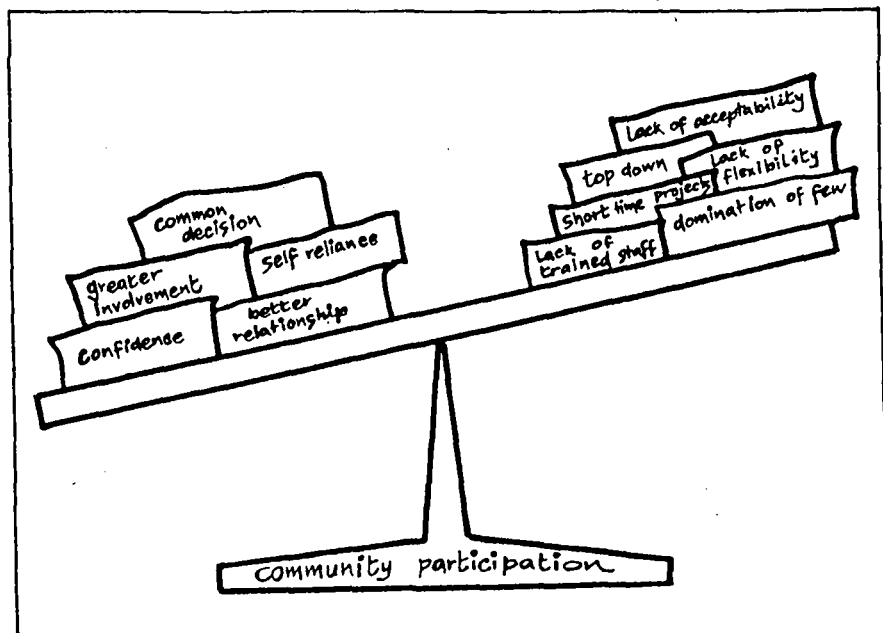
Community Participation, which will form the basis for a book on Health Education soon to be published from London shortly.

## Benefits of Community Participation

If the community have been involved in choosing priorities and deciding on plans they are much more likely to become involved in the programme. Community Participation leads to greater involvement and motivation by the people because they see the programme to be meeting THEIR needs.

Health education is often aimed at persuading people to take up services such as ante-natal, child health etc. The reasons for low utilisation and uptake are often because the services are poorly located, inaccessible, inconveniently timed and not perceived as relevant. If communities have been involved in making plans for their surroundings they will be more willing to contribute money or labour to the schemes.

The enthusiasm that comes from community participation can lead to a greater sense of self-reliance for the future. Eg — water is often a need that communities see. They are usually



willing to participate in water programmes because they see that benefits will come. The feeling of community solidarity and self-reliance from participating in decisions over their own future through a water project can lead to further activities.

For ordinary people the experience of participating in programmes builds up confidence that they can make decisions over their future. Communities learn problem solving skills and self-reliance.

Community participation leads to a better relationship between the community and health workers. There is trust and a feeling of partnership

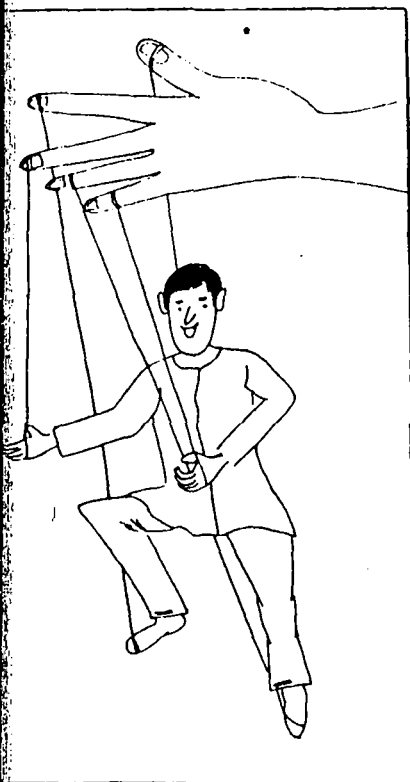
**Problems:** Some problems can arise in community participation programmes. Many people find this concept difficult to accept. They may see themselves as the experts and not recognize that the community should have a say in their own affairs.

Another problem is with the concept of needs. Planners and health workers have criticised basing a health programme on a community's felt needs, on the grounds that the community are not really able to define their own needs. But very often what the health services and other

external agencies think the community needs is quite different from what the community themselves hold as felt needs.

If we look at how people define their felt needs we see that they are based on their judgement of the present situation and possibilities for change. These judgements may depend on the beliefs about the extent and nature of health problems, their causes and possibilities for prevention and cure. These beliefs are influenced by their previous experience, education, understanding of epidemiology and biology. So felt needs may be based on a realistic assessment of their situation by the community. But they can also be based on misunderstandings and lack of critical knowledge.

Another problem with felt needs comes from the lack of flexibility of programmes to deal with what the community raise as needs. The community do not usually separate their needs into administratively convenient topics like health, education, community development or employment. People may raise poor roads or lack of irrigation for their crops as their most important needs. Health may not even be mentioned.



Another problem comes with the concept of community itself. We often assume that everyone in a village or community agree with each other and share the same felt needs. This is not always the case. People may disagree with each other. Frequently the needs that emerge from meetings are those of the dominant powerful groups. The needs of disadvantaged sections of the community such as the poor or women may be ignored. Social stratification and other forms of divisions can exist according to religion, language, tribe or caste. It is essential to understand the power structure and divisions in a community.

A community divided in its interests and felt needs and poorly organised to take advantage of available resources needs an external input to provide the stimulus for change. Many projects have failed because they did not recognise the need for field staff to act as community organisers or because such staff were not given the training to work with communities.

In primary health care it is the health workers in health centres and clinics who are supposed to carry out this community organisation and work with communities to select and train village health workers and initiate community action on health issues. Yet most of them receive little training on methods for working with communities.

Another serious problem comes from the short time scale of many projects. Effective community participation is a process that takes time to develop. Unfortunately many health programmes are planned on a short time scale of two or three years. However, it is extremely difficult to develop genuine community participation in such a short time.

Community participation can bring considerable benefits but there are also many difficulties in the implementation of community participation strategies. But these difficulties can be

overcome and effective community participation programmes be implemented with proper planning.

### Planning for Community Participation

It is important that everyone involved in implementing the programme meet and carefully consider the implications of community participation strategy. They should be made aware of the advantages of letting their communities decide for themselves what their priorities should be.

It is important to involve persons from other departments such as agriculture, rural development and adult literacy, as the community may bring up needs that cannot be met by the health services. Since health, social and economic needs are all interrelated it is important to work as a team.

If genuinely promoting community participation objectives will be determined by the community themselves. So keep objectives open ended and when setting objectives do not be too rigid on desired outcomes.

As the main point of community participation is to develop self-reliance, critical awareness and problem solving skills in communities, this should be reflected in the objectives.

Community participation should be seen as a process over time. It cannot be achieved through occasional visits and holding meetings. Common stages in the community participation process are:

- selection of area,
- entry,
- getting to know the community,
- initial action,
- building the organisation,
- further activities
- withdrawal and end of formal project output.

### The process

Once the area is selected the field worker identifies and makes contact

with opinion leaders, field workers from Government and NGOs through meetings and informal contacts. Opinion leaders are individuals with special influence like religious leaders, teachers or elders. They can be a great help in understanding the community.

Building up community participation involves not only meeting individuals to find out about problems of the area but also involves working with large groups. It is usual to have a community meeting early in the programme as it provides an opportunity for everybody to participate in the discussion.

Out of the large meeting a small group is often formed, for example,



village Water Committee. The community worker encourages them to select short term achievable objectives which will unite different sections in common action, but lets the community take the lead.

The success of this initial action results in individuals in the group gaining more confidence and attracting more members. The need for some structure becomes apparent and the community worker advises on community structure etc.

The community begins to develop trust and confidence in the community worker and will listen to suggestions for further action. The Community Worker continues dialogue with the community and sets up educational activities in response to the wishes of the community.

The perspective of the community is broadened and they are prepared to tackle wider issues. Individuals in the community begin to acquire a range of skills as a result of their involvement. The community worker advises on the organisation of the community and helps to resolve any internal tensions and conflicts. The community acts on further issues. The community worker begins to take a less active role and encourages the community to take more responsibility for maintaining the project.

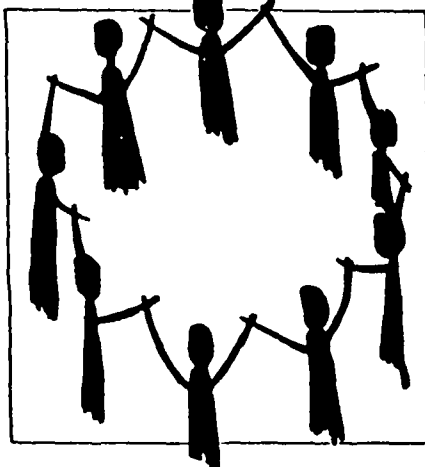
The community worker collects data for final evaluation. The local community participates in the evaluation of the project.

The community worker leaves and the momentum of community activities continues or collapses depending on strength of the community structure created during the community programme.

These steps should not be applied in a rigid way. They should be seen as overlapping components of a process of working with communities.

### Building in learning experiences

It is important to build learning experiences into community participation programmes. In this way, the



community will be able to understand more about the different factors that influence their health and how these factors can be changed.

But the approach to teaching should be quite different from traditional health education. It is important to use methods which encourage the community to ask questions and develop a critical awareness of their situation. Participatory learning methods have the following characteristics.

- 1 Opportunities built in for discussions, feedback and participation.
- 2 Involves simulations, role plays and problem-solving exercises.
- 3 Less emphasis on acquisition of specific knowledge and more on

development of problem solving skills, critical thinking, reflection and analysis.

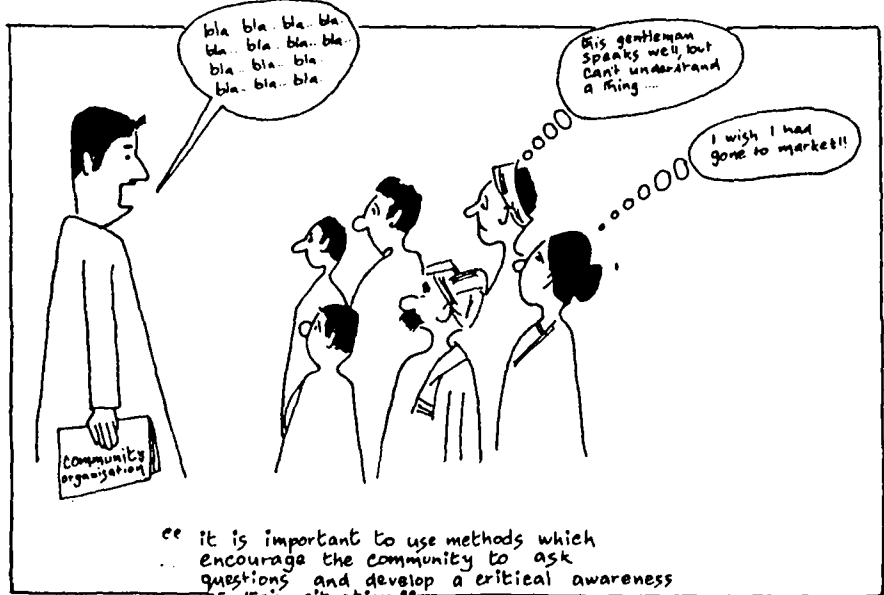
- 4 Uses small groups (less than 20)
- 5 Open ended with objectives determined by the whole group.
- 6 Trainer acts as facilitator to process, rather than teacher and "expert".

### Community health worker

In primary health programmes it is common to encourage communities to select one of themselves to receive simple training as village health workers. They are able to be highly effective communicators because they share the same background characteristics as their fellow villagers. Their effectiveness depends a great deal on the degree of community involvement in their selection, their training and the degree of support received by the programme.

However, there is also the need for skilled field workers to provide support for lay workers and facilitate the process of community participation. The training of field workers should enable them to:

- 1 understand community structures
- 2 identify opinion leaders
- 3 be good listeners and communicators
- 4 work with individuals and groups



- 5 advise on community organisations
- 6 use participatory learning methods

While it is helpful to have full-time community workers, community participation should not be seen as something that can only be done when a programme has full time community workers on its staff. Health workers should be trained to incorporate community organisation activities within their normal activities.

**Evaluation**

Community participation programmes require special approaches to evaluation. Community involvement should not be restricted only to planning and implementation. If you take participation seriously, the community should be involved in the evaluation of the programme as well. Evaluation itself becomes a learning experience in which everybody looks at what has been achieved and decides what more needs to be done.

Following is a checklist of questions for finding the degree of participation in a programme.

- 1 Is the community involved in planning management and control of the health programme at the community level? Were the felt needs of the community found out at the outset of the programme and was notice taken of them in planning the programme objectives?

- 2 What forms of social organisation exist in the community and to what extent have they been involved in the decision-making process e.g. Farmers cooperatives, clubs, churches, political organisations, trade unions etc.?

- 3 Is there a mechanism for dialogue between health system personnel and community leadership?

- 4 Is there a mechanism for community representatives to be involved in decision-making at higher levels and is this effective?

- 5 Is there any evidence of the external agents changing their plans as a

result of criticism from the community?

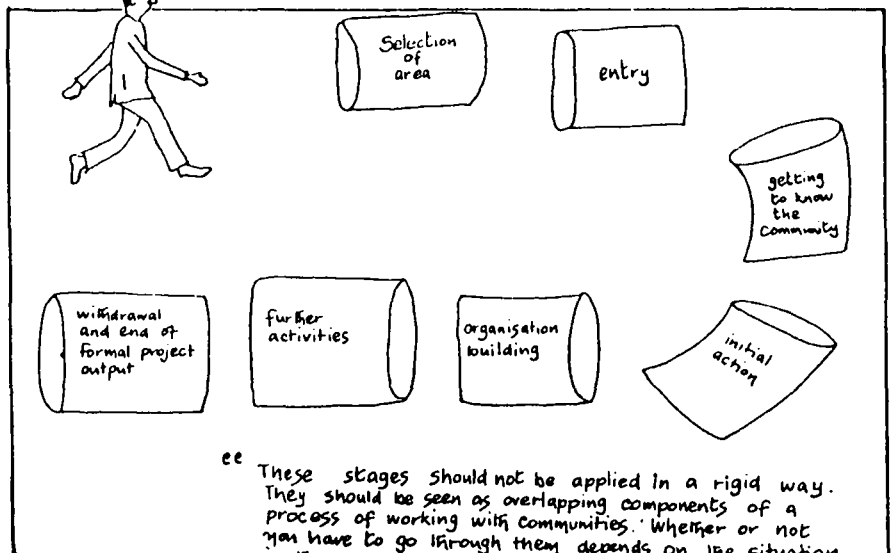
- 6 Are deprived groups e.g. poor, landless, unemployed, women adequately represented in the decision making process?

- 7 Are local resources used e.g. labour, buildings, money?

- 8 Were the community involved in the evaluation of the project and drafting of the final report?

**Conclusion**

The most important resources for the promotion of health are the people themselves. Through community participation you can use that resource to improve the health of the people.



ee These stages should not be applied in a rigid way. They should be seen as overlapping components of a process of working with communities. Whether or not you have to go through them depends on the situation in the community and what has already happened.