

Augmenting frameworks for appraising the practices of community-based health interventions

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<https://lib.itg.be/pdf/itg/2009/2009hppl0335.pdf>

Accepted 20 April 2009

This paper aims at augmenting the frameworks proposed by Rifkin in 1996 to distinguish between target-oriented and empowerment approaches to participation in community-based health interventions. In her paper, Rifkin defined three criteria: who makes decisions on resource allocation, expected outcome and outcome assessment. We propose five additional criteria: the definition of community, the characteristics of the capacity-building process, the leadership characteristics, the documentation process, and ethical issues regarding participation. Derived from our analysis of a community-based project, the proposed criteria are discussed in the light of the principles of Popular Education and other literature on community participation. The augmented frameworks are intended to assist health professionals and planners interested in the empowerment approach of community participation to consciously sharpen their practice.

Keywords Community participation, empowerment, ethics, participatory research, values

KEY MESSAGES

- The frameworks to distinguish between target-oriented and empowerment approaches to participation in community-based health interventions need to be augmented with additional criteria: the definition of community, the characteristics of the capacity building process, the leadership characteristics, the documentation process, and ethical issues regarding participation.
- The augmented frameworks will assist health professionals and planners interested in the empowerment approach of community participation to improve their practice.

Introduction

Despite community participation being advocated as a solid cornerstone of international health policies (Zakus and Lysack 1998), most research projects, health interventions and programmes tend, in practice, to be designed with centralized decision-making, specific objectives, targets and directives determined without community input and, when necessary,

traditional, formal and top-down training (Chambers 1994; Laverack and Labonte 2000). The gap between theory and practice reflects the uncertainty about community participation strategies (Rifkin 1996). The discourse on community participation continues to be disconnected from reality because health professionals have not yet resolved the tensions between top-down and bottom-up approaches widely described and discussed in the literature (Rifkin 1986, 1996; Laverack and Labonte 2000; Morgan 2001).

Top-down and bottom-up approaches translate into practice the two frameworks of reference regarding community participation: target-oriented and empowerment, respectively (Rifkin 1996). Both illustrate how participation can be understood and achieved in health programmes. To summarize, within the target-oriented framework, participation is viewed as a

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means to the end of health improvements and a way to mobilize community resources to support health services and interventions. Involvement of people is passive and activities are decided upon, designed and planned by health professionals. Evaluation of success or failure is often based on the quantification of changes observed in the health status of the population. In contrast, in the empowerment framework, participation is seen as an end in itself. The aim is to enable local people to take power over decisions that affect their lives and their health. In this perspective, community participation is understood as a dynamic process in which people, through learning and involvement, gain access to and control over health care resources. Involvement of people is active and based on community initiatives. The evaluation, often with strong qualitative components, focuses on the processes and how people perceive and achieve social change. However, in practice, when attempting to achieve community participation, the differences between the two frameworks may become blurred.

We applied Rifkin's frameworks in a pilot research project aiming to achieve community participation in *Aedes aegypti* control. We performed a qualitative content analysis of project documents using the three criteria recommended by Rifkin (1996) to distinguish between the target-oriented and empowerment frameworks: who makes decisions on resource allocation (professionals *versus* community members), expected outcome (health status *versus* social change) and outcome assessment (quantitative *versus* qualitative). The examination of the data focused on identifying signs of changes in the conception of community participation over time, and on the strengths and weaknesses of the project in relation to community participation. The analysis proved useful and revealed a shift in the pilot project's conceptual framework of community participation from target-oriented to a more empowering approach, and the implication thereof in the implementation of the pilot project (Pérez *et al.* 2007).

However, we discovered that the three criteria proposed by Rifkin (1996) captured only partially the main changes that, in theory and practice, occurred during 5 years of the project. Iteratively scrutinizing project documents through an inductive analysis, other additional criteria emerged (Pérez *et al.* 2007). This paper aims to discuss the value of these criteria with the intent to assist health professionals and planners to make a conscious shift towards an empowerment approach of community participation.

It is useful to highlight the theoretical assumptions regarding community participation underlying this paper. We root our analysis in the ethical, philosophical, theoretical and methodological principles of Popular Education expressed in Freire's writings (Freire 1970, 1973, 1976). From this perspective, participation in health matters is understood as a learning process for changing power relationships among all actors involved: health personnel, formal and informal leaders as well as lay people of the community. To be successful, participation relies on the development of the people's ownership towards programmes, the assumption of responsibilities and involvement in decision-making throughout the process.

Moving towards this type of participatory process is a complex, not always conscious, route within which consistent overall positioning as well as inconsistencies and unclear

situations are observed. Hence, it is useful to analyse participation in its multiple dimensions. Bringing face to face our praxis inspired by Popular Education and literature on community participation, we propose the following five criteria to be added to the three criteria proposed by Rifkin (1996): the definition of community, the characteristics of the capacity building process, the leadership characteristics, the documentation process, and attention to ethical issues regarding participation. The following sections of this paper describe and discuss each of these criteria. For each, we also provide some practical examples of how they allowed changes to be made in the strategy of our pilot project for vector control, shifting it progressively towards the empowerment framework.

Additional criteria to distinguish target-oriented and empowerment frameworks

The definition of community

Many definitions of community have been put forward based on structural or functional elements, or a combination of both (Arias 1995). Structural elements define the community in geographic or demographic terms (Kingsley 1948; Chiony 1968); while functional elements refer to sociological aspects such as the presence of local roots (Sánchez 1991), identity, existence of social interactions (Ander-Egg 1980; Fernández 1984), common ideological, religious and cultural values (Marchioni 1987), and the history of the society (Kisnerman 1986). Overall, four elements seem to be fundamental for the definition of a community: common geographical area, sense of ownership and identity, social relationships, and interactions.

In the field of health, the concept of community often describes the group or groups of people targeted by health programmes. Geographic or demographic definitions have predominated for pragmatic and epidemiological reasons (Espino *et al.* 2004). In many cases, the difficulties encountered in community-based health programmes have been due to this inadequate and narrow conceptualization of what constitutes a community (Linares 1996; Lysack 1996).

Espino *et al.* (2004) provide some examples of these difficulties. For instance, a common epidemiological definition of community is a group of people at risk for a given disease. Community-based programmes rooted in this definition fail to take into account all the different social, political and cultural features this group of people can have. For pragmatic reasons, another common definition of community emphasizes the geographical dimension. This emphasis pays little attention to non-geographical features of the communities, such as sense of ownership, identity and traditions that could make a difference when programmes are implemented.

An empowerment framework takes into account social and cultural features of the community in order to contextualize health actions and generate commitment and sustainable involvement of community members. In addition, community members are considered as subjects of health actions that have diverse purposes. Viewing the community as a subject of social change entails an approach that encourages and creates skills among the community members to overcome their living

conditions by identifying continuously their principal problems and the best solutions for resolving them (Díaz 1995). On the contrary, the target-oriented framework is more associated with utilitarian approaches of the community as the object of health interventions, and usually it is defined narrowly and viewed as a homogeneous ideal entity.

In our community-based vector control project, the recognition of the heterogeneous nature of the community brought changes to the participatory strategy and actions in order to target different stakeholders within the community. For instance, differences in learning needs between community health practitioners and community leaders were acknowledged. The mass communication strategy designed at the onset was decentralized and replaced by the elaboration of local communication strategies, adapted to the needs of neighbourhoods with different socio-economic levels. Changes were also introduced in the organizational set-up of the project and the level of implementation was reduced from 30 000 to 1000 inhabitants, allowing more involvement of individuals in decision-making.

Characteristics of the capacity building process and the underlying educational model

This criterion describes the education model underlying the capacity building process. Every pedagogical model implies a mode of communication, just like every mode of communication entails a way of participation (Kaplún 2002). Although capacity building is commonly accepted as a key aspect to achieve community involvement in health (Crisp *et al.* 2000; Laverack 2003; Sennun *et al.* 2006), the literature is conflicted on whether capacity building should be seen as a means or an end (Labonte and Laverack 2001; Gibbon *et al.* 2002).

Chino and Debruyne (2006) affirm that community capacity building must be a participatory process where mutual learning takes place, rather than a linear, static, time-oriented format. A pedagogical model, based on Paulo Freire's theory of Popular Education, is intrinsically linked to participatory learning methods. If the fundamental purpose of education is social transformation toward full participation in society, the methods to achieve this objective must be different from those which impede and discourage community involvement and ownership (Freire 1970).

Comparing the two frameworks, the target-oriented one entails a more conventional pedagogical model with a unidirectional transmission of knowledge. Capacity building within an empowerment framework follows a methodology that ensures dialogue among equals, experience-based learning, collective contribution to knowledge building, and a dialectic relationship between theory and practice. Within this framework, health professionals will, consciously, pay more attention to the way capacities are built. The design or description of educational activities will clearly reflect whether the focus is on content rather than process, or vice versa. Differences in how the community knowledge is listened to, valued and taken into account can also be assessed.

Building-up community capacities towards participation was both a key concern of our community-based project and the entry point to motivate, mobilize and organize people for decision-making in *Aedes aegypti* control. However, some of the

stakeholders were reluctant to attend workshops on community empowerment and lacked commitment and responsibility. The researchers acknowledged a weakness in the capacity building process. Consequently, the pedagogical model used in workshops was reformulated, increasing participants' motivation in taking part in the project and raising their self-esteem. They realized the way they usually approached the community was inappropriate and learned to work with others.

Leadership characteristics

Leadership is the process of influencing, guiding and directing people for the achievement of specific goals. This criterion characterizes the relationships of health professionals with others.

In the literature, leadership has been commonly considered a critical factor for attaining community participation. Rifkin (1996) did not include leadership when comparing the target-oriented and empowerment frameworks. However, in an earlier article on measuring participation, she considered leadership to be one of five elements that influence participation (Rifkin *et al.* 1988). The latter paper stresses the importance of exploring the characteristics of leadership, and how leadership responds to or represents disadvantaged groups. Laverack and Wallerstein (2001) and Laverack (2003) also proposed leadership as one of the operational domains that allow people to organize and mobilize themselves toward social and political change.

However, leadership has usually been seen as a person-centred matter, even when various individuals emerge as central figures within a process. Korten (1980) stated that leadership was one of the key elements in successful Asian rural development stories. The author argued the need for a charismatic leader in the power building process. Laverack (2006) commented on the disadvantages of individual leaders within participatory processes. We agree with authors that argue that leadership in an empowerment framework should be a shared collective act (Montero 2004; Laverack 2006). Democratic leadership facilitates true decentralization of power and knowledge. Hence, health professionals should be aware that their dominant position in guiding the process of improving health status restrains shared leadership.

This criterion also encompasses native versus outsider leadership, and their relative strength. Some authors argue that participation in managing daily-life community matters is a fundamental condition that should pre-exist in a community before any external participatory proposal be initiated (Linares 1996; Rebellato 1997). Nevertheless, the two frameworks of participation seem to require a certain degree of outside motivation (Morgan 2001). Terms such as 'promoting' and 'encouraging' participation imply actions coming from outside of the community.

It seems unrealistic to think that community participation is spontaneously generated (Toledo 2007). As a social learning process (Pérez *et al.* 2007), external agents can play a very important role in fostering participation and offering appropriate knowledge for decision-making, especially within powerless and discouraged communities (Morgan 2001).

Within an empowerment approach, the relation between knowledge and power cannot be ignored. The power and

influence of professionals external to the community needs to be properly understood. Exclusive external leadership of community development processes cannot be accepted. The position adopted by professionals must facilitate involvement of community members. This does not imply that technical knowledge should be discarded, but a proper balance with popular knowledge must be established as well as changing the power relationships generated (Rebellato 1997).

The extremes of the continuum of participation expressed through leadership can be described as unique leadership (person-centered), autocratic or paternalistic for the target-oriented framework, versus collective leadership, fully shared with community members and professionals (eventually including other sectors) on the empowerment side.

At the beginning of our pilot project, leadership was more external and paternalist. Management and decision-making were mainly in the hands of professionals external to the community. Only the highest local health staff were consulted for some decisions. By the end of the project, through establishing coordination teams at different levels, leadership was decentralized. Important decisions on 'how', 'where', 'with whom' and 'when' to implement project activities were made jointly by local health staff at different levels, formal and informal leaders, and members of the general population. The role of the outsiders became limited to offering necessary technical information to facilitate decision-making.

Documentation process

Any community-based health intervention will at some point in time require some kind of process documentation and follow-up through monitoring and evaluation for fine-tuning or reorienting objectives and processes. In some cases, the intervention can include a research component. In practice, the methodologies used are very diverse and can be more or less formalized and explicit.

Our point is that whatever the methods used for monitoring and evaluation, they should allow for broad participation of all project actors. Information resulting from a given field experience needs to be organized in order to reconstruct it, analyse it in-depth and undertake a self-critical assessment to draw lessons from it. The challenge in the documentation process is to move beyond narrative descriptions to theory through reflection and critical appraisal of the practices (Jara 2002). Indeed, improvements in achieving participation can only be possible if the successes and failures of what is being done are properly analysed. Thus the results and conclusions will be more accepted and used by all.

It seems obvious that aiming at community empowerment implies adopting participatory approaches to evaluation and research. However, to what extent are health professionals willing to do so? In this process they may struggle with traditional scientific standards, fear of losing control of the research exercise and scepticism about the value of knowledge emanating from people's life experiences.

A huge body of literature exists on participatory research (PR), participatory action research (PAR) and empowerment evaluation, and many different interpretations have been given (De Koning and Martin 1996). Due to the specific objective of social change that these approaches have, the kind of

knowledge they generate is related with social action and allows the population to acquire the insights they need to change their lives (Hall 1981).

Looking back at Rifkin's frameworks, an empowerment framework will entail participatory or empowerment evaluation approaches focusing on processes and, in the case of research, will take the form of PR or PAR. An empowerment framework looks for explanations of how and why certain results are obtained, aiming at community involvement in decision-making. Within this framework there is an explicit intention to understand how participatory strategies are implemented and to consciously modify them if needed. In contrast, a target-oriented framework will favour more classical research procedures and impact evaluations focusing on specific outcomes, paying less attention to how these outcomes are achieved and related to the participatory strategies implemented.

At the onset of our community-based project, most of the project documents emanated from the external researchers, but progressively more and more documents were produced by project actors. Also, the documentation process allowed a rigorous critique of the project and led to the recognition that despite our theoretical assumptions regarding participation, our practices at times restrained participation. Changes could therefore be made.

Ethical issues regarding participation

Ethics is a social product that establishes standards for human actions, power relationships, and certain degrees of freedom for individuals (Gutierrez 2004). What is essential with ethics is that it cuts across of all the criteria proposed above.

In the health field, beyond the internationally developed guidelines on the ethics of research involving human subjects (Nuremberg Code 1996; Emanuel *et al.* 2000; World Medical Association 2000), little has been written about the ethics of participation in community-based interventions and programmes. However, it is possible to find in the literature some ethical concerns in relation to participation in research (Green *et al.* 1995; Dickert and Sugarman 2005; Khanlou and Peter 2005).

Our basic concerns regarding ethics encompass the goals and the process of participatory interventions, but also the involvement of community members in what we have called above the documentation process.

Regarding the goals of community participation, the ethical implication is to bring positive social change to the community through making people active subjects of change (Rebellato 1997). Due to the empowering aim of the participatory strategies, the potential of the community to take power over decisions that affect their health should therefore be assessed, as well as the commitment of the actors involved in the process towards reaching this goal (Khanlou and Peter 2005).

In addition, an ethical perspective on community participation must express an appropriate relation between individual and collective interests, and also between local and national interests, taking into account the conflicts that can possibly be generated (Dávalos 1997). Empowerment efforts at the local level can lead to frustrations if they are not articulated with macro-social level policies in conducive environments, or if they do not lead to changes in global policies in unfavourable ones

(D'Angelo 2004). Participatory strategies challenge existing conditions and bear the risk of increasing the vulnerability and marginalization of communities involved (Khanlou and Peter 2005). Moreover, the promotion of community involvement can be a pretext for political and social manipulation of communities (Ugalde 1985). For instance, participation can be utilized as a political control strategy of the State when decentralization is a means to privatize social services (Collins and Green 1994). Bronfman and Gleizer (1994) advance that community participation can have negative consequences for health if it leads to offer low-quality services and poorly trained human resources.

Regarding the process of participation, ethics implies more than choosing an approach or a methodology. It encompasses values such as solidarity, respect of diversity and differences, and commitment to social justice, equity, autonomy, conflict resolution and shared decision-making. Pre-existent traditional ways of participation and the role of existing community organizations are also to be taken into account in the empowerment process (Reballato 1997). Other ethical issues are to respect the free will of people to participate or not (taking into account schedules and additional burdens that their involvement implies) and the possibility to withdraw from the process. Not all activities and processes need to be participatory and people do not necessarily want to participate all the time, nor do they have to (Sánchez 1991).

Finally, in the process documentation, ethical concerns are to generate knowledge useful for action rather than for understanding alone (Khanlou and Peter 2005), to ensure that the community members participate in the definition of the research or evaluation problem and are enabled to contribute to it and, if they did not participate throughout, that results are fed back and discussed with them. If the project comprises a research component and thus takes the form of PR or PAR, all ethical issues related to such research should be taken into account (Green *et al.* 1995; Khanlou and Peter 2005).

If we follow the argument of Minkler and Wallerstein (2003) that PAR is not a method for conducting research but rather an orientation to research, most participatory interventions rooted within the empowerment framework will take, at least implicitly, such an orientation. As such, and since research and ethics are linked together, concerns for ethical issues are likely to be present. On the contrary, most interventions rooted in the target-oriented framework will not include research components (or these will merely be limited to outcome evaluation). Thus, they are less likely to incorporate ethical concerns. If ever present, ethics will be person-related.

In our vector control project, ethical concerns related to participation emerged gradually. At first, little attention was paid to these issues. Ethics came in when considering potential problems that would need to be avoided: compulsory involvement in project activities for health staff and formal leaders; manipulating the population's needs; creating or reinforcing conflict of interests among stakeholders; and creating false expectations about the resolution of community problems or potential benefits. Later, questioning our practice from an ethical point of view, the project was understood as a mere proposal to be discussed and modified on the way, and

mechanisms were established to ensure participation in decision-making, in capacity building, in establishing communication strategies, and in planning and evaluation.

Conclusions

The five criteria discussed above are expressions or dimensions that participation takes in practice. Even though this paper has discussed each criterion separately, health professionals and planners must be aware of the complex and dynamic interactions among them. For instance, changes in the nature of leadership are directly influenced by the capacity building process; documenting and monitoring ethical issues guide and feed back capacity building.

Participation is not only a matter of theory. It is above all a question of values and approaches to the field. Hence, health professionals must go beyond discussing theoretical definitions and dimensions of participation, and look at the way these dimensions are expressed in their practices. As stated by Reballato (1997), when discourse and practices on community participation are dissociated, the way forward is to relate the two through a reflection on practices.

The criteria are not solely meant to be used for evaluation purposes but to improve practices. This was also one of the aims of Rifkin's framework (Rifkin 1996). We therefore suggest that health professionals and planners interested in transforming their practices on community participation might consciously move them towards an empowerment approach by applying the criterion proposed by Rifkin—who makes decisions on resource allocation, expected outcome and outcome assessment—and the five criterion discussed above: the definition of community; the capacity-building process and underlying pedagogical model; the nature of leadership; the documentation process; and ethical concerns.

In practical terms, the frameworks can be translated into questions such as: Am I empowering the key stakeholders or community groups? Is my pedagogical approach too directive? Are we sharing the results of what we learn with the community? Are we encouraging or strengthening a teamwork approach for guiding the process and planning collective actions? Are we too paternalist? What is our role or responsibility as professionals? Do we establish a mechanism for collective decision-making? To whom and to how many people do we give the chance to be involved in decision-making? Do we respect the communities' interest and viewpoints? Asking yourself these kinds of questions can only improve your practice.

The meaning and the value of community participation has been discussed since the inception of the concept in Alma-Ata. The contradiction between utilitarian and empowerment approaches is 'built-in' to the concept and discussions will go on (Morgan 2001). The challenge is not to accommodate target-oriented and empowerment approaches. It is rather to augment the empowerment framework, contrasting it with the target-oriented framework in order to emphasize the gap between the discourse on community participation and the utilitarian approaches, therefore permitting health professionals and planners interested in the empowerment approach to consciously sharpen their practice.

Acknowledgements

We thank Linda Lloyd and Werner Soors for their helpful comments on an earlier draft of the manuscript. The research was funded by the Cuban Ministry of Health and through a framework agreement between the Institute of Tropical Medicine "Pedro Kouri", the Institute of Tropical Medicine (Antwerp) and the Belgium Directorate-General for Development Cooperation.

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