

Community-Produced Materials for Health Education

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HEALTH EDUCATION IS GROUNDED philosophically in the model of a partnership between the client and the professional (1; 2) in which each partner shares the responsibility and initiative. In addition, health educators have adopted a central theoretical framework in which learning is conceived to be a process of participation and collaboration that is prompted by the learner's lifelong drive for understanding and personal growth (3). Learning theorists Mico and Ross

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(4) suggest nine principles of learning that are fundamental to health education programs. All of these may be interpreted as learner-centered, learner-active, and requiring learner-"expert" collaboration. The participatory process is as important in practice as in theory. After reviewing 36 rural development projects in Africa and Latin America in a 1976 study for the Agency for International Development, researchers of Development Alternatives, Inc., concluded that the key determinants—drawn from a list of 25 possibilities—in these projects' success were small farmer involvement in decision making and resource commitment to complement the work of outside "experts" (5).

In learning, participation may be viewed not only as an efficacious method of transferring knowledge, but also as a process by which the learner, by becoming involved, gains confidence in solving his or her problems. Participation allows the learner to recognize ability not only in himself or herself but also in other "nonexpert" members of the community. Most educational efforts in the past have concentrated on effecting changes in people's knowledge under the assumption

that increased knowledge would change behavior. However, in recent years emphasis has shifted away from strategies designed to change knowledge to experiential education activities that are learner directed. The self-care, mutual-aid movement is one example. Levin notes that the person educated in self-care "by reason of his/her expanded base of knowledge, skills, and confidence in personal health management, represents a more viable participant in actions to achieve social programs responsive to individual and community health interests" (6).

In the view of two men who are both educators and philosophers, Friere (7) and Illich (8), the consequences of participatory learning are liberating and life confirming. The consequences of the omission of participation are oppression and alienation of the learner. For example, Friere describes what he terms the banking method of education, in which the learner is viewed as an object into which knowledge is to be poured, and from whom little competence, creativity, or resources are expected. This concept is similar to one that is often described in the health education literature as the fallacy of the empty vessel. In

this concept, the learner is viewed as an empty vessel, devoid of knowledge and experience, into which we pour our directives, advice, and rules for living. At best, this approach is ineffective; at worst, it is dehumanizing and oppressive.

Illich (8) further describes a pervasive alienation resulting from passive education and advanced technology. He calls the alienation of man from his ability to act the most extreme form of alienation. In this case, the person has become so dependent on "experts" and "expert institutions" that his or her ability to act is suspended, since it is contingent only on "expert" advice. One definition of "expertness" is a monopoly of information and skills; experts may promote a policy of restricting any effective dissemination of information to the client population for fear that they (the experts) will be needed no longer.

The trend toward dependence and reliance on experts and away from reliance on self and other members of one's community is antithetical to the goals of health education. The development of collaborative models for learning and for creating learning materials is one way that a client's confidence can be built up and the competence of clients recognized.

A Participatory Learning Model

One participatory learning model is a photonovel. Its use as described in this paper, we believe is consistent with the goals of health education and client activism. A photonovel (called "photonovella" in Spanish-speaking countries) is a booklet similar to an American comic book, but photographs of real people and real places replace the cartoons; the dialog is presented in word bubbles, as in comic books (9, 10).

Photonovels have been a popular

form of literature for entertainment in South America and some European countries. They had not been used as tools of health education in this country, however, until during the winter and spring of 1977-78, an applied research branch of the New York State Department of Health, the Rodent Control Evaluation Laboratory in Troy, adapted the basic concepts of the photonovel to a participatory learning model. The Troy project was initiated by a few agency staff members, who contacted members of the local community and community organizers to discuss the possibility of developing a photonovel focused on the community's problems (12).

Communications were established between agency staff and members of the community in an effort to arrive at a truly collaborative relationship. In discussions of fundamental community problems at several open meetings, enough storyline material was generated for a photonovel. Together, a group of some 10 to 15 people then chose community action as a means for achieving environmental sanitation and rodent control. With the agency staff acting as facilitators, members of the community produced a 16-page photonovel, complete with sketches of characters and dialog for the frame of every page. This process required only a few intense sessions of discussion and laying out stick figure drawings for eventual photographs. Each of these sessions lasted 3 to 4 hours.

The community members who were to be the photographed actors were selected, and after half a dozen photography sessions, this phase was completed. Work was restricted to hours (much of it on weekends) that were convenient for the client community. When the photographs had been printed, the community chose the prints to be used in the final layout. A neigh-

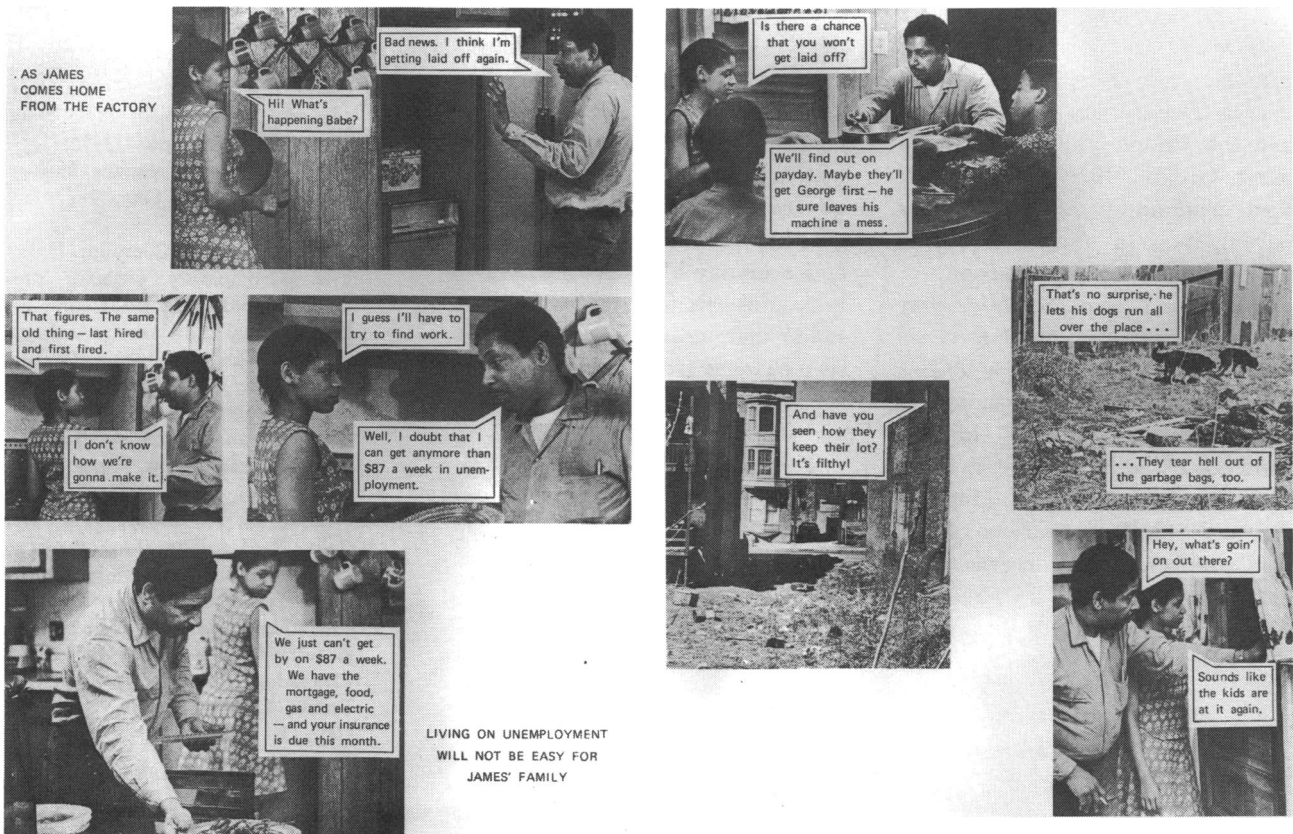
borhood printer was selected to produce the booklets to emphasize further the orientation to the community.

Almost half of the 1,500 booklets published were mailed to community residents as part of an evaluation of the Troy Project. The remainder were distributed directly by the community organization involved in the production and by the New York State Department of Health. (An evaluation of the project was presented at the Xth International Health Education Conference, held in 1979 in London. This paper is available upon request to Roter.)

At the risk of redundancy, it must be stressed that the client community controlled all aspects of the production and content of their photonovel, "A Working Neighborhood . . . What Does It Take?" Because of this high level of direct participation, one can reasonably expect that the community will produce a photonovel on its own in the future.

Advantages of This Model

Many benefits can accrue from a participatory learning model and client-produced material. Foremost are the respect and dignity resulting from having people involved in all aspects of a program that affects their lives. When community clients are co-participants with agency personnel who are serving as facilitators, a whole new level of shared respect, competence, and interdependence is stimulated. In addition, clients who participate in producing materials dealing with pressing problems are likely to become actively involved in a constructive way with these issues. Thus, program goals are enhanced as clients and staff discuss a problem, the solutions to that problem, or skills to help solve it. The clients who participate in a project are more likely to remain in the community



than is a transient “expert,” and they can also promote the use of the product by their friends and family. Community members who are unable to work directly on the production nevertheless benefit indirectly by being able to read something that has been tailored to local environmental, socioeconomic, and cultural conditions.

Decentralized production is important not only because of its local relevance, but also because it will increase local revenue, for example, by the use of a local printer in the client community. Moreover, the community-produced material is almost certain to cost less than “expert”-produced material. The development and consulting expenses for “Rudy Rat Says” (13), the standard New York State Health Department booklet on rat control, were about \$5,000. The cost for the photonovel produced in the Troy project was less than \$100.

Various methods can be used to

produce communications that will attract and hold the attention of the audience. The educational message can be combined with an issue that interests the target population, or it can be combined with an element of the population’s culture. When members of a target population are involved in the design of the message, these issues or elements are in the forefront. Client participation can help instill a sense of power, pride, and progress in members of the community. Seeing people from their own community within the context of a media product may give people a better feeling about themselves and that community; familiar faces and places add to the attraction. Also, when people see their friends and neighbors portrayed as meeting together and solving problems, they may become more confident, have more pride in their community, and develop a feeling of power that will help them solve their problems.

Diverse Uses of Photonovel

Many topics or skills relating to health would be appropriate subjects for photonovels, although the subjects might vary in the scope of their application. For example, a photonovel focusing on community problems in Troy, N.Y., is relevant to an audience in a limited geographic area. However, a publication on teenage cigarette smoking might be used by a wider audience. Some examples of subjects that have been developed in photonovels follow:

Community awareness campaigns and community organizing

A Working Neighborhood . . . What Does It Take? (12). Developed in Troy, N.Y., with Frantz, Comings, and Cain (1978)—the community action described in this paper. (In essence, all other examples listed here have been modeled, in some way, after the Troy project.)

Lead Poisoning in the Rural Community (14). Developed through the Rensselaer County Health Department (Troy, N.Y.) and the Hoosic Valley Family Interest Group (1979)—to increase rural community awareness and participation in a childhood lead poisoning prevention program.

Pembinaan Desa Tunikameseang Dengan Cara Baru (The Renewal of Tunikameseang Village with a New Method) (15). Developed in Tunikameseang Village in the Province of South Sulawesi, Indonesia, by Mangan, Sahabuddin, and Tawany (1979)—a variety of village problems and concerns. This model was intended for use as a catalyst for community action and as a basic literacy tool.

Patient education

Living with Cystic Fibrosis (16). Developed in Springfield, Mass., with Cone and Schwartz (1979)—concerns of adolescent cystic fibrosis patients.

School health education

Teens and Decision Making (17). Completed in Franklin County, Mass., with Rudd and Kichen (1980)—issues of decision making and cigarette smoking. This photonovel also explores the capability of the county's technical high schools to produce low-cost relevant educational materials for other schools in their area.

In producing all of these photonovels, a participatory process was followed. The clients determined the content, issues, story, dialog, layout, and design of the publication. In addition, participants directed all phases of the production, as writers, actors, photographers, and designers.

Conclusions

Navarro (18) has argued that a major weakness of health education

is its ideology of "blaming the victim," which fosters a sense of individual responsibility and reaction to socially induced, health-threatening conditions, rather than a more effective and political collective responsiveness. Navarro's argument goes beyond environmental hazards and everyday lifestyle behaviors; it maintains that collective action rather than individual-centered lifestyle changes are needed to counteract the stresses of Western society and its economy.

The investment of health education efforts in community-empowered activities may be an important step in coming to terms with victim-blaming. Moreover, through such activities, health education can fulfill its people-enhancing and people-serving potential. We hope that further studies of the dynamics of collective responsibility and of programs fostering collective problem-solving will be included among health education's research priorities. Clearly, we must devise new educational and social tools that will engender the participation of people while inspiring them to assume responsibility for local self-determination and well-being.

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