COMMUNITY DEVELOPMENT THROUGH LEARNING COMMUNITY APPROACH: DEVISING STRATEGY FOR HEALTH PROMOTION

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Abstract

Health promotion communication encompass a broad range of activities and approaches which focus on individual, community and all other stakeholders and also on environmental influences on behaviour. Bringing about changes in behaviour is critical for the success of health promotion programmes which may be related to such themes as HIV/AIDS education, safe drinking water habits, reproductive and child health issues etc. However, changing attitude and behaviour, especially of adults is not an easy task. Therefore, a definite communication strategy has to be evolved, formulated and implemented for effecting changes in behaviour of the target group. This paper tries to devise a strategy for health education aimed at health promotion of the community which is an important purpose of community development. The strategy thus talked, analyzed and formulated here is based on the premises that community participation is essential for development. Communication for health promotion is a process that is crucial for community development.

Introduction

Community development through a learning community approach facilitates the gathering of information, knowledge, skills, attitudes and values that together build a community's capacity to successfully respond to, and direct, economic and social change. The six traditional objectives of community development are given by the acronym CHEERS where C stands for Citizenship/civic education , H for Health promotion, E for Economic development, other E for Environmental/ecological sustainability, R for Rural/urban development and S for Social Development/planning. One or more of these purposes have been served in many communities over the past generation, but often with no explicit analysis of the learning needs or assets that exist. Fortunately, these purposes are increasingly viewed holistically and all or each can be informed and infused by a learning-based approach. Thus, prior or current local initiatives are not replaced by a learning community approach but rather are acknowledged and built upon – an approach supported by most community members.

This paper tries to devise a strategy for health education aimed at health promotion of the community which is an important purpose of community development. The strategy thus talked, analyzed and formulated here is based on the premises that community participation is essential for development. Communication for health promotion is a process that is crucial for community development. It operates through four main strategies – advocacy to raise resources and political and social leadership commitment of the community for development, awareness and public education to create an environment for acceptance of the programme and provide information in order to change perceptions. Social mobilization for community participation and ownership of the programme and programme communication for changes in knowledge, attitude and practice of specific participant community in the programme.

Advocacy is a process of gathering, organizing and formulating information into an argument, to be communicated through various interpersonal media channels to political and social leaders residing within a community with a view to gaining their commitment and support for a programme. It is aimed at the political, social and religious leaders at the national, regional and local levels. The primary message for advocacy is the advantage of health interventions to the individual and family, community and nation. The channels are individual meetings with senior leaders, small group meetings and reinforcement materials like pamphlets, booklets and leaflets.

Awareness and public education is a process of presenting information to increase awareness and educate the targeted community about health and hygiene practices. This is a process of empowerment with knowledge, the first step to bring about a change in community members' perceptions and behaviour.

Social Mobilization is a process of bringing together all feasible inter-sectoral social partners to raise demand for and sustain progress towards ensuring community participation in health promotion programmes. Social mobilization entails meetings with inter-sectoral and regional planner groups, community leaders and local

NGOs and other functionaries. It translates into reaching/mobilizing the community for participation. Community meetings and field observation visits are the primary channels for social mobilization.

Programme communication is a formative research based, consultative process of addressing knowledge, attitudes and practices of specific groups of programme participants in order to develop or change those behaviours that have an impact on the development objectives. Programme communication is aimed at the primary stakeholders in health intervention programmes – the community members, especially women, care givers, children, institutions in the health sector as well as decision makers at the household level. Information may be given using the mass media channels, wall paintings or poster but the primary communication materials include booklets, pamphlets, flipbooks, performances based on traditional media, film shows and so on.

Community participation is a process based on dialogue, consultation and empowerment of the people in a community in order to identify their own problems , decide on how best to overcome them and make plans to seek appropriate solutions and assistance. The frontline workers, social animators or NGOs initiate community participation. Their capabilities and skills should be enhanced through training and small group sessions. The frontline workers need to be trained on conducting sessions on participatory learning and action, appraisal of the local situation and conducting planning exercises with the community. They should be empowered on how to catalyze change in the community. Training modules, reporting formats, role-play exercises are some of the materials that they may need. The Figure-1 below explains the process of communication leading to behaviour change in a community also incorporates the BASNEF1 model for understanding behaviour change in health promotion.

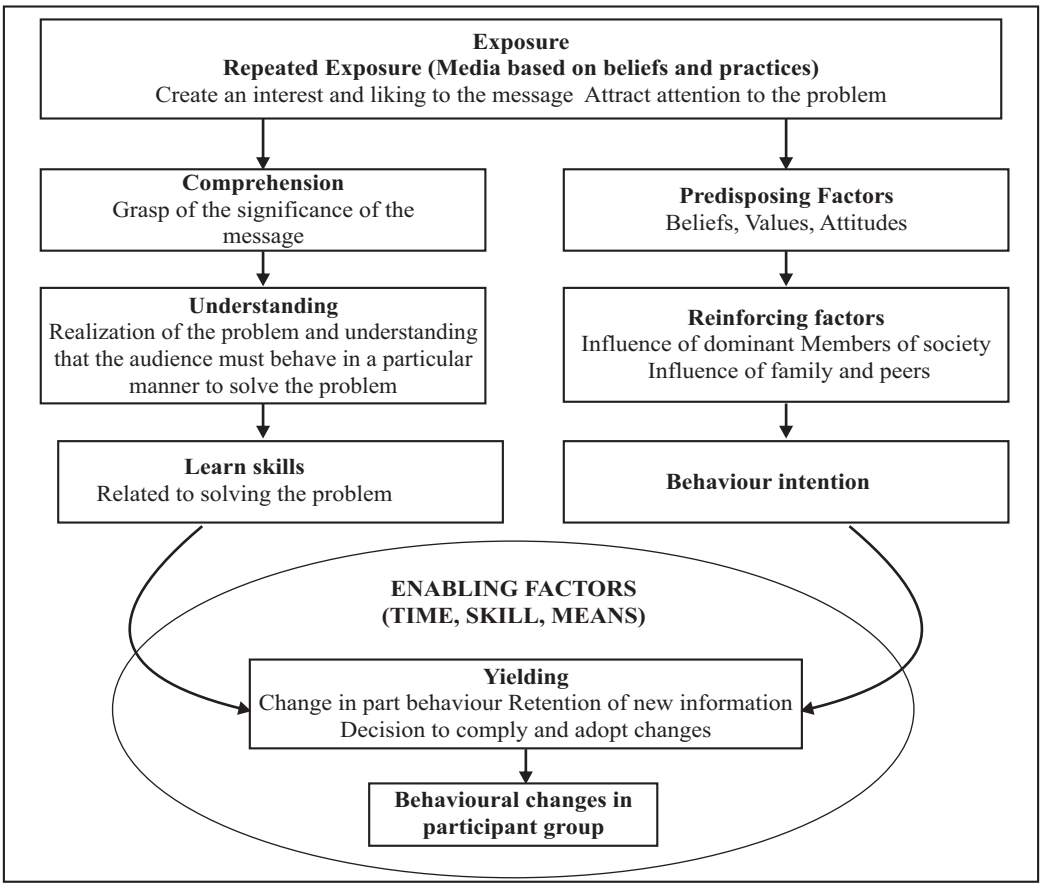

Figure-1 The process of communication leading to behaviour change in a community

Development of the Communication Design

The communication design is a culmination of the communication assessment, setting objectives and identifying outputs, defining messages and selecting channels, developing media products and processes and developing the monitoring and evaluation(M&E) indicators as well as the feedback system. Figure-2 explains the communication design-

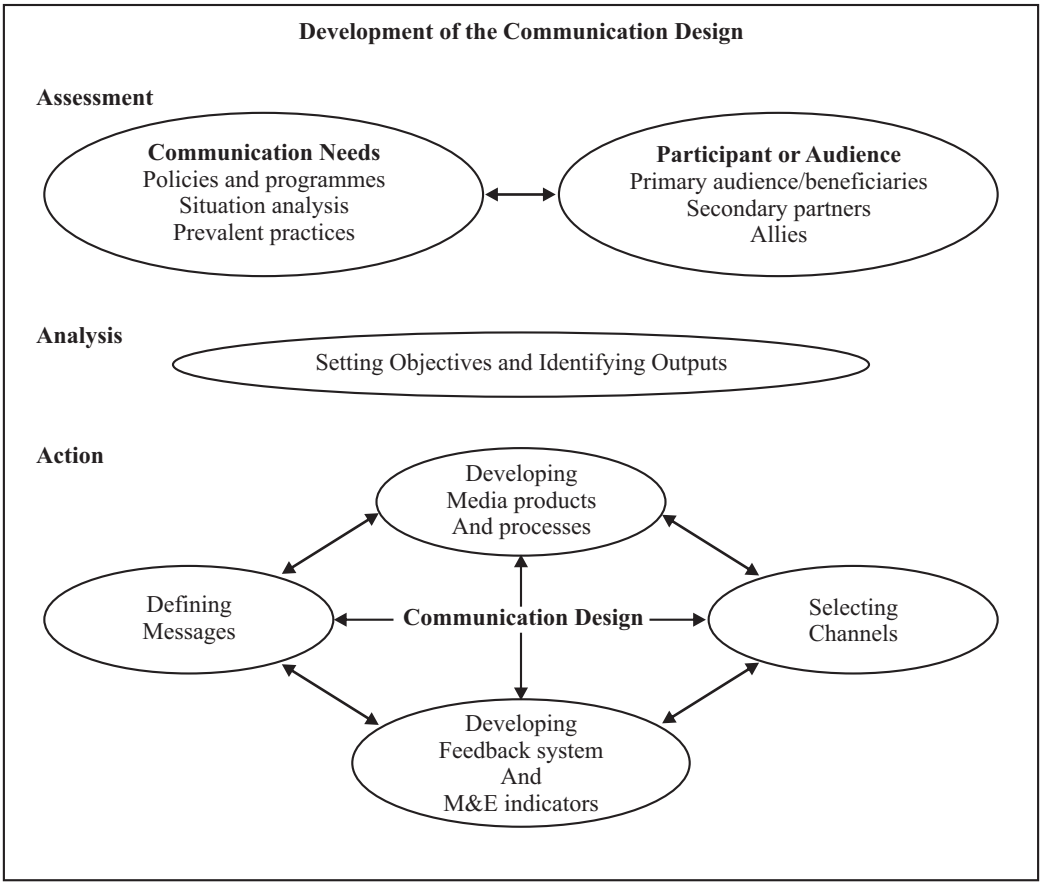

Figure-2 The communication design

Communication Assessment

Communication assessment involves the appraisal of Communication needs and the audience or participant group.

A. Assessing communication needs

An assessment of the communication needs entails reviewing –

- The health policies and programmes that exist.
- Recent studies giving situation analysis. In case recent data is not available, rapid assessment studies may be undertaken before developing the communication design.
- Prevalent practices with regard to the thrust area reflected through rapid assessment studies, Participatory Rural Appraisal exercises and focus group discussions with a representative sample of the participant group.

The key interventions in terms of communication inputs to be identified – the behavioural practices followed actual messages that must be communicated, how the messages must be packaged and the channels most likely to be effective.

B. Assessing the Participant group

The person at whom the communication strategy is directed is called the participant group. These are the people that media and channels want to contact, inform and effect change among. Out of the total population to be reached through the communication intervention, the participant group whom the intervention is focussed at must be defined.

The participant cluster can then be segmented into groups. Segmentation helps to focus the communication, saves time, effort and resources by dividing the audience and using the most effective and efficient means to reach each segment. Primarily, the participant group can be segmented into –

Primary audience or beneficiaries – Those who suffer most from the problem and will directly benefit from the programme intervention.

Secondary Partners - Those who most influence the beneficiaries and who must be involved and respond to the communication interventions, e.g. the frontline workers, motivators, social animators, village leaders, NGOs etc.

Partners and allies -Those organizations, groups and networks that can support the participant group, the political and social leaders who can create the conducive environment, policies and legislation that can influence adoption of health programmes & practices. The characteristics of target group are depicted in Table-I –

Table-1
The characteristics of target group

Target Audience	Why? Objective	Who?	Where?	Channels
Primary	Change health practices	Mothers, children	Ho mes, schools, community	Home visits, interpersonal communication lessons in schools, traditional folk media, Mass media as a catalyst
Secondary	Support the changes in health practices	Community workers, teachers, women in community, men.	Community, neighbourhood, school, etc	Meetings, radio boo klets, special events, etc.
Tertiary	Support healthy life promotion, provide enabling environment	Religious leaders, political and social leaders, NGOs, government partners etc.	Community gatherings, special venues, offices etc.	Mass media, meetings, seminar, workshops, ceremonies, etc.

Action for development of Communication Design

1. Defining messages

A message is a specific piece of information, dealing with aspects of behaviour that needs to be changed. The messages for advocacy, social mobilization and communication are dependent on the communication analysis, assessment of the participant group, their knowledge, attitudes and practices as well as the ongoing activities related to communication for health education. The following steps assist in developing messages –

(I) Study of existing communication materials – An inventory of materials previously developed, produced and used should be developed. The inventory should indicate:

- The target audience for which these materials were intended should be understood – location, language group, age group, sex, socio-economic status.
- Objectives for each of the materials-the intent and utility.
- Messages communicated in the existing materials and impact studies (if any) on the use of the developed materials.
- Reports on field testing, actual use or suggested improvement of the materials.

(ii) Listing of Behavioural Data & studies – The list of previously conducted studies should indicate:

- The current practices and habits
- Cultural values of the participant groups - the religious practices followed, the formalities and practices of interaction between the people, who takes decisions in the families, role and status of women.
- Life styles of the people, prevalence and use of traditional and folk media in the region, practices of relaxation and entertainment followed.

(iii) Analysis of the Behaviour to be changed – Based on the assessment of the existing materials a list of priority messages that must be communicated to bring about a lasting change in behaviour should be developed. Some of the messages of the previously designed materials may be used and new ones added.

2. Selecting channels, defining media

A channel is the medium that most effectively and efficiently communicates the identified message to the participant group. Different channels are used for advocacy, social mobilization, programme communication and training and capacity building. While each channel and media has its own advantages and disadvantages, criteria that must be kept in mind while selection is –

- Perceived credibility, e.g. a booklet giving statistics may have more credibility than a play in which the statistics are narrated.
- Appeal, e.g., a play is very appealing to any type of audience.
- Audience ability to comprehend the media.
- Literacy levels of the audience – while most media should not require a high degree of literacy, those reaching the secondary and tertiary groups must be more information oriented.
- Coverage area – national, regional, local. Where do the participant group live and their local customs and language.
- Duration and frequency of the message – While some messages need to be ongoing (e.g. for a sanitation campaign, hand washing with soap before eating can be an ongoing message), other can be seasonal or even sporadic (importance of using ORS during diarrhoea during the monsoon months or during months when high incidence of diarrhoea is reported). Some messages can be used in a campaign and then withdrawn.
- Visual information in the message.
- Habits of the people – norms to determine viewership, frequency and free time patterns.

The Table-2 below gives the target audience, role and usage of the different media.

Table-2
The target audience, role and usage of the different media

Media	Target audience and participant group	Role	Usage	Limitations
Mass Media – 1. TV	Users and general public – illiterate and literate	Informative Provides credibility to the field level worker Catalytic presence	Infomercials Educative drama	Expensive Constantly under competition from the entertainment channels
2. Radio	Users and general public – illiterate and literate	Supplementary information Catalytic presence Provides credibility to the field level worker	Infomercials Panel discussions Presence in special programmes	One way channel Audience reaction, participation and interest difficult to assess. Must be supported by personal follow up.
3. Newspapers and Newsletters	Literate users and general public	Informative	Advertisements Editorial articles	Limited to literate audience. Newsletters can be effective for networking of social animators and motivators.
4. VOW	Users – illiterate and literate	Penetrative interactive, informative and entertaining Provides credibility to the field level worker	Infomercials Educative drama series.	Expensive Can be effective if coupled with a campaign
1. Wall Paintings 2. Banners, 3. Tin plates, 4. Posters	User group – semiliterate and literate	Supplementary information	Informative reminders	Can be easily ignored Limited to simple messages
Interpersonal – 1. Flipbooks	Small user groups	Informative Interactive	Interactive material for small group discussion	User, social animator, must have skills to use properly
2. Manuals 3. Booklets	Social Animators and village level workers	Informative Reference	Reference materials with information on 'how to'	Some degree of literacy essential.
4. Charts 5. Flipcharts	Small group	Discussion aid	Reference materials for discussions in small groups	User, social animator, must have skills to use properly
6. Newsletters and wall news papers	Small group discussion	Informative Catalytic	Reference materials for small group discussions and networking	Some degree of literacy essential User, social animator, must have skills to use properly

1. Developing Media products and processes

The three A's have to be to be kept in mind while developing media products. They are –

- Access and availability (of equipment, the media etc.)
- Appropriateness of the product
- Audience media habits

Pre-test

All materials must be pre-tested before mass production. The pre-test must check the following –

- Technical aspects on a communication expert – text, script, visuals, theme, colour, etc of the media must be evaluated by a specialist.
- Impact factors on a pilot audience – attractiveness, attention getting, message clarity, information retention, acceptability, self-involvement must be assessed on viewers/listeners/spectators/users group.

2. Developing a feedback system / Monitoring & Evaluation indicators

Monitoring of a communication design is different from pre-testing the media. The purpose of pre-testing is to anticipate problems while monitoring intends to identify the problems after they occur and attempts course correction. Monitoring is an ongoing process. It should begin at the research stage and go on till the communication plan is implemented. An indicative checklist for monitoring is given as Table – 3 below.

Table-3

Indicative checklist for monitoring

Aspects that can be monitored	Indicators
Product development	(a) Is the product appropriate for the intended audience? (b) Is it appropriate for the message it communicates? (c) Is the product being pretested? (d) What is the unit cost of production? (e) What are the volumes of the products produced?
Distribution and Use of the media	(a) What is the schedule of distribution of materials? (b) What is the planned distribution system? (c) Is the communication material available in field – display of wall paintings, flyers, poster etc ? (d) What are the airing schedules of mass media like TV and radio programmes? (e) Are community members aware of the existence of the media? (f) Have they seen it, used it? (g) Have the users of the materials been trained? (h) Have any tracking studies been planned and conducted?
Seasonality	(a) What are the seasonality statistics of the problem? (b) Is the communication design focussing on it ?
Identification of problems	(a) Have any rapid assessment studies been planned to measure comprehension, recall and practice? (b) Does the communication design have scope for identifi cation of problems? (c) Is there a scope for course correction?
Feedback to planners/designers to redesign messages	(a) What is the system for getting feedback after use of a product/design (b) Have any rapid assessment studies been planned to measure comprehension, recall, practice and feedback? (c) How is the feedback communicated to the designers?

Note: Hubley, J. (1993) introduced the BASNEF model for understanding behaviours in health communication: Beliefs, Attitudes, Subjective Norms and Enabling Factors.

Conclusion

Thus, health promotion communication is the process with synchronized actions for creating awareness, changing attitudes and perceptions, forcing intersectoral linkages, reaching standardized information to the people in order to ultimately alter behaviour patterns. When combined with development of skills and capabilities and provision of an enabling environment, communication strategy for health promotion plays a central role in positive behaviour development, empowerment and lasting behavioural changes among individual and groups within a community.

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