



DYNAMICS OF PARTICIPATION IN A COMMUNITY HEALTH PROJECT*

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Abstract—Although the term 'participation' is widely used in discussing community development strategies, there has been relatively little said about the characteristics of 'participatory relationships', i.e. the interactions between community developers and those who stand to benefit from community development initiatives. There is seen to be a need for case studies which attempt to understand the relational and communicative processes involved in participatory development.

The paper presents an analysis of the participatory dynamics of a community health development project. The principal source of data is interviews conducted with thirteen selected participants in the project. Analysis of interview data using a structured hermeneutic method led to a description of the meaning of participation for each of the participants interviewed. Further interpretation led to the identification of a number of modes of participation in the project as a whole. For each mode of participation descriptions were developed of how it was perceived by others not participating from that mode. An attempt was made to understand the dynamics of the project in terms of the relationship between the different modes of participation and in terms of the discrepancies between how participants saw themselves and how others saw them.

Finally, these problems were discussed at a general theoretical level and suggestions were made about how such problems might be alleviated. Copyright © Elsevier Science Ltd

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1. INTRODUCTION

The term 'participation' has come to prominence in the health field through the emergence of the 'primary health care' (PHC) movement [1-3]. Although the term has come to have different meanings in different PHC contexts [1, 3], it is generally used to refer to processes of communication and joint action between communities and health development workers. The purpose of such participatory processes is usually envisaged as the planning and implementing of community development strategies and health services which are responsive to community health needs, and which are sensitive to the political, social and economic realities of the context in question.

Not only in community health development, but in the development field in general, the term participation has enjoyed wide use, for at least the past fifteen years. 'Participation' is a key concept in the 'people centred' approach to development [4-10] and in the 'participatory research movement', which emerged alongside the people centred development approach [4, 11, 12]. Here, as in the PHC movement, the term has been so loosely applied that its

explanatory value has been somewhat compromised. A considerable degree of confusion seems to prevail amongst policy makers, social scientists, development workers and local people involved in development, as to its definition and implications [13]. Rahnema [13] is critical of the use of the term participation and suggests that it has become something of a 'buzz-word', which is inappropriately used to legitimize any and all community development projects.

In attempting to establish a common ground between different ways of talking about participation, we suggest that the approaches mentioned above are essentially talking about the need to bring about some form or other of co-operative action between a community and an outside resource or agent, in the hope of improving the conditions of existence of the community. This implies that for whatever historical reasons, the community in question has been alienated from the resources which are needed in order for it to develop in a desired direction. The nature of such alienation invariably involves marginalization of the community from the means of exercising power (political, economic, technical, intellectual, etc.) to bring about changes, and the participatory process is seen as a way of correcting this. It is not surprising, therefore, that the term 'empowerment' and the term 'participation' are so closely interwoven [14-

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16]. Indeed participatory processes are usually conceived of as a means to developing a community in such a way that the community begins to participate more actively, in one way or another, in tasks and benefits associated with access to resources and increased decision-making power. This implies, according to Freire [17], a changing relationship between those who have been historically dominant and those who have been marginalized from the exercise of power. It is surprising therefore that more has not been written about the relational dynamics between participants in development projects. There is a lack of literature dealing with how participatory relationships are formed and sustained between parties who are grossly different in terms of access to skills, resources, education, political power and the sense that their own individual efforts can make a difference.

There is a need to study participatory development processes which claim to involve community participation, to develop ways of thinking about different types of participation and their interaction, and to develop a critical understanding of the communicative processes involved in so-called participation. We have found little evidence of indepth, evaluative research which examines communicative ethics in context, i.e. through case study. For these reasons we were motivated to undertake a study of a community health development project which we had recently been involved in as participants.

The context in which this project took place (South Africa, 1992) added a further interest to the study. In present day South Africa there is a widespread recognition, across political boundaries and in all areas of the Public Service, that there is a need for transformation of existing public services. There is also a broad consensus that the process of transformation requires 'community participation' in the planning and implementation of new services. The recent history of South Africa is such that within a matter of a few years only, the idea of community participation in political and social processes has replaced a system of unilateral, government dominated public service policy formulation and implementation. Having evolved over such a short period of time, the transition towards greater community participation in the utilization of resources and the planning of services, has accentuated the difficulties involved in the co-operative working together of parties who are grossly different in terms of their relative capacities to engage in planning and implementing new service programmes. The 'transition' situation also involves the working together of people who were until fairly recently deeply committed to political struggle rather than co-operation. The history of this struggle and the legacy of the past inevitably continue to create a degree of suspicion and mistrust and will arguably do so for some time to come. These factors militate against the development of

shared understanding and co-operative action and there is a need in South Africa for there to be greater understanding of how these problems undermine community development initiatives, and how they can be overcome.

In the following section we outline the project which was the focus of our research.

2. CONTEXT OF THE RESEARCH

The project was part of a national initiative which, in co-operation with an international donor, co-ordinated local projects in various centres of South Africa. The broad aim of the programme was to promote the development of centres for the training of health personnel in South Africa, which are responsive to community needs, and which are appropriate in terms of social and economic conditions in the country. The programme endorsed the idea of partnership between health services, training institutions and communities in need, and was aimed at assisting communities in addressing health issues identified by people in those communities as being critical to them. The project which forms the focus of this study is confined to the process in one of the centres.

The project was one of twelve accepted by the funders from a pool of sixty proposals nationwide. This meant that the project would receive financial support for the development of a comprehensive proposal based on a broader process of community consultation, and which was to be generated jointly by the 'partners' within a period of one year.

The following participants were involved: a university, local community based organizations and political organizations, local development and welfare 'non-governmental organizations', local health institutions (including a psychiatric hospital, a general hospital and a number of community health clinics), individual members from various communities within the town of 90,000 people and the donor agency represented by an advisory group consisting of South Africans.

The project was initially located at a university institute. Two co-ordinators were employed and a volunteer steering committee was formed which supposedly represented the leadership of the partners involved. Subsequently task forces were established consisting primarily of community members who had been present at early meetings (which had been widely publicized and which welcomed anybody who was interested), as well as others drawn in through personal contact. Each task force undertook a needs analysis of a sector of the community (women, youth, men, elderly).

Once the needs had been identified and their causes and consequences considered, the task forces discussed what actions were required and what resources were available to address the problems identified. The needs were grouped according to

possible projects through which they could be addressed. Eventually seven projects with various sub-projects were developed. They included projects on job creation, media, health education and literacy. These were brought together under the banner of a holistic primary health development approach. The final proposal was drawn together by the steering committee and presented to the donors.

The year long process culminated in an evaluation by a panel of health professionals representing the donor organization, who visited the various 'project sites', spoke to key persons involved, and finally addressed a joint meeting of the participants. At this meeting they expressed their reasons for rejecting the proposal as qualifying for further funding. (They did not provide a written report giving details of why they did not accept the proposal.) In their verbal report they expressed the view that participation of the community in the process leading to the drafting of the proposal was not as it should have been, in terms of active participation and the sense that the community was committed to the project. It was felt that the project had not sufficiently developed leadership by community members and that control was still very much in the hands of the institutional 'partners'. It was also said that there were signs that the educational and health institutions involved were not sufficiently accommodating of the community oriented health care approach which the funders supported. They felt that the proposal drafting process had not led to the establishment of sufficiently strong links between educational institutions, health services and the community. Furthermore, it was said that the project, in attempting to be comprehensive, did not have sufficient coherence and it was said that the various sub-projects did not seem to link together into an integral programme. The project was seen as too broad, lacking a specific health focus and particularly a health education focus.

Given the above context, we set out to articulate the interactions which characterized the project (i.e. the relational dynamics of participation) and to ask questions about how specific difficulties involved might have been averted. We also aimed to explore ways of assessing participatory processes, and for this reason the following description of methodology is accompanied by a reflection upon the process of the research itself.

3. THE RESEARCH

3.1. Methodological orientation

The study was guided by the 'grounded theory' approach suggested by Glaser and Strauss [18]. This approach is particularly useful in situations where there is not a well established body of existing theory to guide the researchers. In terms of this

approach the purpose of research is to develop better ways of thinking about a phenomenon.

The methodological process also contains features of the 'grounded hermeneutic research' approach [19] and in particular the idea that research questions should develop during the course of the research. The intended outcome is to discover better questions and through this, better ways of articulating (organizing into parts for purposes of understanding) the phenomena under study. A hermeneutical model is exploratory, discovery-oriented and theory-generating rather than hypothesis-testing [20] and involves a reflective process of engaging with the data, during which the questions guiding the research are re-examined and reformulated [21]. The process of asking more perspicacious, better defined questions, leads to knowing a phenomenon better.

3.2. Data gathering

The two researchers conducted most of the interviews themselves, but co-opted the services of a Xhosa speaking interviewer for interviewing four subjects whose first language was Xhosa and who were not fluent in English. This third interviewer was also involved in compiling and refining the interview schedule.

It should be mentioned that both researchers and the additional interviewer were originally involved in the project as participants, and the idea of the present study was only conceived some months after the project. In the context of the project the two researchers had been affiliated to the university and each was also a member of a different community organization involved in the project, while the additional interviewer was a part-time project coordinator and a member of one of the community organizations involved.

The researchers formulated the research questions in such a way as to steer subjects away from reflecting upon what they 'thought' about the project. Rather the questions focused upon the description of direct experiences which they had as participants in the project. By focusing on the description of events we hoped to gain access to the understanding of events in the context of the events, and to avoid 'second order' reflections which might be quite divorced from the way in which events were actually experienced.

A 12 question interview schedule was developed which sought descriptions of: How subjects became involved in the project and their motivations; the form of their involvement and how it changed over time; their experience of meetings; their experience of other participants; their experience of the outcome. Two examples follow: Question (5) 'What were you hoping to achieve by being involved in the project? (a) Respond as an individual and (b) if you represented an organization, describe what your organization was hoping to achieve.' Question

(9) 'Try to remember one of the group meetings and describe how it was. How did you feel at that meeting?'

A sample of 13 subjects was drawn from the three different 'partners': the formal health sector, the community and the university. As the participation of people fluctuated over time it is difficult to indicate the exact size of the population involved in the project, but there were probably about 50 participants actively involved in the project throughout its duration. We attempted to select subjects so as to represent a broad range of different ways of participating in the project.

3.3. Data analysis

The 'reading guide' method [21] was adapted for use with the interview material. The development of a reading guide begins with the generation of a set of questions through which the data is to be interpreted (Stage 1). A second stage reading guides facilitates further and deeper exploration of the material (Stage 2).

The reading guide method requires the researchers to underline with different coloured pens any material in the transcribed interviews which relates, even in an oblique way, to each of the questions in the reading guide. Subsequently the material relating to each question is clustered together and summarized as a response to the question.

Stage 1: Reading guide for individual interviews.

- (a) How did the subject experience his/her own participation in the project?
- (b) How did the subject see the grouping of other actors in the project?
- (c) How did the subject experience the participation of other actors in the project?
- (d) What was the subject's understanding of the process of the project and its problems?

At this point in the analysis it became apparent that there were certain commonly identified 'modes of participating', but these were differently understood by different participants. It was emerging that this difference was central to the relational and communicative processes of the project. To obtain a general account of the dynamics of participation in the project as a whole, which would elucidate how the different forms of participation interacted, a second reading guide was developed and applied to the summarized descriptions obtained in Stage 1.

Stage 2: Reading guide for describing modes of participation and their interaction. (The following two questions were used to 'read' across the Stage 1 summaries.)

- (a) What types of modes of participating can be identified? (At this level we were seeking to identify the modes of participation from the perspective of how participants had described their *own* participation. It was deemed poss-

ible that an actor may have participated in a number of modes.)

- (b) From the point of view of each of these modes of participating how are the roles of the other participants perceived?

3.4. Findings of study

The above data analytic process led to a description of four modes of participation. Each mode will now be presented from the perspective of adopting the particular mode. Thereafter, a 're-description' of each mode of participation from the perspective of those not identifying with it is presented, so as to highlight the relational dynamics between the modes of participation.

3.4.1. Modes of participation.

Mode 1: Participating from the Perspective of Having Organizational Resources and Special Project Skills

Respondents who identified with this mode of participation felt that they had a contribution to make in terms of skills in areas such as proposal writing, group facilitation and communication. Participation from this mode meant that participants perceived themselves as being in leadership roles because of their relatively better developed capacity to communicate and facilitate communication in the context of the project. They felt that they had sufficient knowledge of community needs, in relation to the specific resources available, to enable them to translate community needs into projects in the course of drafting sub-project proposals. In doing this they felt that although they were dominating the group process they were following rational plans of action based on a consideration of what could realistically be provided and what would work. They felt that a point in the community consultation process was reached where implementation strategies had to be designed and incorporated into a proposal, if the project was to go any further. Having the skills to write proposals they felt called upon to take responsibility at this time. The process of proposal writing involved a degree of re-formulating implementation strategies, which appeared to need further clarification and specificity. Mode 1 participants recognized their dominance because of this, but the pressures of time did not allow them to replay the cumbersome process of consultation with other participants.

Mode 1 participants tended not to identify with the project as a whole so much as with the specific sub-project in which they were engaged and saw themselves as being most useful to the community at this level. They saw themselves as potentially having to 'carry' the sub-project which they were specifically involved with, at least initially, because the community might not, in their view, be able to do so due to lack of skills and resources.

Mode 2: Participating as a Representative of a Non-Community Based Institution Motivated to Participate in the Project

Participants identifying with this mode of participation represented their institutional and professional needs for greater community involvement, and felt encouraged by their institutions to participate. They felt the need to extend existing institutional programmes in a community oriented direction and at the same time saw their institutions benefitting from involvement, both materially and in terms of credibility in the 'new South Africa'. They believed that the project would give them resources to work out programmes that they thought were good for both the community and themselves.

They were eager to attend to the needs of the community, but believed that they already had an understanding of what these needs were and particularly how alleviation strategies should be implemented. These were in line with pre-determined organizational agendas which were conceived as the most appropriate ways whereby the institutions could serve community needs. Mode 2 participants did not see any fundamental discontinuity between the expressed community needs and the implementation strategies which they devised. Some felt that the needs which their own involvement served could have been anticipated without the extensive community needs analysis, and to this extent tended to see the needs analysis more as a means of gaining co-operation and credibility for the project than as a genuine information gathering exercise.

Like Mode 1 participants they believed they could best serve the project by adopting a role which was almost exclusively within their own sphere of professional interest, and believed that to do otherwise would dilute the capacities of the institution and/or profession into 'lower level' projects for which they were overqualified.

The funders (including the evaluators who visited the project site) could be included in the Mode 2 category, to the extent that they also regarded themselves as having resources to offer for community development, and brought a set of institutionally pre-determined and relatively non-negotiable conditions to the project, which participants had to accept to ensure the continued participation of the funders.

Mode 3: Participating from the Perspective of Identifying with the Group ('Black' Township Community) Which the Project Defined as Having the Needs to be Met.

Mode 3 participation involved identification with what was regarded as the 'black', marginalized constituency which the project defined as having the needs to be met. From this mode it was believed that the programme should empower the community to the extent of the community having control

over the resources and the process of the project. Participating in Mode 3 meant representing the community in negotiating this control.

Mode 3 participants felt ambivalent about participating because they felt they might be getting involved in a project which served the interests of the powerful above the interests of those in need. Their perception in this regard was mediated by what they knew had historically been the case in the context of this community and the society as a whole. Their presuppositions were confirmed when they began to see the process gradually being dominated by those with skills and institutional support. This perception led to energized Mode 3 participation which took on the character of resistance or opposition.

Those Mode 3 participants without skills which would enable them to participate actively in the project felt in need of skills, but not having them, felt that they had little choice but to allow those who possessed skills to take charge of the project planning.

Mode 4: Participating from the Perspective of Trying to Co-ordinate the Process and to Bring Coherence to the Project as a Whole

Participants in this mode saw themselves as initiative takers who directed and guided the project from its inception. They felt responsible for the project and its outcome although they felt that it was rightfully the community's project.

Employed co-ordinators and the steering committee were the main participants from the Mode 4 perspective. While they possessed the types of skills represented by Mode 1 participation, their participation was distinctive in that their domain of involvement was the project as a whole rather than specific parts of the project. From the perspective of the project as a whole it was incumbent on them to sustain the initiative of the project and to introduce action to overcome problems which arose, and especially problems which threatened to diminish the active involvement of all participants. Participants in this mode also saw themselves as mediating between the funders and the project, i.e. trying to keep the project within the bounds of what the funders expected and simultaneously trying to meet community needs as these were directly expressed by the communities involved.

3.4.2. Relationships between modes of participation.

(1) 'Other' Perspectives on Participating from the Standpoint of Having Organizational Resources and Special Project Skills

Members of the community whose needs the project was primarily concerned about, experienced Mode 1 participants with a sense of ambivalence. On the one hand they were seen as needed and valuable because of the skills they had. On the

other hand they were mistrusted because they tended to dominate the process through being more active in group discussions and in the application of their skills. They were seen as having better access to the funders and this was seen to enhance their status and power in the context of the project and led to those not possessing such skills feeling marginalized.

The identification of needs had a very specific and formalized place in the project. There was a clearly defined needs-analysis phase, which assessed the needs of a particular group of people (the 'disadvantaged'). Once this stage had passed, real participation of those that had the needs, was from the point of view of Mode 3 participants (those representing those needs), overshadowed by those with skills and resources (Mode 1). Those identified with the disadvantaged community (Mode 3) felt that there was in the course of the process of interpreting needs into actions, a tendency on the part of those with skills and specialist knowledge to dominate the project and its formulation. They believed that this allowed a superimposition of professional and institutional agendas (Mode 2) upon the real needs of the community which had been expressed in the original needs analysis. Those with skills and resources were seen to have interpreted community needs into programmes of action according to their own prejudicial interpretations of what was most expedient and in ways which favoured Mode 2 (non-community based institutions) interests.

(2) *'Other' Perspectives on Participating as a Representative of a Non-Community Based Institution Motivated to Participate in the Project*

Participants identifying with Mode 2 were mistrusted by those identifying with community needs (Mode 3). Mode 2 participation was seen as featuring attempts to foist professional and institutional agendas upon the needs of the community, and as involving an unwillingness to engage with the 'black' constituency of the project. The alleviation strategies proposed by Mode 2 participants were seen as inappropriate for the needs identified, as being self-serving, and as lacking opportunity for empowering the community served. Mode 2 participants were regarded as having a typically 'white' attitude by Mode 3 participants, in that they showed a subtle form of arrogance which was seen as consistent with the history of 'whites' in South Africa who "think that they know what is good for 'black' people".

Mode 4 participation (principally co-ordinators) was characterized by an awareness of the need to bring Mode 2 participants more in line with community needs, but Mode 2 participants were threatened by pressures brought to bear in order to achieve this, and felt that if their own needs were not taken into account they would have to withdraw from the project.

(3) *'Other' Perspectives on Participating from the Standpoint of Identifying with the Group ('Black' Township Community) Which the Project Defined as Having the Needs to be Met*

The more active participants identifying with Mode 3 were, from the perspective of Mode 2 (institutional/professional) participation, seen as wanting to bring their own political aspirations and needs to bear on the project. Mode 2 participants felt that the participatory needs analysis was a sufficient measure of community needs and felt that Mode 3 participants were being overly sensitive in saying that the project did not address community needs. Mode 1 participants felt that these Mode 3 participants were being destructive towards the entire process, to the extent that they were critical without making an explicit and constructive contribution towards the development of alternatives.

Interestingly no-one identified with the role of participating as a 'white' person. While Mode 3 participants characterized others as being 'typically white', the others being referred to did not see 'whiteness' as a characteristic of their own. Mode 3 participants were selfconscious in their identification with 'black' people and had an awareness of the dynamics of 'whiteness-blackness' at all levels of the project. (There were 'whites' amongst this group who also tended to be aware of racial stratifications, but only insofar as they identified with 'black' aspirations.) The 'white' mode of participation, not 'owned' by anyone, haunted the project, creating ill-feeling and suspicion amongst some. The lack of reflection by some 'white' participants, on what it means to be 'white' in a South African context ultimately led to anger and resentment from the perspective of Mode 3. Mode 3 participants perceived an identification of the need to dominate and control with 'whiteness', and this led to the belief that the 'black' participants who were in positions of power in the project and who were identified with the project as a whole (Mode 4) had been won over to what was seen as a 'white' side.

Mode 3 participants who occupied less prominent positions in the project because they had fewer skills were experienced by Mode 1 and 2 participants with mixed feelings of pity because of their predicament, frustration because of their 'apathetic' attitude, interest and excitement because of the unexpected insights they provided, and a degree of unpredictability because of their unfamiliarity. Because of their lack of domination of group processes they were experienced as looking for leadership and direction in areas where they did not have the capacity to take strong initiatives.

(4) *'Other' Perspectives on Participating from the Standpoint of Trying to Co-ordinate the Process and to Bring Coherence to the Project as a Whole*

Participants identifying with Mode 4 were seen by others as controlling the project and together

with the funders, as providing its basic vision. They were seen as the most motivated participants and the ones through whom the sub-projects were bound together. They were seen to be identified with the project as a whole.

Viewed from the perspective of Mode 3 participation an important reason for the failure of the project was the failure of co-ordinators (Mode 4) to remain faithful to community needs. They were regarded by Mode 3 participants as having become aligned with Mode 2 participants and increasingly they were viewed as having 'sold out' to institutional interests.

Mode 2 (institutional and professional) participants saw co-ordinators as putting pressure on them to adjust their ideas in ways which were unacceptable to the institutions involved and did not suit the aspirations and already existing institutional programmes and plans.

From the perspective of those with special project skills (Mode 1), co-ordinators were blamed for Mode 1 participants' frustrations at having to take responsibility for group facilitation processes and sub-project proposal writing. Mode 1 reluctance to take responsibility appears to have been mediated by the feeling that Mode 1 participation was being drawn on beyond what Mode 1 participants had initially thought would be necessary. It was also mediated by the thought that co-ordinators had not successfully created a context for active participation by all, and this was seen to be part of the co-ordinators task. The ensuing frustration was blamed on the co-ordinators to the extent that the co-ordinators were seen as bearing ultimate responsibility for the furtherance of the project.

For most of the respondents in the study there was a lack of clarity about what the project as a whole was about. They showed that they had *knowingly* allowed the co-ordinators to carry the vision of the project as a whole on their behalf. To the extent that both Mode 3 and to a lesser extent Mode 2 participants eventually declared the co-ordinators partisan the cohesion of the joint project tended to fragment into a loosely related collection of sub-projects.

Furthermore, perception of the project leaders/co-ordinators as having been aligned with a particular group precluded them from playing the role of mediator between partners. The leaders/co-ordinators, in spite of an awareness of the need for facilitating communication amongst participants and in spite of attempts to do this, were perceived by those identifying with community needs as being more familiar with and finally more aligned with the mode of participation of experts and institutions than with the direct needs of the community. This meant that they could not stand 'inbetween', and they were thus not positioned to mediate conflicts

of understanding and interest, and promote a common vision.

4. DISCUSSION: THE CREATION OF AN ENVIRONMENT CONDUCTIVE TO PARTICIPATION

The following discussion further explores the relational dynamics involved in the project. Interventions are suggested which might serve to overcome the sorts of problems encountered in the project and in other similar projects. The following ideas are also a response to a 'theoretical' problem which exists in the literature and which we came to be aware of in seeking a theoretical framework for our suggestions. This problem will briefly be introduced before specific suggestions are discussed.

Frequent reference to the 'dialogical model' of communication can be found in the participatory development literature. Several authors in the field of participatory development have stressed the similarity between the concepts of 'participation' and 'dialogue' [22-25]. They suggest that 'dialogue' is a kind of communicative context which enables participation. The problem with this model is that it sees dialogue as a 'means' through which participation should proceed, but in reality the community development situation, as we see in the study, almost implies that at the outset there will be different capacities for engaging in participatory action between participants. Dialogue requires an equality of participatory capacity [26] and in our opinion this makes problematic the use of the term 'dialogue' to refer to the 'means' of community development, where the capacity for engaging in the participatory process is inevitably less for some of the participants, i.e. where 'partners' differ greatly in terms of access to legitimate and dominant modes of participation.

Freire [17] suggests that dialogue is both a 'means' of communication *and* a 'goal' towards which communication strives. However, it is our impression that this 'solution' merely confounds the understanding of what the term dialogue means, and does not overcome the problem, outlined above, associated with the use of the term dialogue to refer to the 'means' of development. Our view is that dialogue is not a means so much as an ideal towards which participatory projects should strive. We suggest that in Freire's work and in the literature in general, there is a lack of elaboration upon how dialogue can be fostered in contexts which are, to use Freire's term, 'anti-dialogical'.

The present authors believe that it is exactly in those situations where dialogue is not easily attained that participatory methodology is usually proposed by funders as the most appropriate approach, and the project studied is a good example of this. Almost by definition development work requires joint action and decision making between partners who differ in their degree of

familiarity with and access to dominant modes of participation, and hence in their capacity to take an active role in participatory development initiatives. We believe that the following suggestions may go some way towards alleviating this problem. Together the suggestions are intended to be 'dialogue enabling'.

4.1. Preparation for partnership

In the context of community development, especially in societies in a process of democratic transition, one might expect participation to lead towards a situation where all parties feel that they have the capacity to influence the development of the project. This requires 'capacity building', through which there is development of the capacity of the more marginalized participants to increasingly engage in all the activities of the project.

Chesler [27] describes the need to mobilize consumer activism in health care through the medium of self help groups. The effectiveness of self help groups, or any other community based health interest groups, in bringing about meaningful change in the health system, is dependent upon their organizational and communicative capacity to engage in dialogue at a level where structural changes in the health system can be brought about. In the project studied this was a problem. For example, there was a tendency for the community not to be involved in proposal writing; because of this there was domination by other groups in the course of proposal writing and the community effectively lost its voice. As the project moved beyond the initial needs assessment phase the community whose needs were assessed became increasingly disengaged from project activities, because they did not have the capacity to engage in project planning beyond expression of their needs, at least relative to the capacities of the other participants.

Capacity building, which can take many forms [28], 'enables' people to participate actively in development processes and usually entails some form of skills enhancement. In the context of the project studied this might have involved, for example, training in skills for proposal writing or workshop facilitation. Under optimal conditions one would expect to find an increasing involvement of those who previously did not have the capacity to participate fully, in all phases of project development. It follows that development projects should incorporate within their objectives the need to build the capacity for active participation.

It is arguable that not all development projects would require the same degree of capacity building. It is necessary in this respect to distinguish between projects which involve a comprehensive process of community health development, and those which are more task specific or 'selective' in orientation [29, 30]. In the latter case the specific objectives of the development process are pre-determined. In the

former case the initial objectives are very general and oriented towards facilitation of a comprehensive process of community development. Following Kieffer [14] and Korten [31], such comprehensive processes of community development always require capacity building, and this takes time, perhaps years. It would seem that the project studied took a very broad or comprehensive vision which was not accommodated by the funder imposed condition that a proposal be generated within a year. It appears that the funders envisaged a project which was more selective in orientation and did not allow for capacity building. When a process of comprehensive community development is being proposed, the time taken to reach the desired objectives cannot easily be predicted and in our opinion should not be too rigidly prescribed.

We feel that there was also a need in the project studied to develop the participatory capacity of professionals and those representing institutional interests. In this case it was not so much skills enhancement, but 're-orientation' that was required. The mode of participation from the perspective of having special project skills (Mode 1) and from the perspective of representing a profession/institution (Mode 2) seemed to exclude recognition of the need for self-change. These modes of participation tended to be accompanied by clear, pre-formed ideas about what would be most appropriate in terms of the type of professional services needed. Certain professional participants felt pressurized to reformulate their own professional identities and interests, and for this reason became increasingly hostile towards the project. This concurs with La Gaipa's [32] finding that some professionals are comfortable with traditional nonegalitarian, unidirectional relationships with laypersons that engender dependence and indebtedness and are reluctant to change their relationships with recipients of their services. It seems important to understand the attitudes of health professionals to the relationships between themselves and the public, and to find ways of changing these where necessary [33].

As Stewart [34] has pointed out, in the case of professionals interacting with mutual aid self help groups, educational preparation is needed to facilitate the transition from provider to partner. Professionals engaging in processes requiring community participation can expect to encounter frustrations should they fail to understand that the process of participation requires them to reconsider the nature of the services that they are in the business of providing. It may also require them to think more holistically and broadly about the role of their profession in community development. An important task of any project involving professional-community interface should be to facilitate development in the professional sector. In the project studied this could have been achieved, for example, through training seminars which devel-

oped a better understanding of the vision of primary health care and participatory development, as a precursor to participation. This might have led to greater openness on the part of professionals towards reconstructing professional roles, which may in turn have gone some way towards preventing the intransigence that eventually set in on both sides, partially as a response to professional reluctance to change.

4.2. *Assessment of needs and interests*

In the project all parties had their own reasons for participating in the project, i.e. involvement was attractive because in some way it served their own particular needs and interests. Yet the project only evaluated the needs of a particular group (the disadvantaged 'black' community) and when the needs of the other participants started to be expressed and accommodated in the project, ill-feeling was created.

All partners have needs and interests which must be assessed and brought to the participatory development encounter. The demands of the funders, the institutional and professional aspirations involved and the needs of the individual actors should be acknowledged as forces having a bearing on the project. The findings of the study suggest that when interests are not expressed, but nevertheless impact upon decision making processes, they are regarded as externally imposed, rather than legitimate and inherent needs in the context of the project. If such interests were to be expressed at the outset there may initially be less apparent 'common interest', but ultimately this would lead to a greater propensity to face conflicts of interest and resolve them. A process of needs analysis in respect of all groups of participants would allow greater transparency of the forces at play and obviate the ill-will, alienation and sense of being dominated which accompany the operation of undisclosed needs, interests and agendas.

4.3. *A dynamic relation between needs and strategies*

People can know what they lack only to the extent that they know that an alternative is possible. For example, I cannot know my need for spectacles if I do not know of spectacles as a possibility. I may not even know I am short-sighted until the horizons of my sight have been thrown into relief by the suggestion that my seeing capacity could be different.

To give an example from the project, amongst the needs expressed by the communities involved in the needs assessment were many needs which related to the domain of psychology. Yet the community could not and did not directly express their need for psychological services, because they did not know what psychologists have to offer. On the other hand a professional psychologist involved in

the project was not in a position to know what kind of psychological services would have adequately served the community, because he had little intimate knowledge of the community and its needs. His ideas about what he had to offer had been forged in another context, and although certain of his skills were potentially valuable, they needed to be honed in relation to community needs in order to be relevant. Neither the community nor the psychologist could know what was desirable and appropriate *prior* to the participatory process.

The 'local', experiential knowledge of the community, and professional knowledge, represent two distinct domains of knowledge [35], or frames of understanding. Through closer interaction of these frames of understanding in the context of the project, a third, shared perspective may have emerged. Such a perspective could conceivably have incorporated the contributions of both community and professional knowledge, an intimate understanding of the realities and needs experienced in the context, and an understanding of specific professional competencies and possible services.

On both sides a greater understanding was required of the fact that needs and strategies cannot be considered apart. It is our belief that the process of needs assessment should not occur as a discrete and preliminary stage of such projects, which is completed and then translated into strategy. Needs analysis should be conducted as a dialogue which takes into account, *ab initio*, the nature of possibilities and resources that exist. Ideally the process of translating needs into strategies of action should be achieved in partnership and as an ongoing process. Because intervention strategies follow on from and develop in relation to the continuing assessment of needs, planners should be cautious about prematurely deciding on intervention strategies. We believe that the need for community consultation should be increasingly emphasized rather than de-emphasized as the proposal drafting stage is reached.

4.4. *Taking the broader context into consideration*

Our study leads us to believe that the nature of participation is strongly determined by existing relations within the society and these are interpolated into participatory processes within projects. For example, the politics of race was significant in determining degrees of trust and groupings in the project studied, and especially in the development of the community vs professional alignment which came to be a feature of the project.

The project participants organized themselves along ideological lines following patterns of social and political stratification which, to an extent, cut across the categories of the three ostensible partners. It was partly the dynamics between these ideological groupings that determined the outcome of the project. These dynamics might have been pre-

dicted had the socio-political context of the project been taken more fully into account. It might have been seen as inevitable, given the context of apartheid, that the politics of race would be a major factor in the development of relationships between partners.

We can extrapolate from the above the need to take into account in participatory development projects, the context out of which a project emerges. This point is endorsed by Cohen and Uphoff [6], Kieffer [14] and Swift and Levin [15]. The 'context' in the present case involved the history of previous community-institution encounters, as well as the broad socio-political history of the society. These histories were present in the minds of the participants (some more than others) and in the ways in which they had been historically prepared to engage with the other partners. For example, for some Mode 3 participants certain institutions (e.g. hospitals) represented instruments of domination and sites of elitism, and initiatives arising out of these institutions were regarded with suspicion. This had a significant impact upon the communicative dynamics of the project, which could have been addressed had historical-contextual obstacles to participation been raised for discussion and cast as problems along with the more explicit problems which the project attempted to address. Left unaddressed, this context and especially the suspicion and mistrust which form a part of it, had a negative impact upon the dynamics of the communication process from the start and at all levels.

4.5. *Meta-communication*

A number of people interviewed in the study remarked, when asked how they experienced others' participation, that they would be curious to know how others had experienced their own participation. Although we never confronted our interviewees with the ways in which their own participation had been described by others, it seems likely, given the discrepancy between their self-descriptions and the ways that others saw them, that they would have been surprised by these descriptions. In some cases they would probably have wanted to contest the ways that others had characterized their participation, or at least to discuss and clarify the conflicts of interpretation. We believe that if such discussion had taken place in the context of the project, it would have gone some way towards avoiding the misunderstandings that emerged.

The full range of modes of participation in the project is something that the researchers were able to reveal as a result of the methodology they applied, and not something that any of the participants were aware of through having participated in the project. The self-understanding of each participant in the project was considered by the researchers to have significant 'blind-spots' and this seemed to impede the development of dialogue within

the context of the project. The same can be said of the researchers who realized as the result of the research that their own 'prior' understanding, developed in the course of their original participation in the project, had been quite subjective, and suffered from a restricted purview.

We believe that the facilitation of understanding between participants can be achieved through ongoing reflection, in the context of group meetings, on group dynamics and processes. Such reflection would ideally provide a bird's eye view of all perspectives represented in the project and the interaction between these perspectives. This would, we believe, go some way towards filling-in the 'blind-spots' which lead to misunderstanding. We might refer to the need for such reflection as the need for 'meta-communication', or perhaps 'meta-dialogue', i.e. dialogue about group communication processes.

Evaluation of group dynamics needs to become not something that occurs after the fact, but should be incorporated as a fundamental feature of group facilitation. It seems a necessity that the question "What is happening here?" be brought at all levels of participatory action. A brief closing discussion about the process of each meeting, conducted at the close of each meeting, for example, might have done much to circumvent the gradual accrual of unexpressed negative sentiments which eventually eroded the will to participate on the part of some participants.

Some empirical evidence in support of our suggestion of the need for 'meta-dialogue' is found in the work of Ellsworth [36]. She attempted to engage marginalized minority group participants in a group pedagogical process. The exercise faltered because the discursive dynamics of marginalization precluded participants from engaging fully in the dialogical process. But when such participants were invited to reflect upon dialogical process it assisted them to overcome, for example, reticence about contributing to the discussion. Marks [37], in a similar vein, expresses optimism about the strategic reflection upon discourses involving domination, as a way of interrupting such discourses.

5. CONCLUSION

Considering the resources and energy that have already been lost in the growth and premature demise of a great many projects similar to the one studied above, it seems pressingly necessary to study and understand the communicative and participatory processes that underlie unsatisfactory outcomes and those which provide a recipe for success. We have stressed the need for researching participatory projects and we hope that the study has shown the value of the creative application of qualitative research methods in this type of research.

The study shows that the conditions which give rise to the need for participatory methodology are

quite the opposite of ideal dialogical conditions. We believe that the deleterious effects of the imbalance of participatory capacity between participants in development initiatives, need to be better understood. We feel that the suggestions which we have made regarding correction of some of the problems associated with such imbalances in the project which we researched, may be applicable to other participatory development initiatives. These suggestions are not intended to be exhaustive, but to stimulate thinking and research on issues which are central not only in community health development, but in all social development processes involving the meeting of communities seeking development and those who offer resources and expertise in serving the interests of such communities.

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