HEALTH PROMOTION AND DISEASE PREVENTION **A Handbook for Teachers, Researchers, Health Professionals and Decision Makers**	
Title	**Community Development for Health Promotion**
Module: 1.4	**ECTS: 0.5**
Author(s), degrees, institution(s)	**Vesna Bjegovic**, MD, MSc, PhD, Associate Professor Institute of Social Medicine and Centre School of Public Health, School of Medicine, University of Belgrade, Serbia **Milena Santric-Milicevic,** MD, MSc Institute of Social Medicine and Centre School of Public Health, School of Medicine, University of Belgrade, Serbia **Sanja Matovic-Miljanovic,** MD, MSc Euro Health Group, Balkan Office, Belgrade, Serbia
Address for correspondence	**Vesna Bjegovic**, MD, MSc, PhD, Associate Professor School of Medicine, University of Belgrade Dr Subotica 15, 11000 Belgrade, Serbia Tel. +381 11 643 830 Fax: +381 11 659 533 E-mail: <bjegov@eunet.yu>
Key words	Community development, health promotion, partnerships, program sustainability
Learning objectives	After completing this module students should: • be familiar with the »healthy community concept«; • explore the similarities and differences between different types of building healthy communities; • be able to initiate sustainability of healthy community programmes through the wide partnership; • accept the importance of project such as »Healthy Cities«, »Healthy Schools« »Healthy Kindergartens« »Healthy Hospitals«, »Healthy Universities «, etc; • summarize the needs for establishing such a programme.

Abstract	Development of a healthy community today represents an important process from different stand point, especially for improvement of population health and for health promotion intervention among vulnerable population groups such as women and children, adolescents, poor people and refugees. Community orientated approach particularly ensures proper identification and meeting the needs of underserved population groups which are most often not recognised among under, either because they belong to special ethnical or cultural groups or to groups of poor. Community strengthening for improvement of their health is realised through the wide and sustainable partnership of local community members, their leaders, supportive organisations, financers and governmental institutions, which is present in all phases of health promotion intervention. Examples of community based health promotion programmes, in world and in Serbia, show that wide partnership ensures improvement of numerous health determinants which is impossible to achieve by isolated health service activities. Authentic community leaders that are educated for successful leadership during all phases have prominence in development of these programmes. Achievement of their long-term sustainability through the multidisciplinary approach is a constant challenge to community based health promotion programmes.
Teaching methods	Teaching methods include introductory lecture, exercises, and interactive methods such as small group discussions.
Specific recommendations for teachers	• work under teacher supervision/individual students' work proportion: 30%/70%; • facilities: a computer room; • equipment: computers (1 computer on 2-3 students), LCD projection equipment, internet connection, access to the bibliographic data-bases; • training materials: recommended readings are available in the internet; • teacher shouldo be ready to help students to explore the health promotion programmes and projects at WEB sites of WHO, CDC as well as the WEB site of Canada. • target audience: master degree students according to Bologna scheme.
Assessment of students	Assessment is based on seminar paper and its presentation to other students, and oral exam.

COMMUNITY DEVELOPMENT FOR HEALTH PROMOTION

Vesna Bjegovic, Milena Santric-Milicevic, Sanja Matovic-Miljanovic

Introduction

In the course of last two decades, after adoption of Declaration on Primary Health Care, community support has been recognised as exceptionally important element of population health improvement, especially of vulnerable population groups such as women and children, adolescents, poor people and refugees. But this interest of the health care for the community is not new and existed in previous centuries, when communities provided support to people's healers, as it is done today in some traditional cultures. At the end of 19th century participation of community was basic factor of public health movements that developed in European and other countries. However, in a first half of the 20th century development of big cities and achievements of medicine in treatment of infectious diseases limited activities of the community. Local and regional planning led to a separation of places where people live and where they work, and development of electronic media led to the loss of need to maintain relations with members of the local communities (1).

After the Second World War, the community is again re-affirmed since limited effects of the medicine based on curative approach are confirmed (hospital treatments, one-way relations doctor – patient and expensive technologies). Numerous surveys provide the evidences that efficiency of the medical technology for improvement of community health is by far lower in comparison with activities that such community can perform for its own health (2). Illustrative example is the difference in efficiency of intensive neonatal care for infants with lower body mass than normal and efficiency of community work with future mothers with provision of good prenatal care (3).

In addition to this, in spite of the development of the expensive health care it becomes less accessible to vulnerable individuals, families and community, not only in undeveloped, but also in highly developed countries. Large number of people affected by poverty lives in rural areas or city suburbs, not managing to satisfy the basic needs, and their communities are characteristic for numerous risks that endanger health: unsafe drinking water, lack of hygienic distribution of waist, bad living conditions, undulation, unemployment, malnutrition, violence, drug abuse, sexually transmitted diseases, teenage pregnancies (1).

For these reasons, building of *healthy communities* is today a leading goal of modern health systems and health institutions that recognise the importance of prevention of ill-health statuses through the development of healthy life styles and healthy environment. Modern reforms of the health system compulsorily consider the support of the community recognising that population health is also determined numerous factors outside medical care and that those factors can be controlled by community itself, through its cooperation with other sectors, such as sector of agriculture, water supply, education (4). Today, worldwide, many governmental and non-governmental organisations that develop models of health improvement and their implementation in local communities are established (5).

Community

Community concept itself is differently explained depending on discipline that is handling this term. Therefore, even in 1955, Hillery collected and analysed 94 definitions of this term, noticing three basic components of the community (6):

- people in social interaction;
- within geographical area, and
- those that have one or more common relations.

Much later, experts were also engaged in definition of this term. Bracht, for example, defined community as *»a group of people that shares common values and institutions«* (7). Nagy and Fawcett state that community most often entails group of people who share common place, experience or interest, so that it includes people who live in the same territory (same neighbourhood, same city or same state) (8). However, they emphasize that individuals can feel as a part of the community, above all since they share same experience, for example:

- •racial and ethnical communities (Serbian community, European community or African);
- religious communities (Orthodox community, Catholic or Muslim);
- community of disabled individuals (with visual, developmental or mental disabilities).

One of newest is also Nutbeam's definition (9). He explains community as »*specific group of people who often live in defined geographical zone, share common culture, values and norms, and is organised through social structure according to the relationships that community developed over the time*«. Members of the community gain personal and social identity by sharing common beliefs, values and norms that are developed in past and can be modified in future. Individuals in community are aware of their identity as a group and share common needs and dedication to satisfy those needs. In modern communities, especially in developed countries, individuals do not only belong to one isolated community, but rather join into larger number of communities based on different features such as territory, occupation, social interests and use of spare time. Examples of these are business communities, working communities or different children's communities.

In last years, idea of community that reside a certain physical space is more and more received with reserve and the advantage is given to »virtual« communities (10). Development and expansion of interactive media and computer technology remove geographical differences among traditional communities. Development of Internet is the next example that shows that physical distance determines little differences among communities that use Internet, so that importance of component of geographical zones is more and more decreasing (11).

From the aspect of improvement of mother and child health, Rifkin emphasizes that it is necessary to abandon certain erroneous assumptions on community, that are often present in establishment of community based programmes (2):

1. *»Communities are homogeneous«*. In contrary, communities are most often not homogeneous, and interests of their members often exceeded community goals, especially if they are poor.
2. *»Knowledge automatically creates desired changes in behaviour*«. In reality, communities do not change adopted forms of behaviour when new ones are presented, and experience shows that traditional community behaviour often has certain value. Long time is needed for smaller or bigger desired change of behaviour.
3. *»Community leaders act with the aim to achieve highest interests for community members«*. Actions of leaders are not always for the benefit of whole community. What often happens is that persons with the influence on community members, redirect the

benefits of the preventive programme towards personal promotion or promotion of their families, neglecting the interests of the community.

4. *»Financers and promoters of community programmes share same goals of community development«*. Most often, this is not the case, since financers most often want to mobilise the resources of the community itself, as soon as it is possible, while promoters of the programme give advantage to development of the confidence among community members, which takes certain time, and for which the conflict of interest arises.
5. *»Activities of community development do not create conflicts for planners«*. In essence, management of community based programmes can have serious problems if it is not sufficiently flexible in adjusting defined goals to the dynamic development of activities in community. Above all, time is needed for activities to develop, and hence community give priority to other needs that were recognised in programme goals and individual interests may exceed those of the group.

From the aspect of improvement of mother and child health, important fact is that mothers and children represent most important segment of any community, and it is therefore needed to ensure their involvement in programmes, especially when it comes to the improvement of the health care for women. Pizurki and associates analyze several factors that determine involvement of women in community based programmes (12)

- their traditional and natural role in provision of health services;
- better possibilities for information flow towards female members of the community and children, with the creation of informal »network« of communications;
- women often have stronger roots in the community, especially in societies that are developing;
- many traditional activities of woman, such as preparation of meals, maintenance of hygiene or care for children, reflect aspects of the inter-sectoral cooperation for health improvement and finally;
- women's organisations that already exist in many communities provide ready structure for their participation in health improvement programme.

Development and enabling (strengthening) the community

Closely related to the community is a concept of the *community development*, which is affirmed in 1950s through the movement for community development under the auspices of United Nations. At that time, different initiatives based on community commenced, such as mothers' clubs in Europe, and interestingly, as stated by Tones (13), that for the first time this concept is considered in literature in an article by Leo Baric from 1955, under title »Health Education in community development«, in which the importance of the culture and dynamics of community on the territory of Yugoslavia is analysed. Also, one of first projects organised for development of the community in the world ran in 1950s in our country, in Ivanjica, with the goal of decreasing infant mortality through the community action, and improvement of infant, children, pregnant women and mothers' health care (14). Practice of development and effective involvement of the community through specific programmes that, partly or fully, were orientated to improvement of health of women and children in our country was present even later (15, 16, 17).

Firstly, term »community development« means mass health-educational activities in poor, rural areas, and later its meaning expanded to numerous joint activities of community,

governmental and non-governmental organisations that represent process for improvement of economic, social and cultural conditions of the community (18).

According to Sanders, community development may be regarded as a method, like programme and like concept (19). As a method, community development is similar to procedures, but in work with community, used by social workers in work with individuals when endeavouring to gain their confidence, define problem or needs, arouse their deliberation on solving problems and improvement of situation, to help in efforts in finding needed resources for improvement. When regarded as a programme, community development ensures improvement of the overall community life, planning on basis of recognised needs of its members, emphasizing the importance of »self-help«, encouragement and education of local leaders and provision of technical support for development in sense of human resources, equipment, material and money. As a concept, community development is similar to primary health care since it emphasizes activities that have multiple purpose, assumes that provision of basic services and material support is base for development and recognises that process by which the goals are reached (local initiatives, trust and cooperation) are more important than goals themselves (20). Tones states, that community development is a process, which starts with people and their needs, considers their values and dignity and promotes equal opportunities for improvement (13).

In process of community development, special place is given to *community actions for health* that represent collective efforts directed towards the increase of control over health determinants, and therefore over the health improvement (9). In Ottawa Charter, the significance of concrete and effective community in establishing priorities for health, adoption of decisions, planning of strategies and their implementation for achievement of better health is emphasized. Concept of *enabling (strengthening, recuperation) of the community* is closely related with definition of community actions for health, in accordance with Ottawa Charter. Capable community is the one in which individuals and organisations apply skills and resources in collective efforts directed towards health priorities and meeting of health needs. Enabling commences with development of community awareness that represents four-level process (13):

- consideration of aspects of reality and problem,
- collective identification and search for roots of reality and problem,
- research on inter-relations, and
- development of action plan for changing the reality.

In the same way as the community development, its enabling entails participation of its members in actions for health, through the active partnership with different sectors of society (21). In organisation of preventive programmes, health workers often neglect the importance of active partnership with the community. Illustrative example was given by Baker, analysing introduction of programme for decrease of incidence of breast and cervix cancer in a certain group of women or the community that most often begins by focus group discussions where health workers present frightening extent of the problem, inviting citizens for get involved in its resolution (22). Since they, most often, omit cultural, marital, religious and other barriers of the community in consideration of breast cancer problem, these programmes do not succeed in influencing the health status of the community significantly, since, regardless how high and tragic rates of breast and cervix cancer are, members of the community do not recognise this as a health priority. Therefore, efficient community based approach must ensure partnership

of its members with health professionals in identifying and solving community issues and must orientate towards health determinants in the way community sees them, even when it comes to the prevention programmes for specific diseases.

Building healthy communities through the wide partnership

People create healthy communities by demonstrating unity and by operating as accelerants of positive changes, finding new modes for actions with the goal of creating an environment that attends to healthy life styles and encourages people to effectuate their own potentials (23). Preconditions for such community improvement are efforts for defining more common problems that are related to each other and partnership (joint work) in their resolution (8). Partnership encourages people to associate and strengthen community capacity for positive changes over time, in different spheres. Also, associating/pooling up of people from different segments of community, by rule, leads to a success. For example, efforts made to improve health of children run through partnership of education authorities, teachers, business people, paediatricians, parents, young and old. Community, which developed successful partnership in one area (such as fight against drug abuse among youth), may easier recognise other priority (such as law immunisation coverage of children) and use gained experience for efficient action (improvement of immunisation coverage) (24).

In developing partnerships, it is extremely important that it is wide, i.e. that it involves representatives from largest possible number of different segments (school, workplace, ministry) and different community levels (neighbourhood, local community, municipality, city, republic). Key participants of such a wide partnership are (24):

- local members of the community - group of people from the community who directly work on health improvement programme, organised through non-profit, non-governmental organisation and state institutions (for example: partners for improvement of children health from this group include people from media, business companies, schools, citizens associations in community, youth organisations, local administration, health institutions, financial institutions;
- support organisations – local, regional or state institutions that provide advisory and technical assistance for running community programmes (for example: university research centre may provide advices in relation to community analysis, strategic planning, management development and evaluation; institutes of public health to provide community with necessary data, such as proportion of children without adequate immunisation); and
- financers, sponsors and governmental institutions – ensure financial resources needed for development of community based programmes, but also for activities of support organisations (these resources need not be continuous, but ensure credibility for groups in community and possibility to secure new resources by alluding the fact that they were financed by respectable foundation or ministry of health).

It is very important that wide partnership, which really represents the whole community, lasts long enough so that changes that lead to improvement of health are achieved, as well as to become accelerator of the community health action. It is considered that needed time is 5 to 10 years (8).

In world today, numerous programmes that include wide community partnership with goal of improving health of mothers and children have been running, regardless whether

they are orientated specifically to these groups or to general population, to numerous health determinants or specific health problem, and are initiated by international organisations, health institutions or local community itself. Typical such programmes that commenced in numerous countries, and in our country as well, are those conducted in accordance with World Health Organization (WHO) and European Union methodology, for example such as, »Healthy Cities« or »Healthy School«. In WHO documents dedicated to »Health for all in 21st century« specially emphasized is the importance of the community and its wide partnership as the basis of sustainable development of the mankind (25). Also, with existing search on Internet, one may notice plenitude of examples for community based projects, in developed as well as in underdeveloped countries. In addition to numerous individual and picturesque illustrations of the project, group descriptions/reviews may be found, such as Flower's who gave detailed examples of healthy community projects in nearly twenty cities in different countries (26).

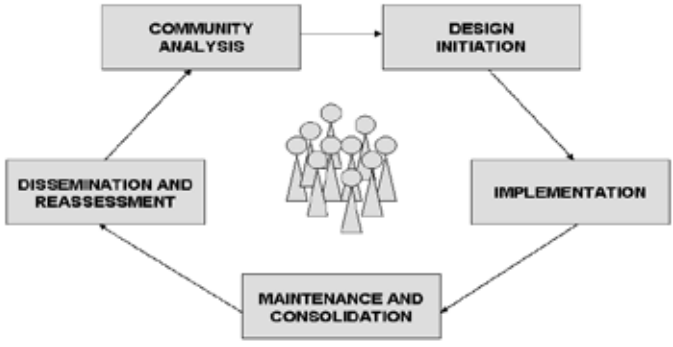
Community based interventions for health improvement

Community based health improvement is most often related to values of modern democracies, since in ideal conditions authority and responsibility for adoption of decisions on health improvement are delegated as closer to the population as possible, and approach favouring exclusively individual responsibility for health is avoided (27). Search of written and electronic publications shows that today numerous health-educational interventions in community have this orientation. Different level of support and participations of the community in project activities aligns them in one of five possible types (28):

1. Type 1.
   Primary goal set for the community is enabling (strengthening) and improvement of socio—economic status, since it is equalised with health.
2. Type 2.
   The same as previous one, but in the course of the community development and identification of needs, community itself discovers needs that are consistent with standards of preventive medicine and health education goals, i.e. needs for better primary health care service, prevention of accidents, through solving children's problem.
3. Type 3.
   It is characterised by »health community projects« that improve health and prevent disease. This is done through building the health profile and assistance to community work much more by the emphasis of »perceived needs« than, for example, recognition of needs to improve cardio-vascular health.
4. Type 4.
   Primary goals are in the sphere of preventive medicine, and this type of interventions is personified in cardio-vascular preventive programmes. Its approach is more »top to the bottom« than previous types, but it recognizes the importance of the community and utilisation of existing forms of leadership.
5. Type 5.
   More limited programmes, with limited community participation, but with use of joint efforts of different organisations, for example media and schools, and residential area or working place service providers.

Since the complexity of implementation of above mentioned community interventions is recognised, numerous models representing guidelines for health workers and community members were developed with the aim of successful implementation and conduct of community health improvement programmes (2 ,7, 8, 11, 27, 29, 30). All these models differ in theoretical basis and complexity, their common characteristics are that they emphasize the process, wide partnership with community members and their participation in all phases of programme development, especially in planning. According to Mittelmark (5), regardless to the number of steps, in all community based health improvement projects, especially those which are centrally initiated, following successive phases may be recognised (Figure 1):

Figure 1. Phases in community-based health improvement project – five stage model for community-based health promotion.



Adapted from: Mittelmark, 1996 (5)

1. Community analysis.
   In almost all models, *community analysis* has exceptionally important place, because specific community actions are planned on the basis of it. In addition to defining needs for health improvement, community analysis also needs to enable defining of its »context« - beliefs and expectations, social structure, immediate issues (such as poverty), financial resources, formal and informal leadership, as well as the extent of experience in joint actions (establishing partnerships) (8). Also, it needs to explain immanent forms of behaviour, conditions of the environment and economical climate, as well as to indicate the capability and readiness of the community to participate in the programme, with recognition of potential barriers. In this phase, the assessment of capabilities of project organisers to implement the project in the community is considered important, which is, unfortunately, often forgotten (31). Community analysis is most often documented by *community level indicators* that serve for direct and indirect measurement of the magnitude of the problem at the local level and success in reaching the defined goals (for example, data on body injuries in schools nay be an indicator of violence in the

community) (8).

2. Project initiation.
   Project initiation is the phase during which all its initiators and community members work together. What precedes joint activities is the identification of interested citizens and their inclusion into working groups as per priorities. Following groups are formed: group for planning, group for selection of the organisational structure, group for defining the mission and goals of the project, group for determining specific strategies and methods for implementation phase, group for health improvement education and those that care for recognition and awarding of successful volunteers and other participants. In this phase, exceptionally important is the selection of the project coordinator, training and provision of the technical support and its activities. Such mobilisation of the community leaders, as well as community members, to contribute to the accomplishment of project goals with their time, resources and talent is known as the *organisation of the community* (32). Rifkin specifies five levels of the community members participation in health improvement programmes that may be active and passive, more or less persuasive for long-term community actions. Those are: participation in benefits of the programme (for example in immunisation), programme activities (for example in distribution of contraceptives), implementation of the programme (implies managerial responsibility for reaching goals that are planned at higher levels, for example organisation of the centre for free activities for youth), programme monitoring and evaluation (ensures modification of determined goals in accordance with process evaluation, which is the rarest form of participation) and programme planning (participation is most active, widest and entails participation in previous phases) (2).
3. Implementation.
   Implementation is the phase during which, through the operational plans and with established priorities, previously jointly planned activities are effectively conducted. This is the phase in which wide participation of citizens and community partnership are realised, and resources, process evaluation and feedback information on possible problems and their resolution are ensured. Although the community is mobilised at the very beginning, its participation is here even more broaden and community health improvement network is generated (33). Special responsibility and obligations for the success of this phase are with the project coordinator who has communication and negotiation skills.
4. Maintenance and consolidation.
   Maintenance and consolidation is the phase in which participants successfully integrate intervention project into the existing community structures, create atmosphere of cooperation that sometimes exceeds conflicting interests of different groups in the community, recruit new volunteers and disseminate information on project activities. This obtains wide acceptability and continuous community involvement. Measure of the success of this phase is the conduct of project activities in community even many years after the project ends (34). Unfortunately, many community projects fail in this phase, which is way many are today interested in solving this problem.
5. Dissemination and reassessment.
   Dissemination and reassessment is continuous process during which the community analysis is renewed, and effectiveness of the intervention project, future courses of community development, management and long-term sustainability of achieved changes are assessed. Project results are summarised and disseminated to community members,

sponsors and anyone interested in health improvement. Endeavour to institutionalise the project is most often in this phase, however much more realistic effect is the inducement community receives with the project to continue with actions for health (5).

Sustainability of community programmes

In addition to the design itself, planning and goals, insurance of the community programme continuity also largely depends on political and social stability of the community as well as on its socio-economic conditions. Previous experiences in improvement of health of women and children, as well as of other community members imply that, regardless how well programmes were designed and planned, longevity and sustainability in community become preconditions for their efficiency and effectiveness (34). Although significant assets are invested in implementation of health programmes in developed countries, those programmes do not sustain long after their initial phase (35,36,37). Primary focus of many programmes for health improvement in community was efficiency while longevity did not have major importance. Programmes were mainly designed as demonstrational or institutional.

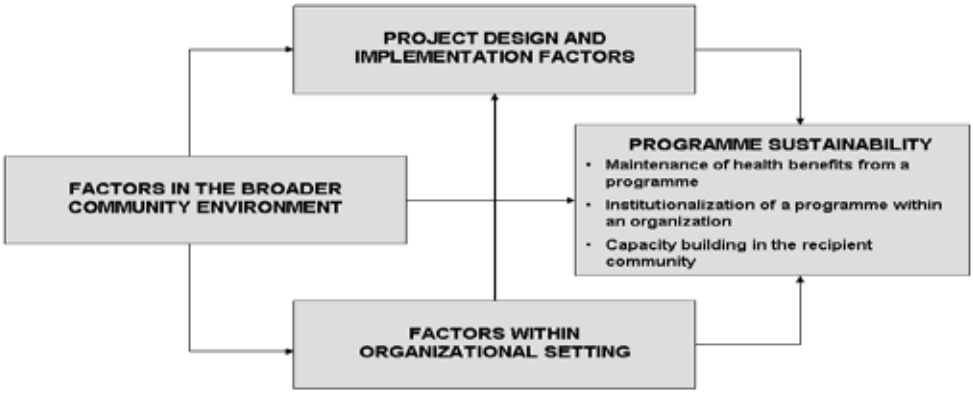
It is believed that there are at least three reasons for which some community health improvement programmes cannot sustain (34, 38, 39):

- programme is ending, but the disease of which the prevention was envisaged in the programme is still preserving;
- many programmes lose their basic resources before their community activities develop, regardless where they take place and which target groups they have, and
- many new programmes suffer due to consequences of previous ones that were stopped or inadequately ended, and therefore lose support and confidence of the community.

Community support today ensures continuity of the health improvement programmes, and therefore represents compulsory goal in intervention planning, and especially planning of necessary resources for running the community programme. One example is the experience from the community project for breast and cervical cancer control (40). This five-year-programme was conducted in Baltimore and was based on education of educators who came from the target community. They educated women emphasizing the importance of screening. At the same time numerous activities ran in cooperation with health service, community volunteer groups and sponsors, such as for example, guided group discussions. They led to expansion of the programme onto other areas of women's health and its popularity in medical circles. However, non-existence of careful resource planning in initial phase conditioned their lack in the phase of implementation of mechanisms for expansion of the community programmes, and therefore programme was not sustainable anymore, i.e. lost the continuity.

Literature quotes different methods for reaching the phenomenon of sustainability of community based health improvement programme, and for the success, what is needed is their combination, since there are no »golden standards«. According to some authors (34), the most important are the following (Figure 2):

Figure 2. Different methods for reaching the phenomenon of sustainability of community based health improvement programme – a framework for conceptualizing programme sustainability.



Adapted from: Shediac-Rizkallah MC, Bone LR. 1998 (34).

- design and programme implementation with the benefit in respect to community health (development of healthy life styles, prevention and mortification of communicable diseases by their eradication);
- its institutionalisation (integration of the programme within governmental and non-governmental organisations that already exist in the community or with existing state programmes for community health);
- inclusion of the whole community and its support to the programme (through the training of community members to provide information or to be leaders for promotion of community health), and
- support of the wider community environment (insurance of socio-economic and political preconditions, support of state institutions, especially of the Government and relevant Ministries).

It is believed, on the basis of existing experience, that optimal period for achieving the programme sustainability, when it can also be evaluated, is five to seven years (34). Important examples of sustainable community programmes exist, especially when it comes to the mother and child health improvement (41, 42, 43, 44).

Exercise

Task 1:

Carefully read the contents of the module and recommended readings.

Task 2:

Discuss with other students the concept of "healthy community" and its importance for the health of the population, especially vulnerable groups.

Task 3:

Visit the nearest healthy community (e.g. a kindergarten, school, university, etc.) in your residence settlement and identify the key features of a process in this community.

Task 4:

Write short seminar paper and resent your findings to other students. Compare your findings to the findings of other students.

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HEALTH PROMOTION AND DISEASE PREVENTION **A Handbook for Teachers, Researchers, Health Professionals and Decision Makers**	
Title	**Community Participation: Role-playing Exercise**
Module: 1.4.1	**ECTS: 0.25**
Author(s), degrees, institution(s)	**Zelimir Jaksic,** MD, PhD, Professor emeritus Andrija Stampar School of Public Health, Medical School University of Zagreb, Zagreb, Croatia
Address for correspondence	**Zelimir Jaksic,** MD, PhD, Professor Andrija Stampar School of Public Health Medical School, University of Zagreb Rockefeller str. 4 10000 Zagreb, Croatia Tel: + 385 1 4590 100 Fax +385 1 4590 182
Key words	community participation, community involvement, community action, health promotion, community health, participatory approach
Learning objectives	After completing this exercise, students and public health professionals should: • To identify different areas, types and other characteristics in • organizing community participation • To understand different factors important in initiating , • supporting, sustaining and spreading community participation • To identify common obstacles to community participation • To review different goals and strategies in implementing the participatory approach.
Abstract	Three different situations (tasks) are described. All of them are based on decision-making process given by professionals and/or local community members. Beside described three real life situations, a different levels and approaches in community participation should be presented, using students' experiences and attitudes.
Teaching methods	Role-playing exercise. Video (camera and videoplayer) (not necessary)
Specific recommendations for teachers	After role-playing, it is strongly recommended to analyse different situations and different solutions, obstacles and prerequisites for community participation and community action (What we did learn?).
Assessment of students	Observation of the role-playing exercise and group discussion

COMMUNITY PARTICIPATION: ROLE-PLAYING EXERCISE

Zelimir Jaksic

Note:

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Task

Each of the following tasks is given to two groups. These two groups discuss the given task and together define circumstances and setting. After that, every group should decide separately about their goals and strategies.

Nota bene:

The groups are not homogenous. In every group individuals have their own interests and strategies. From each group 2-3 members will be elected for the role-playing of a joint meeting as described by the tasks below. The role-playing is presented in the plenary session for 10-15 minutes. The preparation and presentation of role-playing should follow the real-world experiences of participants in the group, avoiding artificial «psychological» constructions.

After the presentation, members of the group who have not participated in role-playing comment the play and particularly the probable consequences of the planned participatory project 6 months after the shown meeting.

TASK 1

The district governor was given instructions to organize a campaign in rural sanitation to prevent further threat of diarrhoeal diseases in his district, a poor rural area with 500.000 inhabitants. His orders were to involve the local communities, because only 30% of estimated total costs should be covered by the government. The villagers are disappointed with previous governmental actions, when high expectations were raised, and promises not fulfilled. However, he has to try again and he might succeed this time, because villagers feel badly the need for improvement of sanitary conditions. He organized a meeting of representatives of different sectors and agencies. Among other decisions, they decided to form a working group to elaborate the community involvement strategy. The working group should consist of 3 experts from the health sector (district health officer, health educator and sanitary technician) and 3 experts from other sectors (agriculture, education and water administration). They have to propose a plan jointly but it is Obvious that a hidden interest of every participant is to manage the whole project. The questions given to them are:

- Propose the strategy and mechanisms for community involvement (raising funds and mobilizing people)
- Propose the managerial structure of the project to support community involvement in the best Possible way...

Group A: health workers
Group B: other members

TASK 2

There is a campaign going on in spacing the pregnancies (family planning). Because it is a repeated experience, the local community is divided, doubtful and disturbed. The local midwife and the teacher organize a meeting, following the instructions of the district authorities, but only few people come. Among those who are attending the meeting, there are people with quite opposite attitudes and beliefs. Few of them have a genuine interest and others, although not directly concerned, think that family planning is against the traditions and dangerous for the future of their community.

Group A: midwife, a young woman, several other supporters of family planning
Group B: teacher, religious leader and several other opponents to the idea

TASK 3

A donating agency, very interested in participatory development in a slum area decided to stimulate the development by investing into a project useful for the majority of people and also stimulating further cooperative undertakings. The condition is that people themselves decide and propose what it should be, and are willing to contribute to it by personal involvement, when the project starts. The representative of the donating agency decided to start the first preparatory meeting of the local Governmental Committee, appointed two years ago, but never very active or concordant. After the last unsuccessful campaign called «Healthy environment, healthy children», suggested by and international agency, the committee has never met again. The chairman is the local priest, very cooperative. Some of the other members represent the local elite, but there is also a very critical group of representatives of youth organization led by the local teacher and community health worker raising unpleasant social and political questions. It is expected that repairs of the roads and houses, improvement in nutrition, safe water, repairs of the school building and other projects will be brought in for consideration. It is clear to the representative that behind many of these projects there are some special interests of individuals and groups. However, he is resolute to insist on a consensus of the Development Committee about what to do and how to plan further involvement of people, against different individual, group, political or pecuniary interests.

Group A:
donor's representative, chairman of the development committee, and 2-3 wealthy people like the local merchant, owner of several houses, et. and several other good-wishing, unsuspecting people

Group B:
teacher, community health worker, members of youth organization, several other good-wishing, unsuspecting people.