Community Organizing Participatory Action Research (COPAR)

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Introduction

COPAR or Community Organizing Participatory Action Research is a vital part of public health nursing. COPAR aims to transform the apathetic, individualistic and voiceless poor into dynamic, participatory and politically responsive community.

Definition

- COPAR stands for Community Organizing Participatory Action Research
- A social development approach that aims to transform the apathetic, individualistic and voiceless poor into dynamic, participatory and politically responsive community.
- A collective, participatory, transformative, liberative, sustained and systematic process of building people’s organizations by mobilizing and enhancing the capabilities and resources of the people for the resolution of their issues and concerns towards effecting change in their existing oppressive and exploitative conditions (1994 National Rural Conference).
- A process by which a community identifies its needs and objectives, develops confidence to take action in respect to them and in doing so, extends and develops cooperative and collaborative attitudes and practices in the community (Ross 1967).
- A continuous and sustained process of educating the people to understand and develop their awareness of the existing conditions, working with the people collectively and efficiently to solve their immediate and long-term problems, and mobilizing the people to develop their capability and readiness to respond and take action on their immediate needs towards solving their long-term problems (CO: A manual of experience, PCPD).

Process

The sequence of steps whereby members of a community come together to critically assess to evaluate community conditions and work together to improve those conditions.

Structure

Refers to a particular group of community members that work together for a common health and health related goals.

Emphasis

1. Community working to solve its own problem.
2. Direction is established internally and externally.
3. Development and implementation of a specific project less important than the development of the capacity of the community to establish the project.
4. Consciousness raising involves perceiving health and medical care within the total structure of society.

Importance

1. COPAR is an important tool for community development and people empowerment as this helps the community workers to generate community participation in development activities.
2. COPAR prepares people/clients to eventually take over the management of a development program in the future.

3. COPAR maximizes community participation and involvement; community resources are mobilized for community services.

**Principles**

1. People especially the most oppressed, exploited and deprived sectors are open to change, have the capacity to change and are able to bring about change.

2. COPAR should be based on the interest of the poorest sector of the community.

3. COPAR should lead to a self-reliant community and society.

**Critical Steps**

1. Integration
2. Social Investigation
3. Tentative program planning
4. Groundwork
5. Meeting
6. Role Play
7. Mobilization or action
8. Evaluation
9. Reflection
10. Organization

**Phases of COPAR**

COPAR has four phases namely: Pre-Entry Phase, Entry Phase, Organization-building phase, and sustenance and strengthening phase.

1. **Pre-Entry Phase**
   Is the initial phase of the organizing process where the community organizer looks for communities to serve and help. Activities include:
   - **Preparation of the Institution**
     - Train faculty and students in COPAR.
     - Formulate plans for institutionalizing COPAR.
     - Revise/enrich curriculum and immersion program.
     - Coordinate participants of other departments.
   - **Site Selection**
     - Initial networking with local government.
     - Conduct preliminary special investigation.
     - Make long/short list of potential communities.
     - Do ocular survey of listed communities.
   - **Criteria for Initial Site Selection**
     - Must have a population of 100-200 families.
• Economically depressed. No strong resistance from the community.
• No serious peace and order problem.
• No similar group or organization holding the same program.

**Identifying Potential Municipalities**
• Make long/short list of potential municipalities

**Identifying Potential Community**
• Do the same process as in selecting municipality.
• Consult key informants and residents.
• Coordinate with local government and NGOs for future activities.

**Choosing Final Community**
• Conduct informal interviews with community residents and key informants.
• Determine the need of the program in the community.
• Take note of political development.
• Develop community profiles for secondary data.
• Develop survey tools.
• Pay courtesy call to community leaders.
• Choose foster families based on guidelines

**Identifying Host Family**
• House is strategically located in the community.
• Should not belong to the rich segment.
• Respected by both formal and informal leaders.
• Neighbors are not hesitant to enter the house.
• No member of the host family should be moving out in the community.

2. Entry Phase
sometimes called the social preparation phase. Is crucial in determining which strategies for organizing would suit the chosen community. Success of the activities depend on how much the community organizers has integrated with the community.

**Guidelines for Entry**
• Recognize the role of local authorities by paying them visits to inform their presence and activities.
• Her appearance, speech, behavior and lifestyle should be in keeping with those of the community residents without disregard of their being role model.
• Avoid raising the consciousness of the community residents; adopt a low-key profile.

**Activities in the Entry Phase**
• **Integration.** Establishing rapport with the people in continuing effort to imbibe community life.
  • living with the community
  • seek out to converse with people where they usually congregate
  • lend a hand in household chores
  • avoid gambling and drinking
• Deepening social investigation/community study
  • verification and enrichment of data collected from initial survey
  • conduct baseline survey by students, results relayed through community assembly

Core Group Formation
• Leader spotting through sociogram.
  • Key Persons. Approached by most people
  • Opinion Leader. Approached by key persons
  • Isolates. Never or hardly consulted

3. Organization-building Phase
Entails the formation of more formal structure and the inclusion of more formal procedure of planning, implementing, and evaluating community-wise activities. It is at this phase where the organized leaders or groups are being given training (formal, informal, OJT) to develop their style in managing their own concerns/programs.

Key Activities
• Community Health Organization (CHO)
  • preparation of legal requirements
  • guidelines in the organization of the CHO by the core group
  • election of officers

Research Team Committee
• Planning Committee
• Health Committee Organization
• Others
• Formation of by-laws by the CHO

4. Sustenance and Strengthening Phase
Occurs when the community organization has already been established and the community members are already actively participating in community-wide undertakings. At this point, the different committees setup in the organization-building phase are already expected to be functioning by way of planning, implementing and evaluating their own programs, with the overall guidance from the community-wide organization.

Key Activities
• Training of CHO for monitoring and implementing of community health program.
• Identification of secondary leaders.
• Linkaging and networking.
• Conduct of mobilization on health and development concerns.
• Implementation of livelihood projects.
Family Nursing Care Plan: Assessment & Diagnoses in Family Nursing Practice

The family nursing process is the same nursing process as applied to the family, the unit of care in the community. These are the common assessment cues and diagnoses for families in creating Family Nursing Care Plans.

First level Assessment

The process of determining existing and potential health conditions or problems of the family. These health conditions are categorized as:

I. Presence of Wellness Condition

Stated as “Potential” or “Readiness”; a clinical or nursing judgment about a client in transition from a specific level of wellness or capability to a higher level. Wellness potential is a nursing judgment on wellness states or conditions based on client's performance, current competencies, or function, clinical data, or explicit expression of desire to achieve a higher level of health or function in a specific area on health promotion and maintenance. Examples of wellness are the following:

A. Potential for Enhanced Capability for:
   - Healthy lifestyle – e.g. nutrition/diet, exercise/activity
   - Healthy maintenance/health management
   - Parenting
   - Breastfeeding
   - Spiritual well-being – process of client’s developing/unfolding of mystery through harmonious interconnectedness that comes from inner strength/sacred source/God (NANDA 2001)
   - Others. Specify.

B. Readiness for Enhanced Capability for:
   - Healthy lifestyle
   - Health maintenance/health management
   - Parenting
   - Breastfeeding
   - Spiritual well-being
   - Others. Specify.

II. Presence of Health Threats
Are conditions that are conducive to disease and accident, or may result to failure to maintain wellness or realize health potential. Examples are the following:

**A. Presence of risk factors of specific diseases (e.g. lifestyle diseases, metabolic syndrome, smoking)**

**B. Threat of cross infection from communicable disease case**

**C. Family size beyond what family resources can adequately provide**

**D. Accident hazards specify.**
- Broken chairs
- Pointed /sharp objects, poisons and medicines improperly kept
- Fire hazards
- Fall hazards
- Others specify.

**E. Faulty/unhealthful nutritional/eating habits or feeding techniques/practices. Specify.**
- Inadequate food intake both in quality and quantity
- Excessive intake of certain nutrients
- Faulty eating habits
- Ineffective breastfeeding
- Faulty feeding techniques

**F. Stress Provoking Factors. Specify.**
- Strained marital relationship
- Strained parent-sibling relationship
- Interpersonal conflicts between family members
- Care-giving burden

**G. Poor Home/Environmental Condition/Sanitation. Specify.**
- Inadequate living space
- Lack of food storage facilities
- Polluted water supply
- Presence of breeding or resting sights of vectors of diseases
- Improper garbage/refuse disposal
- Unsanitary waste disposal
- Improper drainage system
- Poor lightning and ventilation
- Noise pollution
- Air pollution

**H. Unsanitary Food Handling and Preparation**

**I. Unhealthy Lifestyle and Personal Habits/Practices. Specify.**
- Alcohol drinking
- Cigarette/tobacco smoking
- Walking barefooted or inadequate footwear
- Eating raw meat or fish
- Poor personal hygiene
- Self medication/substance abuse
- Sexual promiscuity
- Engaging in dangerous sports
- Inadequate rest or sleep
- Lack of /inadequate exercise/physical activity
- Lack of/relaxation activities
- Non use of self-protection measures (e.g. non use of bed nets in malaria and filariasis endemic areas).

**J. Inherent Personal Characteristics**
- e.g. poor impulse control

**K. Health History, which may Participate/Induce the Occurrence of Health Deficit**
- e.g. previous history of difficult labor.

**L. Inappropriate Role Assumption**
- e.g. child assuming mother’s role, father not assuming his role.

**M. Lack of Immunization/Inadequate Immunization Status Especially of Children**

**N. Family Disunity**
- Self-oriented behavior of member(s)
- Unresolved conflicts of member(s)
- Intolerable disagreement

**O. Others. Specify._________**

**III. Presence of health deficits**
These are instances of failure in health maintenance.
Examples include:
- **A. Illness states, regardless of whether it is diagnosed or undiagnosed by medical practitioner.**
- **B. Failure to thrive/develop according to normal rate**
- **C. Disability**
  Whether congenital or arising from illness; transient/temporary (e.g. aphasia or temporary paralysis after a CVA) or permanent (e.g. leg amputation, blindness from measles, lameness from polio)

**IV. Presence of stress points/foreseeable crisis situations**
These are anticipated periods of unusual demand on the individual or family in terms of adjustment/family resources. Examples of this include:
- **A. Marriage**
- **B. Pregnancy, labor, puerperium**
- **C. Parenthood**
- **D. Additional member-e.g. newborn, lodger**
- **E. Abortion**
- **F. Entrance at school**
- **G. Adolescence**
Second-Level Assessment

Second level assessment identifies the nature or type of nursing problems the family experiences in the performance of their health tasks with respect to a certain health condition or health problem.

I. Inability to recognize the presence of the condition or problem due to:

A. Lack of or inadequate knowledge
   Denial about its existence or severity as a result of fear of consequences of diagnosis of the condition, specifically:
   - Social-stigma, loss of respect of peer/significant others
   - Economic/cost implications
   - Physical consequences
   - Emotional/psychological issues/concerns
B. Attitude/Philosophy in life, which hinders recognition/acceptance of a problem
C. Others. Specify _________

II. Inability to make decisions with respect to taking appropriate health action due to:

A. Failure to comprehend the nature/magnitude of the problem/condition
B. Low salience of the problem/condition
C. Feeling of confusion, helplessness and/or resignation brought about by perceive magnitude/severity of the situation or problem, i.e. failure to break down problems into manageable units of attack.
D. Lack of/inadequate knowledge/insight as to alternative courses of action open to them
E. Inability to decide which action to take from among a list of alternatives
F. Conflicting opinions among family members/significant others regarding action to take.
G. Lack of/inadequate knowledge of community resources for care
H. Fear of consequences of action, specifically:
   - Social consequences
   - Economic consequences
• Physical consequences  
• Emotional/psychological consequences  

I. Negative attitude towards the health condition or problem—by negative attitude is meant one that interferes with rational decision-making. 
J. In accessibility of appropriate resources for care, specifically: 
• Physical Inaccessibility 
• Costs constraints or economic/financial inaccessibility  

K. Lack of trust/confidence in the health personnel/agency  
L. Misconceptions or erroneous information about proposed course(s) of action  
M. Others specify._________  

III. Inability to provide adequate nursing care to the sick, disabled, dependent or vulnerable/at risk member of the family due to:

A. Lack of/inadequate knowledge about the disease/health condition (nature, severity, complications, prognosis and management)  
B. Lack of/inadequate knowledge about child development and care  
C. Lack of/inadequate knowledge of the nature or extent of nursing care needed  
D. Lack of/inadequate knowledge of skill in carrying out the necessary intervention or procedures of child health, complex therapeutic regimen, healthy lifestyle program  
E. Inadequate family resources of care specifically: 
• Absence of responsible member  
• Financial constraints  
• Limitation of luck/lack of physical resources  

F. Significant persons unexpressed feelings (e.g. hostility/anger, guilt, fear/anxiety, despair, rejection) which his/her capacities to provide care.  
H. Philosophy in life which negates/hinder caring for the sick, disabled, dependent, vulnerable/at risk member  
I. Member’s preoccupation with on concerns/interests  
J. Prolonged disease or disabilities, which exhaust supportive capacity of family members.  
K. Altered role performance, specify. 
• Role denials or ambivalence  
• Role strain  
• Role dissatisfaction  
• Role conflict  
• Role confusion  
• Role overload  
L. Others. Specify._________
IV. Inability to provide a home environment conducive to health maintenance and personal development due to:

A. Inadequate family resources specifically:
- Financial constraints/limited financial resources
- Limited physical resources—e.g., lack of space to construct facility

B. Failure to see benefits (specifically long term ones) of investments in home environment improvement

C. Lack of/inadequate knowledge of importance of hygiene and sanitation

D. Lack of/inadequate knowledge of preventive measures

E. Lack of skill in carrying out measures to improve home environment

F. Ineffective communication pattern within the family

G. Lack of supportive relationship among family members

H. Negative attitudes/philosophy in life which is not conducive to health maintenance and personal development

I. Lack of adequate competencies in relating to each other for mutual growth and maturation

Example: reduced ability to meet the physical and psychological needs of other members as a result of family’s preoccupation with current problem or condition.

J. Others specify._________

V. Failure to utilize community resources for health care due to:

A. Lack of/inadequate knowledge of community resources for health care

B. Failure to perceive the benefits of health care/services

C. Lack of trust/confidence in the agency/personnel

D. Previous unpleasant experience with health worker

E. Fear of consequences of action (preventive, diagnostic, therapeutic, rehabilitative) specifically:
- Physical/psychological consequences
- Financial consequences
- Social consequences

F. Unavailability of required care/services

G. Inaccessibility of required services due to:
- Cost constraints
- Physical inaccessibility

H. Lack of or inadequate family resources, specifically
- Manpower resources, e.g., baby sitter
- Financial resources, cost of medicines prescribe

I. Feeling of alienation to/lack of support from the community
- e.g., stigma due to mental illness, AIDS, etc.