Review of Journalism and Mass Communication
December 2015, Vol. 3, No. 2, pp. 1-40
ISSN: 2333-5742 (Print), 2333-5734 (Online)

Published by American Research Institute for Policy Development
DOI: 10.15640/rjmc.v3n2a1
URL: http://dx.doi.org/10.15640/rjmc.v3n2a1

Community Participation in Design and Implementation of Health Campaigns in Nyando Sub County

Jonai Wabwire[1], Charles Nyambuga[2] & Adams Yakub[3]

Abstract

Media disseminates health information through many ways among them health campaigns. Media health campaigns are central to people's ability to acquire knowledge for better health. As such there has been a marked increase in the number of nongovernmental organizations (NGOs) and governmental agencies running health campaigns in Nyando Sub County. With the various forms of media in use in these health campaigns, it is expected that the communicated messages would impact people positively and greatly reduce health problems being propagated. This, however; might not mostly be the case. Hence, the question of how community participation helps towards the design and implementation of health campaign calls for in-depth consideration. Subsequently, there is need to unravel to what extent the community should effectively participate in health campaigns design and implementation of appropriate media. It is on this ground that this study purposed to examine the influence of community participation on health campaign design and implementation in Nyando Sub County. The study population included 38 NGO managers, 6 chiefs, 17 assistant chiefs and 30,439 household heads totaling to 30,500 respondents. Fisher's formula was applied to find sample size of 379 for the households. Random walk technique was then used to get the 381 households. For NGO heads, chiefs and assistant chiefs, purposive sampling was applied to get respondents hence sample sizes of 11, 4, and 6 respectively at saturation levels. Interviews and questionnaires were employed in data collection. Data from households was analyzed using descriptive statistics such as cross tabulation and frequencies. Data from NGO managers and chiefs was brought together using themes to explain findings. Issues discovered as a result of categorizing and sorting data were developed. Study findings showed that there is low level of participation in design and implementation of health campaigns in Nyando Sub County. As such there is participation in decision making, problem identification, community mapping, media programmes and budgeting aspects of the campaign. Participation in Nyando Sub County is beyond nonparticipation and is challenged by

[1] Department of Communication and Media studies, Maseno University.
[2] Department of Communication and Media Studies, Maseno University.
[3] Department of Linguistics, Maseno University.

nonparticipation culture, financial constraints, self appointed leaders and accountability issues. It was noted that it is not easy to achieve high levels of participation since campaign planners are not aware of those levels and their understanding of participatory approaches is scanty. As such this study concluded that campaign planners should regard community participation as key to improving health communication interventions that improve health outcomes of the target community. In this light the study recommended that NGOs and governmental agencies should create enabling environment that incorporates community's needs and aspirations through decentralization of management and decision making responsibilities including participation of local people.

Keyword: Community participation, Design, implementation, health campaigns, health communication, media campaigns

Introduction

Media organizations disseminate information from health campaigns to the target community. Community participation in the design and implementation of this health campaigns as Onyx (1997) and Kawachi (1997) assert is an essential factor in the success of the work of health communication experts. In spite of this, target communities in health communication campaigns from observation do not appear to be getting fully involved in health communication initiatives aiming at them. In situations where they attempt to involve them, they do it partially (Labonte, 1997; WHO, 2000). This inadequate or partial involvement may have a negative impact on health communication campaigns' success. Arnstein (1969) terms inadequate involvement in design and implementation as manipulation and therapy. In her ladder of participation, Arnstein asserts that most campaigns experts pretend to be involving the target community while in the real sense their objective is not to enable people to participate in planning or conducting health communication campaigns, but to enable power holders to educate or cure participants. In this sense as Hart (1997) argues, participants in the campaigns basically support and say what development representatives suggest that should be done, but do not have any understanding of the issue that affects them. WHO (2000) on the other hand suggests that target communities in health campaigns should play a major role in design, implementation, monitoring and evaluation of health communication campaigns. As such this study investigated effective community participation strategies, levels of participation, and ways of participation in Nyando Sub County.

1.2 Health communication

Communication is increasingly recognized as a necessary element of all efforts to improve health. Health communication is the study and use of communication strategies to inform and influence individual and community decisions that enhance health (U.S. Department of Health and Human Services, 2000). Healthy People (2010) confirm the importance of communication as an intellectual framework, a scientific endeavor, and a set of processes and interventions for health improvement. Health communication has become part of life. As such mass media coverage, entertainment programming, and public policy debates are important places for public communication about health. Health communication can contribute to all aspects of disease prevention and control, health promotion as in campaigns, and medical care. It is relevant in a number of contexts of our lives as individuals, patients, members of families and communities, workers, civic participants, and voters.

Thus, health communication is critical for people's exposure to, search for, and use of health information; individuals' ability to reduce or eliminate unhealthy behaviors and adopt healthy behaviors; and individuals' and community groups' ability to make decisions about the health of their workplace, their community, and our society (Healthy People, 2010). Furthermore, as for this study (WHO, 2000) asserts that health communication is central to people's ability to gain access to the public health and healthcare systems; health professional patient interactions; people's ability to engage in appropriate self-care and chronic disease management; and people's understanding of clinical recommendations and expected outcomes. Communication is critical to the work of health professionals and their interactions with each other, their patients, and the information they create and use. Health communication principles must inform the dissemination of information about individual and population health risks, the construction of public health campaigns (Healthy People, 2010).

As such community participation in health communication initiatives such as campaigns serves to empower and enhance the health of communities and the health of people who form a target community (Rosenfeld, 1997). It refers to the process between people, which establishes networks, norms and trust enabling coordination and cooperation for mutual benefit in a health campaign.

Community empowerment is created as a byproduct of community participation; this maintains the property of non-excludability meaning its benefits are available to all living within the community and access is not restricted (Kawachi 1997). Having noted this, previous studies have very little on the extent to which the community should be engaged in health campaign design and implementation for the above mentioned benefits of community participation to be achieved. Therefore this study was interested in finding out the extent to which community participation influence health communication campaigns in Nyando Sub County.

Labonte (1997) calls for community engagement in public participation especially in health communication campaigns arguing that this has translated to direct improvement in the health, adoption of health innovation in campaigns, and well-being of many people by overcoming isolation perceived powerlessness. Onyx (1997) further emphasizes that Community participation is the cause and effect of development providing the possibility for the community health development to prosper whilst simultaneously being a key product of community development. All these are good benefits of participation but the two studies have not developed a clear framework on how or what level participation should be carried out in order to bring improvement in the health sector.

Community empowerment through participation has been identified as a promoter of health, whilst powerlessness is associated with being an increased risk factor for disease (Wallerstein, 1992). Health status, in post-industrial societies, has become a measure of the power and competence of people, with research revealing that it is impossible to create health awareness amongst people who perceive themselves to be powerless (McKnight, 1995). In further reference to McKnight (1995) the powerless, as the objects of concern or care, appear to be immune to the health care and education bestowed upon them, with a large array of communication campaigns proving to be ineffective and consequently abandoned. Ample evidence exists revealing that people who perceive themselves to be powerless experience worse health than those empowered through community participation (Rissel, 1994). As such this study aimed at establishing how powerful the target community should be made as they participate in the design and implementation of health campaigns. Again it is not clear on who should be made powerful bearing in mind the target community may be having people of varied background. Previous studies do not address such issue.

As such this study sought to examine the influence of community participation on design and implementation of health campaigns through; establishing the level and ways of participation health campaign planners engage the Nyando Sub County.

Again traditional public health tools such as health communication campaigns have become part of the problem, amplifying the powerlessness as health has become a victim of professionals and policymakers who attempt to treat the political issue of powerlessness as a technical problem rather than transferring the tools, authority, budgets and income to the people who perceive themselves to be powerless (McKnight, 1995). As such it was not clear whether this was the case in Nyando Sub County. Community participation in health communication campaigns offers the potential for success through the effects of collective political action and structural changes. Accordingly as Putman (1993) posits, high levels of participation tend to characterize economically successful societies. Further, previous research provides evidence that more quality social contacts that people engage in during the design and implementation of health communication campaigns correlate with lower levels of morbidity and increased life expectancy (Rosenfeld 1997).

In addition the importance of community participation in successful health communication campaigns activities is stressed in documents such as the Ottawa Charter for health campaigns, WHO (1986) and the Jarkata Declaration WHO (1997). Community participation has been emphasized as the basis of primary health care, increasing the need to understand the way in which community participation develops (Rfkins, 1986). Community based health campaigns should aim at encouraging empowerment within the community stressing partnership rather than professional dominance. Community members should be considered integral to designing, implementation and evaluation of community health campaign initiatives (Baun, 1998).

Community participation provides the foundation that facilitates a holistic approach to problem solving and attempts to bring different key stakeholders together to engage in problem posing, problem solving and decision making (Labonte, 1997). However, participation in health campaign does not encompass affixed definition, but rather includes a continually unfolding and changing process of negotiation between individuals and group constituencies (Labonte, 1997).

Successful health communication campaigns strategies bring about social change – they change community norms, values and individual behaviours. Accordingly as Labonte (1997) further posits successful strategies should involve synergistic interaction between individuals and larger systems, such as communities. Social change strategies respect differences and foster empowerment and responsibility rather than any predefined good. Having noted the above numerous calls by various scholars for community participation in health campaigns design and implementation, past research had not clearly stated the level to which the target community in design and implementation should take. Various literatures have only strongly called for participation but have not given a framework on this should be done. This was regarded as a serious omission which this study sought to address.

2.0 Methodology

This study was carried out in Nyando Sub County. Study population included 38 NGO managers, 6 chiefs, 17 assistant chiefs and 30,439 household heads (KNBS, 2013; KENPRO 2014). This population was involved in the study since the NGOs in partnership with government officials (chiefs and their assistants) are the designers and implementers of health campaigns whereas the households are the intended consumers of the innovations that come with health communication campaigns.

2.1 Sampling procedure and sample size

Sample size for the respondents from the households was determined using the fisher's formula recommended by Mugenda and Mugenda (1999). This formula is expressed as shown below:

$$nf = n/(1+n/N)$$

Where;

nf = sample size (when the population is less than 10,000).
n = Sample size (when the population is more than 10,000).
This figure is taken to be 384, for a desired accuracy level at 0.05.
N = Size of the study population which in this case is 384.

As such the sample size for the households applying the above formula was 379. For the NGO managers, chiefs, and assistant chiefs purposive sampling was used hence establishing their respective sample sizes at the saturation levels as shown on table 3.1.

Table 1: Sampling frame

Respondents	Population	Sample size	Sampling Procedure
NGO managers	38	11	Purposive sampling
Chiefs	6	4	Purposive sampling
Assistant chiefs	17	6	Purposive sampling
Household heads	30,439	379	Random walk technique
Total	30,500	-	

Source: (KNBS, 2013; KENPRO 2014)

This study employed snowball and simple random sampling procedures. First, the respondents were stratified into respective categories: NGOs managers, chiefs, assistant chiefs and household heads. Then, purposive sampling was applied on 38 NGOs managers and 6 chiefs and 17 assistant chief as key informants up to the point of saturation level. It is at saturation level that the sample sizes of the NGO mangers, chiefs and assistant chiefs were established. Random walk technique was then used to identify 379 household heads to fill in the questionnaires. The study ensured that the 379 households come from all the six (6) locations of Nyando sub County through the aid of the chiefs.

2.2 Interviews

Creswell (1998) advice researchers using interviewing techniques while collecting data, to at least carry out six interviews in their research. It is upon this basis that the current study had 11 interviews with the NGO heads, 4 interviews with chiefs, and 6 interviews with assistant chiefs in Nyando Sub County. As such interview schedules were prepared to help administer the interviews. The researcher started by identifying the officers after which a letter was done requesting them to answer certain questions in line with the study. The venue for the interview was then decided; this was done in line with the respondents wishes. During the interview, data from respondents were noted down; the responses were also recorded by a tape recorder.

These interviews were carried out in the offices of NGO heads, chiefs and their assistants. While applying these data collection methods the study collected data which was only needed for purpose of this research. Data collected supplemented the information in questionnaires.

2.3. Questionnaires

This study with the aid of the three research assistants distributed 379 questionnaires to the sampled respondents drawn from Nyando Sub County households basing on the divisions as shown on table 3.1 below. Nyando Division had 190 questionnaires distributed while Kadibo Division had 189 questionnaires distributed to its households. The researcher then collected the questionnaires for data analysis. Data was then used to determine the level of community participation in Nyando Sub County. To achieve a scholarly accepted response rate, chiefs and their assistant chiefs were requested to allow the researcher to use their meetings 'barazas' to get households fill the questionnaires.

Table 2.2 Distribution of questionnaires in Nyando Sub County Divisions and Wards

Divisions	Wards	No. of households
Nyando	Onjiko, Ahero, Wawidhi, Awasi	190
Kadibo	Kabonyo, Kobura, Katho	189

3.0 Data Analysis, Presentation and Discussion

3.1 Questionnaire return rate

A total of 379 questionnaires were given out to household heads from six locations of Nyando Sub County. Out of the 379 questionnaires 306 were returned. This resulted in a return rate of 80.7 percent which was adequate for analysis. This rate fell within the confines of a large sample size (n>30) and provided a smaller margin of error and good precision (Anderson, Sweeney & Williams, 2003). Data was then analyzed using descriptive statistics such as percentages, frequency distribution and presented in tables and charts using SSPS version 20. Data collected using questionnaires was supplemented by data from interviews.

3.2 Participation in designing and implementation of health campaigns.

To establish whether Nyando Sub County participated in the design and implementation of health communication campaigns running there, this study examined the relationship between age, gender and education levels of respondents on participation in campaign design and implementation. Age, education level and gender were cross tabulated with selected questions in the questionnaire. The three variables (age, education and gender) of the respondents were regarded as important since they are the key variables that exert influence on the attitudes and participation levels of the members of the target community by the health communication campaigns (Abdel, 2012). Again as Mefalopulos (2008) notes, health communication campaign officials consider various demographic status of the target community for effective participation in design and implementation of health communication projects. The analysis, interpretations and discussions were done as follows:

3.2.1 Awareness of campaigns running in Nyando Sub County

The level of awareness on running campaigns was cross tabulated with age as shown in table 4.1 to establish knowledge about running campaigns in Nyando Sub County.

Table 3.1 Cross tabulation of age and community knowledge of health campaigns

		Frequency	Percent	Valid Percent	Cumulative Percent
	YES	220	71.9	71.9	71.9
	NO	86	28.1	28.1	100.0
	Tot.	306	100.0	100.0	

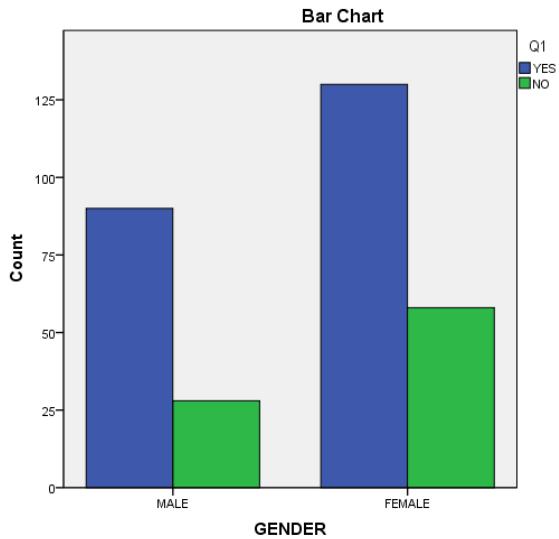
It is apparent in table 3.1 that 71.9 percent of the respondents were aware while 28.1 percent were not aware of the health campaigns running in Nyando Sub County. Those who were aware of the campaigns listed the names of the campaigns among them being polio, HIV/AIDS, Voluntary male circumcision, malaria, tuberculosis, wash your hands etcetera. This implies that people may participate in health campaigns they are aware of and have knowledge about. Information about health campaigns that lead to their awareness is normally disseminated by various media.

Wolfe (1994) identifies a range of staged models of the diffusion process in health campaigns. While the numbers of stages in these models can vary, there is considerable overlap and Rogers (1995) five-stage model is the most frequently cited (Nutley, Davies, and Walter, 2002). One of the stages in the five stages of this model is: Knowledge – the individual (or decision-making unit) is exposed to the innovation's existence and gains some understanding of how it functions. As it is the case with Nyando Sub County those who were aware participated in the design and implementation of the communication campaign and those who were not aware did not participate or participated ignorantly.

3.3.2. Awareness among various genders in design and implementation of campaigns

To get more insights on this issue, gender of participants was analyzed in relations to community's knowledge of campaigns running in Nyando Sub County as presented in figure 3.1

Figure 3.1 Gender and knowledge of health campaigns



From figure 3.1., it can be noted that the overall response that people were aware and had knowledge of the health campaigns in the area was very high compared to those who were not aware with 220 out of 306 respondents and 86 out of 306 respondents respectively.

Based on gender, women formed a large number of respondents as compared to men with 188 out of 306 respondents to 118 out of 306 respondents respectively. However, most men were aware of the health campaigns in the area of study with 90 out of 118 male respondents aware as compared to 130 out of 188 women respondents' aware making 76.3% of men aware to 69.2% of women aware. This implies that women in Nyando Sub County participated in health campaigns which they had little knowledge of. This further implies that though they participated they might not have had enough knowledge about the health communication campaign or may have done it ignorantly.

At a mere glance, this result negates the original organizing hypothesis put forward to guide this study, that there was low level of community awareness of health campaigns in Nyando Sub County. This is a commendable state of affairs implying that the nongovernmental organizations have succeeded in their awareness creation of health campaigns among males and females in the region. Rogers (1995) explains that there are four major theories that deal with the diffusion of innovations. These are the innovation-decision process theory, the individual innovativeness theory, the rate of adoption theory, and the theory of perceived attributes. The innovation decision process theory is based on time and five distinct stages. The first stage is knowledge. Potential adopters of health campaigns must first learn about the innovation in them. Second, they must be persuaded as to the merits of the innovation. Third, they must decide to adopt the innovation. Fourth, once they adopt the innovation, they must implement it. Fifth, they must confirm that their decision to adopt was the appropriate decision. Once these stages are achieved, then diffusion results (Rogers, 1995).

3.3.3 Awareness among people of various educations about health campaigns

Education level of the respondents was examined and cross tabulated against awareness of the campaigns in Nyando Sub County as shown in table 3.2.

Table 3.2 Cross tabulation of education level and knowledge of health campaigns

E. LEVEL				Total
		YES	NO	
	PRIMARY	58	22	80
	SECONDARY	81	37	118
	CERTIFICATE	7	1	8
	DIPLOMA	46	19	65
	DEGREE	26	5	31
	MASTERS	1	0	1
	NONE	1	2	3
Total		220	86	306

From the table 3.2, it is evident that most of the respondents regardless of their level of education were aware of the campaigns comprising of 220 out of 306 respondents as compared to 86 respondents who were not aware. Those who led with having higher level of awareness of the campaigns were those with masters degree with 1out of 1 respondents aware, followed by those with certificate with 7 out of 8 respondents, then those with degree qualification with 26 out of 31 respondents, then those with diploma with 46 out of 65 respondents. Those with secondary education followed with 81 out of 118 respondents, then those with primary education with 58 out of the 80 respondents and lastly those who did not go to school having 1 out of three respondents. This implies that a bigger percentage of the Nyando Sub County people were aware of the campaigns. Awareness is one of the attributes of diffusion of innovations (DOI) theory which guided this study.

Diffusion of Innovations is characterized by four elements: an innovation, communicated via certain channels, over a period of time, to members of a social system to create awareness (Rogers, 1995). The innovation refers to an idea, practice, or object that is perceived as new to an individual in a health campaign. The DOI literature is replete with examples of successful innovations: hybrid corn, modern math, new prescription drugs, and family planning, to name a few. However, the changes in behavior needed to halt the HIV/AIDS and other epidemics constitute what Rogers (1995) has labeled a ''preventive innovation,'' defined as ''an idea that an individual adopts at one point in time in order to lower the probability that some future unwanted event may occur'' (Rogers, 2003).

Although the theory of DOI is very comprehensive, Rao and Svenkerud (1998) have identified the six DOI concepts that are most relevant to lead to campaign adoption. The innovation decision process is an overtime sequence through which a target audience member passes. This sequence has five stages: 1. awareness, 2. knowledge, 3. persuasion, 4. adoption, and 5. implementation.

3.3.4. Participation in design and implementation of campaigns.

To establish whether the Nyando Sub County was part of the design and implementation age, gender and education level of the respondents were cross tabulated with their participation in design and implementation as shown in tables 3.3, 3.4 and figure 3.2.

Table 4.3 Cross tabulation of age and involvement in design and implementation of campaigns

AGE				Total
		YES	NO	
	15-25	48	40	88
	26-35	65	40	105
	36-45	43	21	64
	46-55	20	7	27
	56-65	5	5	10
	> 65	6	6	12
Total		187	119	306

Table 3.3 indicates that respondents were aware of the health communication campaigns conducted comprising of 71.9 of the total respondents. It shows that the age group that most participated in the design and implementation was that of between 26-35 years and the least was that of 56-65 years. However, the age group that was most aware of the health campaign was that of 46-55 years which had 81.2% of the total respondents of that age group with the least aware being the age group of 15-25 years having 62.5% of the total respondents of that group aware of the health campaign. This implies that people may be aware of a campaign but still not participate in their design and implementation. According to the sampled NGO managers people may not participate because of the following:

R1: Some community members do not participate in campaign design and implementation because of the many commitments they have. They are overwhelmed with other responsibilities of life.

R3: "Most community members have the culture of not participating in various development initiatives. They don't see the need. The campaigns are also complicated. People don't like complicated things."

R5: "When the community realizes that there is no motivation for participation they automatically reject any call for participation. Sometimes the communities find the campaign officials very bureaucratic something they are not used to."

From the questionnaires and interview extracts it is clear that not all those who are aware of health campaigns may participate in their design and implementation. From the interviews with the NGO heads it is clear some members did not participate because they had commitments, they did not see the need, the campaigns were complicated and lastly there was no motivation for them to be involved. This according to Bassette (2004) may be the case if the agencies carrying out the campaign lack proper structures that encourage participation. Again Rodgers (1995) in his theory of diffusions of innovations asserts that people may be aware but if the campaigns innovations are complex will still not participate in their design and implementation. Previous studies such as (Bassette, 2004; Tufte, 2009) suggest that awareness of health communication campaign should be created by health campaign developers as this may eventually lead to the target community participating in their design and implementation. This community participation strategy has been endorsed by various studies (Almata declation, 1978; Ottawa charter 1996 and WHO, 1998)

Of those who were involved, some formed part of the design phase as others formed part of the implementation phase as shown in the interview extracts from the NGO managers below.

R1: "Participation in designing was done by consulting the community while in implementation we gave the community the chance to mount posters and set billboards."

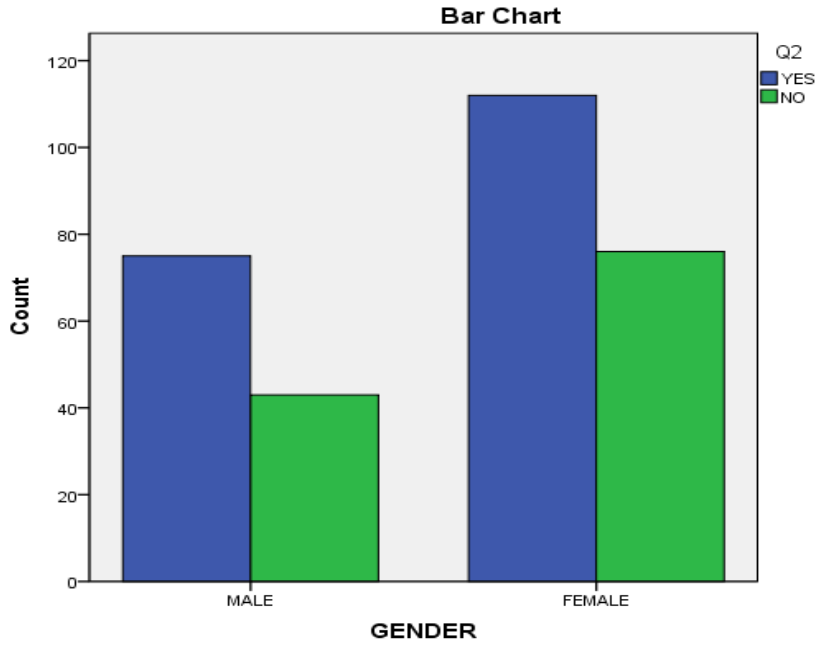
R2: "For our case the community made decision during designing stage and participated in drama, composed songs during the implementation stage."

R3: "I consulted the community on what to do for them during design stage and gave them the opportunity to budget, shoot video and distribution of condoms during the implementation activity"

R4: "Training, consultation, problem identification is what we do during design and during implementation the target community set up billboards, participate in theatre, drama and radio programmes"

Information obtained from interviews clearly shows that the Nyando Sub County to some extent participated in the design and implementation; this was through consultation, decision making, training, problem identification budgeting, shooting of video and distribution of condoms. Involving the community in just some selected aspects of the health campaign is not enough participation as is the case in Nyando Sub County. Previous studies such as (Almata 1978; WHO 2000; Tufte 2009) advice that target community should be involved throughout the health campaign stages. To get more information on the nature of participation gender was cross tabulated with participation in design as shown in figure 3.2.

Figure 3.2 Gender and involvement in design and implementation of health campaigns



From the figure 3.2., it can be noted that a larger percentage was involved in the design and implementation phases of the health communication campaigns with 187 out of 306 respondents agreeing as compared to 119 out of 306 respondents disagreeing. In regard to gender, 75 out of 118 male respondents agreed that they were involved in the design and implementation phases against 43 out of 306 respondents who disagreed. 112 out of 188 women respondents agreed that they were involved in the design and implementation phases against 76 out of 188 women respondents who disagreed.

This shows that a bigger percentage of those who were involved in the design and implementation phases were men with 63.6% as compared to that of women of 59.6%. This implies that there was minimal gender disparity involvement in design and implementation of the health communication campaigns. This finding contradicts findings from the two NGO Heads R5 and R6 who pointed out that women participate more in campaign design and implementation when asked about the level of participation they engage the community in relation to gender of the participants:

R5 "Women participate more in the design and implementation of health campaign more as compared to men"

R6 "In the campaigns that my organization has been running in Nyando Sub County for the last ten years, more women have participated in their design and implementation than men.

Studies such as (Hornik, 1988; Mefalopulos, 2003) attribute failure of health campaigns adoption to poor design and lack of male and female gender support to open opposition to the campaigns' objectives and related activities. Gender relations define amongst other things, how both men and women have access to control of resources in the community. According to Shepherd (1998, pp.150-151), gender analysis comprises: "information to access and control over resources for men and women; division of labour within the household and community; and the participation of men and women in public decision making and organizations". Despite the importance placed upon people's participation in development programmes, many agencies still experience poor participation of women (Guijt and Shah, 1998). According to Slocum, Wichhart, Rocheleau, and Thomas-Slayter (1995), many participatory approaches such as participatory rural appraisal (PRA) do not explicitly address issues of social relations including gender. Rarely do these methodologies take into account gender analysis, gender based differences in labour allocation, and gender differences in access to and control over.

The influence of education level of respondents was also probed as shown in table 4.4 below to get more information for the study.

Table 3.4 Cross tabulation of education level and involvement in design and implementation of campaigns

E. LEVEL				Total
		YES	NO	
	PRIMARY	51	29	80
	SECONDARY	65	53	118
	CERTIFICATE	5	3	8
	DIPLOMA	41	24	65
	DEGREE	23	8	31
	MASTERS	1	0	1
	NONE	1	2	3
		187	119	306

From the table above, it can be noted that respondents from all levels of education agree that they were involved in the design and implementation phases of the health campaigns with 187 out of 306 respondents against 119 out of 306 respondents who disagreed. Those who agreed that they were mostly involved were those with masters having all its members involved. They were followed closely by those with degree with 23 out of 31 members involved. Those with diploma followed with 63% followed by those with primary education with 63%, then those with secondary education with 55% and lastly those who did not go to school with 33.3%. They participated actively or passively through various ways as shown below from the sampled interviews with the chiefs and NGO heads:

R3, "all those who participated in drama for our campaign were picked from Nyando Sub County. We have designed malaria, polio and HIV campaigns". The community identified the launch site for us

C4 "When the health campaign official come to our offices we normally make sure that we help them accordingly. Recently they were in my office and we helped them pick on some people who are currently working with them"

This implies that the education level of someone may determine someones' participation in health communication campaign. This is in line with Richard (1996) who posits that certain kinds of education such as the three Rs: Vocational training and higher education equip a person to perform certain jobs or functions more effectively.

He further argues that education enhances one's ability to receive, decode and understand information and that information processing and interpretation is important for performing some tasks in health communication campaigns design and implementation. According to Rodgers (1995) educated people are likely to form the group of early adopters in any innovation adoption processes. These are people who represent opinion leaders. They enjoy leadership roles, and embrace change opportunities. They are already aware of the need to change and so are very comfortable adopting new ideas. They do not need information to convince them to change.

3.3.5. Cross tabulation of age and community expectations of running health campaigns.

A society has its values and norms and its way of living. These values and norms have to be respected by the campaign designers and implementers for the success of the campaign (Tufte, 2009; WHO, 2000). In most cases, anything that comes to a community in form of innovations must have either a negative or positive impact. As such the community has expectations that the running health campaign improves their lives and not temper with their values. The tables 3.5, 3.6, and figure 3.3 below shows how the respondents in Nyando Sub County viewed the running of health campaigns in line with the expectation of the community.

Table 3.5 Cross tabulation of age and community expectations of running campaigns

AGE							Total
		STRONGLY AGREE	AGREE	NEUTRAL	DISAGREE	STRONGLY DISAGREE	
	15-25	35	21	5	7	19	87
	26-35	53	18	5	11	18	105
	36-45	34	11	5	1	13	64
	46-55	17	6	0	1	3	27
	56-65	3	2	0	1	4	10
	> 65	5	2	1	0	4	12
Total		147	60	16	21	61	305

From the table 3.5, it is clear that a majority of the respondents agreed that the running campaigns were in line with expectation of the community.

Those who agreed according to table 4.5 were 147 out of the 306 respondents, followed with those who strongly disagreed with 61 out of the 306 respondents, then those who agreed with 60 out of 306 respondents, then those who disagreed with 21 out of 306 respondents, then those who were neutral with 16 out of 306 respondents and lastly those who did not give any response having 1 out of 306 respondents. It further shows that those who were in favor of the running campaigns that they were in line with the community expectations were many compared to those who were not in favor. This implies that people of various age groups will always support and participate in heath campaigns that are in line with the community expectations (Freire 1970). Community participation in health campaigns design and implementation is a partnership.

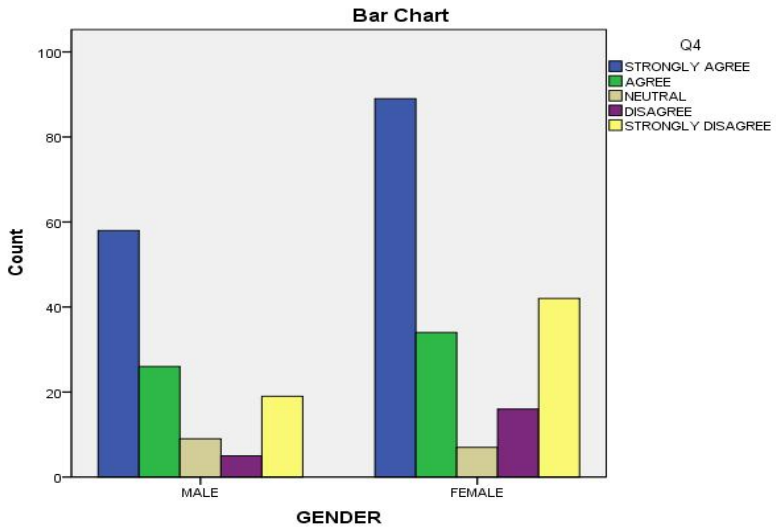
The health campaign planner and the community members, including youths and the adults have knowledge and expertise related to the issue. The health campaign planner know how to facilitate the process and can help community members analyze the health problem, such as identifying factors that contribute to the health issues affecting them. The campaign planner provides the tools and suggests strategies to collect information to help diagnose the cause and extent of the problem (Freire 1997). The planner also has professional knowledge of the reproductive and sexual health field, including best health practices. Community adults are important partners in the process, bringing community perspectives to the issue. They are experts in the community's culture and priorities. They understand the community's resources and constraints. During the process of community mobilization, they often become more knowledgeable about health issues and more vested in identifying and implementing successful strategies to help people stay healthy.

They do this more if the health campaign dealing with the health issues is in line with their expectations (Rodgers, 1995). The process itself helps the community to take ownership of both the problem and the solutions. In so doing, community mobilization also improves program success and sustainability. Various age groups participation as equal partners in this process is essential. People of various age groups in the target community should be intimately involved in any community mobilization strategy. The community has the right and the responsibility as Freire (1970) posits to help diagnose health problems that affect them. Community participation respects people's unique ability to guide the community in understanding how the environment influences health of the community.

The community is uniquely able to look at the best practices and to identify which strategies might have the strongest impact on their decisions and, consequently, on their health. Youth share responsibility for shaping the programs (Freire, 1970)

Respondents' responses basing on their gender were further examined to find out their views on whether the running campaigns were in line with the community expectations as shown in table figure 3.3.

Figure 3.3 Gender and community expectations of health campaigns



From the figure above, it can be noted that most respondents from both genders were highly satisfied that the expectations of the community were met with a total of 147 out of 306 respondents. They were followed by those who strongly disagreed with 61 out of 306 respondents, then those who agreed with 60 out of 306 respondents then those who disagreed with 16 out of 306 respondents and lastly 1 out of 306 respondents who did not respond to the question. Based on gender, female respondents had a larger number of respondents agreeing that the expectations of the community were met with 89 out of 188 female respondents as compared to 58 out of 117 male respondents. Averagely, those who both strongly agreed and agreed were many as compared to those who disagreed and strongly disagreed. This is commendable move in Nyando Sub County to have people of both male and female genders involved in programmes. Cultural norms have in the past dictated behavior of the participants in health initiatives. As Singhal & Rogers (2003) explained, culture can be a barrier or a facilitator in controlling the epidemic.

One aspect of culture, the role of women in a given society—is recognized as central to disease prevention. In many societies the inferior status of women makes them particularly vulnerable to some diseases. A faithful wife who suspects her husband of having multiple partners cannot refuse to have sexual relations with him or negotiate condom use. Young women are often the victims of forced sexual relations, including members of their own family.

Table 3.6 Cross tabulation of education level and community expectations of health campaigns

E.LEVEL							Total
		STRONGLY AGREE	AGREE	NEUTRAL	DISAGREE	STRONGLY DISAGREE	
	PRIMARY	42	13	2	3	20	80
	SECONDARY	60	15	9	10	23	117
	CERTIFICATE	3	3	0	0	2	8
	DTIPLOMA	24	18	5	6	12	65
	DEGREE	16	11	0	2	2	31
	MASTERS	1	0	0	0	0	1
	NONE	1	0	0	0	2	3
Total		147	60	16	21	61	305

From table 3.6 above, it is clear that a large number of respondents agree that the campaigns met the expectations of the community. Out of 305 respondents to the question, 147 strongly agreed, 60 agreed, 16 were neutral, 21 disagreed, and 61 strongly disagreed. Those with at least any level of education had a higher number of respondents agreeing that the expectations of the community were met. Those with no formal education at all had 1 out of three respondents agreeing with the assertion. This implies that educated people are likely to examine a certain health campaign and understand whether it is in line with the community expectations hence participating in its design and implementation. Rodgers (1995) asserts that educated people are likely to form the innovators and early adopters group of campaign innovations. Innovators are the individuals in a system that leads in the adoption of an innovation. Their interest in new ideas leads them out of a local circle of peer networks and into more cosmopolite social relationships. Communication patterns and friendships among a clique of innovators are common, even though the geographical distance between the innovators may be considerable. Being an innovator has several prerequisites.

Control of substantial financial resources is helpful to absorb the possible loss from an unprofitable innovation. The ability to understand and apply complex technical knowledge is also needed. The innovator must be able to cope with a high degree of uncertainty about an innovation at the time of adoption. While an innovator may not be respected by the other members of a social system, the innovator plays an important role in the diffusion process: That of launching the new idea in the system by importing the innovation from outside of the system's boundaries. Thus, the innovator plays a gate keeping role in the flow of new ideas into a system and in most cases they form the elite group of any given social system.

4.3.6. Cross tabulation of age and involvement in the media design and implementation

Media is a means of expressing ideas or communicating with people. This forms the basis of success of any campaign. If communication is done well, then the success of the campaign is assured. Local community involvement in design and implementation message of the campaign makes it successful (Bassette, 2004; Tufte, 2000). The locals understand the mode of communication best, how to communicate and when to communicate certain type of message. It is also more appealing when communication is done with members of the same community as the people become more receptive as compared to strangers. The tables 3.7, 3.8, and figure 3.4 below shows whether the Nyando community was part of the media that was used in the health communication campaigns.

Table 3.7 Cross tabulation of age and involvement in media design and implementation

AGE							Total
		STRONGLY AGREE	AGREE	NEUTRAL	DISAGREE	STRONGLY DISAGREE	
	15-25	39	12	5	9	23	88
	26-35	60	12	3	11	19	105
	36-45	38	11	3	1	11	64
	46-55	17	5	0	1	4	27
	56-65	5	1	0	2	2	10
	> 65	6	1	1	0	4	12
Total		165	42	12	24	63	306

From the table 3.7 above, we can see that a large percentage of the respondents from all the age groups represented strongly agreed that the people of Nyando formed part of the media that was used in communication during the campaigns planning and execution. Media in this context included posters, theatre, songs drama, video and radio programmes. The age group of 26-35 years led by agreeing that the local people formed part of the media used, followed by the age group of 15-25 years, then that of 46-55 years, then that of above 65 years and lastly that of 56-65 years. Those who most disagreed were those of the age group of 15-25 years followed by that of 26-35 years, 36-45 years, above 65 years, 46-55 years and 56-65 years respectively. However, a larger number of the respondents agreed that the Nyando community was part of the media used in the campaign as compared to those who disagreed having 207 out of 306 respondents and 87 out of 306 respondents. Those who were neutral to the question were 12 out of 306 respondents and 1 out of 306 respondents did not answer the question.

Target community being part of health communication campaigns media design and implementation is highly encouraged (Anyaegbunametal.2004). This leads to effective dissemination of information to the target community. Rao and Svenkerud (1998) have identified six diffusion of innovation concepts among them communication channel that is most relevant to disease prevention: Communication channels are the means by which a message is transmitted from one person to another. The innovation-decision process is an over-time sequence through which a target audience member passes. This sequence has five stages: 1. awareness, 2. knowledge, 3. persuasion, 4. adoption, and 5. implementation. According to the NGO managers in the interviews the community was involved in the media message design and implementation in the following ways:

R1: A group of people from the target community is mobilized to craft some messages. As they do this they advise on the choice of words to be used in the campaign, they may also originate or borrow words from other culture as long they will serve the purpose of the campaign appropriately. In the drama, the community volunteered as actors. The acting is based on the campaign themes.

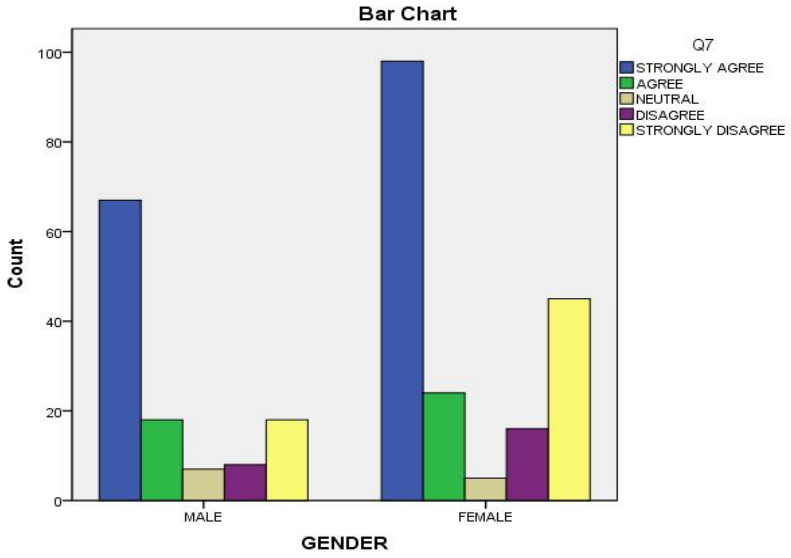
R3: "In my organization, the community participates in PAT (participatory attack theater). In this we involve the community in designing and passing messages in comedies to the target audience. PAT is a symbolic surprise to the community with the aim of changing their way of doing things for their own good. It is a form of edutainment."

R4: "The community was given the opportunity to participate in the theatre performances. In these theatric performances the target community learns about vices which they need to avoid hence improving their lives by living healthy. Some have also helped us to design campaign posters which they mount in various parts of the Sub County. They also advise us on the language to be used in the media since they are the ones who know their culture and the language they cherish. In our organization we do this because if you just come with your own language and word choice you may mislead the community or they may misunderstand you."

In health communication, target community must be involved in the message design and implementation. This ensures that messages convey what is relevant and needed by stakeholders in a given situation (Mody, 1991). The design of appropriate and effective messages refers to the packaging of information deemed important to induce a desired voluntary change in specific audiences by the running campaign. Even if messages are determined and designed in advance, there are instances where relevant content should be presented and discussed in an open form through discussion of themes (Anyaegbunametal, 2004).

Discussion themes, even if open ended, allow participants to reveal their knowledge and to discuss key issues openly, thus raising awareness and generating knowledge on specific issues raised in the health campaigns. In the message design component, the many options can include (1) the content design for messages to persuade individuals to change, (2) the design of materials to stimulate open-ended discussions between different groups of stakeholders, (3) the design of messages to promote or advocate specific health issues, such as public reforms, and (4) the instructional design of training courses to build capacity in specific skills and techniques. What these diverse messages have in common is that, to be effective, their content should be formed through an effective design, based on relevant content that is identified, probed, and validated during the communication based assessment phase. In general, the type of message design adopted depends on the objectives and the communication approaches selected for the development initiative. Whatever the message, it is necessary to have an in-depth understanding of the intended audiences and all the relevant background d data.

Figure 3.4 Gender and participation in media



In figure 3.4., it is evident that most of the respondents agree that the community formed part of the media that was used in the health communication campaigns. Out of the 306 respondents, 165 strongly agreed that the community was part of the media used during the campaign, 43 agreed, 12 were neutral, 24 disagreed and 63 strongly disagreed. Out of the 118 male respondents, 67 strongly agreed that the community formed part of the media used in the health communication campaigns, 18 agreed, 7 were neutral, 8 disagreed, and 18 strongly disagreed. Of 188 female respondents, 98 strongly agreed that the community formed part of the media in the health campaigns, 24 agreed, 5 were neutral, 16 disagreed and 45 strongly disagreed. In general, 72% of men agreed that they formed part of the media used in the campaign while 64.9% of women agreed that they formed part of the media used in the campaign. Some of the media that the community participated in according to the sampled NGO heads include:

R5: "They participated in drama planning, shooting of the drama actions, designing and mounting of posters."

R6: "Some participants were used in the voice overs to be aired on television and radio stations."

Table 3.8 Cross tabulation of education level and community's participation in campaign media

E.LEVEL							Total
		STRONGLY AGREE	AGREE	NEUTRAL	DISAGREE	STRONGLY DISAGREE	
	PRIMARY	45	8	4	4	19	80
	SECONDARY	61	16	3	11	27	118
	CERTIFICATE	6	1	0	0	1	8
	DIPLOMA	32	10	4	6	13	65
	DEGREE	19	7	1	2	2	31
	MASTERS	1	0	0	0	0	1
	NONE	1	0	0	1	1	3
Total		165	42	12	24	63	306

From the table 3.8, it shows that out of the 306 respondents, 165 strongly agreed that the community was part of the media used, 42 agreed, 12 were neutral, 24 disagreed, and 63 strongly disagreed. This shows that most of the respondents were in favor that the community was part of the media used in the communication campaign. A large number of respondents from various levels of education except none agreed that the community was part of the media used.

The current conception of communication for development has led to a broadening of the way message design and implementation could be conceived and adopted. Mody (1991) was one of the first health communication scholars and practitioners to argue that participatory message design and implementation is more effective than the traditional “expert-driven” type of approach. In previous studies, Anyaegbunam, Mefalopulos, and Moetsabi (2004) highlighted how message design can be considered also in a dialogic mode. In this sense, it is referred to as “discussion theme” and regards open ended content aimed at stimulating dialog among various groups of stakeholders. This approach is particularly valuable when addressing sensitive health issues on which the audience’s knowledge and inputs are considered particularly beneficial. Generating and sharing knowledge can also occur in other ways. Whereby words are usually associated with messages and exchanges of meaning, in certain cultures the absence of words can also carry a meaning, and the communication specialist must be aware of this in order to avoid unexpected situations and misunderstandings.

The indigenous population of Nyando, in Kenya, for instance, attributes a great value to silence, as a way to manifest their opposition to an issue. As indicated by Mefalopulos (1999): "If words gain the consensus, silence can express the dissent."

3.3. 7. Cross tabulation of age and decisions making in campaign design and implementation

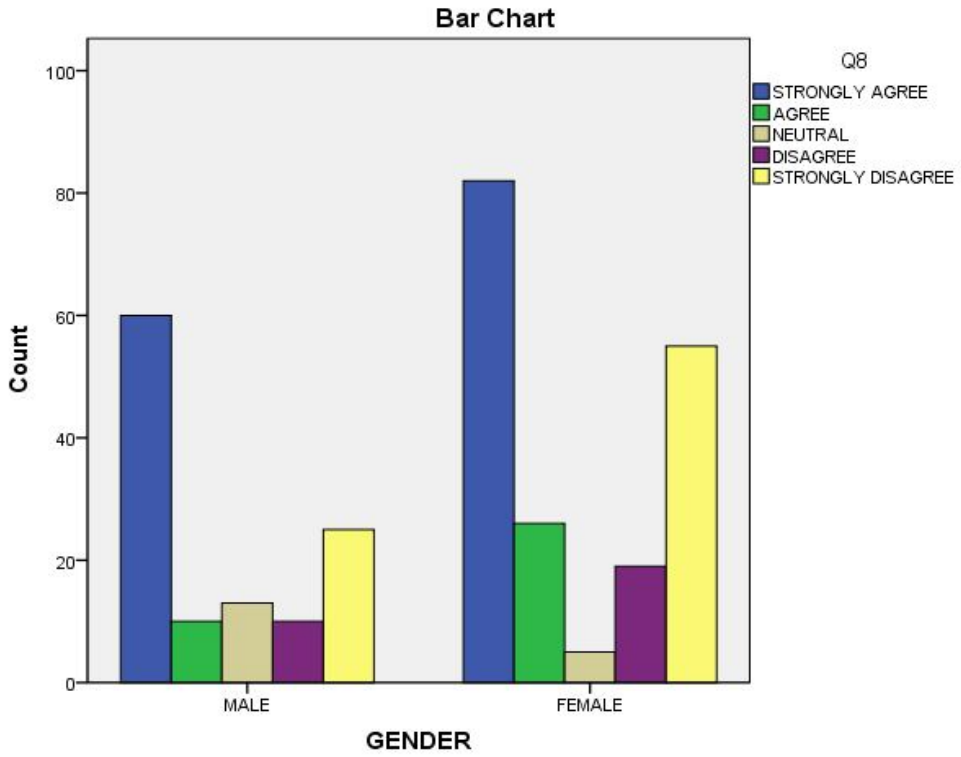
Decision making is the process of reaching decisions, towards certain information or occurrences. It can be a decision to accept or decline the information. Success of any campaign is measured by how the community responds to such communication. This measures whether the information passed across was adopted or not. The tables 3.9, 3.10 and figure 3.5 below shows how decisions were made based on the health communication campaigns conducted in the Nyando Sub County.

Table 3.9 Cross tabulation of age and decision making in campaign design and implementation

							Total
		STRONGLY AGREE	AGREE	NEUTRAL	DISAGREE	STRONGLY DISAGREE	
AGE	15-25	29	14	7	7	31	88
	26-35	52	10	6	16	20	104
	36-45	37	5	2	4	16	64
	46-55	16	4	2	0	5	27
	56-65	2	3	0	2	3	10
	> 65	6	0	1	0	5	12
Total		142	36	18	29	80	305

From the table above, it can be noted that a larger number of the respondents strongly agreed and agreed that they made decisions concerning the health communication campaigns as compared to those who disagreed and strongly disagreed comprising of 178 out of 306 respondents and 109 out of 306 respondents respectively. Those who were neutral were 18 out of 306 respondents and one respondent did not give any response to the question.

Figure 3.5 Gender and decision making in campaign design and implementation



From this figure 3.5, it can be noted that a large number of respondents, both men and women made decisions in regard to the campaigns as compared to those who both did not make any decision and those who responded neutral. In regard to gender, it is clear that a larger number of men strongly agreed that the community made decisions in regard to the campaigns with 60 out of 11 male respondents as compared to their female counterparts with 82 out of 188 female respondents. Generally, a total of 70 out of 118 men respondents were in favor that the community adopted the innovations and 108 out of 188 women respondents who disagreed. 5 out of 188 female respondents and 1 out of 188 were neutral and did not respond respectively. For men, a total of 86 out of 118 male respondents were in favor that the community adopted the innovations against 26 out of 118 male respondents who disagreed. 13 out of 118 male respondents were neutral.

Table 3.10 Cross tabulation of education level and decision making in campaigns' design and implementation.

E.LEVEL							Total
		STRONGLY AGREE	AGREE	NEUTRAL	DISAGREE	STRONGLY DISAGREE	
	PRIMARY	40	9	3	5	23	80
	SECONDARY	53	11	10	9	34	117
	CERTIFICATE	5	1	0	1	1	8
	DIPLOMA	27	10	4	11	13	65
	DEGREE	15	5	1	3	7	31
	MASTERS	1	0	0	0	0	1
	NONE	1	0	0	0	2	3
Total		142	36	18	29	80	305

From this table 3.10 it is evident that a large number of respondents agreed that they made decisions in regard to the health campaigns compared to those who disagreed. It shows that 142 out of 306 respondents strongly agree, 36 out of 306 respondents agree, 18 out of 306 disagree, 80 out of 306 respondents strongly disagree and 1 out of 306 respondents did not respond to this question. It still shows that all the respondents from all categories of education level, the larger number of respondents agree that they made decisions in regard to the communications from the campaign except those without any formal education who had a large number disagreeing

3.3.8 Level of participation in design and implementation of the campaigns.

Key players of the campaigns are the NGOs and public health officers. They are the ones who facilitate the running of the programs in line with the government. This question aimed at probing whether the NGOs allowed the community to fully participate in the design and implementation of the campaigns as shown in tables 3.11.

Table 3.11 Level of participation in design and implementation of campaigns

							Total
		STRONGLY AGREE	AGREE	NEUTRAL	DISAGREE	STRONGLY DISAGREE	
AGE	15-25	37	19	5	7	20	88
	26-35	59	13	1	11	20	104
	36-45	38	9	3	1	13	64
	46-55	13	7	2	0	5	27
	56-65	3	3	0	1	3	10
	> 65	6	0	2	0	4	12
Total		156	51	13	20	65	305

In table 3.12, we can see that regardless of the age groups, those who were in agreement that NGOs allowed the community to participate were many as compared to those who were against, neutral and did not respond to this question, with 207 out of 306 respondents, 85 out of 306 respondents, 13 out of 306 respondents and 1 out of 306 respondents respectively.

In the study findings it is clear that the Nyando Sub County community participated in the design and implementation of the health campaigns currently running there. However community participation as Arnestein (1969) posits is an umbrella term for many different practices. As such the following are sample extracts from NGO Heads on how they engaged the Nyando Sub County community:

R9: "The Nyando community is always consulted before we do anything, they do mapping of the area, budgeting, problem identification, mobilization of people to participate, acting in drama, being part of the radio programmes and many other areas."

R10: "As the head of the NGO in this area I always make sure the community gets the chance to make decisions, recently the Nyando community participated in the last generation theatre drama, they were also part of the VMC launching activity."

R11: "Consultation is very important, it's the first thing I encourage my team to encourage the community. I also give the community a chance to participate song composition, drama and other things."

From the sampled interview extracts above it is apparent that there are some aspects of participation in Nyando Sub County. It is basing on this sentiments that conclusion may be made about the level or extent of participation existing in Nyando Sub County. It is important to recognize different degrees or levels of participation as described by Arnstein (65) and Brager and Specht (66) in their ladders or continuums.

Numerous studies Arnstein 1969; Bassette 2004; Tufte 2009) call for high degree or level of community participation. The challenge for many people working for NGOs, health authorities and other agencies is to move up the ladder, finding new tools and techniques that promote active and genuine involvement, citizenship and empowerment rather than settling for more passive process of providing information and consultation. Clearly this style of participation could only flourish in societies with apolitical culture that encourages it (Kahssay, 1999) and as highlighted above a number of commentators (Tam 1995, Bookchin 1992) have argued for a new system of governance that supports this approach. It is important to be pragmatic and to acknowledge that it is not always possible or appropriate to aim for the top rung of the ladder as (Kummeling, 1999) has highlighted in research on community participation in healthy cities.

5.0 Conclusion

Community participation in health campaigns is increasingly recognized as key to improving and maintaining interventions that improve health outcomes of the target community. To date, community participation has most often been seen as an intervention to improve health outcomes rather than a process to implement and support health campaigns to sustain these outcomes. To understand the relationship between community participation and improved health outcomes, new frameworks are needed. Examining community participation as a process and dealing with critical issues around empowerment, ownership, cost effectiveness and sustainability of health improvements would move this dialogue further.

Just like it is the case in Nyando Sub County community participation means different things to different people. For instance to a chief, it might mean calling a 'baraza' and telling the people what is good for them while to a headmaster, it might mean telling the community that more schools are needed. There is consensus however, that community participation has connections with levels of conscious involvement in the types of actions and duties that have been taken and the degree of responsibility (Kiamba, 1992). Among communities in developed countries, community participation is mainly defined in terms of citizen participation and it is conceptualized as an end in itself.

In developing countries like Kenya where Nyando Sub County falls, community participation is more often understood in terms of "involvement of the people" in planning and other government processes with the view of increasing trust and confidence in the government so that people could accept plans and decisions made by the government for them in solving their problems (Midgley, 1986, pp. 13-44). Community participation is also seen and evaluated in terms of "granting individuals or groups of people a voice" in planning, decisions and service delivery (Egziabher, 1990). A comprehensive conceptualization of community participation in design and implementation of health campaign could be extended to also refer to the process through which members of a community express their feelings about health issues or articulate their needs among themselves.

Mary (1986, p. 126) observes that community participation serves immediate instrumental goals such as the identification of felt needs as well as the mobilization of local resources. In a summary, community participation means readiness of the nongovernmental organizations, government and the community to accept certain responsibilities and activities towards a particular health communication campaign. It also means that value of each group contribution is seen, appreciated and used in the health campaign design and implementation (Yeung & McGee, 1986, p. 97). As such this study concluded that there is participation in Nyando Sub County but at low level. This low level participation is what Arnestein (1969) termed as tokenism participation. As such there is call for high level participation in Nyando Sub County which Arnestein (1969) describes as citizen power in Nyando Sub County.

Basing on the finding of this study community participation in health campaigns serves to empower and enhance the health of communities and the health of people who form a target community. Findings also confirmed that community participation is the process between or among people that establishes networks, norms and trust enabling coordination and cooperation for mutual benefit in a health campaign design and implementation. Community empowerment is created as a result of community participation; this maintains the property of non-excludability meaning its benefits are available to all living within the community and access is not restricted (Kawachi, 1997; Rosenfeld, 1997).).

Previous studies such as Labonte (1997) and this call for community engagement in public participation especially in health communication campaigns arguing that this has shown direct improvement in the health, adoption of health innovation in campaigns, and well-being of many people by overcoming isolation perceived powerlessness. This is in line with the finding of this study conducted in Nyando Sub County. Again just as found in this study, Onyx (1997) further emphasizes that Community participation is the cause and effect of development providing the possibility for the community health development to prosper whilst simultaneously being a key product of community development. Community empowerment through participation has been identified as a promoter of health, whilst powerlessness is associated with being an increased risk factor for disease (Wallerstein, 1992).

Health status, in post-industrial societies, has become a measure of the power and competence of people, with research revealing that it is impossible to create health awareness amongst people who perceive them to be powerless (McKnight, 1995). In further reference to McKnight (1995) the powerless, as the objects of concern or care, appear to be immune to the health care and education bestowed upon them, with a large array of communication campaigns proving to be ineffective and consequently abandoned. Ample evidence exists revealing that people who perceive they to be powerless experience worse health than those empowered through community participation in health communication campaign (Rissel, 1994).

Participation of a community in any health campaign can occur in many ways. These may include providing labour, materials, cash, involvement in problem identification and planning, involvement in implementation, monitoring, evaluation (Barrow, 1996, pp. 119-162). There is however, consensus that gives emphasis to different aspects of participation such as high or low level, active and passive participation, perverse and genuine participation (Davis-Case, 1992). In this study, various forms of involvement of the local community by nongovernmental organizations were identified. They included community mobilization, consultation, community mapping, poster mounting, decision making, budgeting, drama acts, video shooting, distribution of condoms, and performance in theatre, music composition, and excreta. One of the key debates in the participatory development communication field is around who participates in design and implementation of health campaigns, how, and to what level.

In an attempt to answer questions raised in these debates Arnstein (1969; Brager, 1973) devised levels of participation which this study focused on to examine the situation of participation in Nyando Sub County. At the lowest level of Arnstein (1969) ladder is non –participation. This is the lowest rungs of the ladder and the least level of participatory which Arnstein, (1969) terms as participants manipulation and therapy. In Nyando sub county it was noted that the community participated beyond non-participation level. This was found out in interviews carried out with NGO managers and chiefs. All those who were interviewed mentioned various ways the community was involved in the campaign design and implementation.

At the level of non-participation, there is no value for the health communication campaign participants. The real objectives of non participation is "not to enable people to participate in planning or conducting health communication campaigns, but to enable power–holders to 'educate' or 'cure' the participants" (Arnstein, 1969). Participants do also say what development representatives suggest that should be done, but do not have any understanding of the issue that affects them (Hart, 1997). As such there is no participation for mutual gain for both the responsible nongovernmental organization and the target community. Call for participation at this level is basically not genuine since it only aids the campaign sponsors to achieve their goals at the expense of the target audience. This is not the case in Nyando Sub County since the NGOs running campaigns there give the community chance to express itself and participate in numerous activities.

Information sharing and consultation between the NGO running health campaign and the target community characterizes what Arnestein (1969) terms as tokenism. It involves a symbolic gesture of power sharing, but is essentially a substitute for the real thing. Tokenism is at level three of the ladder of participation. Informing at level three of the ladder, is indicative of tokenism, where information is offered to supposedly participating community. In Nyando Sub County there are some NGOs practicing participation at tokenism level. While information is a vital step for any development campaign, at this level, information takes form of one way communication from development agent to recipient. This is clearly contrary to Freirean notions of dialogue and development (Freire, 1970).

In Nyando Sub County the community was at some point consulted by the campaign officials. Arnstein, (1969) cites consultation as a form of tokenism in designing and implementation of health campaigns.

Although she recognizes the importance of consultation and dialogue in participation process, she states that unless that is coupled with other forms of participation in designing and implementation of campaigns, there is no guarantee that opinions of participants will be taken into account. Bassette (2004), states that consulting alone is not enough participation. Target community should be involved in all stages of health campaigns including decision making.

The study also found out that the communities were involved in various activities and roles. For instance people participated in drama, mounting of posters, launching of the campaign etc. The people who participated in these activities were handpicked from the Nyando Sub County community according to the NGO heads and chiefs. This handpicking of participants may not characterize true participation in health campaign design and implementation. At the fifth level of Arnestein (1969) placation, there is hand-picking of selected individuals to be involved in decision-making process. Community participants are informed about the project but are assigned particular roles that they have not chosen (Hart, 1997). Development communication scholars such as Servaes (1991) present a critique of this type of false dialogue, and call for a new model of communications for participatory development that is based on genuine dialogue, information sharing, mutual understanding and agreement, and collective action. As such the ways of participation NGOs in Nyando Sub County engages its target community confirms low level of participation in the region.

Most of the respondents agreed that they participated in the health communication campaign design and implementation. It was also surprising to note that some people confirmed participation in campaign design and implementation but could not identify even a single health campaign running in Nyando Sub County. This confirmed ignorance of what participation is from the Nyando Sub County community's perspective. Ignorance of running campaigns among some respondents indicated that sometimes the target community may not be aware of the health initiatives in their area but still claim to be part of the campaign design and implementations just because of the benefits of the benefits that come with them.

Collected data clearly showed that Nyando Sub County community participated in the design and implementation of the health campaign currently running there.

NGO heads interviewed noted that the Nyando community participated in problem identification, drama, radio and television programmes, mounting of posters, singing, mobilization and many other activities. Participation in these activities revealed that there are some levels of participation in Nyando Sub County. Again, data showed that a section of the community is ignorant of what participation in design and implementation in health campaigns is. This implies that having maximum participation of the community members in health campaigns design and implementation is not an easy task. As such it is was concluded that participation in Nyando Sub County is at tokenism level. This is a low level participation according to (Arnestein 1969).

References

Abdel A. R. (2012) Local people attitudes towards community forestry practices: Acase study of Kosti Province Central Sudan. *International Journal of Forestry Research*, V7, PP 20-34

Arnstein, S. (1969). Eight rungs on a ladder of citizen participation. *Journal of the Institute of American Planners 35, 216-224.*

Ascroft, J. & Masilela, S. (1994). Participatory Decision Making in Third World Development. In: White, S.A., nair, K.S. & Ascroft, J. (eds.), *Participatory Communication: Working for Change and Development*, New Delhi: Sage, pp. 259-294. Atwood, R. & Mcanany.

Baun F. (1998).Measuring effectiveness in community-based health promotion. In Davis JK, Macdonald G, eds. Quality and effectivesness in health promotion. London.

Bessette, G. (2004).*Guide to Participatory Development Communication*. International Development Research Centre. Ottawa, Singapore.

Bessette, G., and Rajasunderam, C., V. (1996).*Participatory Communication for Development: A West African Agenda*. IDRC and Penang: Southbound, Ottawa

Davis-Case D., (1990). 'Participation: Personal Relationship to Power' pp 27-32 *In* Davis-Case, A., Granholn H; & Voipoi Varpu.(eds) *Planning and Management of Participatory Forestry Projects Vol 2: Readings Participatory* The Finish Government Printing Centre.

Egziabher T. B. G., (1990). 'Participation: Partners with the Peasants' pp 18-26. *In* Davis-Case, A., Granholn H; & Voipoi Varpu.(eds) *Planning and Management of Participatory Forestry Projects Vol 2: Readings Participatory* The Finish Government Printing Centre.

Freire, P. (1970). *The Pedagogy of the Oppressed*. Penguin, London.

Freire, P. (1970). Pedagogy of the Oppressed (M. Bergman Ramos, Trans.), New York: Herder and Herder.

Freire, P. (1973a). Education for Critical Consciousness, New York: Seabury Press.

Freire, P. (1973b). ¿Extensión o Comunicación? (L. Ronzoni, Trans.), Buenos Aires: Siglo XXI.

Freire, P. (1997). Pedagogy of the Heart (D. Macedo & A. Oliveira, Trans.), New York: Continuum.

Gabel, D. (1995). *NARST president's speech at the annual meeting of the National* Association for Research in Science Teaching. CA, San Franisco.

Guijt, I. and Shah, M.K. (eds) (1998). *The Myth of Community: Gender issues in participatory development*. London: ITDG Publishing.

Hart, R. (1997). *Children's Participation: The Theory and Practice of Involving Young* EiteL, B. & Ochola, O. (2006). *Integrated flood hazard, risk and vulnerability assessment in Nyando Basin, Kenya: options for land use planning*. [Web:] http://www2.geog.uni-heidelberg.de/ physio/forschung/nyandobasin.htm [Date of access: 4 Feb. 2015]. *Citizens in Community Development and Environmental Care.* Oakdale, CA, U.S.A. Earthscan Publications Ltd.

Healthy People (2010). Health and Human services. U.S. Department of Health and Human Services.

Hornik., R., C. (978) The role of communication in education. Research, Stanford University Institute for Communication.

Hornick, R.C. (1988). Development Communication. Information, Agriculture, and Nutrition in the Third World. New York: University Press of America.

Kawachi I. (1997). Social capital, income inequality, and mortality. *American Journal of Public Health*, 87: 1491**.**

Kiamba J.M., (1992). 'The Role of Community Participation in Housing Improvement'.A Paper Presented at a Seminar on *Participatory Rural Appraisal* (PRA) held at Silver Springs Hotel, Nairobi on 30th – 31st July, 1992.

KNBS (2013) *Statistical abstract*. Nairobi,Nairobi, Government printer

KNBS. (2009).*Population and housing highlights.*Nairobi, Government printer.

Kummeling, P. (1999).*Community Participation in Healthy Cities.* Maastricht University Press, Maastricht .

Labonte R. (1997). Power, participation and partnership for health promotion. VicHealth

Mary R. H., (1986) 'Mobilising People for Social Development: Approaches andTechniques for Popular Participation'. *In Regional Development Dialogue Vol 7 No 1,* UNCRD, Nagoya.

MCI. (2011).*Health Report Nyanza Province.* UNDP, Nairobi, Kenya.

Mefalopulos, P. (2003) *Theory and Practice of Participatory Communication: The case of the FAO Project "Communication for Development in Southern Africa"*. University of Texas at Austin.

Melkote, S. (1991).*Communication for Development in the Third World: Theory and Practice.* Sage Publications, New Delhi-London: .

Merton, R., K., Fiske, M., & Kendall, P., L. (1956). *The focused interview.* Free Press, Glencoe, IL.

Midgley J., (1986) *Community Participation, Social Development and the State.* Methuen and Co. Ltd., London.

Mlenge W. C., 1991. 'Participation: Genuine or Perverse?' pp 5-8. *In* Davis-Case, A., Granholn H; & Voipoi Varpu.(eds) *Planning and Management of Participatory Forestry Projects Vol 2: Readings Participatory* The Finish Government Printing Centre.

MOH. (2010).*Kenya National AIDs Strategic Plan*. Office of the president, Nairobi, Kenya.

Moumie, M., and Ahmed, S. (2011).*Gender Needs Assessment for Kisumu city, Kenya,* New York, NY USA.

Nutley, S., Davies, H. and Walter, I. 2002. Conceptual Synthesis 1: Learning from the Diffusion of Innovations. ESRC UK Centre for Evidence Based Policy and Practice, Working Paper 10.

Richard., R. N and Edmund S.P. (1996) Investing in Humans, Technological Diffusions and Economic Growth. *The American Economic Review,* 56. 1, 69-75

Oakley, P. (1998).*Outcomes and Impact: Evaluating Change in Development Strategies: A Resource Book*. Earthscan Publications.

Onyx J.(1997). Mesearing social capital in five communities in NSW; An analysis. Sydney: Center for Australian Community Organisations and Management. McKnight J.(1995) Health and empowerment. *Canadian Journal of Public Health*, 76 (1), 37-38.

Ratzan, S.C. (1994). Health communication, challenges for the 21st century; Special issue. *American Behavioral Scientist,* 32-77.

Rice, E. R. & Atkins K., C. (2013) Public Communication Campaigns. london. New Delhi: Sage Publications.

Richards, G., Thomas, F. & Nain, P. (2001).*Communication and Development;The Freorean Connection.* Columbia University press, Columbia.

Rissel C. (1994). Empowerment: The holy grail of health promotion? *Health promotion International*, 9(1); 39-47

Ritchie, J., Lewis, J. & Elam, G. (2003).*Designing and selecting samples.* In Jane Ritchie & Jane Lewis (Eds.), Qualitative research practice. A guide for social science students and researchers (pp.77-108) Thousand Oaks, CA: Sage.

Ryan, B. & Gross, N. C. (1943). The diffusion of hybrid seed corn in two Iowa communities. *Rural Sociology*, 8, 15-24.

Rogers, E. M. (1995). *Diffusion of innovations* (4th ed.). New York: Free Press.

Rosen, E. Y., Quesada, A. P., & Summers, S. L. (1998). *Changing the world through media education*. Golden, CO: Fulcrum Resources.

Rogers, E., M. (1983).*Diffusion of innovations.* The Free Press, New York, USA.

Ronald, E. (2000). *Public Communication campaigns.* Sage Publications, University of California, Santa Barbara, USA.

Routledge.Conner, M. & Norman, P. (1996). *Predicting Health Behavior. Search and Practice with Social Cognition Models.* Open University Press: Ballmore: Buckingham.

Rosenstock, I. (1974). Historical Origins of the Health Belief Model. *Health Education Monographs.*Vol. 2 No. 4.

Rfkins S. (1986). Lessons from community participation in health programmes, *Healthy Policy and Planning* 1 (3); 240-249

Rosenfeld E.R. (1997).*Social Support and Health status:Litrature Review.* Adelaide; South Australian Community Health Research Unit

Shepherd, A. (1998). Sustainable rural development. MacMillan.

The Jakarta Declation on Leading Health Promotion into the 22st Century. Geneva, World Health Organization.

Tsouros, A. (1990). Healthy cities mean community action. *Health Promotion International* 5, 177-178.

Tufte, T. (2009).*Media and Glocal Change: Rethinking Communication for Development.* Malmo University press, Sweden.

Uphoff, N. (1985). Fitting projects to people in Cernea, M. M. (ed.) (1985) *Putting people first: sociological variables in rural development.* Oxford University Press, Oxford, UK, pp. 369-378.

WHO. (2000).*World health report: Improving performance.* World Bank, Geneva

WHO. (2002).*Healthy Cities Phase III Evaluation. Findings from Section 1B: Community Participation.* Centre for Urban Health WHO Regional Office for Europe, Copenhagen.

Woods, N. (2006).*Behaviour change communication in emergencies: A toolkit.* Nepal: United Nations Children's Fund.

Wallerstein N. (1992). Powerlessness, empowerment, and Health: Implications for health promotion programs. *Behaviour Change*, 6(3), 107-205.

WHO (1986).*Ottawa Charter for Health promotion*. Health Promotion.

Yeung Y. M. & McGee T.G., (1986) *Community Participation in Delivering. Urban Services in Asia.* IDRC, Ottawa.