Community participation in health education programmes: A case of study of a tuberculosis programme in the rural communities of Thabana-Morena, Lesotho

By

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A Dissertation submitted to the Department of Sociology, Anthropology and Social Work in Partial Fulfilment of the Requirements for the Degree of Master of Science in Sociology.

National University of Lesotho **September 2012**

Roma

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CHAPTER ONE

INTRODUCTION

1.1 BACKGROUND OF THE STUDY

Heath education is an important component of preventive medicine and of health promotion. It is an active process that is directed at changing people's attitudes and influencing their behavior in health related matters (De Haan, 2005:32). Edelman and Mandle (1998:225) note that health education is not merely information distribution, nor is it an activity that is used to increase awareness; rather, it involves guiding people through stages of problem solving and decision-making. Further, Stanhope and Lancaster (2004:294) assert that health education is part of comprehensive health care which should form part of care at all levels of prevention medicine: at the primary, secondary and tertiary levels.

Furthermore, health education is viewed as one of the strategies to improve the health of communities. A message from the Director- General of the World Health Organization (WHO) stated that world health will improve only if people themselves become involved in planning, implementing and having a say about their own health and health care (WHO, 1988). The message is explicit, though, if there are any preventive measures

which deny people to participate or be involved in health education programmes, this will not be achieved. Involvement or community participation will not just happen if the stumbling blocks are still in existence. He suggested that to overcome the stumbling blocks in health education, concentration should not only be on health promotion and care. In order to overcome some obstacles that hinder participation, social and economic aspects of health problems as well as cultural issues should be observed.

As Green and Kreuter (1999) state that there had been initiatives taken by different institutions or organizations to educate people about their health in different communities whether rural or urban that are faced with health problems such as Tuberculosis (TB). A review by WHO in 1970 showed that more than half of the population of the globe did not have access to adequate health care, either because of poor delivery of health services or financial constraints. Due to the gap that was widening between populations within countries, in 1977, the Health Assembly resolved that the main social target for governments and WHO in the coming decades should be the attainment by all citizens of the world by the year 2000 of a level of health that will permit them to lead a socially and economically productive life. Primary Health Care (PHC) was a key to attaining “Healthy People by the year 2000” (World Health Report, 1995). Consequently, the international conference on Primary Health Care, which met in Alma-Ata on the twelfth day of September in 1978, expressed the need for urgent action by all governments, health and development workers, and the world community to protect and promote the health of the people. It suggested aspects which would promote and protect the health of the people and among the eight aspects; health education and health problems were emphasized (Dennill, King and Human, 1999). According to WHO (1988), health education is central to primary health care, which in turn is the primary means of achieving “Health for all”.

In September 1980, the Regional Committee for Africa approved the regional strategy for attaining the social target of ”Health for All by the year 2000” (WHO Regional Office for Africa, 1987:9) and in 1981, the Health Assembly approved the definitive global strategy for health for all by the year 2000. These initiatives influenced health development in Lesotho. A conference held in Riga in 1988 noted that Primary Health

Care coverage had improved, but deficiencies were still there (World Health Report, 2005:89). The amount of information available to health-policy-makers and planners of the time of the Declaration of Alma-Ata on Primary Health Care was limited. Data were rarely collected and used at national level, and feedback mechanisms from central to local levels were missing because the research development strategies were poorly financed in many countries, so strategies were developed on little information about health (World Health Report, 2003:108). Moreover, delegates at the Global Ministerial Forum on Research for health issued a "Call for Action" urging governments to allocate at least 2% of the budgets of health ministries to research development agencies so that recent data could be accessed for good policy-making for TB epidemic per se. As a follow up to the declaration, all African states attended the meeting in Bakoma, Mali, urging governments to pursue innovative financing mechanisms for research for health and to link evidence to policy-making (WHO, 2009).

In August 1997, a Health Sector Committee was established by the WHO to improve cooperation in addressing common health problems affecting member states, such as HIV and TB. One of the priorities set in their protocol based on five principles was to promote health through healthy public policy, health education and producing appropriate educational material (De Haan, 2005), and this was due to deteriorating health of the world population (WHO, 2005). In addition, the Millennium Development Goals (MDGs) focusing on aspects such as reducing child mortality, improving maternal health and combating malaria, HIV/AIDS and other diseases, set in September 2000 have been vitally important in providing impetus to accelerate actions towards health goals within the context of development despite many other problems such as lack of financial resources perceived that hinder their accomplishment (Government of Lesotho, 2005).

Moreover, as one of the strategies of ratifying PHC in Lesotho, a policy which made a huge positive impact was formulated to improve health, even though, this was not the first strategy, considering the formulation of National Tuberculosis Control Programme of 1967 which was recklessly initiated, since it did not have a central coordinating mechanism which ensured proper management (Tsikoane, 1999:26). The national

health and social welfare policy formulated in 2002 is based on PHC principles which included community participation; inter-sectoral collaboration; disease prevention and health promotion through behavioral change and equity (International Conference on Primary Health Care and Health Systems in Africa, 2008). In accordance with health and social welfare policy of Lesotho, communities shall not be mere consumers of services, but shall actively participate in decision-making and planning for health and social services, as well as in implementation of programmes. The success of health delivery system has been greatly influenced by the level of community participation in the implementation of public health interventions (Government of Lesotho, 2005). PHC presented a shift from centralized service delivery to a more decentralized approach that promotes and depends on comprehensive community participation in Lesotho, even though; this shift is faced by financial barriers.

With the commencement of Health Sector Reform Program in 1999, the Ministry of Health and Social Welfare (MoHSW) has been able to develop a ten year policy and thereafter a strategic plan covering six years. One of the major priorities of the policy was set to target health problems such as TB, health education and its promotion (Ranotsi and Worku, 2006). Additionally, Poverty Reduction Strategy of 2005 indicated that the signing of the Memorandum of understanding by the Government of Lesotho (GoL) and the Christian Health Association of Lesotho (CHAL) has led to health development because it led to a strong collaboration in addressing health problems. Following this, the development of Health Service Areas (HSAs), the District Health Package and Essential Service Package (DHPESP) and District Management Improvement (DMI) Project have led to an improved health service delivery and the development of Disease Control which initiated a TB control Programme. Hence, the Lesotho Cooperation Strategy (LCS) of 2008-2013 was developed to monitor the progress. It cannot be denied that there have been some few positive changes so far, despite the problems such as lack of resources.

Therefore, Lesotho as one of the states party to the World Health Organization made initiatives and catered for the offering of health education either by government or Non-governmental Organizations (NGOs) (WHO, 1998:77). Prior to these initiatives, the

community hardly ever participated in health education (Lesotho Review, 2000), but after Lesotho adhered to the declaration, the situation changed. Awareness of the public's need for improved education in disease prevention, increased due to increasing medical costs and for the fact that relatively little attention had been focused on the concepts of wellness or on health promotion either by the individual or by the community (WHO, 1998 and Lesotho Review, 2000).

As elsewhere, the colonial administration in Basotuland paid much more attention to other diseases, not the least of which was leprosy, than it did to the control, let alone the prevention of TB. The danger posed by TB remained unheeded throughout a greater part of inter-war period notwithstanding clear recognition of its magnitude (Tsikoane, 1999:22). However, the Lesotho review (2000) indicates that the situation of health education in Lesotho is improving each day due to the initiatives taken by the Ministry of Health and Social Welfare, because the human body became an economic factor (healthy people could work and contribute to the national revenue by paying taxes).

The campaigns against serious infectious diseases such as tuberculosis, venereal diseases and on topics such as diet were covered. Additionally, this reflects that biological and medical knowledge were variously disseminated in diverse structures or institutions to improve the health of the people. The collection contains posters, photographs, anatomic models, molds, specimens, films sponsored by the MoHSW and the National AIDS Commission (NAC) such as *"Lekau la poho*" and "*Tholoana tsa bohlola*" which are meant to educate people on the prevention of HIV and AIDS and have been shortened into series on the Lesotho Television (LTV) to disseminate information weekly; health guides and photo documentation of exhibitions and newspapers. Conversely, the effectiveness of media is limited depending on the fact that 69.4% of the rural people do not have access to it (Demographic and Health Survey, 2004:29). The successful implementation or use of these collections is enhanced by the support of government of Lesotho and Non-government organizations such as NAC, Solidermed and Lesotho Red Cross Society. The collection of this impersonal health education shows that initiatives are being taken to empower

communities with the health information, but the question still remains on whether they influence health behavior.

Some Basotho communities, particularly those in urban areas are participating in health education programmes, though, not fully because they are solely engaged in implementation of these programmes especially those facilitated by NGOs. Moreover, due to the realization that health education is vital for promoting health care, key members of the community like chiefs, councilors, village health workers, teachers, community nurses and nurse clinicians are engaged in such initiatives. Health education in Lesotho is even more emphasized in cases of those people infected and affected by HIV/AIDS, though it is not only limited to HIV/AIDS, but even to other diseases such as cancer, tuberculosis and diabetes (Lesotho Review, 2000). However, there are problems facing the decentralization of health education and the involvement of the community as a whole particularly in rural areas, in their own health improvement (WHO, 1998). Some of these problems include lack of resources to formulate comprehensive programmes and also the use of facilitators who are not informed on how to include people in health development, hence, the involvement of the rural communities in their health is destabilized. Makoa, Mpemi, Tsekoa, Ralejoane, Biesman, Brugha and Odonkor (2009) indicate that even the country's topography acts as barrier to this decentralization, as most remote areas are inaccessible, and there is shortage of health personnel. A report by the Medecins Sans Frontiers (MSF) (2009) in Makoa et al (2009:126) shows that only two of the 171 health centers in Lesotho had the minimum staffing requirement.

Basically, a TB health education programme is a structurally designed communication strategy that is meant to be most suitable for addressing different social groups. The purpose of this implementation is for social mobilization, in order, to spread out awareness of TB across different communities, so that TB occurrences, prevalence and mortality rate are reduced in those areas (Rieder, 1999). The aim is to implement an operational and feasible intervention, in order, to convey factual messages, such as warning people that TB is treatable, medication is affordable and the successful completion of treatment requires a patient to adhere to a fairly strict daily regime.

Additionally, it utilizes a holistic approach in developing communities, whereby target groups are empowered to become self-sustainable through education (Coker, 2012:23). It is normally implemented where there is high detection rate and it is bound to be administered by an organized professional body. The rationale behind its adoption is to do away with poor health systems or undesigned programmes that seriously hinder efforts to adopt healthy lifestyles.

This study is undertaken to assess community participation in health education programmes in the rural communities of Thabana-Morena, Lesotho. The study looks particularly into the Tuberculosis (TB) programme implemented as part of the disease control by the MOHSW. Tuberculosis control remains the biggest challenge facing not only Disease Control, but the entire Ministry and the country as a whole. This is because of unhealthy lifestyles that lead to the increase of TB incidences, but this does not imply that only unhealthy lifestyles cause TB. Some working conditions can cause TB such as mining. Additionally, the government has even gone as far as formulating a TB policy and its strategic plan, as well as Direct Observation Treatment Strategy (DOTS) to control the disease; but the number of admissions in hospitals increased from 553 per 100 000 in 2000, 576(2001), 613 (2002), 635 (2003), 643 (2004), 639 (2005), 638 (2006), 637 in 2007 to 640 in 2008 (WHO Report, 2009) and this is not a surprise, considering that in 2004 only 1.7% of the Basotho knew that unhealthy lifestyles could cause TB (Demographic and Health Survey, 2004). Lack of health information among Basotho led to erroneous interpretation of TB, some associated it with witchcraft, “sejeso” while some thought it was solely an occupational disease, yet it is also communicable (Makoae, 1999; Matobo, 1999). These figures uncover that TB cases have been increasing which might be a result of lack of TB information; hence much attention is also given to it and for the fact that it is an opportunistic disease in people infected by HIV worsening their situation.

As a result, this study calls for an adaptation of a strong psychological and theoretical orientation, in order, to make certain sociological assumptions related to health. The rationale behind the use of psychological model is based on the fact that most sociological theories that deal with social reactions and influencing factors, fail to

specifically relate these aspects to health risks that, ultimately, lead to social disorganizations in societies. Instead, they focus on the inequalities of health status of individuals (Lauder, 1998). Therefore, Health Belief Model as a psychological theory was used in this study, since it delineates the modifying factors or social pressures, such as socio-economic, structural and demographic aspects that determine social reactions towards health risks perceived. Hence, this psychological approach was adopted to explain the reasoned actions or planned behaviour of individuals towards TB health programmes in Thabana-Morena rural communities.

1.2 Statement of the problem

Health education in Lesotho has been faced with difficulties, due to lack of technical assistance for health educators, research, evaluation of health information exchange, inappropriate ways of involving people and poor allocation of resources for the implementation of comprehensive programmes (National Center for Health Education, 2005). Dennill, King and Swanepoel (1998) noted that community participation in health care delivery is professed by the majority of countries, yet there is some skepticism with regard to its success, looking at the increasing rate of illnesses due to unhealthy lifestyles. Further, several research projects conducted on issues relating to participatory health education in Lesotho, such as that conducted by the School of Development Studies of the University of KwaZulu-Natal on the perception of sex education for young people in Lesotho and that conducted by the Lesotho Vulnerability Assessment Committee (LVAC) on nutrition education in 2008, revealed that many Basotho do not participate fully in health education programmes as a result of poorly structured programmes, lacking commitment to health development and discriminatory.

In Lesotho, most health education programmes, such as that of NAC meant to promote health at community level and to alleviate health problems, and the Know Your Status (KYS) campaign are not inclusive. World Health Report (2003:108) asserts that donor driven programmes are usually problematic, since they lack commitment to design inclusive programmes, hence fail to disseminate health information. This has led to people adhering to the myths about the diseases such as associating TB with witchcraft and, hence, fail to prevent them or adapt their behaviours to healthy lifestyles (Lesotho

Review, 2000). Outstandingly, Tuberculosis is a serious health problem in its own right, an opportunistic disease and a leading cause in HIV positive people (Ministry of Health and Social Welfare, 2008). However, HIV/AIDS is receiving more attention, yet TB and HIV/AIDS prevention are both matters of urgency (Nastasya, 2010:56). This research examined community participation in health education programmes in Thabana-Morena area with particular reference to TB programmes, since TB continues to be the major source of morbidity and mortality, which stood at 37% in 2007 (WHO Report, 2009:203).

1.3 OBJECTIVES OF THE STUDY

1.3.1 General objective

The main objective of the study is to examine the extent to which the rural communities participate in a TB health education programme in the Thabana-Morena area, Lesotho.

1.3.2 Specific objectives

1) To determine the levels at which the rural communities of Thabana-Morena participate and the roles they play in a TB health education programme.

2) To assess the effectiveness of participation of rural communities of Thabana-Morena in a TB health education programme.

3) To examine the characteristics of those who participate that can affect effective participation.

4) To examine the challenges faced by the rural communities in participating in a health education programme of TB.

1.4 Research questions

1) At which level do rural communities participate in a TB health education programme?

2) What roles do they play in a TB health education programme?

3) How effective is community participation in the extension of a TB health education programme?

4) What are the characteristics of those who participate in a TB health education programme?

5) What are the challenges faced by the rural communities of Thabana-Morena in participating in the implementation of the programme?

1.5 Justification of the study

In recognition of the dire need to alleviate health problems particularly TB as the second pandemic (WHO Report, 2009:1), this study will contribute to knowledge on how to involve people in health development through the use of community orientated health education programmes. Through this study, the community members of Thabana-Morena, the health educators and programme directors will speak their views, preferences as well as their challenges that they face, which will serve as an advice for other programmes to be implemented in Thabana-Morena or even in any other rural area in Lesotho. It will also be informative to academics and researchers.

The utilization of health research results and recommendations in policy-making in Lesotho contributes to policies that are responsive to the health needs of the people, since they become informed. Moreover, the insights and involvement of the Thabana-Morena community participants will significantly add to the existing literature or research; it will contribute to the knowledge and the understanding of what is happening as far as health education in communities is concerned. Theories can be reviewed relying on this study as a source of knowledge. Also, involvement of the Thabana-Morena community in this study as informants will make them realize the importance of health education and health in general. Additionally, the study is a requirement for the fulfillment of the requirements of Master of Science in Rural sociology. After the completion of the study, the final report will be submitted to the Ministry of Health and Social Welfare and other NGOs such as Partners in Health, so as to disseminate the findings of the study.

1.6 Scope of the study

The study focuses on community participation in health education programmes. That is, how the community of Thabana-Morena participates in the health education programme of TB and their impact. The study does not focus on health promotion, but specifically on one of its aspects being health education that is participatory.

1.7 Definitions of concepts

1.7.1 Community participation

Community participation is seen as a process that ensures local people's cooperation or collaboration with externally introduced development programmes or project. It is an instrument that can help to reverse the exclusion and to provide poor people with the basis for their more direct involvement and initiative (Kahssay and Oakley, 1999:7). As Bells (1994) states, community participation is a process by which people are enabled to become actively and genuinely involved in defining the issues of concern to them, in making decisions about factors that affect their lives. In this study, community participation refers to the active involvement of the community, particularly the disadvantaged groups such as women, children, disabled, elderly and the poorest, in decision making, planning, implementation and evaluation of their own developmental activities. It should be understood as a process to establish participation between the health educators and local communities in order to increase local self-reliance and social control over health care.

1.7.2 Health education programmes

It refers to consciously constructed opportunities for learning involving some form of communication designed to improve health literacy, including improving knowledge and developing life skills which are conducive to individuals and community health (WHO, 1998:40). As Sil (nd), a health education programme is a planned sequence and combination of activities designed to influence people to live healthy lifestyles. In this study, health education programme refers to a system of projects or services intended to educate people about health behavior. These programmes normally involve equipment, materials, money, personnel and time. These kinds of projects indirectly

involve planned learning about health problems and the strategies to enhance a better outcome.

1.7.3 Community roles

According to Schultz and Lavenda (1995:633), community roles are the rights and duties associated with their status. These roles are those socially approved and that are in alignment with their culture. In this study, community roles are those rights and duties they are allocated in health education programmes which complement to bring solidarity.

1.7.4 Unhealthy lifestyle

Unhealthy lifestyles are ways of living that are not promotive of good health and longer life expectancy. These include choices and practices concerning a poor diet and food habits, drug abuse and the excessive consumption of alcohol (Cockerham, 1998:82). In this study, unhealthy lifestyles refer to ways of living that do not promote good health and longer life expectancy.

1.7.5 Tuberculosis

It is an infectious disease caused by bacteria whose scientific name is Mycobacterium tuberculosis. It most commonly affects the lungs but can also involve almost any organ of the body. It can be treated successfully with antibiotics. A person can be infected by sputum from the air (MedicineNet, nd).

1.8 Structure of the study

The study is structured in five chapters; chapter one entails the background, which gives the history of health education and community participation, the objectives of the study, the research questions, statement of the problem and the justification of the study. The second chapter reviews the literature on community participation in health education and other related concepts whereas the third chapter states clearly the methodology of the study. The fourth chapter presents the findings of the study that

have been derived from data analyzed, followed by the fifth chapter, which summarizes the findings, concludes and provides recommendations.

1.9 Summary

This chapter details the introductory aspects of this study, which entails the background of the study illustrating clearly the evolution of health education and community participation in communities, the statement of the problem demonstrating the real problem being studied at Thabana-Morena rural communities, the objectives of the study have listed, as well as the research questions that were utilized to collect data for this study and it is also justified in this section why this study was undertaken. Additionally, the scope of the study was pointed out, the concepts that seem important in this study are defined and lastly, the structure of the study is outlined.

CHAPTER TWO

Literature review and theoretical framework

2.1 Introduction

The literature review seeks to evaluate what other authors have articulated about community participation in health education programmes in societies with reference to the findings of empirical studies that have been conducted on this topic of interest. The study reviews the literature on the situation of TB in Lesotho, community roles in health education programmes and the levels of prevention that the community should participate in. It also assesses the socio-demographic factors that influence participation in health education programmes, the positive impacts that the community reap from participating in health education programmes and health education in schools. The health education programmes that have been implemented and the challenges that face the community in participating and the programmes are reviewed.

2.2.1 The situation of Tuberculosis in Lesotho

Lesotho appears to be swimming against the tide of TB with statistics suggesting the prevalence rate is actually on the rise. TB notification is 640/100 000 and with treatment success being 74% in 2008 which is below the global target of 85% (MOHSW Decentralization strategy, 2009). A large proportion of these TB cases are due to men who worked in the mines in the Republic of South Africa (RSA); they have been exposed to silica dust in mine shafts that affect their lungs and leaving them prone to the contraction of TB (AIDS and Rights Alliance for Southern Africa, 2008). However, there are a vast number of undiagnosed cases of TB, due to the fact that many people delay to consult doctors. On the other hand, 13 520 people had all forms of TB in 2009 (National TB programme, 2010). This airborne disease continues to kill people and even those infected with HIV and AIDS because of persistent problems such as ignorance to adopt healthy lifestyles, non-participatory health education programmes, lack of resources to provide healthcare services, general lack of usage of data for policy-making and planning, and lack of commitment to hygiene, which could promote the health of the people and the community. According to Bloomfield, Stanwell-Smith, Crevel and Picccu (2006), home hygiene is most vital for breaking the chain of infection. However, in the developing world, for decades, universal access to water and sanitation has been problematic, hence undermining initiatives to live hygienically.

Donnelly (2009) indicates that the Lesotho's Minister of Health and Social Welfare stated that the best way for Lesotho to fight TB is to take the lead by implementing strategies that reduce the burden. The co-infection of HIV/TB has forced the government of Lesotho to make the prevention and control of TB to be a national priority. The government is under pressure to upgrade the poor and old infrastructure in line with the demands brought by TB and AIDS. An estimated 70% to 80% of HIV people are co-infected. Some patients are selected for multi-drug resistant for treatment to fight TB mortality. Community health workers are recruited for caring for patients of TB. They ensure that patients are adhering to the treatment regime.

Some NGOs such as Partners in Health, Foundation for Innovative Diagnostic, Clinton Foundation, Royal TB Foundation and Global Fund play a vital role in the control and prevention of TB. These NGOs try to collaborate with the GOL so that they can help

each other in achieving development. Lesotho celebrates World TB day and the campaign on 24th March 2011 focused on individuals who have found new ways to stop TB and who serve as inspiration (Nastasya, 2010). The MOHSW is trying by all means to improve the Direct-Observed Treatment Strategy of TB, though, lack of resources still challenge this initiative. Lesotho as one of the state party of WHO, is influenced by the WHO global TB strategy and global plan to stop TB (2006-2015) which gives a major thrust to community engagement (Ramakant, 2009). However, the GOL is reluctant to give power to people to lead development interventions considering the top-down approach they utilize in development projects that denies rural communities a chance to participate. The biggest challenge still remains of the public seeming to know less about their vulnerability to the airborne mycobacterium-bacterial that causes TB (Maama, 2010:12). Again, TB is still stigmatized due to lack of information about this disease (Ramakant, 2009). Even so, community orientated health education programmes on TB would alleviate this problem for communities will be able to participate and learn so as to live healthy lifestyles.

In addition, the MDGs are guiding principles for communities in Lesotho and that is if they target at achieving, particularly, the sixth MDG which aims at combating HIV/AIDS, Malaria, TB and other diseases. Nevertheless, WHO (2008:5) indicates that without commitment and wide spread research on TB, the MDG: 6 is unlikely to be reached. To ensure that the MDGs are achieved, it is important that health care services are available to all Basotho and they have a say about them, wherever they are, whenever they require these, irrespective of their socio-economic status and geographic location. There must, therefore, be equitable distribution of health services, in turn; this would result in people preventing TB (Makoa et al, 2009:11). Basically, health education programmes should be implemented in all the communities and particularly in rural areas since that is where 76% of the citizens of Lesotho reside (Demographic and Health Survey, 2004). Some people in rural areas live far from the health centres in which they could get more information on the methods of participation in health education about TB. These programmes are designed based on certain levels of prevention.

2.2.2 Community roles and levels deemed important in health education programmes

Participation is a process through which stakeholders' influence and share control over development initiatives, decisions, and resources that affect their lives (Cooke and Khothari, 2001:5). It becomes clear that if the community participates in health education programmes, they will have to have a say in the health development initiatives that affect them. Diem and Moyer (2005:41); Health Promotion International (1996); Basavanthappa (2008:215) highlighted that the community has a role to play in the process of health developments that take account of educating people about healthy lifestyles and hygiene which include the analysis of the problem, planning, implementation and, monitoring and evaluation. These phases are considered to be levels and at each level the community has different roles to play. Oakley (1991:46) asserts that in a situation where the community is involved in these four phases, a bottom-up approach is utilized. This implies that the facilitators do not decide and plan what the community should do, instead the community decides by itself.

On the other hand, Kahssay and Oakley (1999) state that top-down curative health strategies have been less successful in achieving better and sustained good health. Community involvement was limited to resource and manpower contributions to health programmes, but there was little active involvement in health programme design and implementation. An essential ingredient of the new worldwide strategy being bottom-up is the massive involvement of people themselves not just in the support and functioning of health services, but more importantly in determining health priorities and the allocation of scarce health resources; hence it is necessary to utilize this approach.

2.2.2.1 Problem analysis

The assumption behind problem analysis is that there is a clear cause and a clear solution (Bartle, 2007). Indeed, it can be useful in many situations to find out what caused a problem and how it developed, because if the community would succeed in finding this out, the cause would be eliminated, thereby, solving the problem. The community has to play a role in the analysis of the problem as the first phase of the

programme. As Bartle (2007) declares, problem or situational analysis is a process through which the general characteristics and problems of the community are identified. It involves the identification and definition of the characteristics and problems that are specific to particular categories of people in the community. Diem and Moyer (2005:281) indicate that the most effective way to recruit individuals is to ask them to join the group and identify what they could contribute. These would include people with disabilities, women, youth, the elderly, men and children because they are the key members of the community. Diem and Moyer (2005:4) further argue that analysis of the problem would draw from different perspectives to define the problem clearly such as TB prevalence. The members will be able to discern whether an issue is sufficiently important to warrant as a health problem. In as far as the identification of needs is concerned, the facilitator should understand how the community's existing knowledge, skills, and motivation influence learning about TB per se and this would be followed by the identification of resources such as, equipment, stakeholders and others in order to set up an effective learning about TB.

There are certain barriers to learning which should be identified and strategies developed to curb them. Such barriers include lack of time, money, space, energy, confidence and organizational support as well as communication barriers. Cultural and language differences between the facilitator and the community members or from learning materials that are inappropriate to the community members' educational level might result in community members not being educated, but confused. Such adverse influences can be minimized with vigilant awareness of both initial and newly developing barriers during the educational process (Stanhope and Lancaster, 2004:313).

Problems regarding proposed interventions and solutions should be well defined (Kennelly, 2009). The implication is that the setbacks facing community participation should be identified before the implementation of the programme so as to ensure the accomplishment of the programme. This is said to be a dynamic process due to the fact that different stakeholders are expected to share ideas in assessing the problem and suggesting solutions. Problem solving is done through collecting information necessary on the past, present and future to understand the community as a whole which includes

chiefs, traditional healers and others. This information should be based on the community experiences about health. Problem analysis can also be defined as dissecting and thoroughly studying the problem, such as unhealthy lifestyles leading to high prevalence of TB, with the objective of understanding how the problem emerged and how it grew to its current position (Visser, 2004:12).

Despite the observation that problem analysis is significant; its usefulness is enormously overrated even when it has not been done accurately. Some health problems are usually claimed to have been analyzed, although they are complex in a sense that the information needed for analysis of the problem is not easily accessible, that searching for their causes may be fruitless. Usually, this clearly results to unidentifiable root cause (Bartle, 1997; Visser, 2004). For example, if there is a conflict in the management team, the community members, generally, will not be able to find the root cause of that conflict for they have the authority to control the directions of the discussions. Again, it is not always the case that the community accepts a problem to be a health one, since the constructed meanings shared by a community are powerful and guide the behavior such as religion; which often perpetuates denial of a problem.

2.2.2.2 A plan is a template for the programme

In decision making, the action that the community takes is meant to make it become stronger by permitting them to have a say about factors that influence their lives. As such, empowering the community means that the facilitator cannot make decisions on behalf of the community. Participation is, therefore, needed first to determine what they need most. According to Uphoff (1991:117), the main issue here is the voice of the community, particularly, of those potentially affected, not a few or dominant people. Similarly, the community should have a say in a TB health education programme. There is a need to plan the decision-making process and the community should have a vigorous role in this process so as to adjust their health status or emergency preparedness. Planning is as important as health development because it leads to the realization of development of objectives and goals. It is seen as a learning process by which community members can improve their own actions and gain self-reliance. The

community should be involved in all the stages of planning. That is to say a comprehensive planning should be done gradually following the prescribed steps of planning until they have reached the apex. Planning should be done in the hands of all, not only a committee. In a nutshell, participatory learning is characterized by a bottom-up approach and it must be incremental (Swanepoel and De Beer, 1998).

Moreover, the community would plan on how to implement the programme. Initially, Bartle (2007) affirms that goals and objectives are set in planning. A goal is a general statement of what should be done to solve the problem. It defines, broadly, what is expected out of a programme meant to educate people about healthy lifestyles and how the community should participate. An objective emerges from the problem that needs to be addressed and signals the final destination of the programme. It should make clear what, where, when and how the situation will be changed, it should be measurable; it must be able to quantify the targets and benefits, it must be feasible, realistic and time-bound. It must generate structures and strategies determining inputs that are needed and roles to be played (Bartle, 2007). The engagement of the community in the process of setting objectives is vital for they will know the advantage and the ways of attaining health development.

A plan helps to guide the work from start to finish in order to achieve the desired goal. It details the work that will be done. At the same time, it serves as a tool for communicating with stakeholders in a community-orientated TB health education programme. Work plans usually consist of three main components: the task list, the schedule and the budget that the members of a health education programme should set out (USAID, 2010). CommunityNet Aotoarea (2010) highlights that the objective is to gather data, analyze information and decide on an implementation plan necessary for the participating community to attain its objective. This is, basically, a plan of what needs to be done, where, when and how, to attain health development through the implementation of a health education programme with the involvement of every community member. It is at this juncture, where the community works out the detailed tasks to be done.

The work plan allows participants to break the programme of emergency preparedness down into manageable modules that can be assigned, scheduled, tracked and organized. The work plan consists of tasks or cohesive units of work on a programme-bundled into hierarchies and milestones (UNESCO, 2010:7). Milestones divide the project into logical, measurable segments, such that when all the milestones are completed, the project should be done. Upon completion of the task list, the project schedule and budget can be prepared. Then, the community can participate in the programme they fully own more particularly when the implementation team is suggested. USAID (2010); Community Energy (nd) behold that in planning, the implementation team is proposed, which will put the objective into practice. This team is proposed by the community involved.

2.2.2.3 Implementation

Basavanthappa (2008) further asserts that it is vital for the community to participate in the implementation phase which implies that action is taken by all. Bartle (2007) indicates that implementation is the doing stage of the programme. It is the stage where all the planned activities are put into action. That means strengths and weaknesses being internal forces, opportunities and threats, will have been identified (UNESCO, 2010). In this phase you can expect to come across some unforeseen issues that may mean the programme will take longer, cost more and/or not be up to the quality hoped for. Perhaps, the community overlooked an important item; it defined the scope and now includes it. An effective control system is needed to keep track on such issues. The strengths and opportunities are positive forces that should be exploited to efficiently implement a health education programme of TB and the weaknesses are hindrances that can hamper project implementation. The implementors will have devised means of overcoming them.

2.2.2.4 Monitoring

Monitoring is important at this implementation phase to ensure that the health education programme is implemented as per schedule set by a rural community. As such monitoring activities should appear on the work plan and should involve the community

(Basavanthappa, 2008; UNESCO, 2010). Monitoring is also important to ensure that activities are implemented as planned by the community troubled. This helps the implementers, being the rural community, to measure how well they are achieving their objective. This is based on the understanding that the process through which a health education programme is implemented had a lot of effect on its use, operation and maintenance.

2.2.2.5 Evaluation

The fact that the programmes are made for the community, it is rational to include them at every stage including evaluation stage because the success of the programmes can be measured by their adaptation and the adoption of healthy lifestyles influenced by the programme. This indicates that the community has a role to play in evaluation too. As Diem and Moyer (2005) indicate, evaluation refers to a process whereby the community assesses whether the desired outcomes have been procured or not. Stanhope and Lancaster (2004:310-13) state that evaluation is an important aspect in the process of community participation or educational process. It provides a systematic and logical method for making decisions to improve the TB educational programme that the community participates in. It is a formal process that helps the individual to find out whether the programme being implemented is working as planned and the impact that a group or programme is making. It is an attempt to systematically assess the impact of programmes on problems they are designed to address (Kennelly, 2009).

Also, it is an essential phase in the planning cycle and will provide the community with information to improve the participatory TB programme. Christchurch City Council in CommunityNet Aotearea (2010) indicates that it involves the systematic collection and analysis of data needed to make decisions. It is an essential aspect of good decision making that the rural communities should engage in. It helps to establish the appropriateness, effectiveness, efficiency and economy of the programme (Basavanthappa, 2008:215). Ideally, evaluations for rural communities participating would mean a process for learning about improving the quality, effectiveness and or efficiency of proposed and existing services.

In addition, it should include the follow-up of educator or facilitator in the community orientated health education programme, process evaluation and product evaluation. Educator follow up intends to assess whether he/she is facilitating the programme as planned. In particular, process evaluation examines the dynamic components of the educational programme. It follows and assesses the movements and management of information transfer and attempts to keep the objectives on track (Bartle, 2007). It is necessary throughout the TB educational programme to determine whether goals and objectives of an implemented TB programme are being met and the time required for their accomplishment is being attained by the rural community. The outcomes are measured against the original objectives to examine whether the desired outcome is attained. It is affirmed that evaluation is done because it also generates information regarding an advocacy agenda (Kennelly, 2009). It further enhances management decision making, improve programme operations in order to maximize benefits to programme participants and targeted populations.

Moreover, participatory programmes are, therefore, required to include communities in all the levels of the interventions in order to be considered as inclusive and transformatory. They should have a say in every matter concerning the intervention so that rural communities can be empowered to be accountable in every work they do. Although, according to CommunityNet Aotearea (2010), communities are normally disempowered to take the responsibility of their health, yet they are to be accountable. In fact, Makoa et al (2009:117) still indicate that the provision of health care in Lesotho has always been the responsibility of the family during the initial stages of the disease. Failure of the family to improve their health, opened doors for traditional healers to take over as they are accessible in terms of geographical setting and found among communities as compared to healthcare professionals who operated far from the rural people who needed healthcare services. This shows that the engagement of the traditional healer in seeking solutions to the health problems reduced the burden on hospitals for people who needed services in hospitals. Therefore, the programme process should be left in the hands of the community to solve their problems with the assistance of an expert acting as a facilitator.

In instances where they are included in every matter of the TB programme per se, the goal may not be reached. In a cross-sectional study conducted by Matebesi, Meulemas and Timmerman (2003) in Free State Province in RSA, to investigate the factors influencing recourse to healthcare in TB patients, it was revealed that the low levels of awareness are likely to have two causes. The fact that health education about TB and advocacy programmes do not reach the community at large and the general culture of patients passively receiving instructions rather than being actively involved in their own treatment or prevention are the causes. Most people delay to consult the doctors because of the fact that they rely heavily on home remedy. Lack of knowledge or awareness about TB was found to cause people to delay in seeking healthy lifestyles. This is not only the case in these areas, this is probably the case in Lesotho considering that in the 2004 health survey 41.4% of women and 29.3% of men indicated that they did not know the causes of TB. TB programmes which cannot ensure community involvement and adequate levels of adherence are worse than no interventions at all (Dick, 2003:24) in Van Rensburg, Meulemans, Van Heunis and Van Rensburg-Bonthuyzan (2005).

Makoa et al (2009) show that there are ongoing efforts that are meant to address the challenges of health in line with the National Vision 2020 of Lesotho, which is expressed as follows: *"the country will have been a good quality health system with facilities and infrastructure accessible and affordable to all Basotho, irrespective of income, disabilities, geographical location and wealth*" (Vision 2020, 2004). However, without the involvement of the community in their health development, it is highly likely that in 2020 we would continue to be stuck in the current situation of health service delivery because the government cannot solely attain development without the support of the Basotho communities. Hence, rural communities should participate in community orientated programmes. These programmes are designed based on certain levels of prevention.

2.2.3 Levels of prevention that the community participates in.

Different health education programmes are designed based on either one of the levels or all of them. Even if a programme is based on one of these levels, it is worth noting

that the community has a role to play in any of them. Peberty and Kats (1997:164); Tones and Tilford (1994) and McKenzie and Smelter (2001:6) harmonize that universally, health care systems are often organized to provide effective and efficient prevention and care for diseases. It is necessary for people to modify behaviors which are responsible for causing diseases, given that prevention is better than cure. Human behavior plays a significant part in the aetiology and management of all diseases, education is needed to persuade people to behave appropriately to attain self-help. In this way, community participation is the most vital component, since it is the community that prevents illness by adopting healthy lifestyles. Their involvement means empowerment and partnership to make informed decisions about their health. Basically, they identified three levels of prevention of which the community has to participate in, which are primary, secondary and tertiary prevention.

Primary prevention persuades individuals to adopt behaviors believed to reduce risk of disease or adopt healthy lifestyles concerned with health education. In case of TB, people would participate in being educated on how to prevent this disease even before they can contract it. Secondary prevention persuades individuals to comply with medical treatment. At this stage, the TB patients and other parties supporting them are empowered with the health information on how to successfully adhere to the six months treatment and its vitality. Also, tertiary prevention persuades patients to resume normal behaviors as appropriate, to comply with medical treatment, including palliative measures and to adjust to limitations resulting from diseases (Tones and Tilford, 1994; Katz and Peberdy, 1997). The sick role that a person assumes, forces him or her to seek help and live healthy lifestyles.

Tuberculosis patients are equipped with skills on how to live a normal life still adhering to medical treatment so that they can still feel part of the community. In order to achieve these three levels of prevention, the community is supposed to be involved in them for they play a vital role in influencing people to adopt healthy lifestyles so as to live longer and to avoid spreading the TB germs through unhealthy lifestyles such as spitting in the open. Community participation is the key to enhancing commitment either emotionally or psychologically to prevention of diseases such as TB and others. However, it remains

a fact that much as they have these roles in prevention, there are influential factors that determine whether they will participate or not, defined by the demographic factors such as gender, religion and social class. The discussion below focuses on these variables.

2.2.4 Socio-demographic factors

According to Stanhope and Lancaster (2004), a variety of factors influence an individual's decision to participate in health education programmes. These include demographic, geographic, economic, psychological, social and spiritual characteristics. According to Curtis (2004), the social model of health sees the health of the individual person as the outcome of a range of socio-economic and political determinants, as well as medical care. It is necessary to identify these modifying factors when developing a health education programme because they determine the feasibility of implementing the intervention.

Further, Bomar (2004) asserts that the understanding of health relates strongly to individually and collectively constructed ideas about the significance of the body. It has been demonstrated that individuals vary in their perception of what count as healthy or unhealthy in their illness (Donovan, 1990) in Curtis (2004:2-3). More commonly, it is viewed as ideas about health providing freedom or 'release' to do as one pleases, or as functional ability to carry out key roles, such as work as an employee or a homemaker. These 'health beliefs' are held by different individuals, in varying degrees. However, there is a tendency for some elements of health perceptions to be shared and reinforced collectively among people in the same society. This gives rise to what may be seen as culturally specific aspects of health beliefs, which may be of particular social and geographical settings (Brinkerhoff, 2003).

2.2.4.1 The role of gender in health education programmes

According to Tsouros (1990:34), gender is a health determinant, but gender itself is shaped, particularly, by socialization. Men and women have different ways of responding to health education because they have been enculturated into different behaviours. Men and women differ on hostility levels and this plays a role in whether they will participate in a programme or change their health lifestyles (Cockerham, 2002).

Men are perceived to be often hostile when it comes to adopting healthy lifestyles, whereas women are more likely to involve themselves and take their health status seriously whether adverse or good due to the fact that they are socialized from childhood to be caretakers and their biological make up, that of reproduction, influences them to visit health centres more often than men, hence, they find it unproblematic to care for themselves. As for men, their hostility may be influenced by the fact that they have been socialized to believe that everything they do is reasonable such as lifestyles of drinking alcohol and smoking cigarettes which are also seen as characteristics of masculinity. There are other behavioural aspects believed to be appropriate for males of which they are socialized into and copy them from other male figures such as fathers. Contrary to what Cockerham stipulated about good participation of women in gaining healthy lifestyles, Wainwright (2008:115) declares that, lately, women are also prone to unhealthy behavior because they are prone to behave in a way that is more 'male' than that of women in the past, due to the fact that culturally designed expectations out of males and females have changed, they would ignore to participate. For instance, females can now work outside the household, they engage in both formal and informal sectors.

Nevertheless, Van Staden and Du Toit (2000:56) detected that most community orientated health education programmes leave this issue of gender in health education not considered. This may act as barrier to social change due to the fact that some people may decide not to participate when they feel that it hinders their gender roles approved by society such as rearing children. Also, the increasing tendency among women to work away from home could passively narrow the differences in health and illness among women and men. This implies that they are both susceptible to the contraction of TB, since they engage in occupations such as mining which is contaminant. In addition, Sady (2000:17) states that it is difficult to finally attain a democratic participation with regard to inequalities. Gender inequality hinders community participation in TB programmes in a sense that men, per se, may avoid to engage themselves in activities that they feel make them equal to women such as learning together and being given the same responsibility. These impact negatively on the programme since not every community member will participate, hence there would

not be partnership that is necessary for empowerment and ownership in health development.

2.2.4.2 The role of religion in health education

Cockerham (2001:98) posits that religious attitudes and behavior can have effect on numerous health related activities that people ought to participate in. Religion assists individuals in finding meanings in health, illness and suffering (Bomar, 2004). People belong to different religious organizations which have different religious beliefs, values and symbols that interpret health and coping strategies differently. An example can be the interpretation of Faith in God which promotes strength and responsibility; all these are instrumental as building blocks for a shared community religious core (Curran, 1983 in Bomar, 2004:20). Explicitly, faith in God provides the basic foundation for all activities, beliefs and conversations within a community because people value these beliefs and they guide their behaviour. Finally, religion has power to control the person's decision of whether to participate or not in the health education programme. For example, if they feel that the health education is undermining their religious beliefs, they will not participate. An exploratory study by Oshi, Nakalema and Oshi (2004:12) indicates that strong religious and traditional norms restrict the transmission of HIV and AIDS prevention measures to their students in Nigeria because sex education is prohibited among children. It is believed that they may actually want to experience what they are being taught about. They interpret some of the protective devices, such as the use of condoms unreligious. This implies that religious attitudes may hinder participation or influence it in TB health education programme.

Positively, coping is enhanced and depression is lessened in those who depend on religion. For example, the Adventist AIDS international Ministry in Lesotho as a church-run organization provides a way of coping for people infected by educating them about HIV and AIDS that goes along with the biblical quotations (Adventist Mission, 2010). For example, Romans 12, verse 1 states "I beseech you therefore, brethren, by the mercies of God, that ye present your bodies a living sacrifice, holy, acceptable unto God, which is your reasonable service" (Holy Bible, 2004:503). It is quite clear that these influential factors may negatively or positively impact on initiatives to educate people about their

health, since people belong to different doctrines that interpret these quotations differently.

Most church ethics are against the use of alcohol, drugs, tobacco and others. This shows that for those who value these ethics, which are retrieved from the holy bible, health behaviour will be attained as well as participation in programmes. Churches such as Lesotho Evangelical Church (LEC), Roman Catholic Church (RCC) and Anglican Church value these ethics, therefore, their members would participate in educational programmes which intend to reduce TB prevalence and are more likely to adopt healthy lifestyles. Koning and Bloom (1993:34) in their study indicated that church participation plays a vital role in influencing the decision to improve one's health status. Commonly, church attendance is an important correlate of positive health care practices, especially for the most vulnerable subgroups such as children, the elderly, women and the disabled people, the universal and chronically ill because they need solace. A large nine year prospective study that used a nationally representative sample showed that frequent church goers manage to live preventive lives, since biblical messages read at church influence their behaviour (Matebesi et al, 2004). Community and faith-based organizations present additional opportunities to improve the health of the low-income and the minority. Moreover, there is growing evidence that religious involvement, in addition, to providing greater access to health intervention, exerts positive and diverse health benefits for most people, since religious participation reduces mortality risks by influencing healthy lifestyles (Aaron, Levine and Burstin, 2003).

Furthermore, Livingston et al (1999) in Aaron et al (2003:16) showed that religious afflictions or religiousness is also related to several improvements in quality-of-life indicators; these include a more optimistic life orientation, greater perceived social support, improved life satisfaction, improved adjustment to chronic diseases and higher resilience to stress and lower levels of anxiety. This is, again, still due to the influential biblical messages that support healthy lifestyles. Curtis (2004:29) has demonstrated that religious participation is related to healthy behaviour, especially among women.

Bomar (2004:20) asserts that, although, religion has many positive factors, there is evidence that some individuals use their belief in a Supreme being (God), in a way that

is detrimental to their health due to the fact that they may ignore to participate or adopt healthy lifestyles if they are to compromise their religious beliefs. Explicitly, a person may not eat proteins, particularly the Zionists who do not consume pork because it is said that it has evil spirit, if his/her religious belief prohibits, hence this impacts adversely on the health, since the body needs proteins to stay healthy. This implies that even in instances where people have participated in the programme, some religious groups may still ignore to adopt healthy lifestyles. Cockerham (1998:126) too, indicates that a few religious groups prohibit their members from seeking modern medical treatment or health information. The groups utilize faith healing and communal prayers in treating illness. This clearly implies that some religions offer alternatives to delaying or forgoing treatment of TB perhaps, because of religious beliefs. For example, some churches have often claimed that it is a sin to consult medical doctors and it shows that a person does not have faith if a person does that, and some are against blood transfusion and organ transplants, such as the Jehovah's Witness. Probably, in a TB health education programme, a situation like this would prompt some people to decide not to participate.

Another example of religion being detrimental to human health is drawn from a qualitative report on Rural American women with hypertension. Bomar (2004) states that some participants believe that "God is in control". "If I take pills, then it shows that I have no faith". This is to say religious beliefs can make people forgo or delay treatment or prevention; hence unhealthy lifestyles are to be observed. This shows that religion may lead to people misinterpreting health issues. As well, in the rural area of Limpopo Province (Tintwlo) researchers in their study uncovered that respondents (63%) said TB was due to disobedience of traditional rules and so the ancestors were punishing them for not taking instructions (Verbergt, Floblets and Meulemans, 2005:180). Consequently, people possibly will find participation in TB health education programmes useless as it is believed that it obstructs their religious beliefs.

2.2.4.3 The role of income

Income is a key determinant of good health lifestyle. Naidoo and Wills (2005:18) detected that it is the mediating factor that determines access to a host of variables

related to health. Poverty leads to poor health and excess mortality because it is not possible to participate in health education sessions. For example, a person who is poor cannot purchase food, cannot afford medical bills and poor agricultural production influences unhealthy eating styles. The relationship between poverty and ill-health can be perceived in reduced access to material resources such as income, good quality housing, neighborhood and work environment, and constrained behavioural choices such as increased rates of smoking as a coping mechanism or reduced social networks to healthy food, due to high prices and local availability. Psycho-social factors such as reduced social networks and feelings of low self-worth and self-esteem also influence community participation since those with low self-esteem or self-worth may decide to reserve their engagement in health education programmes (Diem and Moyer, 2005:65).

Poverty, which arbitrates one's status in a community, is both absolute and relative and it determines whether an individual will participate in the health education programme or adopt healthy lifestyles. Absolute poverty refers to a condition of income that is insufficient to pay for the basics of a healthy life, whereas relative poverty is the state of lack of resources by people to obtain the types of diet and other health needs in order to participate in the activities of good living conditions and ameneties which are customary, or at least widely encouraged or approved in societies to which they belong (Naidoo and Wills, 2005). Community members who are relatively poor may decide to participate in a TB programme to some extent, while those absolutely poor may decide not to participate because they spend most of their time trying to meet their basic needs.

Weber (1978) in Cockerham (1998) posits that people's lives are measured according to their different class structure. Class is an objective dimension of social life signified by how much money and property one has, while, status is subjective in that it consists of the amount of esteem a person is accorded by other people. The upper class acquires the most resources which permit them to participate and live healthy lifestyles that are influenced by health education programmes of TB per se, though the lower class with less resources find it hard to do that. Nevertheless, the upper class is also prone to live unhealthy lifestyles since the resources they have access to, may permit them to afford even unhealthy practices. As Ritzer (2000) adds, members of a status group share a

lifestyle differing from another status group; one's lifestyle is a reflection of how much one consumes. This view applies to health lifestyles of those susceptible to TB because when one pursues a healthy lifestyle, that person attempts to produce good health according to his or her degree of motivation, effort and capabilities. Even if the TB health education programme informs people about ways of avoiding to be infected by TB, the class that one falls into determines his/her participation in a programme or the ability to successfully adopt healthy lifestyles.

Weber did not ignore the socio-economic conditions necessary for a specific lifestyle. He expressed his views of lifestyles in three distinctive terms, being lifestyle and lifestyle conduct influenced by life chances. Life conduct refers to the choices that people have in the lifestyle they wish to adopt, but the potential for reaching these choices is influenced by their life chances (Cockerham, 2002:92-93). Max Weber (1978) asserts that, indeed, the life chances that enhance participation in a healthy lifestyle are greatest among upper and middle socio-economic groups who have the best resources to support their lifestyles choices. All these variables influence the decision a community may take towards a TB programme that is to be implemented in their location and if they do participate, there are likely positive impacts to be reaped.

2.2.5 The effectiveness of the community's participation in health education programmes

In 1986, an initiative to support good healthy lifestyle based on the Ottawa charter was declared by most countries from the globe which signaled the formal recognition of the concept of health promotion and community participation. Davey, Gray and Seale (1995:377) discerned that the Charter is about enabling people to increase control over their health and to improve it. To reach a state of complete physical, mental and social well-being of the communities, an individual or group must be able to identify and realize their aspirations, to satisfy needs and to change or cope with the environment. Health is, therefore, seen as a resource for everyday life, not the objective of living. As a result, health promotion is not just the responsibility of the health sector, but goes beyond healthy lifestyles to well-being. This implies that this concept integrates ideas of the community and personal effort in health promotion by focusing on the process of

enabling individuals, through social action to take control of their own health. Explicitly, this indicates that an individual is responsible for his or her health, though; there are barriers to taking responsibility such as poverty, religion and gender.

Gran (1983) in Swanepoel and De Beer (2006:28) argues that there are two points of emphasis through participation: there is a solid and local knowledge base used for development. Again, people who do not participate in their own development have no affinity for development. People are mobilized to participate in a programme, they are not just there to make them feel part of the intervention; they are there to contribute with their mental and physical capabilities. Oakley (1991:17), further, shows that they are there because it is their democratic right to make decisions regarding the programme which involves their future. Community participation in health care delivery is more than a basic requirement for the attainment of optimal health of the community (Dennill, King and Swanepoel, 1998:81). Consequently, their participation in matters that concern their health will result to health development. A community that participates in a TB programme would be able to reduce the burden of diseases. The solution to the problem of ill-health in most societies involves individual responsibility, in the first instance, and social responsibility through public legislation and private voluntary effort, in the second instance (Davey et al, 1995).

Okoro (1995) in Dennill et al (1998:41) is of the opinion that the achievement of an appropriate health care delivery system will solely be possible if there is involvement of all the people including those at the grassroot level. Cooney (1994) still in Dennill et al (1998:57), in turn, reminds us that one of the concepts of active involvement appears a bit skeptical, by adding that although nobody would deny the legitimacy of this concept, the extent to which such involvement occurs remains a controversial issue. With reference to Lesotho, lack of resources and the topography lead to community participation being divisive. According to Van Rensburg (1992:29), it can be argued that communities, groups, families and individuals can do something to improve their own health and that they may want to take responsibility for them. Chilisa (2006:113) postulated that community participation results to empowerment, ownership, capacity

building and accountability; therefore, this is a case where the community participates in health education programmes.

2.2.5.1 Empowerment

It is widely recognized that effective people's participation is essential for empowerment. Empowerment, in health promotion, may be social, cultural, psychological or political processes through which individuals and social groups are able to express their needs, present their concerns, devise strategies for involvement in decision making and achieve political, social and cultural action to meet those needs (Naidoo and Wills, 2005:152). In consideration to health education programmes of TB, which are participatory, it becomes clear that if the community manages to gain control over their own health matters, they would ultimately live healthy lifestyles because they have power to direct their lifestyles. Further, in empowerment, participant orientation is a basic prerequisite of health work (Hagquist and Starrin, 1997). Shepard (1997:79) in Swanepoel (1998) is of the same opinion that true participation should be tightly knit with empowerment so that, ultimately, the community would be in position to plan as well as implement their own development.

Furthermore, Chamberlin (2010); Werner (1988) share a common view that key elements of empowerment are identified to be access to information, ability to make decisions, assertiveness and self-esteem to make decisions about their health. There is a strong relationship between empowerment and health literacy (WHO, 1998:32). De Haan (2005:31) posits that people need to be empowered by supplying them with information that is appropriate to the individuals as well as the community and other specific needs. The information gained should enable them to make informed decisions that will contribute to their own good health. The process of giving people the knowledge they need and providing them with a healthy environment to live in, is a way of not only preventing disease, but also attaining and maintaining health.

In a case of TB programmes, people's participation would give them power to make choices of adopting healthy lifestyles that would, in turn, reduce TB prevalence. It is necessary to recognize that empowerment does not occur to the individual alone, but

with other people. Kent (1988) in Swanepoel (2002) defines empowerment as the acquisition of power and the ability to give its effect, such power manifests in groups of people working together. Community participation in health education programmes, such as those meant to educate people about TB, empowers included groups in order to increase their access to and control over health development resources that determine their lives, since they work together and it is a personal process combined (WHO, 1998:5). In fact, power cannot be taught or be given instead it can be taken (Chilisa, 2006). As a person brings about change, he or she increases feelings of mastery and control. This, in turn, leads to further and more effective change in rural communities. Moreover, in this concept of an empowered community, individuals and organizations apply their skills and resources in collective efforts to address health priorities and meet their respective needs.

According to Hagquist and Starrin (1997:23), it can be seen as a relational concept in its meaning of giving power and authority to a person. It is a social action process that promotes participation of people, organizations and communities in gaining control over their lives in their community and larger society. According to this perspective, empowerment is not characterized as achieving power to dominate others, but power to act with others to affect change (Joint Committee on Terminology, 2001:26). According to WHO (1998:89), the concept of community empowerment is closely related to the Ottawa Charter definition of community action for health, for it emphasizes the importance of concrete and effective community action in setting priorities for health, making decisions, planning strategies and implementing them to achieve better health. Individuals and organizations within an empowered community provide social support for health through participation; they address conflicts within the community and gain increased influence and control over the determinants of health in their community. Therefore, in order for PHC to be effective, it must encourage people to take positive action for their own well-being. For example, in Nicaragua, the process of conscientisation and community action initiated through non-governmental health programs played a key role in the mobilization of the people in taking control (Chamberlin, 2010).

However, Chamberlin (2010) states that empowerment is a term that has become very popular in health services. Nearly every kind of health program claims to 'empower' its clients, yet in practice there had been few operational definitions of the term that give a clear meaning due to different interpretations that differ from one programme to another. Though, it is that rhetoric, with a flexibility of meaning so broad that it seems to be in danger of losing any inherent meaning, some authors still concur on some of its characteristics. Werner (1988) asserts that in reality empowerment is very vital for achieving health for all. Health depends more on empowerment of and by the people in communities. It is argued that for the concept of empowerment to make a real good impact, it should be viewed as a political process - with a socio-political goal; the equalizing of power and basic rights. Evidence shows that poor health is a result of unfair distribution of resources such as power, knowledge and skills. In Lesotho if there is no empowerment for health, it means TB would kill more than 50% of the victims, as Maama (2010:12) indicates.

2.2.5.2 Capacity building

Participatory communities in health development have the opportunity to be capacitated. Community capacity building is working with the people in the community to recognize and effectively use resources or social capital that they have. This type of work has been called community development, organizational development and citizen engagement (Thompson and Kinne, 1990). In community capacity building, the emphasis is on the process used to bring together community members from across geographical areas or different interest groups to solve common problems and during this process the community is the leader. Community changes and attains capacity building which starts where people are working together (Nyswander, 1966) in Diem and Moyer (2005:265). This increases if there is spirit of teamwork which sustains relationship, solves problems and make group discussions. This also influences a group to collaborate effectively to identify goals and work hard (Mattessich and Monsey, 1997:61) in Diem and Moyer (2005:267). It includes the identification, strengthening and linking of resources, such as local service groups and motivated groups, and the extension of those resources to others in the community for the benefit of health

development. However, it is very lengthy and time consuming since many parties are included in the community (Bratton, 1997:81). To take this point further, McDeth (1999:120) asserts that capacity building is a buzzword if the community is not organized in any development work. This is a fact, in a case where a community is supposed to participate in health education programme and it is not organized particularly in their chores.

Community capacity building is based on the premise that “change” is more likely to be successful and permanent when the people it affects are involved in initiating and promoting it (Thompson and Kinne, 1999:30). The desired outcomes of capacity building are that people and groups have gained experience and confidence in working together to improve their communities’ health. These skills, knowledge and abilities mean that more people in the community are capable of bringing about beneficial change by raising issues, bringing people together; training others and making connections outside the community that are beneficial to the community. Community members receive training in community capacity building skills and can train others (Cockerham, 2001).

Capacity building manages to build social capital through experimentation and learning for community members will have formed bonds with the important structures that will help them improve health even without the assistance of a formal programme (Brisbane, 2000:35). They will have gained skills for addressing their own health problems. However, not every programme leaves people with skills given that some facilitators may ignore the fact that illiterate people need quality time to learn and understand the process of health development. Evidence is drawn from a study conducted by Koning and Martin (1996:17) about a Warmi project implemented in the rural Province of Inquisive, Bolivia to educate the community on maternal and neonatal matters to decrease mortality. The study shows that if people are not equipped with skills on how to participate in health, there will be no change. Communities which are participatory can even consider using their assets to stimulate health development. These assets include social, physical, financial and political capital. Additionally,

Swanepoel (1998: 40) coincides that these community assets are public goods; they are in most cases belonging to the whole community.

Additionally, among the capital types indicated above, bonding social capital is of great importance. This refers to the degree of social cohesion which exists in communities. It refers to the processes between people which establish networks, norms, and social trust, and facilitate co-ordination and co- operation for mutual benefit (WHO, 1998:19). Social capital is popularly taken to be the ability of communities to successfully come together and participate to identify problems, needs, determine and achieve goals to improve community health by adopting healthy lifestyles influenced by the TB programme per se. Social capital is created from the myriad of everyday interactions between people. In the same manner, a community participating in the TB health education programme would network and form bonds. The stronger these networks and bonds, the more likely it is that members of a community will co-operate for mutual benefit. In this way social capital creates good health, and may enhance the benefits of investments for health (WHO, 1998:19).

Accumulating social capital is a prerequisite for optimal use of opportunities offered by TB programmes (Portes, 1998:3). Bonding social capital can be important in one phase to reinforce exclusive identities and maintain homogeneity, while bridging social capital may totally control another phase, to bring people together across social divides (Putman, 2000:22-24). However, Malinko and Starfield (2001) in Matebesi et al (2005) detected that the concept has been stretched, modified and extrapolated to cover many types of relationships at many levels; consequently, the term loses its heuristic value. This shows that community participation in programmes may not influence the formation of bonds that are necessary to persuade co-operation that is essential for development.

2.2.5.3 Ownership

Moreover, if the community is committed to participatory health education programmes, a sense of ownership will arise which is a fundamental element to attaining health behaviour or self-help. Ownership means that people are responsible for and continue to maintain the change after the initial organizing efforts are over (Diem and Moyer,

2005:100). A strong relationship exists between the two principles. As participation increases, feelings of ownership increase. Issues have to be relevant for them to participate so that they can be fully committed (Naidoo and Wills, 2005:35). Ensuring that issues remain relevant will increase active participation and feeling of ownership in health education programmes. In a study conducted by Elfituri, Elmahaishi and MacDonald (1999), it was observed that those programmes that give people the opportunity to think about health and to undertake voluntary changes in their health-related behaviour become successful and a sense of ownership is much stronger because they are given the opportunity to direct tasks in a way suitable to them. People are influenced to make decision about their health and acquire the necessary skills to change their behaviour. In instances where programmes are designed to encourage self-esteem and to empower people to take action about their health, people would value and protect them. People value and protect programmes if they are designed to encourage self-esteem skills which will change their health lifestyles.

2.2.5.4 Accountability

A community that has established a sense of ownership is liable to be accountable. Anderson (2010) delineates accountability as the acknowledgement and assumption of responsibility for action within the scope of a role or position encompassing the obligation to report and be answerable for resulting consequences. Hunt (1998) signifies that it is the responsibility of either an individual or group to perform a specific function. In TB health education programmes, a community that participates and feels empowered and capacitated will be accountable; thus community members will also adopt healthy lifestyles that are meant to alleviate the high prevalence of TB.

2.2.5.5 Health orientated behaviour

The opportunity to participate in health education programmes would also result in healthy lifestyles, hence signaling accountability. According to Cockerham (2001:64), medical sociologists divide health orientated behaviour into two categories being health behaviour and illness behaviour. Community participation would grant people the chance to adopt these healthy behaviours. Illness behaviour as Cockerham (1998:34)

indicates, is the activity undertaken by a person who feels ill for the purpose of defining that illness and seeking relief from it which may be termed secondary prevention. Health behaviour, in contrast, is defined as the activity undertaken by a person who feels ill for the purpose of maintaining or enhancing their health, preventing health problems or achieving a positive body image. This definition of health behaviour does not limit participation to health, but also to people trying to stay healthy. Rather, it includes people in good health, as well as the physically handicapped and persons with chronic illness such as cancer and diabetes, who seek to control or contain their affliction through diet, exercise and other forms of health behaviour. For most people, their health behaviour is meant to prolong their lives and maintain their health and in the desire to attain these, their contraction of TB would be minimized. Health behaviour is made by healthy lifestyles which are patterns of health related behaviour based on choices from the options available that can result in good health to people according to life chances they have if they consider these options (WHO, 1998).

Even though, access to health services is difficult for many Basotho, especially in rural areas, because of the country's terrain, poor road system and high transportation system such as expensive bus fares. Therefore, their participation, in a case where they are provided, is essential for building healthy communities (International Center for AIDS Care and Treatment Programs, 2010). Health care providers must go beyond interdisciplinary approaches and become partners with community members (McBeth and Scheweer, 2000:12). This forms a strong bond that would result in empowerment, accountability, a sense of ownership and capacity building in communities to attain health behaviour. Following is the discussion of health education programmes in schools as the major institution where children can be socialized in healthy lifestyles.

2.2.6 Health education in schools

Health problems impede with students' ability to come to schools, stay in schools or make the most of their opportunity to learn. Although, schools, even those with limited resources, do a great deal to improve student's health by teaching them subjects that include healthy education, such as biology, food and nutrition and agriculture. Thus, healthy lifestyles can be adopted by learners (Sydney, 2005:233). State University

(2010) asserts, the schools that are committed to distributing the health information are more likely to experience a healthy environment. Nonetheless, without the participation of students in educational programmes the targeted group may fail to attain a healthy environment. According to Basavanthappa (2008:825), health education in schools should ensure that the student during his/her years of school attendance will acquire knowledge of scientific health facts, develop positive attitudes towards health, strengthening good health habits. He/ she learns to maintain healthy lifestyles at home and practices new health behaviour to improve his own and his community's health. Mohlomi (2000) indicates that health education programmes in Lesotho high schools become effective in socializing children to adopt healthy behaviour and, hence they should be maintained. According to Elfituri et al (1999), it clearly makes more sense to encourage young people to adopt healthy lifestyles than to change unhealthy behaviour patterns in adulthood because they would have developed negative attitudes that are not easily changed. Therefore, there is general agreement that schools are a key setting for the promotion of health through health education programmes in a sense that if students are taught about TB in schools, they will be equipped with skills on how to prevent it.

Health education in schools is more productive because pupils will know and understand healthy lifestyles and value it as they grow with the aim of influencing health behavior. It recognizes that risk behavior in a range of health and social issues often share the same root causes, the factors and conditions that affect students such as the environment they live in and their socialization. It allows students to develop and demonstrate increasingly sophisticated health related knowledge, attitudes, skills and practices to motivate and assist them to maintain and improve their health, prevent disease and reduce health-related risk behaviours in a variety of health areas, hence their participation is needed in health education to lucratively accomplish this (WHO, 1998:135; Sydney, 2005:233).

Again, school health programmes are said to be one of the most effective strategies that a nation might use to prevent major health and social problems (Mohlomi, 2000). Next to the family, schools are the major institutions for providing the instruction and

experiences that prepare young people for their roles as healthy, productive adults. Schools can-and invariably-play a powerful role in influencing students' health related behaviours. Appropriate school interventions can foster effective education, prevent destructive behaviours and promote enduring health practices (Basavanthappa 2008:826). For many young people in their formative years, schools may, in fact, be the only nurturing and supportive place where they learn health information and have positive behaviour consistently reinforced. In addition, health and success in schools are inextricably intertwined. Good health facilitates children's growth, development and optimal learning, while education contributes to children's knowledge about being healthy. Schools cannot achieve their primary mission of education if students and staff are not healthy and fit physically, mentally and socially (State University, 2010),

Moreover, AAHE (1990) and Green et al (1985) in Cottrell et al (2002:188) indicate that these programs have demonstrated effectiveness when they are well planned, sequential, provided significant time in curriculum and taught by trained health educators. Conversely, it is difficult to teach students the value of health if the school environment is not conducive, due to untidy and unhealthy lifestyles which are predominant, and if there are no resources which permit to practice health skills (WHO, 1988:136). Though, it is difficult dealing with conservative school boards being those that are still holding on to traditional belief, which are pessimistic, parents and community groups when teaching controversial issues such as sex education and drug education. Evidence can be drawn from an exploratory study conducted by Oshi, Nakalema

and Oshi (2004) that revealed that in Nigeria strong religious norms restrict open discussion about sex in schools. School health education programmes are, also, compromised by under qualified teachers expected to educate school children about health behavior (AAHE, 1990), in turn, students end up with no appropriate information to reduce susceptibility and fail to participate in these programmes. Reliable data on the implementation of school programmes is lacking, there are indications that few schools operate to systematically address the habits major health risks (Basavanthappa, 2008).

The case studies below clearly illustrate a community orientated health education programme that is participatory to illustrate the feasibility of this phenomenon.

2.2.7 Health education programmes in Lesotho.

Partners in Health (PIH) *"Bo-mphatho lits'ebeletso tsa bophelo"* implemented a project that was meant to address the issue of HIV and TB. It had come to their realization that Basotho people are being ravaged by a second epidemic being TB which also takes advantage in HIV infected people. Lesotho's TB rate is fourth highest in the world and spreads rapidly, and is particularly deadly where many people's immune systems have been weakened (WHO, 2008). The PIH project in Lesotho was launched in 2006 and it initiated many small projects including educating people about TB and launched a treatment program called multi-resistant tuberculosis (MDR-TB). This project was implemented in many small areas including Ha-Nkau which have achieved to control TB prevalence rate that was increasing by involving the community.

There were mythical issues about TB particularly among illiterate people, but the information was well disseminated and influential. Makoae (1999) and Matobo (1999) comply that most Basotho interpret TB wrongly as "Sejeso" or "Nyoko" (Poison and Bile related disorder); hence fail to adopt healthy lifestyles that reduce susceptibility to contraction of TB. Groups such as teachers, chiefs and priests were also trained on how to engage in this educational process by equipping them with appropriate strategies of delivering the messages about TB process because they have the credibility. Clearly, these are people who are honoured and who are mostly listened to, so what they articulate is often valued. The community members seemed to have their own roles they played which they would not allow the programme to compromise, but the programme was flexible enough to structure the learning process in a way that accommodated their participation. They got skills to control the disease through their participation and they got empowered. They also managed to be partners in health development. Much as the project has done this, traditional belief systems such as belief in the existence of witchcraft and discrimination acted as barriers for some people to participate. These mythical issues which are unreal explanations have power to control most Basotho and mostly impede on community participation. However, this

initiative did not specifically show how the community carried out its roles and how the programme worked and this does not permit full evaluation. However, this is not only the example to give light of the situation but there are some which can be drawn from the globe such as the one discussed below.

2.2.8 A community-based health education programme of Malaria in rural India

Kalajatha is a popular, traditional art form of folk theatre depicting various life experiences of a local socio-cultural setting. In an effective medium of mass communication in the India rural areas, using this medium, an operational feasibility health education programme was carried out for malaria control. In December 2001, the Kalajatha events were performed in the evening hours for two weeks in malaria affected district Karnataka which was contributing 7-10% of malaria cases in South India. 30 local artists and bodies including government and non-governmental organizations actively participated. The Impact of this programme was assessed after two months, on exposed vs non-exposed respondents in which it was uncovered that this model was effective because it could be understood by every community member and the community was fully participating. The Kalajatha served as a tool for information dissemination (Ghosh, Patil, Timari and Dash, 2006).

The result was that the exposed respondents had significant increase in knowledge and change in attitude about malaria and its control strategies, especially on bio-environmental measures. They could easily associate clean water with anopheline breeding and the role of larvivorous fish in malaria control. In 2002, the local community actively co-operated and participated in releasing larvivorous fish, which subsequently resulted in a noteworthy reduction of malaria cases. Immediate behavioral changes, especially maintenance of general sanitation and hygiene did not improve as much as expected due to the fact that some people were still hesitating to live healthy lifestyles, but some changes were perceived. Kalajatha conveyed the important messages on malaria control and prevention to the rural community, hence influenced healthy lifestyles. The detection that people are still reluctant to control malaria led to the operational feasibility and communication efficacy of Kalajatha in health education programmes for bio-medical control of malaria and intersectoral co-ordination and

involvement of all potential partners in health education. The National Institute of Malaria (NIMR) and Community Health Cell (CCHC) jointly initiated this programme.

Partners were identified and planning was effectively done which the community participated in as well as the health officials and these partners were selected from different occupational backgrounds (Gosh et al, 2006). This project symbolizes clearly a picture of community participation in health education programme that was effective for it recognized the need for community participation and intersectoral co-ordination involving various like-minded partners for effective programme implementation. The community acted as stakeholders, essential information was made available about disease and their control methodologies. Ghosh et al (2006) indicated that there is no standard formal strategy for delivering health education messages. Many conventional methods such as posters, pamphlets, hoardings and electronic media, have limited effects on the rural community due to their low literacy rate. The thought of using Kalajatha was non-discriminatory because it could be understood by everyone.

The intersectoral co-operation between various heterogeneous groups is necessary for the accomplishment of health goals and this is exactly what can be done to control the incidence of TB. The Thabana-Morena or Lesotho can use their folk theatre that is more familiar and understandable to the Basotho, especially in rural communities as to disseminate the information about TB. Strategies can be formulated that can be used to engage people in the folk theatre, since the communities are key stakeholders in the health development particularly the case of TB. This shows clearly that if the community is informed, using common ways of educating and learning, healthy lifestyles can be adopted that would alleviate increasing TB cases. People can be capacitated and be empowered to direct their own health to a good one. In fact, theatre is sometimes used to inform people about HIV/AIDS so this could be adopted even for other diseases. Even though, these examples potray the feasibility of community participation in health education, there are challenges facing their implementation and community participation.

2.2.9 Challenges that face the community in participating.

An essential understanding is that effective community participation in health entails a side-by-side involvement of community members and health professionals sharing both power and responsibility (WHO, 2002). However, this has not been the case for obvious reasons such as structural, social and administrative. Oakley (1991) asserts that the practice of participation does not occur in a vacuum; on the contrary, it is susceptible, in both a negative and a positive way, to a whole range of influences. Structural, social and administrative obstacles are kinds of factors that can affect it negatively which can frustrate attempts at participatory health development.

Makoa, Mpemi, Tsekoa, Ralejoane and Biesma, Brugha and Odonkor (2009) designate that natural barriers such as topography and climate pose major challenges. Additionaly, man-made barriers such as attitude of personnel, financial constraints, inadequate and poor management of human and financial resources among others, create complex challenges that may require multisectoral approaches for solutions for health problems. These problems remain to undermine initiatives taken to engage the community in a participatory health education programme of TB in Lesotho.

Lesotho still face many challenges in healthcare delivery, especially around the location and services despite many initiatives undertaken by the government including major reforms that were supported financially and technically by the International Development Partners (IDPs). Some of these reforms include policy issues, structural or functional changes, financial and administrative (MoHSW, 2008). Lesotho review (2000) alerts us that it is much less difficult to provide facilities and access to healthcare services in the lowlands than it is in the mountain areas in the rural parts. The country's terrain has, therefore, become a barrier to access health services with concomitant underutilization of health services. Climatic conditions in summer, leads to the country experiencing heavy rains while in winter snow heavily falls resulting in roads being slippery, hence, communities especially rural ones cannot be reached resulting in health education programmes being unimplemented (UNICEF, GOI, EmOC, 2005). Evidence can be drawn from persistent showers that have caused flooding in most parts of Lesotho, since the last week of December 2010 up to early May 2011. These heavy

rains destroyed crops, various infrastructures such as roads and bridges, mud houses have collapsed and some people have drowned (Matope, 2011).

Furthermore, there is a poor road network and where roads exist; they are sometimes impassable because of lack of bridges (MoHSW, 2005). Most health facilities in Lesotho are inadequately equipped for several reasons such as lack of skilled personnel who even use the equipment and funds for their own benefit. Again, Lesotho's health centers are understaffed and they lack skills on how to involve the community to participate in health education programmes (Mohlomi, 1999:45). Netnews (2009) posits that the health system of Lesotho finds itself under pressure to use unskilled personnel because those who have the capacity migrate to be employed in other countries, since they are paid better salaries and work in good conditions as compared to Lesotho. The Medecins Sans Frontiers (2009) Selibeng sa Ts'epo report shows that in 2008, only two of the 171 health centers in Lesotho had the minimum staffing requirement. The shortage has been exacerbated by attrition in the workforce as a result of lack of motivation, caused by among others, inadequate renumeration, lack of social recognition and lack of opportunities for professional development. These problems have always been the stumbling blocks to involve the community to participate in health education programmes, particularly, relating to shortage of health professionals; thus there is still high TB prevalence chiefly in rural areas.

Naidoo and Wills (2005:110); Kahssay and Oakley (1999:8) comply that community involvement in health is a basic human right of all people and it increases the possibility that health education programmes will be appropriate and successful in meeting the health needs defined by local people. Even though, past experiences have taught the value of community participation, it is also highlighted that there are difficulties faced in mobilizing people. Apathy and disempowerment are identified. It is implied that people who are not used to making decisions, who feel powerless, who are dependent on others refrain from participating in health education programmes. Those who are in authority may be willing to allow people to participate in decision-making but political, religious and commercial interests may discourage participation because they may take a long time and this may hamper with other activities of community life (Michael,

Margetts, Kearney and Arab, 2004). For example, if a person attends a political meeting, a business one or church service the whole of Saturday, it means people of such group would not participate because they have other interests.

Moreover, conflicts between individual and group interests due to the fact that people originate from a wide range of social and economic backgrounds may impact poorly on the effectiveness of programmes, since opposing group may not engage themselves (Bells, 1994). This implies that the differing backgrounds of people resulting in different ways of thinking may lead to the programme being unsuccessful. In addition, poverty entailing lack of resources, ill-health and others discourages people to participate or adopt healthy lifestyles due to the fact that they may fail to attain their health needs struggling for survival. Makoa et al (2009:131) confirmed that poverty in Lesotho is a major barrier to access healthcare services because of high rate of unemployment which is estimated to be 40% of Basotho (Bureau of Statistics, 2006). Many people work seven days a week just to feed their families and may not have time to participate yet their opinions are important. Most of them are engaged in agricultural activities and more time is spent during hoeing and harvesting seasons. Some people may be unwilling to participate due to the belief that they are being misused because of the precedent experiences from development programmes that did not benefit them or feedback and this is usually termed “cynicism” (Stanhope and Lancaster, 2004:308).

Additionally, Stanhope and Lancaster (2004:307-309) observed that there are barriers to community participation either posed by the community or by the health educators. Barriers fall into two broad categories-one having to do with the educator and the other having to do with the learner in health education programmes. Educator related barriers to effective learning, that may even hinder participation, may be direct or indirect. Knowles et al (1998) in Stanhope and Lancaster (2004) asserts that educators may need to deal with difficult people who need to learn health-related information and who cannot be easily organized due to lack of understanding or conflicts. Educators may be concerned about timing a presentation so that it is not too long and not too short in a case where learning is provided by the programme which leads to failure to focus on the understanding of people of health information (Naidoo and Wills, 2005). Educators may

have limited number of professional experiences related to a health topic and they may think that they are not credible with respect to certain topics; hence, the community will not be properly educated about health. They may be overly dependent on notes, consequently, making the process of learning difficult because he or she is not focusing on the understanding of the community. Educators may be concerned about whether media, materials and facilities will function properly other than focusing distinctively on the understanding of the community on what they are being educated and whether the material being used are familiar to make sense.

Learner-related barriers are also direct and indirect, and impact adversely on understanding of health information. Educators normally deal with individuals and populations exhibiting illiteracy or low literacy levels. People who are functionally illiterate are often embarrassed to admit this to healthcare providers and educators (Curtis, 2004). It may be because they have experienced marginalization due to this incapability. They may not ask questions to clarify information and may have problems understanding heath education materials. According to Maama (2010: 12), the National TB programme Manager of Lesotho, people with little education are the least-likely to have heard of TB. The use of materials such as video presentations or slides may be discriminatory of illiterate people. It is important to understand the knowledge and beliefs of learners with low literacy rates and tailor education programmes to the needs of these individuals. Additional information should not be provided until the educator is sure that knowledge and skills are understood and are being incorporated into learners' lives (Davis et al, 2002) in Stanhope and Lancaster (2004). It is estimated that the cost of health care individuals with low literacy who do not receive health education that enables them to make behavioural changes is almost twice the cost of those who do, consequently TB prevalence will continue to increase.

Lack of motivation as the other aspect is identified as a challenge too (Basavanthappa, 2008). Educators find that learners often lack motivation to make behavioural changes because they lack information; therefore, they need to understand the importance of motivation of the individual whom they seek to educate. Motivation is influenced by three factors which include the value of components being "how do I feel about". Learnt

helplessness as the other factor, occurs if individuals experience that over time they cannot control the outcome of events affecting their lives such as poverty or climate; thus there will be no motivation. The lack of relationship between effort and outcome contributes demotivation of clients to make behavioural changes. Motivation to change behaviour occurs when appropriate behavior is initiated and sustained (WHO, 1998). Learner's beliefs about themselves in relation to capacity to act and outcome influence self-efficacy which implies individual's evaluation of their performance capabilities related to a particular type of task. Motivation can be erected by building confidence by creating positive experiences and generate satisfaction by arguing them to use opportunities and newly acquired skills and provide positive feedback (Stanhope and Lancaster, 2004). Therefore, motivated communities will have the confidence to participate in the TB health education programme and, in turn, health behaviour can be expected.

Besides, Naidoo and Wills (1999:52) affirm that there may be feelings of dissatisfaction, suspension or powerlessness or lack of structures to enable people to become involved. Consequently, communities cannot become active if people are not willing or able to give time or energy, where there are high levels of distrust or where there are no networks that link people together. Naidoo and Wills (1999:110); Stanhope and Lancaster (2004) announce that, although, there is progress in involving people in health education; professionals have negative attitudes towards letting communities to lead in addressing their health needs. It becomes difficult for communities to participate because professionals have always been using a top-down approach.

Connor (1997) maintains that one of the problems relates to coordination and integration of diverse interests into the programme plan and implementation. Community participation involves groups, bringing together their different needs in the design and implementation of the programme. This can prove to be very challenging, since not every idea can be taken. Diverse interests may give rise to collective actions' problems as well as conflict among participants, as others may feel that they are not integrated, which leads to the final outcomes being significantly different from what they perceive in the outset of planning process. Bells (1994) adds that participation or

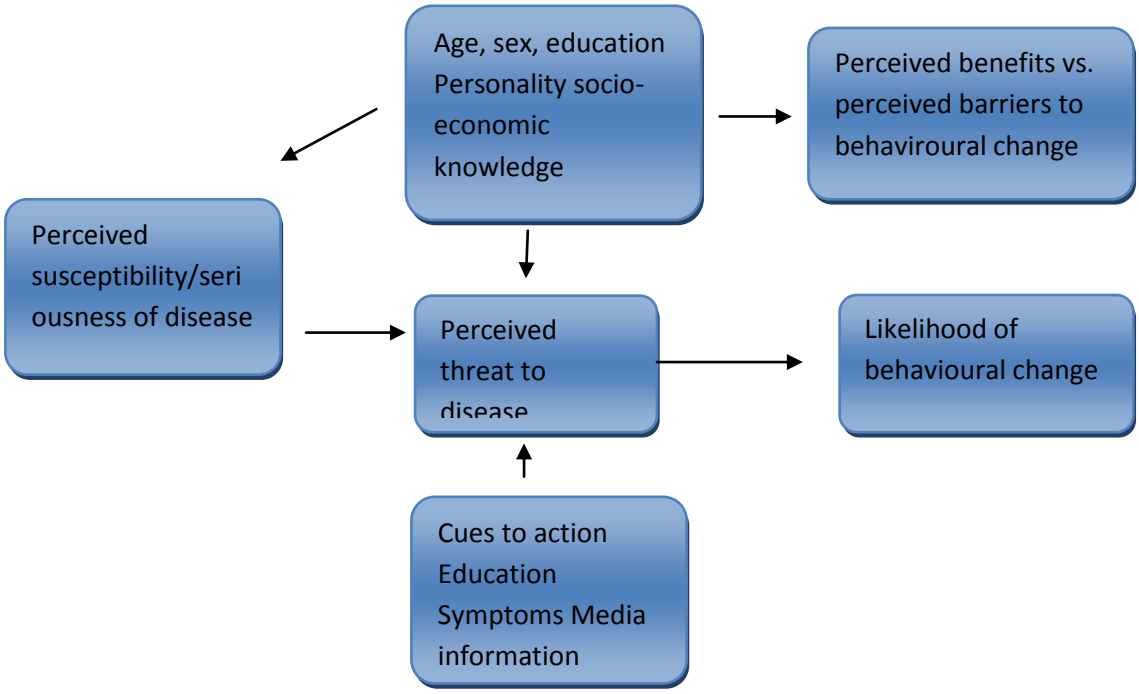
integration of sundry interests may lead to slow decision making in a TB programme per se which, in turn, leads to a long time programme being expensive for that matter.

2.3 Theoretical Framework

2.3.1 Health Belief Model (HBM)

This study is informed by a Health belief model. It is a psychological theory developed by Becker in 1974 and Rosenstock in 1966. This theory focuses on understanding how individuals can modify their behavior towards health risks. It is normally used to explain why people would or would not use health services (Naidoo and Wills, 2005:19). As Donatella (2004:27) indicates, it is hypothesized that behavior depends upon the likelihood of an individual taking action and is based on the interaction between their perceived susceptibility to the problem, the seriousness of the consequences of the problem, the perceived benefits of a specific action and the perceived barriers to taking action. There are variables such as demographic factors, socio-psychological variables and those that are structural which influence the individual's perception and thus indirectly influence health related behavior (Cockerham, 2001). There are also cues to action that act as another influential factor. Below is the figure illustrating the integrated HBM conceptions.

Figure 1: Health Belief Model



Drawing from the case of TB, the probability that a person will engage in a health education programme that educates people about the prevention of this disease will depend on how much an individual feels he or she might contract the disease and how many people are ill or dying because of TB if they do not prevent from being infected by the disease. It is also based on the fact that people see the prevention of TB not negatively impacting on their lives and that the outcome is enjoyable. Chances are even higher to prevent for those who have contact with people who have been diagnosed with TB and this is considered as a cue to action. If people feel that they are at risk of a problem and they can do something about it, this is referred to as self-efficacy. They will do so, provided the benefits outweigh the costs and the social circumstances are supportive.

Once more, it has been shown that advice to change behavior is more effective in those who have certain diseases or if a member of their family has been diagnosed with some other illnesses and if there had been medial comparison that highlights the benefits of change and that makes it feasible. Basically, this theory is vital for explaining the reasons accruing to easy participation in health education and others fail to take, hence some people would decide to take responsibility of their health by participating and why some would not take it. It becomes even more essential in identifying the modifying factors that influence the decision to participate or adopt healthy lifestyles. The health education programmes will be aware of these modifying factors which are variables which have a direct impact on the success of the implementation by reviewing them before planning.

In community health, particularly, rural communities of Thabana-Morena, the health belief model is practical in looking at health-protecting or disease-preventing behaviours. It is believed that the beliefs and attitudes of this community influence the decision to or not to participate in health education so as to attain good health. Their beliefs, attitudes, and information all contribute to motivation and behaviours and are

underlying components in making any decision to change behaviours. The health belief model is helpful for organizing the information for the community about the view of their state of health and what factors would influence them to change their health behavior. Sociologically, this model is best used to explain the interaction of people with the interventions they are exposed to, that affect their organization and social processes. The intervention would obviously affect social organization in a community of Thabana-Morena; hence it is necessary to consider their views in planning the programme. The programmes planned in consideration to the social processes are more likely to succeed. The understanding of the relationship between social structure and individual action helps us to consider how health can be promoted.

Harrison, Mullen and Green (1996) contend that there is a main criticism of this theory. The major weakness of the health belief model is that important determinants being the variables of health behavior, such as positive effects and negative effects, are not identified. Clearly, it only lists the modifying factors such as socio-economic, structural and demographic variables without clearly showing those that would positively or negatively affect the decision to participate in health education programme. Regardless of this notable criticism, the theory has been vital especially in studies related to community and health education programmes such as the study of prevalence of low-back pain in Lesotho mothers conducted in April 1999, which tried to find out the influential factors that are strongly associated with rural mothers. It was applied in the study conducted by Mturi (2003), which explored parents' attitudes to adolescent sexual behavior in Lesotho, which managed to show that individuals do not just irrationally decide not to adopt healthy lifestyles; instead they have their beliefs that guide them and influence their decisions.

Health belief model is of use in this study because it clearly explains health promoting behaviors that are triggered by an interest in preventing disease. These behaviors are influenced by various factors of which determine whether a person will decide to participate in an intervention or not. Its usage helps identify vital factors that influence behavioral change influenced by health education programmes that the communities are involved in for the attainment of self-care or health development.

2.4 Gaps in Literature

Most health education programmes on TB are impersonal such as posters and others, yet this strategy is discriminatory because some people are illiterate so they cannot easily understand the materials. Let alone the fact that they have been partially involved in the development of their health. There is no particular case study on the TB programme in Lesotho that shows specifically how the programme process went like or specific literature. Many studies have been conducted that were related to health education and community participation. Literatures found normally fail to highlight or assess the procedure that has to be followed in implementing the health education programmes that are participatory and in a case where it is found, it is noted that the literature is not recent since it covers the period of 1980s. The recent work only highlights the impersonal health education including media, posters and leaflets. Again, the work reviewed fails to highlight the role of the communities that they should adopt in engaging programmes using the bottom-up approach so that people can be informed and live healthy lifestyles. Therefore, the study aims at filling the gaps in the literature by assessing community participation in the health education programmes in the Thabana-Morena community.

2.5 Conclusion

This chapter presented the situation of TB in Lesotho, the roles and levels at which the community participate in health education programmes, the socio-demographic variables that influence participation, factors that reflect the effectiveness of community participation in health education programmes, health education in schools, the case studies that reflect the feasibility of participatory health education programmes and the challenges facing community participation in programme. The researcher concludes that the literature relating to the real situation on the ground as far as participatory health education programmes are concerned is not enough. Therefore, this study intends to fill the gaps in literature by highlighting clearly the roles, the benefits and challenges facing the community in health education programmes.

2.6 Summary

This section reviewed literature related to TB prevention and community participation that is expected in the process of prevention in societies. The factors that influence participation by communities in the health education programmes that are bottom-up were discussed and levels of prevention that go along with the health status of individuals were discussed in relation to TB situation in Lesotho. It is, further, indicated that communities have roles to play in varies phases of these health education programmes, whether it is implemented for adults or children. The advantages, such as empowerment, accountability, capacity building and others and the challenges facing these programmes, such as topography, lack of motivation, conflicts and others are discussed in detail. Case studies that support the practice of health education are shown, which were implemented in different countries. The psychological theory that informed the study is also discussed and its relevance is illustrated.

CHAPTER THREE

METHODOLOGY

3.1 Introduction

This chapter describes clearly the approach of the study that was considered, it entails the description of the study, the size of the sample of the study and the procedure used to select it, the method of data collection, the method used to analyze the findings and the ethics that were valued.

3.2 Research design

This study was qualitative in nature, Qualitative research offers thick descriptions and allows entry to subjective social constructions of people; it presents the information gathered verbally in a detailed and complete form (Sarantakos, 2005:45). As Gomm (2004:26) states, qualitative research is primarily interested in investigating how people experience the world and or how they make sense out of it and it very much values generalisability. Barbie and Mouton (2001) indicate that this type of research has the main aim of describing and understanding actions in great detail and these actions are described in terms of the actors' own beliefs, history and context. However, Sarantakos (2005:46) argues that the lack of strict research procedures and the high level of subjectivity and relativism give the impression that 'anything goes with such research. It is also relatively very expensive, but still this technique was of value to this study because it enabled detailed descriptions of people's experiences.

3.3 The research setting

Thabana-Morena is a rural community situated in the northern part of the Mafeteng district, one of the ten districts of Lesotho. Lesotho is a kingdom in the Southern part of Africa, completely surrounded by the Republic of South Africa. Thabana-Morena is a community of 630 hectors and 40 kilometers from Mafeteng with a population of 22 679 (Statistical Yearbook, 2008:12). Its geographical coordinates are 29^{o} 56' O' South and 27^{o} 24' O' East. It is broad and surrounded by rugged mountains which provide magnificent scenery. It is a place characterized by dwellings and schools such as Lekoatsa Primary, Sebaki Primary school, Thabana-Morena High school, Roulin High School and others, of which some of them are operated by certain churches (Travelingluck, nd).

This community heavily relies on agriculture as a survival strategy, though; there are those who rely on small businesses. It is a community of worshipers who belong to churches such as Roman Catholic, LEC, Zion and many more. It has various health centers such as clinics, support groups; primary health care centers and traditional healers who also play a role in community health. The population for the study was the entire people in Thabana-Morena communities with respect to known characteristics of the phenomenon. The rationale for selecting this rural community is to explore its health development since most treated TB patients are from this area as indicated by MOHSW (2009) and for the fact that this area has a huge population, which is probably using most of the health resources, yet Mafeteng has got 33.6% health facility (Statistical Yearbook, 2008:12). The study was conducted in Mount Olivet with a de jure of 507, Ha-Konote (377), Ha Bofihla (409), Ha-Mathama (143) and Ha-Turupu (235) (Village list census, 2006) since they had the characteristics of what the study intends to explore in respect of health programmes and a population that varies economically, socially and politically.

3.4 Population

Neuman (2000) describes a research population as the specific pool of cases, individuals or groups of individuals which the researcher wishes to investigate. The

Statistical Year Book (2008:12) indicates that in 2006 the population of Thabana-Morena was estimated to be 11, 360 males and 11, 319 females, which makes a population of 22, 679. The population for this study included all present community members in Thabana-Morena which consisted of village health workers, chiefs, students, teachers, nurses, ordinary community members, counsellors and personnel from the government hospital in Mafeteng. The sample was drawn from the population with respect to the characteristics deemed important to this study and not every individual stood a chance to be selected

3.5 Sampling and selection procedures

Non-probability sampling was used in this study since it was possible to select the most appropriate respondents to give valid information. It is the procedure employed when the number of elements in population is either unknown or cannot be individually identified, as Kumar (2005) postulates. Sarantakos (2005:163) asserts that this sampling technique does not employ the rules of probability theory and does not ensure representativeness. Punch (2005:71); Sarantakos (2005:153) declare that samples are there to offer more detailed information and a high degree of accuracy because they deal with relatively small numbers of units. The types of non-probability sampling techniques that were used are quota sampling because it is least expensive and purposive sampling to select 40 respondents and 1 focus group of 10 individuals.

Quota sampling allowed the researcher to choose the respondents in the context of given quotas. Gomm (2004) and Sarantakos (2005:164) concur that quota sampling is a procedure in which the researcher sets a ‘quota’ of respondents to be chosen from specific population groups, defining the basis of choice and determining its size. More specifically, the researcher considers all the significant dimensions of the population and ensures that each will be represented in the sample. This method of sampling was more inexpensive than other techniques because it did not require sampling frames, it was relatively effective and could be completed in a short time. However, Gomm (2004) affirms that it is biased and, hence compromises valid information. Additionally, purposive sampling also known as judgmental sampling was adopted, in order, to select the sample for quotas of homogenous groups that are chosen for this study. It refers to

a technique whereby the researcher purposely chooses subjects who, in his/her opinion, are thought to be relevant to the research topic (Sarantakos, 1998). It was advantageous because the researcher went to those people who in his/her opinion were likely to have the required information and be willing to share it, even though, it is also said to be biased.

The sample consisted of 50 individuals of which 10 of them were a focus group drawn from different sections of the community as shown in Table 1.

Table 1: Sample size of the respondents

ELEMENTS	**SAMPLE SIZE**
High school students	**1 focus group of 10 students**
Village health workers	**3**
Nurses	**2**
Teachers	**3**
Chiefs	**5**
Ordinary community members	**20**
Counsellors	**3**
Mafeteng hospital personnel	**2**
Traditional healers	**2**
Total	**40** Key informants and **1** focus group

For the fact that respondents in qualitative research are allowed to fully express their views, this resulted in substantial data, so the researcher selected only 40 respondents and 1 focus group so that he/she could find it easy to manage data from a sufficient sample. The researcher selected the above elements from various groups because they

could articulate their views drawing from perspectives of the social constructions in their communities. Village chiefs and counselors as key informants articulated their views since they were the ones who granted permission to programme implementors; high school students' focus group discussion (FGD), which could be accessed over lunchtime, provided data on their experiences in these programmes as well as ordinary community members. Village health workers and nurses as key informants aired their opinions as facilitators together with the teachers. Traditional healers as key informants also articulated themselves since they are consulted by different people about different diseases. Teachers and Mafeteng health personnel as key informants articulated their views as facilitators.

3.6 Methods of data collection

According to Sarantakos (1998:194), data collection takes place in the natural environment of the research. The researcher used focus group discussions, in-depth interviews and key informants to collect data. Morgan (1988) in Punch (2005:168) indicates that the hallmark of focus groups is the explicit use of the group interaction to produce data and insights that would be less accessible without the interaction found in a group. The group situation could, also, stimulate people in making explicit their views, perceptions, motives and reasons. The rationale behind using this method was because it is data-rich and the researcher is allowed to probe; it is flexible, and other strategies can be adapted for more data. It was stimulating, cumulative and elaborative because the units of the study fully took part in the process of collecting data and it was more participatory in nature. However, group conditions might force people to hide their real opinions, especially if their views can have effects on their personal life or professional career. Domination of the discussion by some persons might affect the direction and outcome of the discussion (Sarantakos, 1998:118).

Again, in-depth interviews were also used which refer to a data collection method in which the researcher uses open-ended questions related to the topic to gather information. It is a very good way of accessing people's perceptions, meanings and definitions of situations and constructions of reality. Bless and Higson-Smith (2000:112) further maintains that face-to-face interviews allow the researcher to clarify the

questions as well as probe for more information where such need arises. However, interviews are time consuming and costly as Sarantakos (2005:286) indicates, because they need the researcher to be there or visit the place several times, hence need arises to spend a lot of money. Moreover, key informant interviews were also used to collect data where the researcher was guided by a person who had all the information about the topic of interest, being to find out about the Thabana-Morena health education system, though, at times they were found not to be well informed. These techniques were very vital, since they helped the researcher get precise data about community participation in health education programmes in the Thabana-Morena communities, particularly, when appropriate respondents were purposively selected.

3.7 Data analysis

Qualitative analysis is a process of resolving data into its constituent components, to reveal its characteristic elements and structure. 'Analysis' too involves breaking data down into bits, and then 'beating' the bits together (Ian, 1993:30). Gomm (2004) pointed out that analysis also lays a basis for description. Qualitative analysis often aims to provide 'thorough' descriptions. According to Neuman (1991:421), there is a very important method used for making comparisons that is still used even today, being **analytic comparison**. The method of agreement and method difference form the basis of analytic comparison in qualitative analysis. It is vital because it makes contrasts with alternative explanation; regularities are sought, common cases that appear regularly are identified and grouped together, within a social context. The method of agreement focused on those cases that are common and the method of difference centers around those cases that are different from others.

This method was very useful since it was necessary to group the narrative interviews into their categories or themes which distinguished some answers from others as common, because they are in agreement or in disagreement. That is to say the data was coded and the process of cleaning data was done concurrently. Sarantakos (1998) asserts that coding is a process of sorting data into their categories, into their sub-categories and drawing conclusions. However, Cresswell (1994:153) asserts that qualitative methods are voluminous and cost the researcher a lot of time. The narrative

interviews end up becoming large texts during data collection that require a lot of time to read and code or categorise them, hence making analysis tedious. However, the study takes these criticisms into consideration. The data was presented in a form of descriptive texts that gave a clear idea about the topic and this process drew from different perspectives that were also potrayed in forms of quotations reflecting different opinions of the Thabana-Morena community. The life histories of people about their involvement in the health education programmes were also presented since they would give a clear understanding of their experiences.

3.8 Ethical considerations

Gomm (2004:298) stipulates that research ethics refer to rules of morally good conduct of researchers. They are grounded in moral and political beliefs, which are external to research itself. Neuman (2000) affirms that they are concerns, dilemmas and conflicts that arise over proper way to conduct research because social research can harm participants physically, psychologically, legally and may harm a person's role in a community. To remain ethical the researcher ensured no harm to participants, voluntary participation, confidentiality and anonymity and informed consent.

The researcher read a statement that entailed adequate information about the nature of the research and other aspects. It was read to respondents so that they could get a chance to agree or disagree to ensure informed consent. Privacy was ensured by asking questions that are not personal and sensitive. Again, anonyminity was guaranteed by creating identifications that were not traceable by others and confidentiality was made certain by not publishing any information that would make reference to any particular respondent or that will embarrass subjects or endanger their lives or jobs. These ethics served as guide to the researcher in order to produce empirical findings that did not compromise the lives of the respondents.

3.9 Limitations of the study

1) The major problem that was encountered in conducting this study was that there were lack of resources and this somehow delayed the tasks to be completed.

2) It was also very hard dealing with people who sometimes became too busy to be interviewed such as the key informants, particularly, the nurses and the counselors. This delayed the data collection process.
3) The topography of some places such as Ha-Turupu and Ha-Manthama posed some challenges to the researcher since it complicated accessibility.
4) Transport to Thabana-Morena was problematic because it delayed the researcher to arrive on time in the field, since passengers to this area in the morning were not many.
5) Some respondents were not cooperative whereas others gave their answers with fear due to some of the misconceptions that have been rooted in their minds.
6) Lack of trust in people conducting researches to give information freely with the fear that they will disclose it to the media or newspapers if there are many loopholes within the programme.
7) Following of long procedures to reply to the request for collecting data delayed the collection of data which, in turn, made the researcher to operate under a lot of pressure.

3.10 Conclusion

The study was purely qualitative. Data was collected in the Thabana-Morena area such as Ha-Konote, Ha-Manthama, Mount Olivet, Ha-Bofihla and Ha-Turupu and a sample of fifty was selected using quota and purposive sampling which represented the whole population of Thabana-Morena. The sample was made of village health workers, nurses, chiefs, high school students, counselors, ordinary community members, teachers and traditional healers.

3.11 Summary

This section discussed the methods that were utilized to collect the data need for this study. The following were discussed, the research design, which was qualitative in nature, the research setting being Thabana-Morena, the population of the study, which only covered those with the characteristics deemed important in this study, the sampling and sampling procedure that was followed in selecting 40 respondents and 1 focus

group, and analytic comparison that was used to analyze data. The ethics that were valued and the limitations of this study are indicated.

CHAPTER FOUR

ANALYSIS AND INTERPRETATION OF FINDINGS

4.1 Introduction

This chapter presents the analysis and interpretation of findings with regard to the objectives that were intended to examine the levels at which the rural communities of Thabana-Morena participated and the roles they played in the TB health education programme; the effectiveness of the participation of rural communities of Thabana-Morena in the TB health education programme, the characteristics of those who participated that could affect effective participation and the challenges faced by the rural communities in participating in the TB health education programme.

4.2.1 Socio-demographic characteristics of respondents

This section deals with the socio-demographic characteristics of respondents. The respondents were interviewed according to their age, gender, marital status, educational background and occupation. The rationale for reviewing these variables is because it is believed that they can influence community participation in health education programmes.

Table 2: Distribution of Focus group's socio-demographic characteristics

Socio-demographic characteristics of Focus Group Discussion							
Gender		**Age**		**Educational level**		**Marital status**	
Male	5	15-25	9	Tertiary	0	Married	2

Female	5	26-35	1	High School	10	Single	8
		36-45	0	Secondary	0	Divorced	
		46-55	0	Primary	0	Widowed	
		56 and Older	0	No education	0	Separated	
Total	10	**Total**	10	**Total**	10	**Total**	10

As a way of managing data, in order, to avoid repetitious details, the ten individuals in a form of focus group discussion have been included in the tables below as individuals and for the fact that they are part of the communities.

Table 3: Distribution of respondents by gender

Gender	Number of respondents	Percentage
Females	**30**	**60**
Males	**20**	**40**
Total	**50**	**100**

The Table above shows the distribution of respondents by gender. It demonstrates that of the 50 individuals interviewed, 60% (30) of them were females, while the remaining 40% (20) were males. Females dominated the sample because these were the people who could be found easily in the household, for most of them were housewives and they are the most people who are intensively concerned with caregiving in their homes. They are the ones caring for the lives and health of the children; they regularly visit health centers especially for ante-natal examination. On the other hand, males are often bustling because of agricultural activities, particularly, because they are breadwinners, though, this is not the case in some households for some women are breadwinners too lately. This implies that more females could participate in TB health education programme than males. The interviewees' age ranged from 15 to 56 and above. The following Table shows the respondents by age.

Table 4: Distribution of respondents by age

Age	Number of respondents	Percentage

15-25	**13**	**26**
26-35	**11**	**22**
36-45	**4**	**8**
46-55	**8**	**16**
56 and older	**14**	**28**
Total	**50**	**100**

Drawing from the Table above, it is indicated that 26% (13) of the respondents were aged between 15-25, 22% (11) were aged between 26-35, 8% (4) constituted of those between 36-45, 16% (8) comprised those between 46-55, while those aged 56 and older covered 28% (14). Evidence indicates that those aged 56 and older were mostly interviewed and this is due to the fact that these were people who have cared or contracted TB, particularly, males who worked in the mines in RSA and who more often than not attend public gatherings regardless of its motive. In fact, some were interviewed mostly because they were easily accessible for they are not engaged in various activities such as cooperatives and stokvels due to the fact that as they age, they suffer from other illnesses that do not permit them to engage in various activities that require energetic bodies. The implication is that elderly people participated in greater numbers in the TB health education programme and age determines one's decision to participate. Another variable is education level of respondents interviewed.

Table 5: Distribution of respondents by educational level

Educational level	**Number of respondents**	**Percentage**
Tertiary	**5**	**10**
High school	**11**	**22**
Secondary	**4**	**8**
Primary	**16**	**32**
No education(illiterate)	**14**	**28**
Total	**50**	**100**

As evidenced from the Table above, 10% (5) of the respondents had attended school up to tertiary, 22% (11) attended up to high school, those who attended up to secondary constitute 8% (4), 32% (16) were those who attended up to primary level and 28% (14) indicated that they had never been to school. The majority of the respondents schooled up to primary, because most people in rural communities, particularly females, are married in their early years, since lobola is preferred for most parents of girls. Lobola is rationalized as a transaction that ultimately brings income and property into Basotho families, thus, in order to accumulate more wealth, a girl should be married in her early years before she engages in socially deviant behaviour, such as teenage pregnancy that can hinder the negotiation of higher Lobola. Therefore, they dropped out so as to look after their families. Following is the 28% of the respondents with no education and this is due to the fact that education, particularly, for boys was the second priority in the past years, since livestock rearing was the first precedence and then when they had grown up, they worked in the mines in RSA. Formerly, educational services were not easily accessible. It is evident that most participants in the TB programme were illiterate. Below is the distribution of respondents by occupation.

Table 6: Distribution of respondents by occupation

Occupation	Number of respondents	Percentage
Farmer	**26**	**52**
Teacher	**4**	**8**
Nurse	**4**	**8**
Hawker	**1**	**2**
Unemployed	**12**	**24**
Others	**3**	**6**
Total	**50**	**100**

It is indicated from the Table that 52% (26) of respondents reported that they were farmers, while 8% (4) indicated that they were nurses. A total of 2% (1) indicated that they were hawkers and 24% (12) highlighted that they were unemployed, while others

comprising 6% (3) were engaged in other activities such as domestic work and security guards. The second highest percentage (24%) is made up of those who are unemployed and some emphasized that this is due to the fact that many people have sold their fields and have even used livestock to bury their family members who were mostly killed by HIV/AIDS and TB. Consequently, they cannot resort to being farmers, hence they were able to participate. Most of the participants in the TB educational sessions were farmers. Below is the distribution of respondents by marital status.

Table 7: Distribution of respondents by marital status

Marital status	Number of respondents	Percentage
Married	**23**	**46**
Single	**15**	**30**
Divorced	**1**	**2**
Widowed	**9**	**18**
Separated	**2**	**4**
Total	**50**	**100**

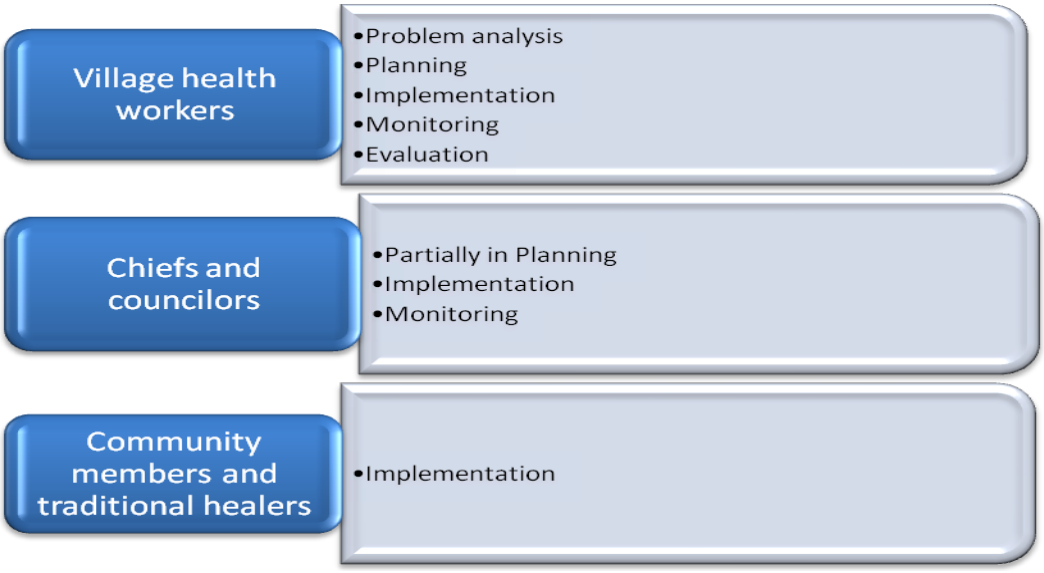
The Table above shows the distribution of respondents by marital status. It shows that 46% (23) of respondents interviewed were married, whereas 30% (15) mentioned that they are single. Again, one of the respondents indicated that she is divorced, 9 (18%) of them are widowed and 4% (2) are separated. Patently, the table shows that the majority of people interviewed who were engaged in a TB health education programme were married. Below is the discussion of the levels at which rural communities participated.

4.2.2 The levels at which the rural communities participated in

MOHSW Decentralization Strategy (2009) declared that Lesotho is swimming against the tide of TB with statistics suggesting that the prevalence rate is actually on the rise. Hence, TB health education programmes are initiated to fight TB. If rural communities are not involved in the programme, they will continue experiencing health problems. Majority of nurses explained that the successful implementation of this programme requires the full engagement of all stakeholders that are concerned about health

development in the rural communities. The realization is that most community development initiatives require the engagement of all actors affected. The figure below portrays the levels at which the stakeholders engaged in TB health education programme.

Figure 2: Levels at which the rural communities participated in



The rural communities of Thabana-Morena (Ha-Turupu, Ha-Manthama, Ha-Bofihla, Ha-Konote and Mount Olivet) indicated that they did participate in the TB health education programme that was administered in their communities by village health workers trained by the clinic at Ha-Konote and the Lesotho Red Cross Society (LRCS) as a Non-governmental Organization which collaborated to fight TB in the rural communities of Thabana-Morena area. The LRCS perceived that a significant problem in the fight against TB is not the availability of medicine, but it lies in the awareness of TB, hence some of their priorities outlined in the policy, is to promote TB and TB/AIDS awareness and address the stigma associated with the diseases. One of the nurses stated,

> *"The initiation of this educational programme is very helpful in increasing awareness considering that most people in rural communities are still in the dark.*

They still fail to distinguish TB from other diseases; hence they fail to act against its contraction."

It is learnt from the above assertion that lack of awareness is a major problem that increases TB prevalence; hence the rural people need to participate in programmes educating them about it. Further, most key informants indicated that they had participated, for the reason that they were formally invited to the public gatherings "Pitso" (a meeting) that used to educate them about TB prevalence, its symptoms, the strategies to responding to the symptoms and the ways of reducing vulnerability to the disease. This fits well with the view of Diem and Moyer (2005:281) that the most effective way to recruit individuals is to ask them to join the group and identify what they could contribute. As well, participation is a process through which stakeholders influence and share control over development initiatives, decisions and resources that affect their lives (Cooke and Kothari, 2001:5). They highlighted that the invitation to the programme session was done by the chiefs' assistants by loudly announcing in the evenings that people should present themselves at *"Pitso"* for the village health workers had vital messages for the community members. People should be called to contribute the resources they have in interventions. One of the key informants at Ha-Turupu articulated,

"*Normally, when the chief's assistant has delivered a message that we are called to a 'Pitso' on a stipulated day and time, we know that we are all expected to attend. In fact, people who will absent themselves without valid reasons are expected to pay M5.00 for disrespecting the chief's instruction. This does not only apply to public gatherings that are meant to address people about health issues but every public gathering that the chief instructs people to attend."*

This shows that attendance of educational session for the community of Ha-Turupu was compulsory and this meant that most people would get the TB health information. Nevertheless, some informants from other rural communities signified that the attendance of the public gatherings called on behalf of the village health workers was voluntary. They were encouraged by village health workers to attend in large numbers with the expectation that those present could influence those who were absent to come

to the educational sessions. It can be argued that effective participation in the educational sessions is vital for the implementation of the programme. This is in support of the HBM by Becker in 1974 that behaviour depends upon the likelihood of an individual taking action (Donatella, 2004:27). One of the respondents at Mount Olivet posited, *"I did not find any problem attending the educational sessions because I did not have to travel a long distance to where they were held for 'Khotla' is right within the community. As you can see our community is very small and I am sure you can reach these households within some few minutes."* Participants and the chiefs highlighted that their participation was possible because the places where the programme was implemented were accessible. Most rural communities could easily participate in the sessions because of the accessibility of places where the *"Pitsos"* were held.

It is evident that accessibility of the location of programme implementation can determine the level of participation. Further, the majority of key informants indicated that people of different ages, groups, incomes and cultural backgrounds participated, particularly, in the first session. Also, some respondents admitted that the first session had a mix of different characteristics of people such as age and religion. The main reason for this was that they wanted to assess if they would benefit anything and their decreasing attendance in the followed sessions showed dissatisfaction. One respondent highlighted,

> *"I wanted first to assess if I could benefit in anyway so that I could see if it is worth sacrificing time for participating in the programme. I find it unreasonable to participate in an activity that would not reward an individual in anyway. As for this of 'thaesese' (relates to pain in the chest), there was nothing much to benefit other than health information so I did not feel like participating more than once."*

Another informant had this to say,

> *"I am tired of attending these sessions teaching us about AIDS. We hear of it everywhere, in churches, buses, funerals and so on; we cannot afford to sacrifice any more time for people talking about it because that is what we have done*

several times. I solely decided to attend when I heard from people who attended first that this time it was TB which killed my eldest son."

The implication is that people are willing to engage only in rewarding programmes. This is in line with the HBM in assuming that before people act, they assess the benefits of a specific action (Donatella, 2004:27). Some chiefs asserted that most of their subjects expect rewards such as food aid when they attend "*Pitso".* In the other session, the number had decreased so badly. This shows clearly that the educational sessions were more representative in the first session while in the other sessions people's interest had decreased.

In a question asked to respondents intended to find out the levels at which the communities participated in the programme, almost all informants indicated that they participated fully in the implementation level of the TB health education programme. It is gathered from the information that they are called only at the initial stage of the programme not in the problem analysis, planning, monitoring and evaluation levels of the programme. Majority of members explained that they attended the educational sessions three times at different times, where they were educated about TB. They stipulated clearly that they were informed by village health workers that TB is a problem and they taught them about it because it is rapidly killing people. This does not come as a surprise as Maama (2010) affirmed that this airborne disease continues to kill people and even those affected by HIV and AIDS because of unhealthy lifestyles. In fact, it is an opportunistic disease in people living with HIV and AIDS (PLWHA).

Meanwhile, the fact that people decide to act against a dire condition because of its seriousness can be, also, related to the assumptions of HBM. Again, they are informed about the appropriate and already developed strategies of engaging in the educational session. Prior to the commencement of the session, the village health workers informed them about the apt ways of participating in a programme so that its goals can be attained successfully without any disruptions. It is evident that the programme facilitators planned on behalf of the community members, the diseases that should be addressed, the ways of fighting them and how the community should be engaged in the

process instead of the community planning its own health. One of the village health workers as the LRCS representative stipulated,

> *"We attend workshops to be educated on how to implement the programme in communities; we analyze the problem with the nurses such as the increasing TB incidences. We come up with a plan on how we can fight this problem and within this plan we devise strategies that we can use to engage the community in the implementation of the strategies to develop the health of communities, along with the implementation. We monitor the process in order for the plan to be achieved as intended and finally we assess the strategy as to reveal whether it was effective on not."*

This affirms that the programme used a top-down approach which normally includes the community only in the implementation level and this is a problem because development does not take place in the context of the people. Oakley (1991:46) conforms that top-down curative health strategies do not permit the community to be fully active in the health education programme. In this case the rural communities did not fully participate in all levels of the programme, hence they only benefited at the implementation level. Most community development interventions that utilize a bottom-up approach become more participatory than those that adopt a top-down approach, even though, there are perceived barriers to using the bottom-up strategy such as lack of resources.

In the focus group discussion of high school students of Form Ds and Form Es, they highlighted that they have never participated in any TB health education programme, not even in their communities, but they had heard parents at home mentioning that they attended an educational session at *'Pitso'*. They have heard for several times about people being called to the chief's place, but if the calling did not specify the particular groups to attend, they never bother to attend even in a case where they are not at school. This is contradictory to what Okoro (1995:45) in Dennill et al (1998) articulated that appropriate healthcare delivery system should be involving every person. Therefore, any initiative meant to develop the community as a whole should involve every person regardless of age, colour and gender. However, even if they were called to attend the educational programme, it would not be possible because they are at

schools most of the time and the educational sessions are conducted during the day. Children in rural communities can only attend "*Pitso"* if the chief assistant specifies that groups of all ages are expected to be there. This reveals that rural people stick to the morals prescribed by their societies. This clearly means that high school students have not been exposed to any TB health education programme and therefore, they did not participate at any level of programme stages. The implication is that the TB health education programme excluded the students and, therefore, they failed to be educated about TB. One student indicated,

> "*I do not see a problem in being exposed to such a programme if it is implemented in our school because we have been educated about HIV and AIDS for several times and it has never been difficult to participate in programmes talking about this disease. We have often played drama during farewells educating other students about HIV/AIDS and drugs. I think it is time we do something about TB, more especially when there are so many people who are infected by it in our communities. I feel so concerned because my brother was killed by TB."*

Another student related a similar story. She stated,

> *"My mother always told me about the information they got from the sessions and it clicked, also, in my mind that based on the facts they are taught, it means I am vulnerable as others. That is when I started to develope an interest of attending, even though, I could not because it would clash with my schooling hours. But, I am certain that we as students would benefit and I feel we deserve to know since we are affected. "*

It is evident that students too feel that they are vulnerable and, therefore, feel they would like to reduce their susceptibility. In particular, the HBM affirms that if people feel that they are susceptible they may want to avoid the contraction of the perceived disease (Cockerham, 2001:108). The educational sessions would be valuable to the students for they would get an opportunity to be prepared for the emergency of TB incidences. One of the teachers asserted, *"It has been emphasized a lot to us that we*

must alert students about the killer disease HIV and AIDS not TB. Even though, it would be easy for us to educate students within the already existing clubs such as Anti-Drug Association of Lesotho (ADAAL) that educates them on how best to fight drug abuse and English clubs that would hold debate sessions about the impact of TB on communities." Dramatization of the educational session would allow participation of different stakeholders with different skills in learning about TB so that people can reduce their receptiveness to it. Drawing evidence from a case study by Ghosh et al (2006) a community-orientated health education programme of Malaria in rural India, which used Kalajatha as an art form of folk theatre, the use of drama or debate by the students would disseminate the TB health information effectively.

Moreover, the students from the Thabana-Morena high school were not included in the implementation of the programme. Although, Sydney (2005:233) warned that health problems impede the students' ability to come to school, stay in school or make the most of their opportunity. More to this point, Basavanthappa (2008:825) noted that health education in schools is vital because students will acquire knowledge of scientific facts; develop positive attitudes towards health and strengthening good health habits. This clearly implies that their engagement in the programme would be advantageous as another group within the community. School health programmes are said to be one of the most effective strategies that a nation might use to prevent major health and social problems (Mohlomi, 2000). Health education is also vital for students for the infection of TB is adverse for every individual.

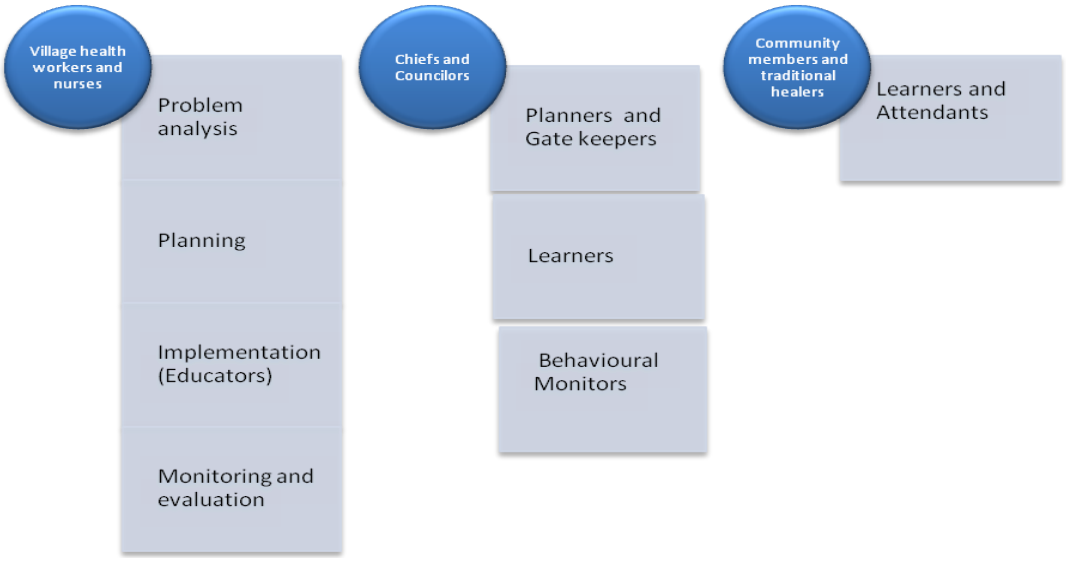
Oakley (1991) asserts that the community that fully participates in problem analysis, planning, implementation, monitoring and evaluation can expect to attain health development. However, in the TB health education programme implemented by the LRCS and the clinic at Ha-Konote, people were only involved at implementation level. Additionally, in this case it is vivid that the TB health education programme implemented in the Thabana-Morena area was designed in such a way that it promotes primary and secondary prevention. Peberty and Kats (1997:164); Tones and Tilford (1994) harmonize that primary prevention level persuades individuals to adopt behaviours believed to reduce the risk of disease while secondary prevention level persuades

individuals to comply with medical treatment. Following are the roles that the community played in the implementation process of the programme.

4.2.3 The roles that the rural communities played in the TB health education programme

Some rural community's members played roles in the TB health education programme. These participants had different roles to play in the programme of TB so that it could be accomplished. According to Van Rensburg (1992), communities, groups, families and individuals can do something to improve their own health and that they may want to take responsibility. In fact, Makoa et al (2009) strongly indicate that in Lesotho, the provision of healthcare has always been the responsibility of the family, during the initial stages of the disease. The complementation of these roles was of essence in fighting TB in communities so that people can attain good health statuses by adopting healthy lifestyles. As the members of the rural communities indicated, they played different roles in the implementation level solely. Community participation in health education programmes results in health development. Below are some of the roles that different stakeholders participated in, during the implementation of the programme.

Figure 3: Roles played by stakeholders in the TB Health Education programme



One of the nurses from the TB ward in Mafeteng hospital pointed out that due to the increasing TB cases in hospitals, the Ministry of Health and Social Welfare instructed TB coordinators to come up with strategies to alleviate the problem by engaging communities in the programme to play a role in solving their health problems. Evidence can be drawn from the case of TB notifications in Lesotho which is 640/100 000 with treatment success being 74% in 2008 which is below the global target of 85% (MOHSW Decentralization Strategy, 2009). With the help of the nurses, they decided to educate the village health workers on how to address the problem of TB in different communities, especially in rural areas. During this process, they used educational sessions that would be held three times at varying times in each community, in order to influence people to adopt healthy lifestyles that can reduce the contraction of TB or HIV/TB. The HBM, also, assumes that there are strategies that influence modification of health lifestyles. Some of the nurses at a clinic at Ha-Konote assert,

> *"The use of village health workers was advantageous because of the shortage of staff, particularly, in rural clinics. This does not offer any opportunity for nurses to be the ones to educate the communities of Thabana-Morena about TB. Village health workers easily immerse themselves in the communities knowing the kind of people they are dealing with."*

> *"The village health workers did not hesitate to educate people about TB and we chose them because we have been working very hard together to inform people about HIV and AIDs. The experience they got from the past programmes on HIV and AIDS were still helpful, even in the fighting of TB."*

One of the village health workers had this to say,

> "*If we fail to help communities to improve their health status, then we have no roles to play because even the workshops that we attend focus on educating about this matter. We feel that this is what we must live for in our communities. In fact, failure to play this role will result to people still living unhealthy lifestyles"*

It is drawn from the above citation that village health workers have many roles to play in maintaining the health of community members. Majority of them alert them on how to

prevent themselves from being infected by certain diseases; they treat and control these endemic diseases by using medical kits given to them. They clearly identified that their major role in a programme was perceived in the problem analysis, planning, implementation, monitoring and evaluation. One of the village health workers indicated,

> *"The nurses trust us for this task of analyzing the health problems of the Ha-Manthama community because they know that we work hand in hand with the community members, since they normally ask for our help when they are bothered by the diseases. We are well informed about the health status of the community members, though; they hide some of the diseases they are suffering from. Families normally consult us when their relatives are ill so we know most of the diseases that trouble them."*

Although, village health workers have these duties in their work; the community is expected to be active in all the levels as Basavanthappa (2008:215) confirms. Within problem analysis, the community would be able to discern whether an issue is sufficiently important to warrant. It would dissect and thoroughly study the problem with the objective to understand how the problem emerged and how it grew to its current situation (Visser, 2004). In planning, the main issue is the voice of the community, particularly, of those potentially affected not a few or dominant people (Uphoff, 1991:117). Planning that involves people is seen as a learning process by which the community can improve their own actions, gain self-sufficiency and self-reliance and move towards self-help. Within the process of planning, the rural communities would decide on the work plan.

Furthermore, USAID (2010) behold that during planning, the implementation team is suggested. Then, planning would be followed by the implementation level, which the rural communities of Thabana–Morena played various roles in. After the implementation, the community has a role in evaluation, which is affirmed by Kennelly (2009) to be vital for generating information regarding programme success or failure, to enhance management decision making, to improve programme operations, to maximize benefits to programme participants. However, the Thabana-Morena rural communities did not get an opportunity to have a say in the evaluation task.

Moreover, the councilors granted permission as well as the chiefs to the village health workers to administer the programme. The chiefs explained that their roles in the programme were to arrange for the meeting *"Pitso"* of the community members and the village health workers. They called the communities to attend the educational sessions that were offered by the programme, which were facilitated by the village health workers. Their major role in the health education programme of TB was very crucial because the village health workers did not possess the credibility to play this role. They are in charge of the community *"Morena o isa sechaba botleng"* (The chief is the good leader in the community*)*; this gives them the authoritative status and respect by the subjects, it is vital for village health workers to collaborate with their chiefs in approaching communities about health issues.

Besides, during the educational session, most chiefs indicated that they participated by monitoring the behaviour of community members because at times they could be a trouble by themselves that disrupted the learning process by talking about irrelevant issues during the sessions. Monitoring is important at this implementation phase to ensure that the programme is implemented as per schedule (UNESCO, 2010). Again, they affirmed that by mere accepting the introduction of the programme in communities under their guidance, this shows their role as gate keepers because they grant permission to programmes if they have assessed that it will benefit people. One of the village health workers at Ha-Konote related, "*We rely on the chiefs to call for the meetings on our behalf because if we would do that by ourselves, people would not bother to show up at the educational sessions. The only person they respect is the chief. They do not even respect their health for they never bother about attending "Pitsos" that addresses health issues. In fact, people in this rural community only want to attend if they are promised to be given donations "Liphallelo" or food packages."* Most importantly, they were learners during this process of education. One of the chiefs highlighted

> "*People in this community often show reluctance when they are supposed to attend the public gatherings and they normally justify it by claiming that they did not hear about the 'Pitso' when it was called so to solve this issue, I instruct my*

assistant to announce the meeting several times before the actual day of the "Pitso"."

It is revealed that people should always be called to participate. Majority of respondents showed that they attended public gatherings whenever they were held so that they learnt the health information about TB, offered by village health workers. As the HBM argues, health information influences the likelihood of action towards a disease. These public gatherings are actually meant for the implementation of the programme. Bartle (2007) defined it as the stage where all planned activities are put into action. Basavanthappa (2008), further, asserts that it is vital for the community to participate in this level because action will be taken by every individual. They indicated that at this level, they participated by asking questions for more clarity about the disease. They cooperated with the village health workers by doing whatever they wanted them to do; they worked together with them in all the ways. In fact, they showed that their attendance of the programme was one of their roles. The end product of cooperation between stakeholders in a programme is the achievement of goals of the programme emphasizing healthy lifestyles.

In addition, the traditional healers designated that they played the same roles of being learners as the community members. They indicated that having acquired information about TB has influenced some of their perceptions positively because they can now detect when a patient needs to be referred to the hospital. One of them pointed out *"In as much as we have attended workshops teaching us how to draw a line between some symptoms that are associated with other diseases such as HIV and AIDS, this one of TB was more informative because they were somehow speaking the language that we all understand. We can tell the difference between "Sejeso" (Food poisoning) and "Thaesese"."* This shows that this educational programme was an eye opener for traditional healers, whereas, high school students indicated that they as children did not participate in the programme at all. It is vital to note that these roles that different community members played were carried out at the implementation level which is the doing stage while village health workers had a role to play at the implementation level and other levels. According to Basavanthappa (2008:215), the principle of active

learning in health education requires the support of participation. These roles in the programme benefited the rural communities, for they were capacitated, empowered and ownership was felt as well as accountability.

4.2.4 The effectiveness of participation of rural communities of Thabana-Morena in a TB health education programme

Davey et al (1995:377) discerned that the Ottawa Charter of 1986 signaled that enabling people to participate in health promotion, a state of complete physical, mental and social well-being can be attained. This would only be possible if an individual or group identified and realized their aspirations to satisfy their needs and change or cope with the environment. In fact, Gran (1983:2) in Swanepoel and De Beer (2006:28) stated that people are there, in an intervention, to contribute with their physical and mental capabilities; in turn, they are rewarded.

The Thabana-Morena's rural communities had roles they played in the implementation of the TB health education programme as they revealed and the roles made them to reap the fruits of their toils; on the other hand, these roles came up with complications. They were empowered; capacity was built in them; they became accountable; they felt a sense of ownership and developed partnership. Different stakeholders had different roles to play in the programme which rewarded them differently for their roles were different, though, they were targeted at the same objective which was to influence people to adopt healthy lifestyles in order to fight TB incidences that are increasing. Below is a figure portraying the rewards of participating in a TB health education programme.

Figure 4: Integrational benefits of participation in a TB Health Education Programme

In real life, an initiative to act positively is rewarded. Besides, the HBM assumes that if people modify their behaviour to live healthy lifestyles they are rewarded with good health status. Hagquist and Strarrin (1997) recognized that effective participation is essential for empowerment. In common with the findings among members of the communities, none of the respondents posited that they did not find their engagement in the programme absolutely disadvantageous. In fact, a majority of participants disclosed that in assuming their roles as learners in the educational sessions, they got information on how to reduce their susceptibility to TB pandemic. They explained,

> "*I feel educated and protected because I now know how I can protect myself against diseases that can be eschewed. I even understand that TB and witchcraft are two different things. Most importantly, I know that TB needs not to be stigmatized and that it can be cured.*"

> "*No more myths in my mind about TB. I am well informed that TB is not "Sejeso", it is curable when people adhere to treatment regime and that TB does not infect only HIV and AIDS patients. I believe it is wise to share the information and in this realization, I make sure that I inform those who found participation meaningless, and who are still blindfolded by the misconception about TB, who still interpret it erroneously because of lack of valid information and who still live unhealthy lifestyles that leave them prone to this disease.*"

In addition, this shows that the information that the respondents got from the health education programme entitled them to control over their health so as to improve it. Kent (1988) in Swanepoel (2002) affirms that empowerment is the acquisition of power and such power manifests in groups of people working together. Village health workers emphasized to them that health is important if they want to experience development of any kind. The information they got empowered them. Chamberlin (2010) and Werner (1988) share a common view that key elements of empowerment are access to information, ability to make decisions, self-esteem to make decisions and assertiveness to decide about their health. Personal effort to attend the programme results in empowerment of communities. Members of communities joined each other in learning about TB and this warranted them the opportunity to share experiences that were explained and solved in the presence of others by village health workers during the educational sessions. Some respondents indicated they could even explain to each other if some did not understand based on the knowledge they got. Chilisa (2006) notes that empowerment does not occur to the individual alone, but with other people. It catalyzes collective action for social change. The information about TB empowered them because they can now make decisions about their health. One of the respondents from Ha-Konote declared,

> *"I am well informed about TB. I know the signs, how to treat and how one can avoid it or how one can be infectious. I even know that people can only be killed by TB if they do not adhere to the 6 months treatment."*

> *"I could not believe some of the stories that some of us revealed and this influenced me to seriously take this powerful information serious so as to use it wisely. I felt that I had power to change my health lifestyles."*

In another interview, one village health worker pronounced,

> "*We teach communities that TB is caused by dusty environments, smokes, silica and asbestos, and we also teach them that one can again avoid these sources to avoid the contraction of TB. We explained to them that early response to the disease can be very advantageous and that relapse for those who already have it*

can be very adverse. In fact, TB is even more adverse for people living with HIV and AIDS for they are prone to many opportunistic diseases."

Most village health workers indicated that despite some challenges they faced such as lack of resources, some community members still managed to cooperate so as to be educated. Most of the respondents revealed that the valid information that they acquired had influenced them to live healthy lifestyles. The information empowered them to make appropriate choices and, in turn, positive change could be attained. They are empowered psychologically and culturally, since their minds are shaped and lifestyles are influenced. Joint Committee on Terminology (2001:26) asserts that empowerment is not characterized by achieving power to dominate, but power to act with others to affect change. The knowledge one got becomes more vital if most people use it wisely.

Additionally, Naidoo and Wills (2005) highlighted that empowerment can only take place if there is partnership being a condition where people work together to attain a health goal. Informants unveiled they have built collaborative relationships among themselves to address their health problems. Most nurses indicated that partnership between village health workers, chiefs and the members of the communities was dedicated to improving the quality of life of every member of the community regardless of age, gender and income status. One of the community members from Ha-Manthama disclosed, *"Our participation in the programme "Sekolo" (as respondents referred to the programme) rewarded us because we learnt about TB successfully due to the cooperation and support we gave to the educators. One would say the educators were somehow motivated to do their work because of the support they got from the people who attended almost every session."* The partnership's goal was to help shape strong and healthy rural communities in Thabana-Morena community. They were able to build connections and coalitions for solutions.

In reality, partnership is most vital for people who want to work together to bring change. Moreover, the health information delivered to communities resulted in accountability in some people. For community members who have attended the programme fully and participated, they are the most likely to take account of their health. In cases whereby individuals take the responsibility of whatever situation in the health life, it shows

accountability. In fact, most respondents disclosed that because of the stories they heard from some participants they felt a need to act by living healthy lifestyles and to take account of the results of their lifestyles; and this is in line with the HBM for it concurs that experiences of others can influence action to adopt health behaviour (Cockerham, 2001). They divulged that even the educational sessions suggested the alternatives of being accountable such as screening for TB. Anderson (2010) delineates accountability as the acknowledgement and assumption of responsibility for action within the scope of a role or position encompassing the obligation to report and be answerable to the consequences. Again, Hunt (1998) signifies that it is the responsibility of either an individual or group to perform a specific function. This implies that if rural communities' members utilize the TB health information that they got from participating in the programme in order to live healthy lifestyles, they are taking responsibility and, also, they will be answerable for the resulting consequences. Some of the community members stated,

> "*We have been educated on how to avoid being infected and now we are reducing vulnerability, as for others who have not started, they know the real issue. I am glad; I know that when I am living a healthy life like this of opening window when we are many in a room, it is because of my effort that I dedicate everyday. I do not spit in any place, I avoid being in dusty environments; such as the ground being swept and I even cover my mouth when I sneeze."*

On the same point, another respondent indicated as follows,

> *"I feared to consult a doctor yet I was feeling ill because for several times I had heard people claiming that TB infects people living with HIV and AIDS only for their CD4 count is low and so they are vulnerable. However, after the educational session I considered to consult a doctor who told me I had contracted TB and I made a mistake by delaying to go to the hospital. I delayed because I got the false information. I was diagnosed and given the treatment regime which I am adhering to successfully because of the advice of village health workers."*

It is implicated that the utilization of health information shows the responsibility that people take, which comes out to be accountability. The members of rural communities revealed that they are living healthy lifestyles after the implementation of the programme. Cockerham (2001) posited that medical sociologists divide health orientated behaviours into two categories being health behaviours and illness behaviour. Evidence can be drawn from the fact that the communities are reducing their vulnerability to TB infection as some indicated, which also shows health behaviour. On the other hand, community members disclosed that they are following the instructions on how to live healthy lifestyles suitable for their healing process, which comes out to be illness behaviour. This indicates that respondents' behaviour is orientated towards healthy lifestyles that are taught by the programme.

Capacity building within communities is enhanced through participation in the health education programme of TB. One of the nurses as a TB coordinator asserted that people gain experience on how to solve problems, particularly, health related problems and they gain confidence in working together when they realize that their contributions are valued and shared among other participants. Most respondents showed that they got the skills, knowledge and capabilities on how to solve health problems and this implies that they are capable of bringing change in their lives. The experiences they had as communities, taught them something that can be of importance in the next programme or project to be implemented in the community such as being accountable and partnership. Thompson and Kinne (1990) indicated that community capacity building materializes when the community works together to recognize and effectively use resources that they have. Some participants indicated that they effectively contributed their mental skills which were the resources they could contribute to the TB programme. Community capacity building starts where people are working together (Nyswander, 1966) in Diem and Moyer (2005:265). One of the chiefs highlighted,

> "*It is my belief that people have learnt how to solve problems that are addressed as a group, putting aside their differences as neighbours, relatives and friends in order to attain development for their community. Probably, this strategy used can even be used for other social problems not only health problems."*

The desired outcomes of capacity building are that people and groups have gained experience and confidence in working together to improve community health. These skills, knowledge and abilities that the rural communities are equipped with, mean that more people in the community are capable of bringing about beneficial change. Through capacity building, rural communities manage to build social capital through experimentation and learning, for community members will have formed bonds with the important structures that will assist them in improving their health. WHO (1998:19) affirms, social capital is created by myriad of everyday interactions between people. Accumulating social capital is a prerequisite for optimal use of all the opportunities offered by the TB programmes. Below are the characteristics of those who participated that affected effective community participation in the rural communities.

4.2.5 The characteristics of those who participated that affected effective participation

According to Stanhope and Lancaster (2004), a variety of factors influence an individual's decision to participate in a health education programme. These include demographic, geographical, economic, psychological, social and spiritual factors. Besides, the respondents in this study differed, economically, socially and politically. These factors influenced participation of the rural communities of the Thabana-Morena realm in the TB health education programme. These factors, also, influenced the implementation of the programme negatively and positively. In particular, the HBM indicates that there are variables that influence the belief to act. Participants showed that their collectively constructed ideas in each rural community influenced community participation and what reckons up as healthy. This indicates that their perceptions differed in terms of what is considered as healthy. The belief about what enumerates as healthy or unhealthy is mostly shared by different communities' members in varying degrees.

Occupation, related to individual's economic status, determined whether individuals would attend educational sessions whenever they were held. Most respondents who attended each time the educational sessions were held during the day, were elderly people aged between 56 and older, who were not actively engaged in agricultural activities and who remained at home most of the time during the day. This, also, shows that most people in rural areas survive through agriculture which takes most of their time. However, some people who were unemployed who constituted 24% could attend the educational sessions because they were not engaged in other activities such as farming. One of the respondents revealed,

> *"I managed to attend the educational session because I am always here. I just lost my job as a domestic worker. I am able to attend every session and I have no regrets because I benefited a lot, I have all the information about TB. I can protect myself from contracting TB. I realized that we may think we know yet we do not."*

Occupation determines an individual's class and, in turn, this class determines whether one will live a healthy lifestyle as Weber noted. For Weber, lower class persons tended to utilize health services because of the culture of poverty (Cockerham, 2008:96-101). Contrary to this, lower class persons failed to attend the sessions properly. Informants in some rural communities disclosed that their class influenced their participation in the health education programme. This, even, influences whether an individual will live a healthy lifestyle after the educational session.

Drawing from these, it is implied that low income people's attendance and those of high income level people differed. Poverty entailing lack of resources and ill-health may prevent people from participating. Makoa et al (2009:131) confirmed that poverty in Lesotho is a major barrier to access to healthcare services. Many people work seven days a week just to feed their families and most of their time is spent in the chores/duties, though, some reserve Sunday as time for going to church or resting. However, village health workers find that some participants often lack motivation to make behavioural changes because they lack information. This goes hand in hand with the learners' beliefs about themselves in relation to the capacity to act and gain the

outcome desired (Stanhope and Lancaster, 2004). Some people with low income spent most of their time in the agricultural activities trying to improve production; so they could not easily participate in the programme, since most educational sessions of TB were held during the day as for few people who were well off, they attended anytime because the TB programme did not compromise their means of survival. This shows that participation in the educational sessions was overlooked by some people considering that most people in rural communities are farmers, however, those constituting 52% interviewed showed that they sacrificed for participation. One hawker from Ha-Bofihla articulated,

> "*I did have an interest in attending all the educational sessions offered by the programme but it was difficult because I spend the rest of the day going to other villages selling clothes because there is low market standard in rural areas. If they would all be held in the evenings I could attend every time but it is not easy for me to compromise even a day for the programme because it would not put a meal on my table for me and for the kids. Anyway, the one session I attended changed my perception about TB and healthy lifestyles that I found vital to adopt."*

One of the chiefs affirmed as follows,

> "*I do not blame people for not showing up in large numbers because these weeds would grow to a point where they destroy the products if they failed to hoe in time. This programme would work best if they had planned to educate people only in the evenings when everybody is there not in varying times."*

Facts indicate that the economical differences of people influence community participation in development programmes. In particular, this is a case in rural areas where most people are poor and survive through activities that take most of their time. This, also, reveals that most people who did not participate in the programme missed the opportunity to be educated about TB and healthy lifestyles to prevent its contraction. Social class, in this case, clearly is associated with or determines differences in morbidity or even mortality of TB among people. Some nurses highlighted that even in a

case where the community has decided to adopt healthy lifestyles, they are faced by crowded living conditions, substandard housing, poor diet and stress all hindering the utilization of information by the poor people. In a way, it can be argued that economic status challenge people in trying to be accountable. This is also what village health workers indicated during the interview. For example, some male respondents who were once migrant labourers who worked in the mines in RSA disclosed that they were more prone to contraction of TB because of the nature of their occupation. They were vulnerable to respiratory diseases such as black lung and TB as other retrenched migrant labourers indicated. Some male respondent had this to say,

> *"Back in the days when I worked in the mines, I contracted TB and this was due to the fact that we used the mine shafts which were said they were contagious to us. Even though, I continued to work because I am a breadwinner so I could not imagine myself unemployed."*

> *"During that time when we worked in the mines, we used to be encouraged to attend sessions that educated us about the prevention of TB but only a few attended the educational session. This is because we were always tired after work; one would feel that what he only wants is to rest. At that time we did not realize that we needed it most because we were the most vulnerable due to the nature of our work. However, the knowledge that we got from the health workers is still very important, there is still plenty of time to use it sensibly."*

One of the respondents states,

> "*I have a husband who is very ill because of HIV and TB who needs to be cared for, who has just been discharged from the hospital, so the question is when do I have liberated time to attend this programme because I work in the fields whereby I hoe and I, also, take care of him I have no one to help me so I am faced with all these heavy tasks that require every minute of my life. The one session I attended out of three is enough."*

Additionally, occupation determines whether one will engage in the intervention because for most people occupation is prioritized. Some participants disclosed that they

as individuals in one community belonged to different political parties which, also, influence their participation in activities that are carried out in the communities such as the TB health programme. They divulged that some people hesitated to participate because they thought that they were going to be encouraged to join other political parties that they did not like. Some key informants announced that community members do not attend any services offered by the ruling party being Lesotho Congress of Democracy (LCD) because they have animosity towards it. One of the village health workers proclaimed, "*I heard that people were indicating that they hesitated to attend the first educational session because they thought I was going to persuade them to join my political party (LCD), since I am the secretary of the community members who favour the party that I am in, so they were waiting for people who attended the first session to inform them about what was said in the first session."* Political, religious and commercial interests may discourage participation (Michael et al, 2004). Another respondent had this to say,

> *"I did not attend the public gathering at first because I had concluded it is just one of the strategies used by political parties when they campaign to call us to meetings that promise us what they know that we need most, when they are not even going to be fulfilled, LCD has a tendency of promising us miracles so I no more want to be lied to."*

Political parties' ideas remain powerful in influencing the decision to participate in health development. As well, gender was one of the characteristics of the participants in the TB health education programme as some village health workers highlighted. Some chiefs revealed that more females attended the educational programme than males did. In fact, table 2 shows this, considering that 60% of females were interviewed against 40%. The real issue which came to the fore each time some of the men were asked to state the reason for this habit, they disclosed that the educational programme deprived them of the power that they have even within the household. The programme operated as if they and women had the same power. Though, initiatives have been made to end patriarchy in most rural communities, but still the patriarchal structure which assumes that men should have power over women exists; in turn, this affected effective

participation of males in the educational programme. One of the chiefs pronounced that failure to attend the educational session would go along with punishment of paying M5.00 because men seemed to draw back and, hence less participation was perceived. One of the village health workers noted,

> *"Women attended in large numbers because they experience a higher prevalence of many illnesses because of the nature of their body and reproduction, though, they tend to live longer than men. Women were mostly not affected by TB because of the nature of their occupation. Men contracted it in the mines. However, they are still vulnerable because their relatives who have contracted it in the mines can infect them."*

According to Tsourus (1990:34), men and women respond differently to health education. Van Staden and Du Toit (2000:56) noted that some people decide not to participate in health education programmes if they compromise their gender roles approved by the society. One of the female respondents aged between 26-35 asserted, "*Sometimes when I wanted to go my husband would remind me that wives cook, rear children and wash the clothes. He would highlight that my attendance of the programme should never distruct these responsibilities because as for him he would not let anything disrupt his going to the field that gives us food."* Nevertheless, the model highlights that if there are perceived barriers to taking action, it will not be initiated (Donatella, 2004:27). Sady (2000:17) confirms that it is difficult to finally attain a democratic participation while inequalities still exist.

Indeed, there were still some women who did not get the chance to participate fully in the TB health education programme because they had to take care of the household chores. Their household chores kept them busy during the day. Most Basotho women are expected to maintain the household in all ways regardless of being married or not and this is a result of socialization. One male had this to say *"I did not like my wife attending because when we both came back, there was nothing to eat. Yet when she was left other tasks could still be done within the household. "* This also shows that in a way marital status, as well, plays a role in influencing community participation. Married

respondents, who constituted 46%, were interviewed consisting of men and women; some of them could have experienced these.

Evidently, people who did not engage in the programme fully as expected or planned, were as many as those who did not attend the programme at all because they ended up with incomplete information and most women were more likely to come across this challenge. In fact, this is what nurses perceived too. This means they would continue their unhealthy lifestyles that lead them to being vulnerable to contracting TB. Below is a typical case that one of the village health workers has come across. She reveals as follows,

> *"Most people who did not attend fully ended up only knowing about the symptoms and not knowing about how to respond to such a case, instead, they would be stigmatizing people when they recognized those whom they have identified to be having these signs of TB and this hurts victims."*

Additionally, most participants at Mount Olivet and Ha-Konote stipulated that one's educational level was a characteristic of the participants, which affected community's decision to participate in health education programme of TB. Most people in the Thabana-Morena locale attended school up to primary level and this is followed by 28% of people who have no educational standard; these groups of people are normally undermined in many developmental actions as one of the village health workers and some nurses evidenced. Due to this experience, most of them alleged that they have a fear of showing up at programmes that are participatory which require their contribution, particularly, mentally. However, some presented themselves at these programmes despite their level of education. It is vivid that the educational level of community members influenced participation in the sessions. One of the respondents at Mount Olivet narrated,

> "*It hurts to be treated badly yet you were called to the session. Some of us did not choose to be illiterate; we had problems, but, the village health workers treated us fairly, though, we as participants embarrassed each other. We, illiterate people, received the same treatment as those other educated*

participants. This marginalization came from other community members who are literate"

Clearly, the details from the participants point out that gender, one's political affiliation, occupation, level of education and marital status were the crucial determinants of community participation in the TB health education programme. This is in support of the HBM that argues that the decision to act is influenced by variables such as demographic and structural factors (Cockerham, 2001:109). An individual would decide to participate regardless of the influence of these characteristics if they have the opportunity to do that, whereas, for some of these determinants seriously hindered their participation in the educational sessions. Below are the challenges that are faced by the community in participating in the programme.

4.2.6 The challenges faced by the rural communities in participating in a TB health education programme

Due to differing backgrounds, people are bound to have differences either politically, socially and economically. The nature of the programme itself creates problems that can hinder community participation in TB health education programmes. There are numerous problems identified by different respondents in different communities in relation to participation and there are those which village health workers identified that are discussed in this section. This is supported by the HBM, for it indicates that if there are barriers perceived, chances are limited for the likelihood of action. Some members of rural communities did admit that some members conflicted with one another; in turn, this destructed the educational sessions because people could not agree on issues such as the convenient time the session should commence and some participants' issues were not given complete attention. Additionally, some respondents indicated that the fact that people belong to different political parties lead to conflicts: some were political when they talked about health issues that concerned them. Parts of the conflicts are those which emanated outside the programme, but which persisted even into the programme implementation phase. A female respondent narrates,

"We as people we have a problem of drawing a line between personal and community issues. I had conflicted with my neighbor over the borrowing of a spade regularly and, since then we do not have a good relationship and during the session, she and her friends would be talking and laughing when I am talking about my experiences as if I did not make sense. I even decided to keep quiet and ignored her but it was hurting."

Therefore, this shows that conflicts between people, who interact, exist and are powerful in influencing development initiatives regardless of them being between individuals or groups. Bells (1994) stipulated that conflicts between individuals and group interests do exist due to the fact that people are from a wide range of social and economic backgrounds. Knowles et al (1998) in Stanhope and Lancaster (2004) support that educators in a health education programme may need to deal with difficult people who need to learn yet they cannot be easily organized due to conflicts or misunderstandings.

Most communities indicated that, even though, they attended the programme execution, the environment where the educational sessions were held, was not comfortable. For example, they revealed that there were no chairs where they could sit during the session; there was no shelter where they could hide from the hot sun and other climate conditions that were destructive. In fact, drawing from the affirmation by UNICEF, GOI and EmOc (2005) still highlighted that climate conditions in Lesotho are adverse because in summer the country experiences heavy rains while in winter snow heavily falls. This implies that the fact that there was no shelter heavily impacted on the community participation in the TB programme implementation. Heavy rains in December 2010 made it evident that the climate conditions can be very agitating as Matope (2011) stated. To take this point further, some village health workers indicated that heavy rains that were persistent during the past season influenced deficient or inactive participation and delayed programme completion in communities. A respondent from Ha-Turupu articulated,

"*Look at me; I am old and ill, meaning I need to take care of myself all the time. How can one expect me to sit on the floor? I think that really hurt, but, we kept on*

attending because we felt that we would leave with something better considering that everyday we learnt a lot about "Thaesese"."

The environment that is not conducive for the implementation can hinder participation. Once more, some respondents asserted that they experienced stigmatization as participants in the TB health education programme for some people believed TB, lately, is contracted by people living with HIV and AIDS. They, further, expressed that people who did not want to participate designated that the participants are the victims so they have no fear of it. Some informants' experiences revealed that the myths about this disease are persistent and some people with no full information treated participants in the programme badly in communities.

Again, they highlighted that village facilitators sometimes favoured some individuals more than others and this hinders effective participation. One of the respondents disclosed, *"During the learning process, the village health worker paid more attention to people close to her particularly to friends, but, when others asked she would answer defectively and even highlight that people should make sure that they ask sensible questions for time is being wasted, yet when others asked stupid questions she did not respond negatively."* Nepotism leads to ineffective community participation for it develops discrimination.

Exclusion of other members of communities led to uneven community participation and, therefore, not everybody got the opportunity to be taught about TB. These excluded groups were the disabled and children including high school students who were at schools during the programme implementation. Most disabled people were left out because there was no transportation so that they could travel to the educational sessions. Some chiefs and respondents reported that transportation was not arranged for the disabled and elderly people who could not reach the areas where the "*Pitso*" was held. Some of them needed to be fetched from their homes and this meant that they were excluded in this way. It is evident that some members of communities never got opportunity to attend sessions despite their interest to attend. One of the female respondents confirmed,

> "*I am raising this issue because my husband was willing to come, but, because he is physically impaired he could not attend. Instead, he relied on the information that I brought home when I had attended the session. People with disabilities were totally overlooked and yet they are the most vulnerable. They were not able to present their needs and experiences or even priorities."*

A physically impaired male articulated,

> *"We are hardly ever involved in local efforts to improve the quality of life. Our voices are ignored yet they are of importance. However, all people regardless of the severity of disability could grow and develop. We are overlooked in efforts to involve people in improving communities. Barriers that hinder the disabled people to participate as community members are attitudinal barriers, lack of transportation, lack of awareness, lack of income and lack of encouragement from community organizations."*

It is noted from the above information that the programme did not include every member of the community. It is common to find that development programme leaves the disabled behind, yet those are the people who are more in dire condition than any other normal community members. However, some village health workers still admitted that this was another problem that was noted.

Netnews (2009) posits that the health system of Lesotho finds itself under pressure to use unskilled personnel because those who have the capacity, migrate to be employed in better paying jobs in other countries. The findings reveal this for most nurses indicated that failing to set an educational standard for recruiting village health workers, creates problems for the programme because those who are not educated take a long time to understand how they should deliver the TB educational messages to their communities, hence, resulting to a long term training. Yet, another time has to be allocated to the implementation of the programme that pursues the understanding of health information by participants. Let alone, the fact that the longer the training process, the more expenses. Educators in a health education programme may have limited number of professional experiences which is adverse for learners (Naidoo and

Wills, 2005). The use of village health workers with low educational level complicates the programme implementation because they fail to facilitate the programme of TB as planned, which leads to the communities still adhering to the myths about the disease more, particularly, because some still believe that it is caused by drinking cold water or any drink. One of the nurses aged 33 narrates,

> *"It would not be fair to ignore those village health workers who do not understand the use of materials to educate communities' members about TB because they are going to confuse the communities' members who already have a problem of understanding the causes and treatments of the diseases that exist in their environment."*

Furthermore, the village health workers highlighted that one of their roles in the TB health education programme was to educate people who were already afflicted by TB on how to live healthy lifestyles that would permit them to resume their day-to-day roles in society. In fact, the village health workers have been trained on how to care for TB patients who have been released from the hospitals, more particularly, they are required to assist them to adher to the treatment regime in order to get well, but problems arise. Many TB patients or their relatives have lack of trust in the village health workers and this makes it difficult for them to help those people who are ill. In most cases, this lack of trust is as a result of the belief that village health workers will bewitch the patient. One community member highlighted, *"Many Basotho believe that when a person is not feeling well that is a good time when most people who hate him or her take a chance by bewitching the person so that the death can be easily blamed on the illness."* These allegations are persistent and some members of the community value them deeply and they challenge the work of village health workers.

Lack of trust on the other party by another does not permit people to learn about TB. Additionally, there have been some cases of village health workers who were expelled when trying to pay home visits to patients, to educate those who cannot attend the sessions. One traditional healer as a village health worker posited, "*I had heard that the son of one of my neighbour was ill due to TB, but her mother had never said a thing about it, I decided that I should pay her a home visit, though, it turned out badly*

because she insulted me. She furiously highlighted that she had heard that we are concerned about issues that do not need our intervention. She asked me to leave." This is so because they are claimed to be witches as some reported. There have been misunderstandings between the patients and village health worker either because of these misconceptions or the tendency for people to hide diseases they are suffering from. It is, therefore, assumed that such people would not bother to participate. There are misconceptions that still hinder participation in programmes.

Moreover, some, also, came across destructive tendencies by the chief when doing their work. One of them highlights "*There is a tendency for the chief and his assistants to believe that he has the authority to make decisions or control us on how we should do our work. He once instructed me to attend a meeting of his political party if we expect him to ask his subjects to attend ours. They sometimes failed to cooperate with us by failing to call community members on our behalf to the programme implementation at a specified time."* This shows that failure to limit one's power in some cases where it should be subdued can be very disruptive.

On the other hand, Lesotho still faces many challenges in healthcare delivery, especially around the location and services despite many initiatives done by the government including major reforms that were supported financially and technically by IDPs (Makoa et al, 2009). There are shortages of materials to educate people about TB. The clinic that works directly with the village health workers already had shortage of materials to educate the patients so the few resources available were shared amongst communities, since many communities needed to learn about TB as some nurses testified. The LRCS had, also, given materials in order to fill the gap experienced by the clinic, but the materials were still limited to be dispersed to all the communities. Respondents indicated that these were charts and leaflets that were very informative.

In addition, most village health workers pointed out that they are not paid consistently; they sometimes use their funds to pay for transportation. It is even expensive and not refunded by the clinics or the government. They pay these lots of money so that they can get to areas where they are given training on how to implement the TB health education programme and if an individual does not have it on a certain day, it means he

or she is bound to miss the training. This causes deficiencies because they fail to implement the programme properly. Some of them showed that they have to walk a long distance because of no funds to pay for their transportation.

> "*The work we do is difficult but no one feels pity for us. We work hard and we are always promised to be paid M300.00 per month but we do not get it every month. It comes once in a while and no one ever explains why the situation is like that. The worst part of it, we get the same amount whether one is new or old. In fact, each time we question we are reminded that we should value the spirit of voluntarism yet we are woken up at nights by people who need our help and who feel that we are paid, so we should help. We are really hurt and this affects the way we do our job."*

All workers need to be rewarded so that they can feel motivated to do their work properly. Furthermore, this issue of rewards sometimes leads to misunderstandings between workers, principally, because of the way the programme operates and this results in conflicts between them, which also leads to interrupted programme during implementation. It is apparent that this negatively impacted on the level of commitment to playing one's role of educating a rural community about healthy lifestyles and reducing exposure to the contraction of TB. They highlighted that during the payment process, new workers are given first priority yet old workers are the ones to be considered first. One of them frantically highlighted,

> "*Sometimes the way the programme is run, it creates problems that lead to conflicts among us. It is not fair to find that new workers get the same treatment or same benefits as old ones. Nepotism exists everywhere because you find that new workers get medical kits before some old workers yet they had applied for them many months ago without getting them."*

Moreover, some key informants perceived that the programme had lack of resources to implement it successfully. On the other hand, village health workers too signified that due to lack of financial resources, they failed to plan the programme along the line of comfortability during the learning process. They failed to provide chairs, shelter, and

transportation for people with disabilities and elderly people from their homes to the programme. This is what other key informants experienced. Yet again, the materials for learning were limited because they could not afford to buy plenty of them; hence, the village health workers shared them amongst themselves so that they could use those available to deliver the health massages in their communities. Nurses from the clinic at Ha-Konote narrated,

> "*One can imagine how difficult it is to deliver services in rural areas. We, already, as clinics, have a shortage of staff, results of patients to be checked for certain disease are not easily accessed in time, and we work in an old environment that permits no privacy for patients. We are trying to decentralize the health services, but, these already existing problems undermine the initiatives we do to cater for every rural area."*

Sometimes, it can be difficult dealing with people who are illiterate, but who need to be educated so that they can improve their health regardless of their educational standards. In fact, nurses in the TB ward in Mafeteng hospital emphasized that these people with low educational standards need more time to be educated about diseases such as TB because they are the most people who are admitted in their wards, who are infected by TB. They are mostly admitted on the basis of this illness, which is more influenced by lack valid health information that can permit them to avoid contracting the disease. However, the information gathered from some key informants unveils that these are the most hostile people when it comes to adopting healthy lifestyles because they do not know the value of health, they only realize when they are ill that their health is significant, as village health workers announced. Curtis (2004) noted that people who are functionally illiterate are often embarrassed to admit this to the educators, fearing marginalization; hence this complicates the learning process. The use of materials such as video presentations or slides may be discriminatory to illiterate people.

Lesotho review (2000) alerts that it is much less difficult to provide facilities and access to healthcare services in the lowlands than it is in the mountain areas being rural areas. As well, the topography of Thabana-Morena creates problems for community participation in health education programme of TB. In fact, some nurses indicated that it

has been difficult for them to deliver some of the services to other areas because of their terrain and some respondents admitted that their places are not easily accessible; it is even more frustrating for nurses whose homes are not in the highlands. Poor road network, particularly, for communities such as Ha-Manthama and Ha-Turupu hinder health development because these places are not simply reached; hence fail to have services such as community halls where these programmes could be held. Makoa et al (2009) noted that natural barriers such as topography and adverse climate conditions pose major challenges to the delivery of health services in rural areas of Lesotho. The village health workers at Ha-Turupu expressed,

> "*This health matter is a political issue. I wish 'm'e mphu (The minister of Health and Social Welfare) could come and see the situation in Ha-Turupu where there are even not many vehicles to transport people, we have no clinics. I wish she could come and talk to us directly, the village health workers, for we have more stories to tell than nurses who never even come to these far places. There is no clinic on top of this hill "Sehlaba" and people are suffering."*

Additionally, chiefs and some members of communities disclosed that some rural people failed to show value of development initiatives that are meant to transform their communities or even their lives as individuals. This is so because some came to the meetings excessively drunk and the drunkards disturbed other people who were willing to participate. Some village health workers confirmed this as one of their challenges that hindered the smooth implementation of the participatory programme. They failed to cooperate with them when they are in this state. It is a known fact that most rural people drink home-made beer such as *"Hopose"* and *"Khoatha*" which is affordable and some of the communities' members spend their days in households that sell it. Some people, particularly women, would be gossiping during the sessions and disturbing other listeners. This shows that some members of rural communities are still disempowered because people who value development share a belief that community development requires their contribution either manually or mentally and they feel that they understand that these are some of the ways to giving them power to change their lives.

4.3 Conclusion

This chapter has presented an analysis of the findings of the study which entails a picture of the extent to which the rural communities of Thabana-Morena participated in the TB health education programme. The respondents reported that they participated in the programme and they contributed in the implementation level. Again, they indicated that their involvement in the programme was beneficial to them and they stated that the participants in the programme had different characteristics, which had influence on the decision to participate. Finally, they admitted that they were faced by many challenges posed by either the community members or the village health workers in participating. Their accounts have been revealed as to potray the real situation at present.

4.5 Summary

This section discussed the findings of the study, which intended to assess the extent to which the Thabana-Morena rural communities participated in the TB health education programme. The voices of the programme participants are captured in this section, which illustrate the real stories pertaining to their participation in the TB health education programmes in different communities. It is revealed that various community members, who were influenced by certain characteristics, participated in the implementation of the programmes, whereas the trainers or facilitators engaged in all five phases of the programmes. Also, it is reported that the programme was effective to some extent, although, there were some challenges that were perceived, during implementation. Additionally, analysis revealed that a top-down approach was adopted in the implementation of the programmes, which was faced with problems relating to inclusion of all members of the communities.

CHAPTER FIVE

DISCUSSION OF FINDINGS, SUMMARY, CONCLUSION AND RECOMMENDATIONS

5.1 Introduction

This chapter intends to discuss the findings of the study; draw conclusions concerning the findings of the study and recommendations are made that can improve community participation in health education programmes or other interventions in rural communities and what could be done to ensure achievement of programme goals.

5.2 Discussions of findings

The views of most of the members of rural communities showed that they participated in the TB programme, particularly, in its implementation level. Although, some indicated that they did not participate for they prioritized their daily activities as more vital. Cooke and Khothari (2005:5) support that participation is a process through which stakeholders influence and share control over development initiatives. This implies that participation by some members of communities fuelled health development. However, as Oakley (1991) highlighted that true participation by communities is perceived whereby they play roles in problem analysis, planning, implementation, monitoring and evaluation. Findings reveal that this was not the case in the communities of Thabana-Morena.

In this case, it is identified that the programme used a top-down down approach which in most cases is ineffective in community orientated programmes. In fact, Oakley (1991) affirms that this approach is less successful in achieving health development. Based on the findings of this study, one can still argue that despite the admiration of a top-down approach, it is still faced by challenges that can make it unproductive, especially in cases whereby people decide not to participate. Again, if this approach is utilized in the context of limited resources, it may be fruitless and discriminatory. An example is drawn from a situation whereby the TB programme could not afford to organize transport for the aged and disabled people as they disclosed and therefore, they were excluded. Hence, the communities' participation was not representative and excluded vulnerable members of the community.

Furthermore, the experiences and perceptions of key informants showed that one's decision to participate is, first, evaluated so as to assess if participation will be beneficial or adverse. Also, in some cases whereby they had an interest in participating, there were barriers that hindered the choice. Even for the majority of the members of the communities, there were characteristics embedded in them which influenced their participation negatively or positively. According to Brinkerhoff (2003), these characteristics are likely to be shared among social or geographical settings.

5.2.1 The application of the Health Belief Model

As shown earlier, the HBM was basic to this study; the findings of this study are to a large extent consistent with its assumptions. The model argues that behaviour depends upon the likelihood of an individuals taking action and it is based on the interaction between their perceived susceptibility to the problem, the seriousness of the consequences of the problem, the perceived benefits of a specific action, the perceived barriers to taking action and cues to action. There are variables such as demographic, socio-psychological and structural factors which influence the individual's perception and, thus indirectly influence health related behaviour.

In this study, it was revealed that, even though, the programme required the participation of members of communities so that they could learn the health information

that influenced them to modify their behaviour; they still felt that they needed to assess it. They evaluated whether they wanted to participate, which determined the likelihood of action and the adoption of healthy lifestyles that would reduce their vulnerability. It is, also, noted from the findings that those who had the belief that they were vulnerable participated and those who perceived that TB is a problem considered engaging in the programme. Those who perceived barriers did not participate while some participated. Indeed, there were challenges faced by people who were engaged in the programme. A female respondent reported

> *"I did have an interest in attending all the educational sessions offered by the programme but it was difficult because I spend the rest of the day selling clothes so I could not attend, particularly, because they were held during the day."*

In the light of barriers hindering community participation, it is perceived that benefits influence participation in the programme such as health information that influenced healthy lifestyles. Failure for the programme to reward in a form of donations as some expected, discouraged participation. Moreover, it is highlighted that there were variables which determined whether people would take action such as gender whereby many females participated compared to males. Insofar as was concerned, occupation, people with low income hesitated to participate. Political interest and marital status were also found to be important variables determining the extent of participation. Having shown the application of the model, there are some recommendations that are outlined below that serve to show how community participation, especially, by rural communities in health education programmes can be improved.

5.3 Summary of findings

The study intended to examine the extent to which communities participate in a health education programme of TB in the Thabana-Morena locale. The views and experiences of informants about community participation and about the programme served as the source of evidence. The findings of this study are as follows:

The facts of the study reveal that the rural communities of Thabana-Morena participated in the TB health education programme administered by village health workers. These

workers were trained by the nurses who had collaborated with LRCS to increase awareness of TB. In fact, the LRCS policy has set their priority to be the promotion of TB and TB/AIDS awareness and address the stigma associated with the diseases. The nurses had shaped the training of the village health workers in such a way that they participated in the problem analysis, planning, implementation, monitoring and evaluation, whereas the members of the rural communities participated in the implementation level of the programme solely. It is noted that they contributed with their mental capacity so that the learning process could be possible. Indeed, facts have shown that their participation was very vital for the implementation of the programme.

Further, it has been noted that various stakeholders had different roles that they played in the programme of TB. The majority of village health workers played the role of analyzing the TB health problem, planning how this problem would be solved with the assistance of the nurses, they were also educators during the implementation level and they also evaluated the programme. Again, during the implementation phase they also paid home visits to patients who have contracted TB, who could not attend the education sessions. Meanwhile, the members of the rural communities including traditional healers played a role by being attendants and learners in the implementation of the programme as well as most chiefs. Besides, findings disclose that chiefs, also, played roles of being gate keepers and monitors of the members who could not cooperate with educators.

Furthermore, the data indicates the programme was effective to some extent because the roles that people played in the educational sessions managed to reward them, particularly, with health information. It is drawn that some people have been empowered; they were left with skills on how to improve their health status; they have been influenced to be accountable; and lastly, they have become partners in learning how to develop their health, which will benefit them even in other development interventions in future. Even though, there were characteristics of the participants which have hindered some members of communities' participation in the programme, such as political interests, occupation, marital status, gender and age as high school students indicated. Despite these characteristics, there were challenges highlighted by key

informants and village health workers that faced community participation of other members which resulted in adherence to myths about TB in some people, such as lack of payment of workers, illiteracy of both workers and learners, lack of resources, the topography, exclusion of other members and lack of motivation by rural community members. On top of this, the utilization of the top-down approach denied the rural communities to engage in every stage as to have a say in every level of the programme that needed their contribution in the desire to develop their health status.

5.4 Conclusions

In conclusion, the data has revealed that the intention to assess the extent to which the rural communities of Thabana-Morena participated in the TB health education programme was attained. Evidence can be drawn from the fact that informants were able to narrate their stories and admonitions that served as evidence to show their attendance in the educational sessions that were meant to influence healthy lifestyles, although, not every community member participated in the programme implementation. This was due to various reasons such as differences in economic backgrounds. Meanwhile, even for some who participated in the programme, their attendance was consistent.

The research findings continued to show that the community members from Ha-Turupu, Ha-Manthama, Ha-Bofihla, Ha-Konote and Mount Olivet participated at the implementation level whereat they played their roles as attendants and learners. For those who assumed these roles, they indicated that they were advantageous for they managed to learn the health information that empowered them and built accountability in them with regard to their health status. The opportunity that they got of working together as a team developed a sense of ownership and partnership in health development. Therefore, it is concluded that community participation in the TB health education programme was to some extent effective. In this way, health services have been extended to reach most people, though, special attention is still needed in the most disadvantaged communities of Thabana-Morena such as Ha-Turupu.

It is vital to take into consideration that there are characteristics of community members which determine the effectiveness of community participation. Some informants disclosed that their differences, which were economical, social and political influenced one's decision to participate regardless of the significance of the educational sessions. Despite these characteristics of community members that affected effective participation in TB educational sessions, there were challenges that faced the participants either caused by the participants or the village health workers as well as the programme. As a result, it is also concluded that challenges facing the participants hinder the efficiency to accomplish the programme goal of educating rural communities about the prevention of TB.

Additionally, drawing from the findings and the literature reviewed, it is concluded that community participation in health education programme especially in the case of TB is possible if properly planned so that it can be in the context of the community being dealt with. Again, the objectives of this study have been achieved based on the results and the model that was being tested had been valid in explaining behaviour towards risks and the likelihood of action against a perceived susceptibility.

5.5 Recommendations

Firstly, programme planners should make initiatives to adopt bottom-up approaches which accommodate high levels of community participation, particularly, when they are dealing with rural people who need to be empowered. In this case the communities will be able to solve what they feel to be a problem and they will suggest the ways in which they intend to participate in the intervention so that they can achieve what they feel is beneficial to them.

Secondly, initiatives to advocate for primary prevention at grassroots level should be constantly supervised by hospitals and clinics for diseases that reveal high prevalence so that people can learn and understand health information and participate well in the programmes so as to attain good health status.

Thirdly, the consistent payment of village health workers by the government for the work that they do will be the most vital initiative so as to motivate them to implement the health orientated community programmes that are participatory as planned.

Fourthly, programmes that require community participation should create a conducive environment to influence effective participation of community members. In fact, this forces the facilitators to choose the most appropriate location so as to permit comfortability in participating in order to appreciate the attainment of the programme goal.

Fifthly, assessment of people's activities by programme planners is recommended so that they can suggest a convenient time for participation based on different interests. This calls for the utilization of expertise to evaluate the feasibility of the intervention to be initiated and this will reveal whether the community can participate or not.

5.6 Suggestions for further studies

Studies to be conducted in future should try to find out the main reasons why most programmes still decide to use top-down curative strategies. Again, they should dig more into the main reasons why the health sector utilizes unskilled personnel in dealing with the rural communities in development programmes and the rationale for exclusion of the disabled people in development interventions, yet popular participation means the inclusion of all people in any development programme. There should be a follow-up on the main reasons why the idea of village health workers is not improving, yet it is a very old concept for it was adopted in 1978; and it is also needed to examine the main reasons why traditional healers still mislead people by making them believe that they cure all diseases.

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Appendix 1

INTERVIEW GUIDE

I am a Masters student at National University of Lesotho in the department of Sociology and Anthropology and I am conducting research as part of my study. The purpose of this study is to investigate community participation in TB health programme in the Thabana-Morena community. In this process, anonymity, confidentiality and no harm are guaranteed.

SECTION A

PERSONAL BACKGROUND

Name of the interviewer: ‘Masemote Grace Molale

Location: Mafeteng

Occupation: National University of Lesotho student

SECTION B

DEMOGRAPHICS

1. Gender
   (a) Male
   (b) Female

2. Marital status
   (a) Single
   (b) Married
   (c) Divorced
   (d) Widowed

3. Educational level
   (a) Tertiary level
   (b) High school level
   (c) Secondary level
   (d) Primary level
   (e) Others

4. How old are you?
   (a) 15-25
   (b) 26-35
   (c) 36-45
   (d) 46-55
   (e) 56-and older

5. Occupation
a) Farmer
b) Teacher
c) Nurse
d) Others

For community members as key informants

SECTION C

1. At which level do rural communities participate in TB health education programme?

a) Do you participate in a health education programme of TB?

a) Which levels are followed in implementing health education programme of TB?

b) What is involved in each of the levels?

c) Who determines these levels?

d) Do you follow them as they are?

e) How many people are engaged in each level?

2. What are the roles played by the rural communities' members in the TB health education programme?

(a) What role do you play in a health education programme of TB?
(b) How do play this role in a health education programme of TB?
(c) When do you play this role?
(d) Do you have the opportunity to select the role you want to play?
(e) Do you share this role?
(f) Are you satisfied with the role you play?

3. What is the effectiveness of Thabana-Morena rural communities' participation in TB health education programme?

(a) What is the advantage of the role you play in a TB health education programme?
(b) How has your involvement in the TB health education programme led to the development of your health?
(c) How do you intend to maintain those positive changes influenced by the TB health education programme?

4. What are the characteristics of people who participate in a TB health education programmes?

a) Who participates in the TB health education programme?

b) What is the criterion for selecting people to participate in the TB health education programme?

c) What is your opinion of these characteristics of the selected people?

5..What are the challenges faced by the community of Thabana-Morena in participating in the TB health education programme?

(a) Do you have the opportunity to play the roles you are assigned fully?

(b) What are the barriers to playing your roles?

(c) Is the TB health education programme accessible to every member of the Thabana-Morena community?

(d) Do you have a good relationship with facilitators of the TB health education programme?

Nurses/Teachers/village health workers as key informants

1. At which level do rural communities participate in a TB health education programme?

a) Do you participate in a health education programme of TB?

a) Which levels are followed in implementing health education programme of TB?

b) What is involved in each of the levels?

c) Who determines these levels?

d) Are they followed as they are?

e) How many people are engaged in each level?

2. What are the roles played by the Thabana-Morena community members in the TB health education programme?

(a) What role do you play in a health education programme of TB?

(b) Do you share this role with other community members?

(c) Which roles do you expect the community to play in a health education programmes?

(d) How do they participate?

(e) When do they participate?

(f) Do they really play their roles?

3. What is the effectiveness of Thabana-Morena rural communities' participation in health education programme of TB?

(a) What are the advantages of playing your role?

(b) What are the advantages of the community participating in health education programme of TB?

(c) Do you think the community should continue participating in health education programmes?

4. What are the characteristics of people who participate in a TB health education programmes?

a) Who participates in the TB health education programme?

b) What is the criterion for selecting people to participate in the TB health education programme?

c) What is your opinion of these characteristics of the selected people?

5. What are the challenges faced by the community of Thabana-Morena in participating in the TB health education programme?

(a) What are the challenges that face your role?

(b) What are the challenges that face the programme itself?

(c) What can be done to alleviate these problems?

Interview guide for Focus group discussions for students

1) Do you participate in a TB health education programme?

2) How is the school disseminating TB knowledge to you?

3) Which levels are followed in implementing health education programme of TB?

3) At which level do you participate?

4) What role do you play in a TB health education programme?

5) How is your participation in TB health education programme benefiting you?

6) What are the characteristics of people who participate?

7) What are the challenges that face your participation in health education programme TB?

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