EXPLORING COMMUNITY PARTICIPATION IN A DIARRHOEA PREVENTION PROGRAM IN KANYAMA, LUSAKA, ZAMBIA

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KEY WORDS

1. Community
2. Constraints
3. Decision making
4. Diarrhoea prevention
5. Exploring
6. Leadership
7. Management
8. Needs identification
9. Participation
10. Resource mobilization

ACRONYMS

CBO	-	Community-based Organisation
CHP	-	Child Health Promoters
CIRDZ	-	Control of Infectious Related Diseases in Zambia
CP	-	Community Participation
DHMT	-	District Health Management Team
HIV/AIDS	-	Human Immune-deficiency Virus/ Acquired Immune Deficiency Syndrome
IMCI	-	Integrated Management of Childhood Illnesses
ITNs	-	Insecticide Treated Nets
JICA	-	Japanese International Corporation Aid
LDHMT	-	Lusaka District Health Management Team
NHC	-	Neighbourhood Health Committee
NGO	-	Non-governmental Organisation
NGOs	-	Non-governmental Organisations
NP	-	Nutrition Promoters
ORS	-	Oral Re-hydration Salts
PMTCT	-	Prevention of Mother to Child HIV Transmission
RDC	-	Residence Development Committees
STDs	-	Sexually Transmitted Diseases
TB	-	Tuberculosis
USAID	-	United States Agency for International Development
VHC	-	Village Health Committee
WHO	-	World Health Organisation

ABSTRACT

The program that was studied is part of the Child Health Program devised and supported by CARE International and implemented in Kanyama, a high density and low cost community found on the outskirts of Lusaka, Zambia. Diarrhoea was identified as one of the three most common diseases affecting the children under the age of five years. Through community participation, the program was implemented by the Kanyama residents to reduce the cases of diarrhoea, malaria and pneumonia among children aged five years and under.

The main aim of the study was to explore the perceptions of the impact of community participation by the community leaders and community members in the diarrhoea prevention program and to establish constraints affecting participation. It sought to find out whether the communities and their leaders have been able to participate fully in the program and, if not, what the barriers to participation are. In addition, the study also sought to find out how the people felt they could solve the barriers to community participation.

The study was qualitative in nature and in-depth interviews containing open-ended questions were conducted with community leaders and community members.

The study was conducted in Kanyama, Lusaka, Zambia – a high density community lacking some of the basic services such as adequate water supply and toilets, and of poor nutritional status just to mention a few issues.

The respondents of the study comprised three community leaders and seven community members from all parts of Kanyama community

The study found that the community understood the root causes of diarrhoea in their community. They also know the importance of community participation which they described as taking part or participating in a community activity to solve an existing problem. The study also established

that decision making in the identification of health problems, implementation of activities, resource mobilization and management of the project is all done by the clinic staff, NGOs such as JICA and CARE International and the Community Leadership. The community itself is just told what is to be done, when and by whom. The community's role includes offering labour and their tools for garbage collection, buying chlorine, charcoal for water treatment and contributing money for toilet construction. The community leadership usually lobby for resources from NGOs, DHMT, and other businesses. The leaders also spearhead the implementation of activities; they are involved in the planning and monitoring of the activities; and they prepare reports and make sure that the activities are implemented.

Barriers to community participation mentioned by the respondents included lack of incentives, people not seeing any direct benefit, and a lack of tools. This was exacerbated by their poverty and low education levels.

Community participation is said to be effective if the community members are involved in all stages of the project cycle. This means that they have to be involved in decision making, planning, implementation, management and monitoring and evaluation activities. Yet this is not taking place in Kanyama. The community made several recommendations to improve community participation.

They suggested that the community should be financially empowered, the volunteers should be motivated and work only for shorter hours and have adequate tools. The community should also be educated on the importance of community participation and the leaders should encourage the community to participate.

DECLARATION

I declare that the work done in this research is my own work. This has not been submitted before for any degree or examination to any University and all the sources I have used or quoted have been indicated and acknowledged as complete reference.

Attracta C. Tembo **2007**

Signed: ----------

DEDICATION

To my children, Mwiza, Sungani, Buchizya and Zubanji Tembo. For the past four years, I have been a bit busy with my school work as well as my office work, and because of this I paid little attention to your pending problems. I lay this work in your hands. For you are my dearest endeavour; I therefore beseech each one of you not to be me if you can't but to be inspired in your ambitions by this, my achievement.

To my late husband, Mr Henry Tembo for the support and encouragement that you rendered me ever since I started my studies up to the time I was in Sweden. Your dreams that you had strengthened me to go ahead and motivated me to complete this work. To you I say I really loved you and appreciated every support that you gave me. And may your sweet soul rest in peace, till we meet.

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I would also like to thank Care International and the Residents of Kanyama community for having allowed me to do my research in Kanyama community and one of the sites for Care International. This fulfilled my research interests and I hope the work contained herein will in

some way contribute to the better performance of both the community members as well as their leaders in the project.

Finally I would like to thank all the respondents during my fieldwork for their perceptions of the research issues. It is upon these perceptions that I have based my results for this thesis and that is what makes the work original. To you all I say 'Thank you very much'.

1.0 INTRODUCTION

1.1 Background

Kanyama, the site of this research, is like many other high-density, peri-urban settlements in Zambia. It faces numerous health problems due to a number of contributing factors such as poor environmental and personal hygiene, poor nutrition, poor water supply, poor housing and of course poverty.

It is a high density site with about 144,091 people. The population for the under five age group is 30,391 (LDHMT 2000). The community is divided into 10 zones for easy implementation of community activities. This is according to Ministry of Health requirements and there about 31 307 households each with an average of 6 to 10 people. Most of the houses are of low cost with a few well-constructed houses with water and a toilet within the premises. One plot has on average 10 households sharing one toilet and sometimes one water tap. Most people are poor, ranging from casual workers, maids, garden boys, and business people with a mixture of languages. Most of them are not in formal employment. The water situation has improved though it is not adequate and it is insufficient to cater for the whole population.

Poor sanitation is still a big problem. There are few toilets in the community and most of them are either full or not well cleaned. This has contributed to the rising number of diarrhoea and cholera cases in the community.

Poor garbage disposal is also a very big problem in the area. This is found almost everywhere in the community though there are usually cleaning campaigns that seem to be effective. The effectiveness is seen in the large number of people who participate in these cleaning campaigns.

The community of Kanyama is serviced by only one mini government hospital with limited in-patient facilities. It is the first point of contact for treatment for patients and those requiring

further treatment are then transferred to the bigger hospital, the University Teaching Hospital in Lusaka. The Kanyama Mini Hospital has many activities such as Maternal and Child care, HIV/AIDS services, In-patient and Out-patient departments, Environmental activities, Nutrition and general medical facilities. There are several community leadership programs that deal in health activities found in the area. These include the Child Health Promoters (CHP), Neighbourhood Health Committee (NHC), Nutrition Promoters (NP) and Residence Development Committees (RDC). The NGOs that are involved in the health programs in the area include Japanese International Corporation Aid (JICA), CARE International, Control of Infectious Related Diseases in Zambia (CIRDZ) and the Prevention of Mother To Child HIV Transmission (PMTCT) project. The community leadership (NHC) which is elected by the people every two years, works hand in hand with this mini hospital and the community in all health matters.

1.2 The Program under Review

The program under review is a community-based diarrhoea prevention program which involves Care International trained Child Health Promoters (CHP) and Neighbourhood Health Committees (NHC) in child health, in conjunction with the District Health Management Team (DHMT). The overall goal of this program is to improve the health of the under fives. The objectives are to improve caretakers' knowledge in the prevention of malaria, diarrhoea and pneumonia among the under fives, encourage behaviour change and to increase child health services in the community. The term caretaker refers to anybody taking care of a child, not necessarily the real parents of the child.

CARE International, through Canadian funding, implemented this child health program which

has been running from 2000 to date in Lusaka, Kasama and Ndola Districts. The activities are undertaken at both community and clinic levels. At the clinic level, the clinicians are trained in Integrated Management of Childhood Illnesses (IMCI), while at community level, the community leaders are trained in prevention of common childhood illnesses such as diarrhoea, malaria, pneumonia, and also other health concerns such water and sanitation, nutrition and HIV/AIDS.

The major programs to prevent diarrhoea include implementing a process by the NHC that involves offering leadership services to the community members, identifying problems, organising people, and deciding how to implement and monitor and evaluate the program. The NHC mobilizes communities for health promotion activities such as health education on the causes and prevention of diarrhoea, building of toilets, good hygiene practices that include safe disposal of waste, proper hand washing practices, cleaning of toilets, proper garbage disposal, safe handling of food, and water treatment. Community participation (CP) is envisaged to be a strong component of this program.

1.3 Research Problem

Diarrhoea is a worldwide problem that is linked to a high mortality rate among children. It is still among the three most common and serious health problems affecting children under five years of age. According to Murray and Lopez (1997), worsening poverty and poor socio-economic factors contribute to this increase. In the year 2000, it caused estimated deaths of about 1.5 million among children below the age of five years worldwide (Victoria et al 2000). It further accounts for nearly 1.6 million deaths or 15% of under-five mortality every year in developing countries (WHO 2003).

Because of the importance of community involvement in tackling the problems of diarrhoea (Eckhard 2004) questions are being asked by CARE International about the impact of CP in their local diarrhoea prevention programmes. Within the Child Health program that they have implemented they look at the preventive, promotive, curative and rehabilitative aspects of Primary Health Care in addition to the importance of incorporating CP. The question arises as to how successful their community strategies have been and what the problems have been with this strategy. Is it because the commitment and strength of CP is not optimal or is CP not as effective a strategy to bring about change as was hoped?

1.4 Research Purpose

The study's main aim was to explore the perceptions of the impact of CP in the diarrhoea prevention program implemented by CARE International in its Child Health project and to establish the constraints affecting participation. It endeavoured to provide answers to the following main questions: What are the perceptions of the impact of CP by the community members and leaders in the program? What are the current obstacles they experience that prevent participation and how best can these be dealt with? The findings from the study will be relevant to other programs that strongly advocate the CP paradigm to reduce or eliminate health problems that are experienced by the communities, in particular those programs where CP is an important component of diarrhoea prevention programs. The need to explore the impact of CP is important for the reduction of morbidity and mortality arising from the numerous health problems facing the communities.

2.0 LITERATURE REVIEW

This literature review discusses the problem of diarrhoea and the current measures for diarrhoea prevention undertaken by large agencies and governments which promote CP as a key element. It also discusses some descriptions of CP, its importance, established barriers and methods used in the literature to measure CP.

2.1 The Problem of Diarrhoea

As noted in the introduction, diarrhoea is a worldwide problem that is linked to a high mortality rate among children (Murray & Lopez 1997). Globally it accounts for nearly 1.6 million deaths (WHO 2003) annually among children. The impact of diarrhoea is more severe in the earliest periods of life, taking into account both the number of episodes per year and the hospital admission rates. It is devastating, not only because 1 in 200 children will die from it, but for those who survive, it has a lifelong impact such as effects on fitness, cognitive function and school performance (Murray & Lopez 1997). Several reports have identified socio-economic, environmental, maternal and nutritional and other characteristics as risk factors for diarrhoeal morbidity or mortality (Awasthi et al 1996, Clemens et al 1999). Poverty, low parental schooling, poor sanitation, lack of adequate water supply, overcrowding, early child-birth, lack of breastfeeding and malnutrition are also factors associated with diarrhoea (Awasthi et al 1996, Howie et al 1997). Lack of safe water, basic sanitation and hygiene may account for as much as 88% of the disease burden due to diarrhoea (WHO/UNICEF 2000)

2.2 Strategies Used in Diarrhoeal Programs

Globally diarrhoeal prevention programs focus on water provision, health education, water

treatment, good sanitation and hygiene practices (Eckhard 2004). In Zambia, most of the control programs include: provision of adequate water supply that is treated either with chlorine or boiled and stored safely, good sanitation practices like safe disposal of excreta, hand washing, cleaning of toilets and proper disposal of garbage. It also includes safe food handling and preparation, encouraging adequate re-heating of leftover food, covering of food and washing fruits and vegetables before eating and promotion of breastfeeding and health education (Ministry of Health, Zambia, 2000). It is similar to the approach used by the USAID's Environmental Health Project that uses the Hygiene Improved Framework (Eckhard 2004). This was developed as a comprehensive approach to diarrhoea prevention and it addresses three key elements. These are;

- Improving access to water and sanitation that includes household technologies like soap, safe water and effective water treatment.
- Promoting hygiene that includes communication, social mobilisation, CP social marketing and advocacy
- Strengthening the enabling environment that includes policy improvement, institutional strengthening, community organisation, financing and cost recovery cross sector and partnerships.

In Zambia most diarrhoea prevention programs for example the CARE Moyo Wa Bana Project implement the above strategies where individuals and the community as a whole are expected to do their bit: for example good home and personal hygiene, adopting a hand washing culture, constructing and using toilets, cleaning the toilets, boiling or chlorinating drinking water, keeping the drinking water safe, ensuring a continuous water supply and taking an interest in

local community activities such as attending health education sessions, and garbage evacuation (Ministry of Health, Zambia 2000). This calls for CP as a main core of the program together with a comprehensive communication strategy, social mobilisation, social marketing and advocacy building on the WHO (1992) recommendations that individuals should be encouraged to participate by giving their views (WHO 1992) on health issues and expressing opinions in order to influence decision making.

This approach recognises that the community members are very important players in the identification of health problems or needs. They should be involved since it is their problem. They should also be able to decide, plan and implement community activities with the guidance of the community leaders. According to WHO (1992), the community roles should include the assessment of their needs, which would include the recognition of their problems and means to find opportunities to address them. They should also be involved in resource mobilisation and be able to play a key role in the allocation of resources in health (Health for All, 1986). Finally they should be able to contribute to the planning and implementation of activities as well as being recipients of the activities (WHO 1986).

Key to the successful implementation of CP is a local community-based organisation with local leadership to lead the process, which has an effective relationship with local government institutions, politicians and health professionals and which excels in collaboration and coordination (Zakus and Lysack 1998). Daniels (1992) argues that such an organisation is most effective if it is established with considerable inputs from the community, either through direct consultation or by election of its members. The importance of community participation was raised as far back as the Alma-Ata Declaration (1978). The Declaration describes a community as being able to use its own social structures and available resources to accomplish community

goals, which should be decided by community representatives and should be consistent with local values. These representatives should work with the people in the community and represent the views of the community in meetings at higher levels. They should be able to use their leadership skills to lead the people in problem identification, planning, resource mobilisation and implementation.

2.3 Defining the Concept of Community Participation

Before looking at how CP is used in this study, it is worth mentioning that the concept of community participation has different interpretations and, with them, different power dynamics between the communities and the professionals that they are working with.

This is clearly seen in the participation ladder as described by Arnstein (1969). The lowest level of the ladder represents non-participation by manipulation where the professionals have all the power.

Next are degrees of tokenism and consultation, followed by higher levels of citizen power such as partnership and delegated power. At the top of the ladder is citizen control described by Rifkin (1986) as being when the power is with the communities. Rifkin (1986) suggests additional approaches for looking at CP. The three approaches are as follows, the medical approach where community participation is defined as activities undertaken by the community following directions of medical professionals in order to reduce individual illness; the health services approach where community participation is seen as the mobilization of community people to take an active part in the delivery of health services and lastly the community development approach which requires community members to become actively involved in decisions about how to improve the condition.

As Rifkin points out, the medical and health services approaches are top down approaches,

where the power rests with the professionals while the third one is a bottom up approach, where power is devolved to the community.

The importance of a bottom up approach to sustainability is shown by Oakley (1989) when he emphasizes how sustainable community participation requires communities to be involved at all levels, including planning, implementation and evaluation of development programs. This demonstrates the difference between people being seen as active participants compared to the other approaches where people are considered as passive recipients (Oakley 1989).

The importance of the community taking an active role is also highlighted by the Legal Dictionary which defines participation as the act of taking part or sharing in something, or to be involved in doing something. This point is further reinforced by the WHO which describes CP as a process where individuals and families assume the responsibility for their own health and welfare and the community at large (WHO 1978). It requires people to become an integral part of the decision making and action process. As they point out, for effective CP, people should be part and parcel of the project from the project identification, planning and implementation to the monitoring and evaluation. Shrimpton (1989) takes this further, stressing that, it is the involvement by the community at large and not only by their elected leaders that is important. Rifkin and colleagues support the view that CP extends beyond a small number of elected leaders. For them CP 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 those needs (Rifkin et al 1988).

In addition to participation, the issue of empowerment is also to be considered. This was commented on by Shrimpton (1989) who notes having power in resource mobilization as one of the key aspects of empowerment. Gita Sen (1997) provides a useful description of

empowerment as a process of gaining power, both control over external resources and the growth in inner self-confidence and capability. She suggests that while external change agents can catalyze the process or create a supportive environment, ultimately the people naturally empower themselves. She also notes that although group processes are often critical of empowerment, personal transformation of individuals is also essential. Finally she said that empowerment is not synonymous with and is indeed a more powerful concept than decentralization, participation or bottom up approaches. This is in line with the CHOICE framework described by Rifkin (2003). CHOICE is an acronym used to identify six areas that are critical for examining the influence of empowerment on health outcomes. These are capacity building, human rights, organizational sustainability, institutional accountability, contribution and enabling environment. People and planners are given a choice to gather and act upon evidence to pursue and implement policies that address empowerment and equity, i.e. the choice of intended beneficiaries to become actively involved in their own health and health care (Rifkin 2003)

2.4 Importance of Community Participation

Having power in decision making is important in relation to both empowerment and service delivery. It will lead to empowerment of individuals and communities and this is an essential component according to the Ottawa Charter in improving health and well being (Baum 1998, Bracht and Tsourous 1990). It will lead people in making decisions about what problems should be prioritized, the plan of activities and implementing and managing the activities (WHO 1992). The importance of CP was recognized by the WHO in its major strategies of the latter part of the twentieth century. As noted above, it is a core principle of the Primary Health Care Approach as described in the Alma Ata Declaration (WHO 1978). It helps the community define what they

want to do and how they want to operate. The vision of Health for All (Mahler 1981) also notes the importance of a broad-based approach to health promotion and disease prevention with an emphasis on the community action, rather than a hospital-based response. According to the two authors above, this means that the community should be able to decide how to promote and prevent diseases in the community rather than having a hospital-based response which is a top down approach to implementing activities. Finally the importance of CP as stressed in the Ottawa Charter (WHO 1986) confirms that CP is important in the process of improving the health and well-being of the members of the community. In addition to this, CP was viewed as a reaffirmation of the role of people in managing their own health (Annett and Nickson 1991).

If people are involved in defining the issues and solving their problems, initiatives are likely to be successful (Daniels 1992). This has been illustrated in a comparative study on sanitation for rural communities done in India by Rao and Joseph (2000) involving two villages where one community had been involved in planning and implementation while the other one was not involved. The findings of the study showed that the village where the program involved communities in planning and implementation was moderately successful as compared to the other one that failed completely. This finding is supported by another sanitation study in Livingstone, Zambia (CARE, 1994) whose aim was to find out reasons why people were not using the constructed pit latrines. In this study it was found that people were not involved in the problem solving process, and the project failed completely.

According to Cheetham (2002), if community participation is implemented properly, certain prerequisites are necessary. Firstly she points out the importance of CP where communities have different needs, problems, beliefs and practices to the professionals, so that the strategies are appropriate for and acceptable to the community.

Secondly she notes that CP should promote shared responsibility by service providers, community members and leaders for the improved health of all in the community.

Thirdly she says that when the communities 'own' the health programs, they can often mobilize resources that may not otherwise be available. This can be achieved by working together to advocate for resources to achieve better programs, services and policies.

Lastly she notes that participation can empower the community members that are involved and this in turn improves health outcomes. These benefits demonstrate the importance of a strong community leadership structure in place to facilitate community participation. According to the Alma-Ata declaration (1978), a community is expected to use its own social structures and available resources to accomplish community goals, which should be decided by community representatives and should be consistent with local values. It stresses that these representatives should work with the people in the community and represent the views of the community in meetings at higher levels. The representatives should use their leadership skills to lead the people in problem identification, planning, resource mobilisation and implementation. .

2.5 Barriers to Effective Community Participation

While CP has been shown to be essential to the success of a program, there are a number of barriers to effective participation. The most common barriers to CP suggested by Baum (1998) include cultural beliefs, the lack of any incentive or ability to participate, or the communities not seeing a direct benefit of a programme. For example, some cultural beliefs hinder women from participating, as it is men, not women who speak out at meetings; people with low self-esteem are often not sure what to contribute and do not understand what CP is all about; and apathy and disempowerment serves as a barrier for people who are not used to making decisions or who feel

powerless, apathetic, or dependent on others (Baum 1998). In addition, in some instances, authorities may be unwilling to allow people to participate in decision making.

Stern and Green (2005) note the different priorities and perspectives that can cause misunderstanding and conflicts between experts and lay people resulting from differences in the way lay people and experts approach decision making. Health professionals judge on scientific objectives and knowledge whereas lay people tend to use common sense and subjective judgements. They also noted how people have been invited to participate in plans and projects that are the priority of the authorities, This means that they are often being asked only to "rubber stamp" official plans. An additional factor is the lack of flexibility and different concepts of voluntarism of donor driven projects (Baum 1998).

Costongs and Springett (1997) also added that lack of time and confidence and having no interest to participate on issues that concern them is another barrier to community participation. Petersen (1996) adds that poverty is a big barrier to CP, particularly if there are few resources to adequately support and encourage community initiatives. Many people work seven days a week for long hours just to be able to feed their families and may not have the time to participate. Therefore the poorest members of the community are not often heard as they cannot afford the time and resources necessary to contribute or participate in the program.

2.6 Evaluating Community Participation

One challenge for program planners is how to evaluate community participation. One question that is asked by researchers is "what should be evaluated, is it the health outcomes, participation levels, improved capacities or some combination of these and how will they be evaluated?" It is therefore very important for community participation programs to identify and measure

indicators of participation (Cheetham. 2002).

However despite these difficulties, there have been several approaches developed to evaluate CP (UNICEF 1981; Rifkin et al 1988, Zimmerman 1995) and most include a range of process indicators that emphasize empowerment over efficiency indicators.

Zimmerman (1995) explains that, because CP and empowerment constitute a dynamic experience and not a static outcome, it is necessary to use process indicators to evaluate a program. The framework by Rifkin et al (1988) employs qualitative indicators for five factors that influence the process and degree of participation. These are: needs assessment, leadership, resource mobilisation, management and organisation. Each dimension is assessed through a series of questions and numerically ranked along a spectrum from narrow to wide participation. A similar framework was promoted by Shrimpton (1996) using the same indicators with the addition of training, orientation of action and monitoring and evaluation.

2.7 Examples of Community Participation in the Literature

There are examples from the literature that have demonstrated some success in involving communities. The case of Lawrence (2000) in New Zealand used the pentagram model (Rifkin et al 1988) in a study to probe whether the rural health trust model was facilitating CP. Information on the five dimensions was collected: needs assessment, leadership, resource mobilisation, management and organisation.

The study found high levels of participation across each of these mentioned dimensions. The community provided labour, material and financial donations and were able to mobilize other funding. There was also a selected leadership in place that was committed to volunteer work and community service.

Shrimpton (1996) cites examples of several government integrated primary health and nutrition care programs that used the same approach to analyse CP. These included the Tamil Nadu Integrated Nutrition Project, the National Growth Monitoring Program of Thailand, the Family Nutrition Improvement Program of Indonesia and the Iringa Nutrition Program of Tanzania. Ratings against each indicator were given for each program (Shrimpton 1996) which showed different levels of rating for the different core areas. In particular, he noted that the community was often not involved in the financial aspect (Shrimpton 1996). He also found that sometimes the community was willing to participate although they were not fully aware of what they were expected to participate in. They were simply told what to do instead of them coming up with something to do on their own. Benjamin et al (2000) also note the lack of involvement of communities in financial aspects of projects. They describe the Bamako Initiative Programme where the health workers seemed to be resisting the people's participation in the co-management of user fees and people were willing to participate. The people knew that they had to pay for the user fees but how the money was managed was not known to them.

Finally, in some forums, community leaders can be present but the health professionals dominate the discussion and decision-making. This was seen during the evaluation of the Noarlunga Healthy Cities Project. It was noted that there were low attendance rates at forum meetings for Health cities Noarlunga (1990), which was because most of the decisions ended up being made by the health professionals.

2.8 Conclusion

Community participation, which has many different interpretations, has been shown to be very important. Yet it is generally not done properly. Despite the rhetoric about community

participation in policy and programs, communities have limited influence over the decision making processes. Issues that are addressed in and by the community are predominantly those nominated by service providers or the funding agencies, and this could have a negative impact on the participation and ownership of the program by the community. For example, the program might leave out some problems that the community feels are very important and need to be solved as a priority, and as a result the community will not be willing to participate. People should be given an opportunity to identify and make decisions about how to solve their own problems in the community. This study will try to look at these issues as they related to the community being studied.

3.0 STUDY AIMS

AIM: To explore the perceptions of the impact of community participation in the diarrhoea prevention program in the Kanyama community of Zambia and to establish the constraints affecting participation.

4.0 OBJECTIVES

1. To assess the role played by community leadership and community members in the diarrhoea prevention program in the following key areas of community participation: decision making in the identification of health problems and key strategies to address these, resource mobilisation, implementation of activities and management of the project.
2. To assess the perception of the effectiveness of the community leadership and community members in the above roles.
3. To determine the barriers to community participation in the diarrhoea program.
4. To explore how best the community and their leaders can improve their participation.

5.0 METHODOLOGY

5.1 Study Design

The research took the form of an exploratory, qualitative study, which investigated the perceptions and experiences of community members and leaders on the impact of community participation in the diarrhoea prevention program.

Qualitative research has special value for investigating complex and sensitive issues and generating information that is in-depth. This made it suitable for this study as, being exploratory, it is inductive and allows for a more flexible investigation of the issue. It also allowed the researcher to record the diversity of experiences, views and meanings of people's experiences in relation to the issues under investigation and to assess how these relate to the broader social context (Kvale 2000). Furthermore, it enabled the researcher to explore the phenomena of interest in the original language of the respondents. This is not only important for the researcher but also from the reader's perspective as well as it ensures that the respondents understand the questions and are in a position to express their views clearly and accurately in their own language. "If you want people to understand better than they otherwise might, provide them information in the form in which they usually experience it" (Lincoln and Guba, 1985).

5.2 Study Population

There were two target populations in the study: community members and community leaders. Community members are those people that belong to the community and community leaders are those belonging to the Neighbourhood Health Committee or Child Health Promoters. All community members with children below the age of five years that have lived in the community for more than one year were eligible for the study. Similarly, leaders who have lived in Kanyama

community for more than one year were eligible for the study. Community leaders represent the community in all health matters and they are elected by the community every two years. After being elected, the leaders are given training in health issues by the existing NGOs such as CARE and JICA in conjunction with the District Health Management Team and the local Government clinic. All community leaders are supposed to be 35 years old and above and should be a permanent resident of the community. Kanyama community has a total of 1500 community leaders and these were all eligible for inclusion in the sample

5.3 Study Target and Sample Size

Purposeful sampling was used to identify the sample. The sample consisted of ten people of whom seven were key community members and three were community leaders. This gave a good representation from all parts of the community since there are ten zones and community respondents were picked from all ten. The key community members were selected on the basis of them being well known, having stayed in the community for more than one year, having an interest in the program and having had their children suffer from diarrhoea at some point. The community leaders were selected on the basis of their having stayed in the community for more than one year and having an interest in the program.

There were more respondents from the community to allow for a possible wider variation of people as compared with the community leaders. It was also recognized that the leaders already had considerable experience of CP through their training and workshops, so it was useful also to have the perceptions of community members who did not have this exposure.

5.4 Data Collection

In-depth interviews were the means of data collection used for this study. The interviews were done with the aim of deeply exploring the respondents' point of view, feelings and perspectives. The technique was able to yield more information by the extensive probing and asking open ended questions, listening to and recording, and then transcribing the answers. Respondents were able to talk freely and spontaneously about their views on CP.

The respondents were given an opportunity to ask for clarity about questions where they were not clear to them in order to reduce ambiguity. This also gave the researcher an opportunity to observe the subject directly and take note of the non-verbal cues.

Two weeks before the interviews the subjects were identified and notified of the interview date, time and venue. For easy accessibility to the venue all the respondents agreed to meet at the health centre that is centrally located in the community. The interviews were all conducted either in English or Nyanja depending on the choice of the respondent. The responses were written down as field notes and recorded with a tape recorder.

Recording of observations was also done and also the researcher's own observations were recorded after each interview. Later in the day, transcribing took place where the response was translated into English for those that answered in Nyanja and written down the way it was said.

At the start of the interviews, the researcher greeted the respondents and then gave an explanation of the purpose of the study and how the findings would be used. The respondents were asked for consent to participate in the study before asking them questions. Those that refused to give consent were left out of the study

5.5 Validity

Prior to the actual data collection exercise, the guiding data collection instrument was piloted. This helped to test the validity of the data collection instrument in order to detect and solve unforeseen problems. The pre-testing (piloting) was done in Kamwala community, a community similar to Kanyama. Two questions for the community had to be changed because respondents had difficulties in answering. The Monitoring and Evaluation Officer from CARE International was invited to act as a second researcher. He was invited to review the transcripts from the ten key informant interviews and then he compared these with the interpretation of the content of the principal researcher.

At the end of interview, a brief overview of the session was presented to the respondents as a form of respondent validation in order for them to reflect on and confirm their views. It also provided them with an opportunity to amend any misinterpretations and to make any other suggestions.

5.6 Data Analysis

Data analysis ran concurrently with data collection to make sure those gaps in understanding were followed up in subsequent interviews. Emerging patterns were looked into which were then amended as insights and patterns emerged in subsequent data collection. An additional strength of qualitative research is that it remains open to analysis at all points in the research process (Gifford, undated). The data collected were analyzed through content analysis to identify themes and patterns that emerged across and within the individual interviews. These data were coded and categorized and analyzed.

6.0 ETHICS

The study was submitted for approval to the Higher Degrees Committee at the University of the Western Cape. When approval was given by the University, a letter for permission to conduct the study in the mentioned community was submitted to the Lusaka District Health Management Board. After receiving the permission from DHMT, permission was sought from the Kanyama Neighbourhood Health Committee. Following standard procedure (CIOMS 1993) at the beginning of each interview an explanation of the study was given and consent to participation in the study was obtained. The aim of the study was explained to the respondents and permission was sought from them to tape record the proceedings as well. The participants were assured of anonymity and although some of the information they provided would be published, their name and identity would not be associated with the publication. They were also informed that they were not required to participate in the study if they did not wish to, they could stop the interview at any time or refuse to answer any questions. The respondent's privacy was observed by having the interviews on a one to one basis in a private setting.

The respondents were given a choice on what language to use and in this study the respondents used either English or Nyanja.

It is planned that feedback on the findings of this study will be disseminated to the community, community leaders, Care International and the District Health Management Team.

7.0 LIMITATIONS

The interviews were conducted at the Kanyama Health Centre which was thought to be more central for all the participants. A room was given for this event that was next to the out-patient department. Two interviews were disrupted because of the noise that came from the patients. As a result we had to stop and wait until the noise died down. The interviews for the two took a bit longer.

Three other participants had babies with them. The babies at some time disturbed the interview. The mothers had to stop answering and started breast feeding their babies. This meant that we had to start the interviews all over again.

The respondents were all from the community sector, having the perceptions of others for example the NGO and clinic staff would have enhanced the study and this limited the scope of the study.

Finally the small number of respondents limits the extent to which the results can be generalized. This however is within the scope of a mini thesis.

8.0 RESULTS

This section provides a description of the perceptions of the respondents on the role of communities and community leaders in decision making in the identification of health problems and key strategies to address these, i.e. what resource mobilization, implementation of activities and management of the project should be; the extent of community participation in the diarrhoea prevention programs; and the barriers affecting community participation.

Before looking at those issues, the themes around the definition and importance of community participation will be described along with the problem of diarrhoea as seen by the community. This will then lead to a description of what the community saw as the roles of communities and community leaders, and the effectiveness in achieving these. The last part will discuss the barriers to community participation and how the community thought these could be best dealt with in order to improve their participation.

8.1 Lay Description of Community Participation

Both community leaders and members described CP as working together as a community or as participating in community activities. They also said that CP was the involvement of community members in community projects, collectively to solve their own problems. Activities that they suggested required the community members to participate in included the building of toilets and holding of meetings to discuss how to solve health problems in the community.

.*"Madam let me give you an example of how the community is involved; recently the community participated in the garbage collection exercise after being told and mobilized by the Neighbourhood Health Committee"* (community member).

A similar view from the perspective of a community leader was:

"*Community participation is seen when we call people to come together to offer their labour, take for example we call people to come and clear the garbage in the community. This is usually done when we as community leaders have made a decision that a cleaning exercise should be done in the community*".

8.2 Importance of Community Participation

The view of both community members and community leaders was that when people participate

in any activity, it brings about personal development as people tend to learn from each other about the problems and also about what is going on in the community. Some said that if everybody participates, work becomes easier. In addition, they suggested that several health problems can be solved in the community such as cleaning the surroundings, and that people can be educated on how to prevent diseases in the community or to further prevent the spread of diseases and outbreaks. Two community members and one community leader said that through community participation, the community will do the activities that they think are important to them since they know their own problems well and would prioritize them.

"Even you madam you agree with me that many heads are better than one when solving a community problem. In addition to this you will find that those that didn't know how to solve a problem will tend to learn from their friends when they do something as a community" (community member.

" if there is a big health problem in the community, a solution is arrived at when people sit to discuss, plan and implement the activities as a team. The community will then work together to solve that problem " (community leader).

8.3 The Perceived Health Problems including their Understanding of Diarrhoea

Diseases such as diarrhoea, measles, malaria, STDs, HIV/AIDS, cholera, malnutrition, vomiting and TB were noted as the most common health problems seen in the community. The link between poor sanitation and environment pollution on health was noted by the respondents. Examples given by the respondents included lack of adequate toilets in the community, poor garbage disposal, poor water supply where some residents use water from wells, dirty surroundings, uncovered food stuffs on the street for sale, lack of safe drinking water and faeces

seen all over the area. From the above it is clear that people know the causes and prevention of diarrhoea.

"Madam if all the above problems were not there in the community, diarrhoea would not be big problem. Just imagine what happens when there are no adequate toilets in community and faeces are seen all over, definitely flies would contaminate the water or food" (community member).

All the people interviewed said that diarrhoea was a big problem in the community. This is reflected in the number of diarrhoea cases seen, and a lot of people are heard complaining of diarrhoea and most of them go to the clinic for treatment

"It is seen year in and year out. It is a big problem. When this disease is at its peak during the rain season, you can't walk more than 100m before you see or hear somebody complaining of diarrhoea" (community member).

Most of the people interviewed said that usually children are the most affected especially those that are under the age of five years.

"If you went to the clinic at any time of the year, you will always see and hear mothers saying that they have brought their children for treatment of diarrhoea. As leaders we are always issuing out ORS sachets in the community and most of it is used by children under the age of five years" (community member).

The respondents recognised that diarrhoea was most prevalent during the hot dry and rain season. This is usually from October through to March. This is the period when there are mangoes and other fruits that attract flies. Flies also breed a lot during the rainy season. Finally a lot of water makes the garbage rot easily, attracting flies, and the dirty water found all over the community contaminates the underground water especially where there are leaking water pipes.

"I have observed that there are usually many flies during the rainy season. This is made worse

when the mangoes are ripe as they attract flies when one is eating them or when they rot. Have you seen if a child is eating a mango outside the house, she will be covered by flies on her face" (community member).

The respondents also recognized the influence of factors like poor hygienic practices that include poor hand washing practices, especially after using the toilet, in contributing to diarrhoea in this community. They also said that the use of unchlorinated or unboiled water, especially from wells, and eating of contaminated foods usually cause diarrhoea. However it was pointed out that many people cannot afford to buy chlorine or even charcoal to boil their drinking water. So although they are aware of the problem, they often are unable to do anything about it.

A few of them said that the causes of diarrhoea in the community are due to eating uncovered foods especially the food sold at the market, and eating of unwashed fruits especially mangoes bought on the street. In addition to this they also said that children are fond of defecating anyhow because they are not trained to use toilets from early childhood and sometimes there are no toilets at their homes.

"Madam there are usually too many flies everywhere because of mangoes and faeces of children seen in the community. Moreover the water that we use is not chlorinated due to lack of funds. The little cash I have, I would rather buy food for my children" (community member).

8.4 Role Played by Community Leaders and Community Members in CP

8.4.1 Decision Making in Identification of Health Problems

The leaders said that decisions about prioritizing issues were made during meetings between the Health Centre Staff and the community leaders. There was, however, a difference in

interpretation, with some leaders arguing that they were involved, while others said that decisions were made by NGOs and /or clinic.

Most said that the decisions were made by the big NGOs like Care International, JICA, CARE and DHMT and leaders were instructed on what should be done in the community. Others noted that decisions were made by the clinic on activities that were supposed to be done in the community. There were a small number of examples where community leaders were involved in actual decisions.

"I have been a leader for three years now and what I have seen is that most of the decisions are made by the clinic or the NGOs running the program. The plans or activities to be done are already known by them and they will only tell the leaders to implement them together with the community members" (community member).

They also pointed out that most decisions that were made for the community were on practical issues such as how to clear the garbage in the community through community mobilization, promotion and usage of toilets and chlorine, and individualistic health education on good hygienic practices. The leaders were not involved in strategic decisions about policy development, service provision or programs and project development

This view of who makes decisions was shared by the leaders and the community members. It is very clear from their responses that community members are not part of the decision making process as shown by the following:-

"As a community member I have never been given a chance to make a decision on what needs to be done in the community. The Neighbourhood Health Committee will always tell us what to do after their meetings with the clinic or other NGOs found in this area" (community member).

The community members pointed out that the only decisions they make are on an individual

basis such as decisions on clearing garbage around their homes, washing hands after using the toilets, cleaning of toilets, water treatment and finding money to have a toilet built at their homes. Although they are involved in the individual decisions, they are not able to influence policy, programs or projects. The community felt that they are simply instructed by the NHC to do the required activities.

"Do you think they can consider us to make decisions? They don't count us and instead just think on our behalf? However my thinking might be different and better than theirs" (community member).

8.4.2 Decision about Resource Allocation

All the people interviewed knew that the leaders were expected to intensify their efforts in offering health education in the community in the following areas: causes and prevention of diarrhoea, proper hand washing methods and practices, preparation of ORS, and how to use chlorine. The leaders had to make a decision on what topics to present. The community saw their leaders as a resource for the community in disseminating knowledge on disease prevention. There were also suggestions that the community leaders should spearhead and monitor the garbage collection program, promote the use of chlorine, monitor and emphasize the cleaning of toilets. They also said that the community leaders do advocacy, distribute ORS, sell chlorine, lime the toilets, check community cleanliness, build toilets for the people at a fee, look for resources, and clean the community together with the people.

As noted above, the community do not see themselves as part and parcel of the decision making process on what topics the leaders should present to the community nor indeed have a say on the topics to be included on their plan for health education in the community. This means that they

expect their leaders to make decisions on all activities to be implemented and the community appear to accept that their role is just about the implementation process which is in contrast to comments made by the community members in relation to their understanding of their situation.

8.4.3 What the Community could Contribute

The view of the leaders was that the community should participate in the implementation of hygienic practices in their homes such as those noted above.

A few said that community members should also cover the pit latrines to avoid flies moving from them to food and that the chlorine should be used correctly and consistently. The children with diarrhoea should be given ORS.

8.4.4 Resources that have been Mobilised

It was clear from the respondents' comments that resources meant manpower of the community members and the equipment that they contributed to be used in the activities. The equipment that was mentioned included the following: hoes, picks, rakes, wheel barrows, forks, shovels and gloves. The manpower was required in times of cleaning campaigns or a garbage collection exercise and this contribution was not valued.

All the community members interviewed stated that manpower was successfully mobilized. The reason for this is that the programs start by having sensitization meetings. Usually the community leaders call people for meetings and ask the people to participate by doing the actual work required, bringing the required equipment with them. The people usually acquire these tools after doing some casual work and they use them for their small scale gardening.

"We are usually called upon by our leaders to come and work in the community. During that

time they ask us to bring with us any tool that each one of us has for example if I have a hoe I will go with it. If one has no tools, they will use their friend's [tools] because we want to make sure we all work" (community member).

Other resources were mobilized by having meetings with community leaders, DHMT/ clinic, CARE and JICA, which contributed materials such as chlorine for purifying water, lime for the toilets, chlorine powder for water wells and Oral Re-hydration Salts and roofing sheets for toilets. Some of this (roofing sheets) had to be paid for by the community. The community also contributed money to have a toilet constructed at their homes and also sometimes buy charcoal for boiling water.

Finally three community members said that the community leaders approached big companies for donations of working tools and other requirements such as Shoprite Stores.

In addition to the resources that were available, the respondents noted other requirements like chlorine.

In conclusion apart from manpower and equipment offered by the community and the other resources that are offered by the NGOs and the Government clinic, two people mentioned that a chemical for cleaning toilets called smart toilet, building materials for construction of toilets such as cement and blocks and money to train the community on diarrhoea prevention so that they can train the community in turn were some of the resources that were needed in the program.

The contributions that were valued most were the chlorine that was bought by the community, the payments for constructing toilets, buying of roofing sheets and charcoal. The labour and equipment offered by the community members was not valued.

8.5 Implementation of the Activities

The activities that were seen to have worked well were those in which the community took individual responsibility and those that needed cheap labour.

It was recognized by the community members that what was working well was the tasks that they were required to do at a practical, individual level. These included activities such as washing hands, keeping surroundings clean, cleaning of toilets, covering of food, using chlorine or boiling water to make it safe for drinking. They also stated that some activities that were implemented by the community leaders and NGOs were about practical tasks, such as liming of toilets, putting chlorine powder in wells, building of toilets, selling chlorine and garbage collection. The educative role for example was giving health education and was also undertaken by the clinic staff.

The NHC was also involved in conducting meetings or writing posters on what needs to be done and when, as well as informing the community when certain activities will be held and what the community is expected to do - for example the cleaning campaigns.

The leaders and NGOs specifically had to do certain activities which did not involve the community, because in order for them to do those activities they had to be trained. For example, for chlorine sales they indicated that this can only be done by the leaders for accountability purposes. This involved a level of mistrust. The leaders saw their role in liming toilets as being appropriate because they were trained and the community members were not. They also, however, thought that if the community did their own liming they might end up using the lime for painting their homes.

8.5.1 What Activities Worked Well as Seen by the Community and Why?

The respondents said that the garbage collection and health exercise worked very well. The process of communication used was effective where the leadership chose to use a megaphone to convey the message across to the community, as this reached a larger number of people. The persons who were using the megaphone used all the languages found in the community to announce the message. Because of this the community came in numbers to participate and they brought their tools required for the exercise. The community believed the message and also understood the need to participate. They saw the problem as theirs and knew what benefits it would bring if they participated. They had to decide whether to participate individually despite the fact that they were faced with a lot of other individual problems, such as lack of adequate food at home to feed their families. One had to choose whether to participate in these community activities or go and work to earn money.

"Although we have a lot of problems as a community, really one has to decide wisely whether to spend his time doing community work or go and look for a job to earn an income for his family. Otherwise his family will die of hunger" (community member).

Some interviewees indicated that attending health education sessions by the community was successful. They attributed this to effective communication and community mobilization. As a result, there was an understanding of the need for some of the activities, such as buying of chlorine or boiling of water.

8.5.2 What Didn't Work Out Well and Why

By contrast, the following did not work well: chlorinating of shallow wells and construction of toilets. Chlorinating of shallow wells did not work out because the supplies from DHMT were

inadequate to cater for the whole community. Construction of toilets was very difficult in the beginning because the tenants expected the landlords to pay the builders and for the building materials. This also was because most of the people in the community are not working, and they would rather buy food then chlorine. The supplies of chlorine were sometimes not adequate, especially when in high demand.

8.6 Barriers to Community Participation

Most of the community members noted the poor economy as a barrier, as people are busy looking for jobs so that they can earn money to support their families.

"Madam, things are hard these days and if you can't find something to do to make money, your children will die of hunger." Because of this most people don't have time to do community work" (community member).

There was therefore a lack of involvement by volunteers. The leaders also talked about the negative attitude seen in some people, which can be explained by the constraints suffered by the community members and the unrealistic expectations that are made of them.

People would want to be paid for work done, and they also said that most people are busy looking for jobs or money for their families. Some people interviewed attributed the poor participation to low education levels. Others said that some people do not participate because they do not see any direct benefit or advantages to participating, while others are too lazy to participate.

Although the leaders mentioned a lack of motivation or lack of incentives as a barrier to community participation, the results suggest that it is not about a lack of motivation but more about the practical realities of their lives. Yet many donors and/or facilitating agents have

unrealistic expectations of community participation by the community, which leads to a mismatch between what is required and what is possible, and to the comments about a lack of motivation.

"Think of it madam, if they call me to come and clean the community and my family has no food at home, and meanwhile there is somewhere where there is casual work being offered, where do you think I would choose to go. Definitely I would choose to go where I will get a direct benefit at the end" (community member).

Finally it was mentioned that there was no proper coordination and communication between the existing agencies in the area. Although the agencies have a similar understanding of how CP should be done in the community, some of them pay the community for any work done. Others offer material support to the volunteers. This is interesting because they are all operating in the same area and of course with different targets and objectives for their programs. This de-motivates those that are not given anything at all.

The non-involvement of the community members in decision making is yet another problem seen in this community. Some members explained that decisions about what needs to be done are usually done by the professionals and NGOs. Sometimes the leaders are involved. This is a big barrier in the sense that the community is not participating in this important stage where they are supposed to think of how best to solve their problem in the community.

"In this community the people are not even invited at the forums where the decisions are made. What we see are just instructions of what is supposed to be done by the community. Sometimes they should allow us to be present so that they hear what we have to say as well" (community member).

8.7. Ways of Improving Community Participation

It is interesting to note that within the overall constraints of poverty, the respondents have made suggestions that they believe could improve community participation.

All leaders interviewed said that the volunteers should be motivated by giving them incentives as this will assist in alleviating their poverty even if in a minor way. In addition to this, it was suggested that volunteers should work for only two hours in a day for voluntary work instead of spending many hours. The community too should be motivated through financial empowerment by improving the poor economic situation of most households. Some community members and leaders mentioned that provision of micro or small scale loans in the community could empower members in the community financially. Educating community members on the importance of community participation was also noted as being very important. In addition to this, more than half of the community members interviewed indicated that it was very important to motivate or encourage people to work as a team and involve them in decision making about all activities that involve their lives so that they will feel they are important in the program. They felt that they should be involved in decision making about planning, implementation, managing and mobilizing the necessary resources required. This would be useful so that the leaders could find out from the community how certain things can be done and when.

"You will find that sometimes these community leaders just come with their own times and dates when cleaning campaigns can be done. Sometimes most people are out to their fields or to look for money in the mornings and the best time to participate is in the afternoon" (community member).

"Moreover we are not there when these decisions are made. Decisions to plan, implement and mobilise resources is done by the leaders and other NGOs or the clinic. We are not even

consulted. We are just told to come and work on a particular day. Do you think it is our program?" (community member).

It was also suggested that regular meetings with stakeholders were very vital and that offering refreshments to the volunteers after doing work was necessary. Tools or equipment should be available and there must be good communication with the community by leaders by announcing the activities to people using the megaphones. Meetings to plan how and when to implement activities were also noted as essential. Good communication and coordination should also exist between the agencies in the area so that there are uniform standards and expectations of volunteers. It was also mentioned that the leaders should be known by the community and should approach the people with respect.

9.0 DISCUSSION

91. Understanding of the Concept of Community Participation

Rifkin and colleagues defined CP as 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 those needs (Rifkin et al 1988). This is a bottom up approach form of CP requiring people to become an integral part of decision making and action process. It requires community members to become actively involved in decisions about how to improve their living conditions.

On the importance of CP the respondents clearly stated that when communities participate in any activity, development will be seen, work becomes easier, and a lot of health problems can be solved in that way. CP will lead people to make decisions about what problems should be

prioritized, plan the activities, implement and manage the activities (WHO 1992). The respondents in this study had a clear understanding of the value of CP. This is evidenced by the similarity of comments that they made to the principles of the Ottawa Charter (1986). In particular they talked about the way that it empowers individuals, and the importance of solving their own problems. As seen in the Ottawa Charter, CP is vital in improving the health and well-being of people in the community (WHO 1986). This will lead to empowerment of individuals and communities if they are given a chance to identify their problems, to decide how to solve the problem and decide which one should be solved first and so forth.

9.2 Understanding the Root Causes of their Health Problems

The most common diseases mentioned by the respondents were diarrhoea, measles, malaria, STDs, HIV/AIDS, cholera, malnutrition, vomiting and TB. All the respondents stated that diarrhoea was the biggest health problem in the area affecting all people in the community, with children under the age of five years being the most affected. This is in line with Murray and Lopez (1997) who said that it is a worldwide problem that is linked to a high mortality rate among children under five years of age. It is very important to note that the community in the study understand the root causes of diarrhoea and so they are well able to be involved in seeking solutions. They described the causes or determinants of diarrhoea as being related to poor sanitation, including the lack of adequate toilet facilities, poor garbage disposal, and poor water supply, dirty surroundings, uncovered foods on the street, and a lack of safe drinking water, all an indication of their awareness of the impact of poor living conditions on their health. This is again in line with the literature. Awasthi et al (1996), for example, showed that poverty, poor sanitation, lack of adequate water supply, overcrowding and malnutrition are some of the factors

associated with diarrhoea. WHO/UNICEF (2000) also pointed out that a lack of safe water, basic sanitation and poor hygiene may account for as much as 88% of the disease burden due to diarrhoea.

This understanding demonstrates that the community is capable of participating more than they are at present. The causes are well known by them, but they are not given an opportunity to make decisions to address the problems. Rather than the passive participation that is seen, where the people are told what to do, they could be proactive and give suggestions about what action should be taken.

9.3 Professional 'Top –Down ' led Community Participation

As noted, for effective CP, people should be part and parcel of the project identification, planning, implementation, monitoring and evaluation. Shrimpton (1989) stressed this, noting that CP is the involvement by the community at large and not only by their elected leaders.

Yet in practice, the community was not involved in decision making. CP was viewed as involving community members in an individual capacity to solve their own practical problems such as offering space and money to build toilets, attending meetings, and cleaning of the community, washing hands and chlorinating water. It is also clearly indicated that community members were not given a chance to participate in certain activities like selling chlorine, liming the toilets, chlorinating water in shallow wells and building toilets. They were also not involved in decision making about identification of health problems, resource mobilisation, and implementation of activities and management of the project.

Instead, the respondents generally felt that decisions were made by the Health Centre staff, DHMT, and NGOs like JICA and CARE and occasionally by the community leaders. The

instructions about health and hygiene tended to come from the NGOs, through to the leaders and then to the communities. While useful, the means of communicating the instructions did little to empower the communities or to even to check whether they had the relevant knowledge or awareness of their own. This level of community participation can be seen as one of the levels in Arnstein's ladder of participation, where the communities are informed, rather than fully involved (Arnstein 1989).

It is therefore clear that there is a top down approach in Kanyama where the community waits to be told what to do. This is in line with Rifkin's description of the top down approach (1986), where people are told after a decision has been made elsewhere. The community cannot decide what to do on their own, despite the health education that has told them what they are supposed to do as individuals. The only decision they make is to actually agree whether to do these activities or not, for example whether to wash their hands after using the toilet, chlorinate their water, pay funds to have a toilet built at their homes.

9.4 Resources

In addition to the role of communities in community participation, Shrimpton (1989) stresses power in resource mobilisation is one of the key aspects of empowerment. The community in this study has been mobilized and requested by the community leaders to offer manpower for the community activities and to bring their own working tools. Additional resources that are provided by the NGOs and DHMT are given after having meetings with the community leadership. Whether the community can afford to be involved or not is not considered, especially given that the community is not consulted on how much they can afford to pay for resources.

The Alma-Ata Declaration (WHO 1978) states that a community is expected to use its own

social structures and available resources to accomplish community goals, and this should be decided upon by the community and its leadership. An observation from this study is that all the resources from outside the community were mobilised by the community leadership while the community members had no hand in this. This is a disadvantage to the community members as they are not given an opportunity to decide what type of resources to solicit from other sources.

9.5 Training

In addition to the material resources offered by the NGOs and DHMT, funds for training the community leaders were offered as well. Training is very important especially if the acquired knowledge is passed on to the community.

After the training the community leaders offer health education sessions in the community to create awareness on what diarrhoea is, the causes and how to prevent it in the community. From the responses that were made by the community members it was clear that health education was very effective. However, as noted above, despite the community having this knowledge, the decisions on what activities should be done or what resources should be contributed by the community were decided upon by the professionals, plus at times the leadership.

9.6 Division of Labour

The presence of a community leadership is very important in the facilitation of

CP (Baum 1998). The community in Kanyama had a leadership structure in place that was elected by the community members.

It is very clear that all the activities are spearheaded by the community leadership together with the Health Centre staff and the existing NGOs in the area. These are the ones who decide what

should be done and the sharing out of roles. Generally there are activities that are typically implemented by either the community or leaders, and these are done separately. The leaders are required to sensitize and spearhead the activities and to check and monitor to make sure the planned activities are implemented. They also joined the community to do some of the actual work like the garbage cleaning exercise. All activities that involved money or required some technical knowhow were handled by the leaders. This is in line with Baum (1998) who noted that community leaders will only allow the community members to participate in certain activities and those involving money will only be done by the leaders for fear of mismanagement. This actually confirms the lack of trust in the communities and/or a lack of capacity for the communities to carry out such activities. The people are kept in their place as cheap labour and nothing more than that.

Baum (1998) argues that cynicism tends to occur in programs where people are invited to participate in plans and projects, only to find later that they were being asked only to rubber stamp official plans. What was found in this study is that the community are usually asked only to contribute their labour. This includes practical activities: garbage collection, buying and using chlorine or boiling water, paying for toilet constructions, giving food to the builders, washing their hands and covering food.

Finally the community do recognize the activities done by the leaders. Most people knew that there was a leadership in place that was involved in mobilizing the community to do community activities.

9.7 Barriers to Community Participation

Both leaders and community members were lacking incentives and/or motivation. This is a common problem seen in most programs that involve volunteers. Most of these volunteers are unemployed and many people in the community are very poor. If the resources are not adequate, then people might not participate. Petersen (1996) states that poverty is a big barrier to CP. He also noted that if there are few resources to adequately support and encourage community initiatives, ill health and poverty can prevent them from participating. He also said that the poorest members of the community are not often heard as they cannot afford the time and resources necessary to contribute or participate in the program. This was true of this study, where the community members were not even given a chance to have their voice heard.

Among the many roles of the leadership/NGOs is recognising and addressing poverty. To some extent they are addressing poverty in the sense that they are able to mobilize the resources that are lacking in the community to prevent diseases. Take for example the supply of powdered chlorine for chlorinating shallow wells at no fee at all. However, this is a small contribution in a significantly large problem.

It has been said that community members are often unwilling to participate due to lack of time, confidence or interest or that they are only willing to participate on issues that specifically concern them (Costongs and Springett 1997). In this study some community members indicated that their unwillingness to participate in community activities was because they do not have time or interest. They also stated that they would rather go to work to earn money for buying food for their families, or participate only where there is a direct benefit to them.

This type of response was noted by Baum (1998), who pointed out that people generally want to see a direct benefit for them to participate, or to have incentives offered. Even though the

respondents are aware of the problems, it is not seen as a priority or within their scope to do anything about it, as their priorities are about jobs and supporting their families. As a result, some of them would want to be paid for work done. In practice, some agencies do make promises of material gain or other incentives to increase participation, and in these cases, the attendance is high. In this community there are three big NGOs and they have their different concepts about CP and voluntarism. At one time JICA was paying the volunteers while CARE International was not, and as a result JICA had higher attendances in their activities than CARE.

Other aspects noted by Baum (1998) that influence community participation include a well-established network in the community that includes community leaders, clearly stated roles and time commitments for community volunteers, local ownership of the program from the onset and availability of resources for solving the problem at hand. According to the Alma-Ata declaration (1978), a community is expected to use its own social structures and available resources to accomplish community goals, which should be decided on by community representatives and should be consistent with local values. Although there is a well-established network of community leadership in Kanyama, time commitment might be an issue here. The leaders might want to be committed, but they lack time since they have to go and look for jobs in order to find money to feed their families. As stated earlier, they might also want incentives for doing the work. Yet resources may not be available.

To some extent there is also apathy resulting from disempowerment in the program. Common community members are not, as noted, involved in the decision making process, depending on their leaders and clinic to make decisions on their behalf to solve a problem. However, given their need to earn a living and the resulting lack of time to do community activities, and the lack of involvement in decision making, it is a positive sign that they are still able to mobilize and

offer their resources for a community activity.

10.0 CONCLUSION

The study has revealed the type of community participation that is seen in the Kanyama Community. From a public health point of view, community participation is a very vital aspect in all community programs and in this case it gives a significant health impact if all community members and leaders are involved throughout, including in the decision making process.

Although different researchers have evaluated CP using either quantitative or qualitative methodologies, the findings are similar. Rifkin (1986) provided three approaches to CP; the third approach was assessed in this study. This was the bottom up approach where power is devolved to the community. This means that for effective participation to take place, people should be part and parcel of the project identification, planning, implementation, monitoring and evaluation.

Shrimpton (1989) stresses that CP is the involvement of the community at large, and not only the elected leaders. He also adds that resource mobilization is an important aspect of empowerment. Even when the community has a clear understanding on the importance of CP, their maximum participation can be achieved only if all the levels or indicators of CP are taken into consideration. If not, then what they know and what is being done can be totally different. In this study it was seen that decision making was not considered to be part of the role of the communities, concluding that what they were doing was not CP. This is confirmed by the fact that the community understands the root causes of diarrhoea and so they can be able to make decisions on how to solve these problems around them. However opportunity for the community

to make decisions in the identification, planning, implementation, resource mobilization and managing their activities was not availed to them. It was seen that all decisions were made by the NGOs, clinic staff and in a few instances by the community leaders.

Therefore it may be concluded that the experience of the community was that CP was simply being involved or participating in a community activity. Their role was seen as only offering labour and their tools. The community members were not given a chance to have their voice heard.

It is very important that people are involved in the decision making process through sensitization and having forums, for example, through meetings where the people can be given an opportunity to make decisions over the community activities. Importantly, it is not just sensitization that is required, because they can be aware but not have a role. So it is the structures and power of those making the decisions that would have to change.

It is hoped that this study will help improve CP in the community programs. The recommendations that follow are intended to assist this process.

11.0 RECOMMENDATIONS

Some recommendations on how to improve CP were given by the community members themselves. .

Financial Considerations:

It was recommended that all volunteers should be motivated by giving them incentives. The community also mentioned that the volunteers should work for only two hours in a day for

voluntary work so that they can have time to work to earn an income to support their families.

They also recommended that the community should be motivated through financial empowerment of some kind to improve the poor economy hitting most households in the area.

If the people have something to do economically, they can have adequate time to participate in community activities.

Awareness of Community Participation

Educating community members on the importance of CP will help improve the participation levels by people. In addition to this, some members mentioned that it is very important for the community to be encouraged to work as a team, as a means of involving them in decision making.

Resources and Equipment

Resources required for any activity should be readily available for people to effectively carry out the work. In this study we saw that in some instances chlorine powder and chlorine liquid were not adequate. The people recommended that all the tools should be readily available.

Communication and Leadership

The community also recommended that there should be good communication with the community on the community activities to be done well in advance and the dates should be agreed upon with the community.

The study has also revealed that the community has a well-structured leadership that was elected by the people.

Increased Involvement in Decision making.

The community members and leaders revealed that decision making was mostly done by the NGOs and health centre staff. They recommended that they should also be involved in the decision making process since most of the problems or issues at hand affected their lives.

Sustainability

Finally, it is very important that the community is involved at all stages so that there is a sense of ownership of the programme.

It is hoped that the findings of this study and the above recommendations will be highly utilized so that CP is improved not only in Kanyama but anywhere where there are programs that depend on CP.

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13.0 APPENDIX

A1. QUESTIONNAIRE FOR COMMUNITY LEADERS

1 What do you understand by the term community participation?

2 What activities/programs have you implemented with the community?

3 What contribution do you think you can make on diarrhoea prevention program?

4 What contributions do you think the community can make in the diarrhoea prevention program?

5 How are decisions made about what needs to be done?

6 What resources have been mobilized for the program? What was your role in this?

7 What activities have been implemented to prevent diarrhoea in the community?

8 What was your role?

9 Which activities have the community been involved in?

10 Which activities have the community not been involved in? Why was that?

11 What was the role in the management of the project?

12 What do you think stops people from participating in the program?

13 How can you improve the participation by both you and the community?

A2 QUESTIONNAIRE FOR COMMUNITY MEMBERS

1. What do you understand by the term community participation?
2. How important is community participation?
3. What are some of the health problems affecting your community?
4. What is your understanding of diarrhoea in your community?
5. Who is most affected?
6. When is it most prevalent?
7. What are the causes of diarrhoea in your community?
8. What activities have been implemented to address and prevent further episodes of diarrhoea by individuals and the community as a whole?
9. As a community who spearheads the activities to prevent diarrhoea in the community?
10. How are decisions made on what should be done?
11. How are these activities implemented?
12. What resources were required for implementing the diarrhoea program?
13. How were these resources mobilized?
14. Describe the contributions community members have made to diarrhoea prevention activities
15. Was the contribution valued?
16. Was the contribution effective?
17. What worked well? Why did it work well?
18. What didn't work well?
19. Why didn't it work well?

20. What role (s) do your community leaders play in the prevention of diarrhoea?

21. What do you think stops people from participating in the programs?

22. What do you think can be done to improve your participation as well as the Community as a whole in preventing diarrhoea?