REPORT FROM FIELD

Reflections on use of Participatory methods in the Capacity Building Program for Tribal Community Health Volunteers

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Abstract

Background: Participatory Rural Appraisal (PRA) constitutes a process of involvement with rural people, for indigenous knowledge building exercises. The effectiveness of such capacity building programs, depends largely on fulfilling objectives which reflect the real needs of the people, while ensuring their participation. As part of a project for self-reliant villages, where community volunteers were trained in various aspects of health, participatory methods were chosen over conventional models of capacity building. **Objectives:** 1. To develop a model participatory capacity building program for grass root level health functionaries based on participatory need assessment using PRA techniques. 2. To develop an appropriate teaching methodology using participatory learning approaches. 3. To assess the impact of the training program based on pre and post evaluation. **Results**: The training program based on participatory approach resulted in a statistically significant difference in the knowledge of the volunteers.

Key Words *()*

Participatory Rural Appraisal; capacity building; tribal; community volunteers

Introduction

Participatory methods evolved as a result of the disillusionment from the conventional models of development based on top-down approach, as there existed a wide gap between perceptions of the people and perceptions of the development professionals (1). Participatory Rural Appraisal (PRA) constitutes a process of involvement with rural people for indigenous knowledge-building exercises. It is a way of learning from and with people, to investigate, analyse and evaluate constraints and opportunities, and helps to make informed and timely decisions regarding developmental programs (2).

Capacity building programs aim at empowering people, through increased awareness and skill development. The effectiveness of these programs, depends on fulfillment of objectives reflecting the real needs of the people, while ensuring their participation. People learn best when they are actively involved in the learning process. Therefore, use of participatory methods is crucial in designing need-oriented and learner-centered capacity building programs.

Overview of Training

Our department, since its inception, has been involved in training of community health volunteers, under public and private agencies. The present training was undertaken as part of a 'Self Reliant Villages' program, which follows a multi-dimensional

approach, involving capacity building of local community, through trained community volunteers as change agents. The training was designed in a phased manner; 21 Tribal volunteers from three tribal development blocks in Kerala, India, participated in the first phase of the program. Follow-up activities and further training were undertaken by peripheral health training centers of our institution, functioning in their area.

Steps in the development of curriculum

The initial outline of the curriculum was prepared by the curriculum development team comprising of experts in the field of community health, sociologists and BCC specialist. Key areas were identified, based on desk review and previous work experience with tribal communities, and later finalized by incorporating issues that emerged during participatory need assessment with the volunteers, prior to the commencement of training sessions. A pre-test was also administered using a structured questionnaire to assess basic health awareness.

Participatory Need Assessment using PRA

For rapid assessment of problems, Cobweb (fig.1), a Participatory Rapid Appraisal (PRA) technique was used. Participants discussed health issues, marked down these issues around a circle on the floor and rated them on a scale of 1 to 10. PRA generated useful data, based on which, the content was refined and curriculum was developed.

Aims & Objectives

1. To develop a model participatory capacity building program for grass root level health functionaries based on participatory need assessment using PRA techniques.
2. To develop an appropriate teaching methodology using participatory learning approaches.
3. To assess the impact of the training program based on pre and post evaluation

Methods

The training focused on specific messages, as well as hands-on exercises and practical sessions in the field. Lesson plans for each session, covered learning objectives and key messages, and specified teaching methods such as group discussions, role plays, demonstrations, group work, brain-storming sessions, educational videos and BCC materials. Participatory methods were employed to assess existing knowledge, attitude and behaviour pertaining to major health issues in the community. A variety of education methods such as posters, educational films and role plays were used to reinforce learning. They were also taught about the importance of health education, organizing education sessions and use of various methods to disseminate information effectively in community settings using individual, group and mass methods. Session-wise handouts were prepared and distributed.

Participatory techniques used were; Cob web (Figure 1), Fish bone technique (Figure 2), Group Discussion and Venn diagram (Figure 3).

The topics covered were water, sanitation and hygiene, communicable diseases, nutrition, maternal and child health, family planning, women's health issues, substance abuse, health care delivery system, mental health, geriatric health, government schemes and programs for tribes and Behaviour Change Communication.

These subjects were further divided into sub topics, based on relevant issues identified during the desk review and participatory rapid assessment. Group activities were included to facilitate group learning and for assessing prevailing practices and associated barriers to action.

Result and Observations

PRA techniques effectively revealed many beliefs and prevailing practices related to hygiene, diet, maternal and child health and health-seeking behaviour of tribal community. Fish bone technique identified hygiene related behaviour and barriers to healthy behavior; for example, apart from ignorance, other factors like acute water scarcity and inadequate systems for waste management influence hygiene behaviour of people. Distinctive cultural and traditional beliefs, influence lifestyle patterns of the people and result in certain unhealthy behaviour like walking barefoot and open air defecation. During the session on water purification methods, volunteers revealed that the community, in general, has an aversion towards chlorination and boiling of drinking water; their usual habit is to drink water from natural sources as such.

Participants in groups were asked to prepare a sample diet pattern of the tribal community in order to assess diet pattern and determine locally available food. It was noted that even though most of the food items were available locally, variety was lacking in their diet. Milk was not consumed as it was costly, fruit consumption was very low and among cereal

and millets they consumed mainly rice while wheat, ragi, maize etc. were rarely consumed. Honey was available, but not consumed. Nutrient intake was inadequate for their physical activity levels. They did not maintain kitchen gardens, reasons stated being lack of space, water shortage and lack of good quality seeds.

MCH was surrounded by conventional beliefs and practices. A few important points discussed were poor intake of fruits and vegetables, lack of knowledge and fear of taking 2 doses of TT vaccination in pregnancy and wide prevalence of consanguineous marriage and child marriages. The volunteers said that lack of awareness and unavailability of transport facilities were reasons for deliveries at home. Beliefs like eating fruits such as papaya and pineapple causing abortion, drinking hot water harming the fetus and leucorrhea caused by drinking rice water, and some practices like applying a paste made of cow dung and turmeric powder on the umbilicus of the newborn were mentioned. The harmful effects of such practices were explained to the volunteers.

Group discussion on Infant and Young Child Nutrition practices revealed that exclusive breast feeding for 6 months was rarely practiced. During this period babies were given other feeds such as water, tea, Cerelac and artificial milk feeds. Prelacteal feed such as calamus, honey and gold were also given.

Certain healthy practices could also be identified related to weaning; children were given porridge made of ragi/rava with milk, sugar and ghee, boiled and mashed banana, potato, sweet potato, rice with dal, ghee and pappad, idli, egg yolk and 'Amrutham'– a food supplement from anganwadis.

Participants identified abuse of tobacco and alcohol as major issues. They reported rampant use of these in the tribal settlements and that even young children were dependent. They were also aware that widespread use of tobacco, especially chewed forms, was a leading cause of the highly prevalent oral cancer. Participants in groups, divided based on their locality, discussed magnitude of the problem and action to be taken at the community level against this growing menace.

Rapid assessment of the existing health care facilities and health seeking behaviour of tribals was also done in groups using 'Venn diagram', in which various institutions were plotted in order of influence. This was an informative session which brought out many factors responsible for underutilization of health services such as non-availability of doctors, paramedics, essential drugs and equipment, inadequate infrastructure, constraints of distance and the lack of transport and communication facilities. They appreciated services rendered by organizations such as ours, reasons stated being approachability of doctors and outreach camps in tribal colonies which provided health care to the needy and most vulnerable, living in remote areas.

Though earlier training programs had been conducted for the tribal community, many facts came to light only during the PRA sessions.

Analysis of Pre and Post- test scores showed statistically significant difference (p value = .001.)

Use of PRA techniques were not only useful in identifying health and social issues, but also effectively brought out barriers associated with unhealthy behavior, ensured active participation of trainees, promoted group learning and enabled trainees to help frame need-oriented training and provide concrete ideas on required plan of action for their community.

Conclusion

Tribes, over the years, have been experiencing innumerable social and health issues. Various agencies have been working relentlessly for empowering the tribal community, but conventional models of developmental approach, could not make substantial impact in their lives. The newer developmental initiatives like empowerment, participatory approaches, capacity building are known to be the proven strategies for health promotion and development, but these have not been effectively built into our programs especially for indigenous people like tribes.

Through this, we have made an attempt to use participatory approach for framing more realistic approaches and methods, to build the capacity of grass root level health volunteers by better understanding of ground realities, apart from building their knowledge and skills on health aspects. Our experience was rewarding. Those trained are involved in effective service to their communities.

Recommendation

We recommend incorporating participatory techniques in capacity building programs which can make tremendous impact in the dimensions of community participation and sustainability, the keys to success of any developmental activity.

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Figures

FIGURE 1 COBWEB TECHNIQUE

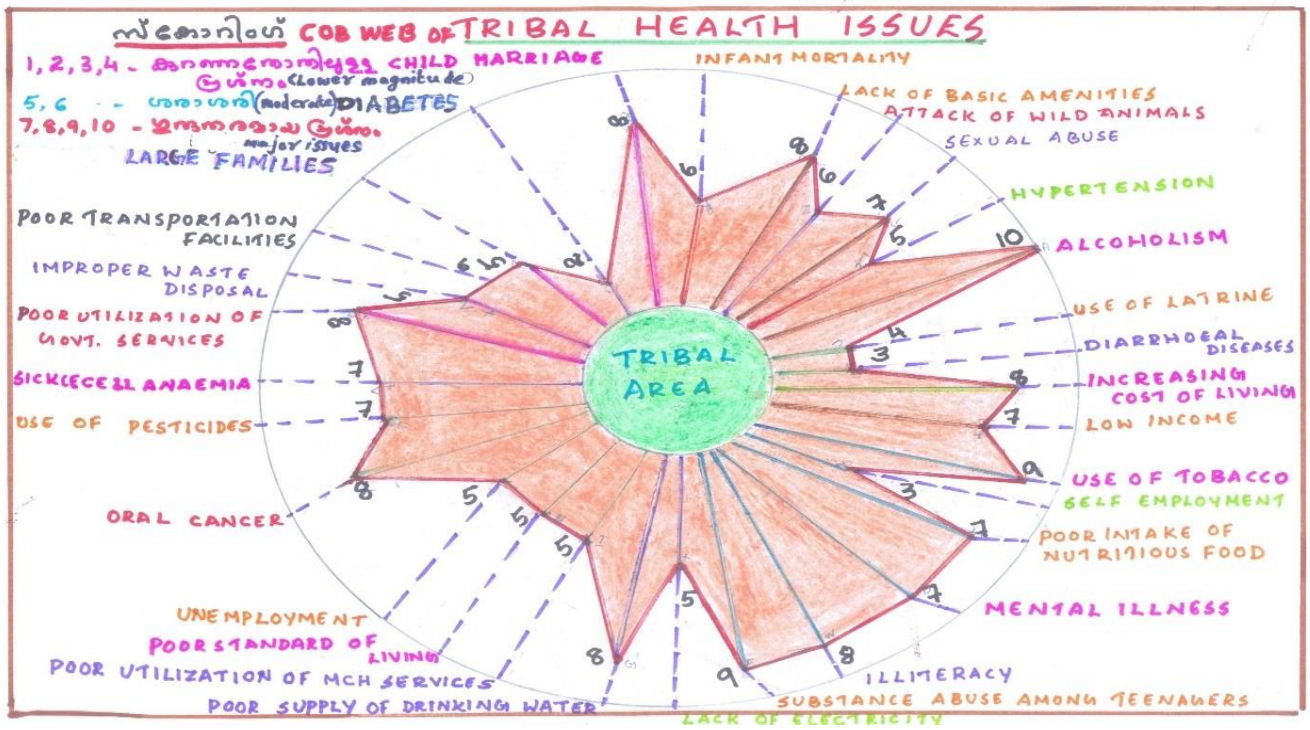

FIGURE 2 FISH BONE TECHNIQUE

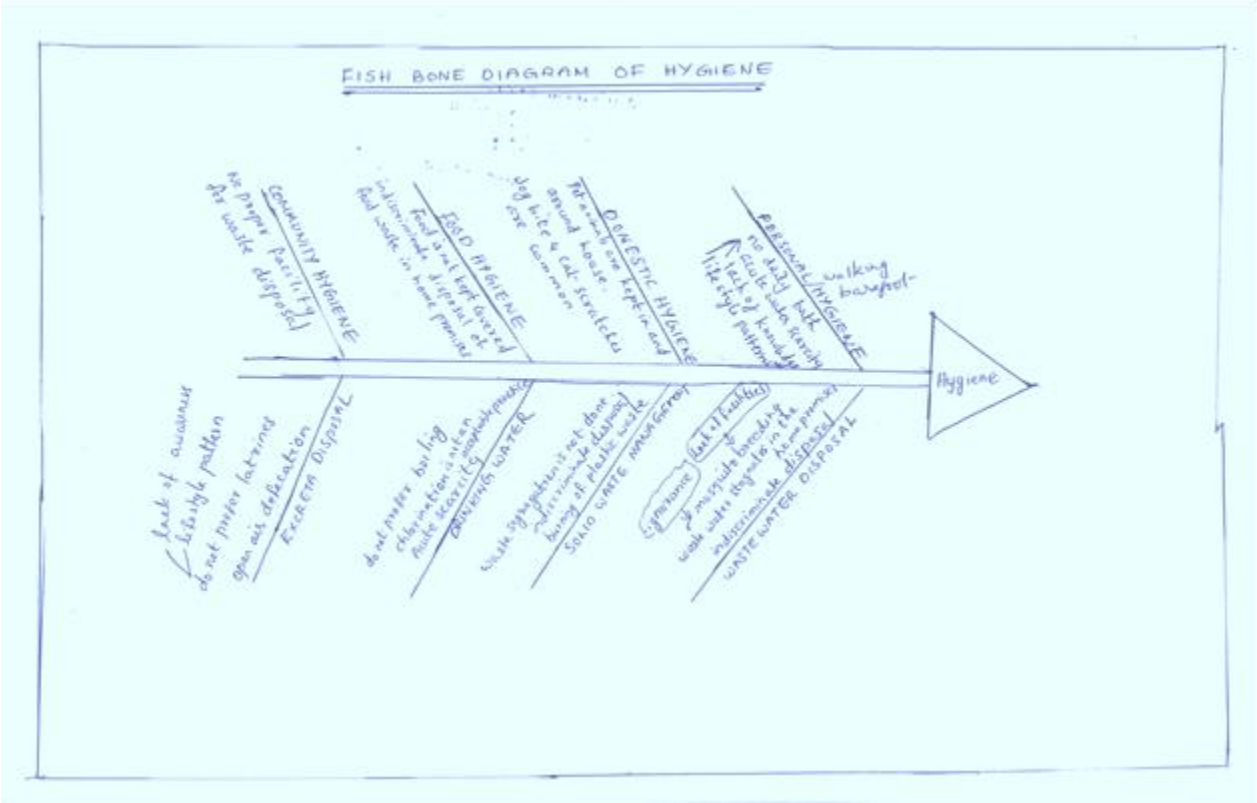

FIGURE 3 VENN DIAGRAM