TRAINING WORKSHOP ON PARTICIPATORY METHODS FOR A PEOPLE CENTRED HEALTH SYSTEM

"Strengthening community focused, primary health care oriented approaches to social accountability and action"

MEETING REPORT

Training and Research Support Centre (TARSC)
through the
Community of Practitioners in Accountability and Social Action in Health (COPASAH)
and the
Regional Network for Equity in Health in east and southern Africa (EQUINET)

held at
Chengeta Lodge, Zimbabwe

7th – 10th October 2013

With support from Open Society Foundations

Table of Contents

1. Background 3

2. Welcome and Introductions 5

3. Introduction to people-centred Health Systems and Social Accountability 5
   3.1 Introduction: the Human Sculpture 5
   3.2 Health systems in east and southern Africa: the context 6
   3.3 Accountability and the Right to Health 7

4. The PRA Process 9

5. Developing Follow-up Work: Defining the Change 10

6. Understanding Community 11
   6.1 Identifying different types of power in a community 12

7. Understanding Health 12
   7.1 What do we mean by health? 12
   7.2 Identifying health needs and their causes 13

8. Strengthening Community-focused Approaches to Social Accountability 14
   8.1 Assessing health service delivery and resourcing at community level 15
   8.2 Improving communication between communities and health services 16
   8.3 Measuring Progress 17

9. Follow up Work and Next Steps 18
   9.1 Development of Proposals 18
   9.2 Opportunities for networking 19

10. Reflections on the Workshop and Closing 19

Appendix One: List of Participants 21
Appendix Two: Training Workshop Programme 23

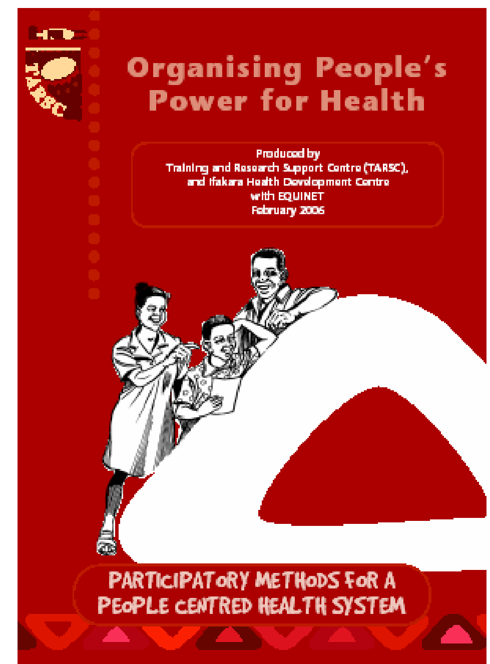
1. Background

In 2013 TARSC through COPASAH and EQUINET held a regional workshop on Participatory Approaches to Strengthening People-Centred Health Systems in the east and southern Africa (ESA) region. The training brought together 28 delegates from 7 countries in east and southern Africa (see Appendix One for list of participants) to discuss and deepen our understanding on ways to strengthen primary health care through improved public involvement and health service accountability.

The training came about because of a joint interest within all three lead organisations to explore how Participatory Reflection and Action (PRA) approaches could be used to raise community voice in strengthening the functioning and resourcing of primary health care (PHC) systems in the region. The **Community of Practitioners in Accountability and Social Action in Health** (COPASAH), who initiated the training with support from Open Society Foundations (OSF), is a global network of practitioners with a strong focus on building the field of community monitoring for accountability in health. The **Training and Research Support Centre** (TARSC), based in Zimbabwe, has a strong community based research and community monitoring programme to build social power in health and uses a multiplicity of complementary approaches – including PRA - to generate relevant knowledge, and raise community voice and actions. TARSC is the lead for the pra4equity network in the **Regional Network for Equity in Health in east and southern Africa** (EQUINET), a consortium network that aims to promote and realise shared values of equity and social justice in health in east and southern Africa. Thus, this training drew on the knowledge base of the pra4equity network (coming from 20 studies in 9 countries in the ESA region), as well as the learning coming out of COPASAH, to explore ways of improving public involvement, social action and social accountability in health for local level action and advocacy.[1]

The training specifically aimed:

- To build an understanding of PRA approaches and their use in strengthening people centred health systems
- To draw on experiences in the east and southern African region for strengthening community focused and PHC oriented approaches to community roles in social accountability and action.
- To work through practical examples of PRA approaches and their application in areas of work that participants are involved with at community level.
- To provide initial mentoring and support to development of research and training proposals in this field.
- To strengthen participant engagement in the COPASAH and EQUINET networks in the interest of deepening knowledge, debate and actions on issues of health equity and social justice.



[1] See the bibliography sections of www.copasah.net , www.equinetafrica.org and www.tarsc.org for access to a wide range of resources on community monitoring and social accountability, health equity and social justice, and the use of PRA for building people centred health systems.

The training used an existing EQUINET training toolkit on ‘Organising People’s Power for Health’ produced by TARSC and Ifakara Health Institute (IHI, Tanzania) in 2005. This toolkit (called the ‘PRA toolkit’ in this report) is separately available[2] and provides details on many of the sessions and how they were conducted, so this report does not record this information. As a training workshop using PRA methods, the meeting involved dialogue and exchange of experiences, activities to encourage reflection and discussions on follow up, lessons learned and many other activities (see the full programme in Appendix Two). This report cannot do justice to the rich and diverse exchanges that took place in the meeting, but we have tried to capture through quotes and pictures some of these exchanges and the major agreed areas of action and reflection arising from the meeting.

Our facilitators for different sessions of the meeting were Barbara Kaim from TARSC, Robinah Kaitiritimba from the Uganda National Health Consumers/Users Organisation (UNHCO), and Clara Mbwili and Adah Zulu from the Lusaka District Health Management (LDHMT) Team in the Ministry of Health in Zambia. This report was prepared by TARSC, with support from Isabella Matambanadzo.

The 28 participants, representing18 organisations from 7 countries – that is, from Kenya, South Africa, South Sudan, Tanzania, Uganda, Zambia and Zimbabwe - brought a diversity of skills, experience and knowledge from different work contexts. We were community health activists, civil society organisation reps, health workers, people working in state health departments, academics and researchers. We came from different parts of the region and left as a learning community!

[2] See http://www.equinetafrica.org/bibl/docs/EQUINET%20PRA%20toolkit%20for%20web.pdf

2. Welcome and Introductions

Barbara Kaim, from TARSC, welcomed all delegates to the training and especially welcomed those who had travelled from the region to Zimbabwe. After a brief introduction to the three lead organisations, she introduced the theme of the training. She noted that the pra4equity network within EQUINET had been using PRA in health for almost a decade and has applied it to a range of questions, including ways of strengthening relations between communities and frontline health workers, and in examining how to overcome community and health system barriers to prevention and treatment of HIV and AIDS. The work has been done in the interest of exploring how to make our health systems work better, especially for marginalised communities. This training will explore another facet of this work, asking a different set of questions related to how we can raise community voice through use of participatory approaches to improve the functioning and resourcing of our health systems at primary care level. Thus, we are using PRA as an entry point to exploring issues related to social accountability. This is why the coming together of COPASAH and EQUINET is so valuable.

This introduction was followed by a participatory tool- called the Buses Game – which provided a social x-ray of the group. It showed that the group was evenly distributed by gender, that we came from a wide range of countries and institutions, and that we all had a commitment to working with communities either at local, district or national level. The most interesting learning coming out of this exercise was how the group was divided between those who mainly worked in programmes that focused on community-based accountability work, such as in the use of the Citizens Score Card, while others came from a stronger focus on using PRA in health. We could already see that one of our challenges was to break out of these silos to explore the link between the two.

3. Introduction to people-centred Health Systems and Social Accountability

3.1 Introduction: the Human Sculpture

This became the focus of our next session, facilitated by Adah Zulu and Clara Mbwili from LDHMT. The activity is taken from the PRA toolkit, Activity 17, page 51.

We began our discussions by reflecting on the extent to which our health systems are people-centred and how this, in turn, impacts on issues of accountability. Taking the example of a teenage girl in her 3rd trimester coming to the clinic for the first time, we developed a ‘human sculpture’ of how we think the health services in our countries would *currently* respond. How would she be treated at the clinic? How would the family and community support her? How would other community members be treated? How would the health worker relate to her? Would she get the care she came for? Who else was important for this, in and beyond that community? What we saw was that the pregnant teenager was powerless in ensuring that her health needs were met. Resources to support the local health workers were far away, with decisions coming from the capital of the city or from boardrooms of international agencies such as the IMF or World Bank. The picture below (left) shows the actors in the human sculpture pointing to whom they thought they were accountable. The young girl is isolated (see photo on next page).

When we moved the human sculpture around to reflect on what we thought a people-centred health system *should* look like (see photo below), we saw that the teenager was now at the centre of a caring community, with the health workers linked to and listening to her needs, and with resources flowing from the Finance and Health Ministries to the local clinic. There was a much greater sense of accountability – both in terms of service delivery and in the allocation of resources - from the top echelons of the system down to the clinic to meet the needs of the young girl.

This activity vividly pointed to the fact that building a people-centred health system is not simply a technical question, but needs to build on the power of individuals, communities, health workers and others to create the changes needed to ensure people's right to health. Participatory methods provide a means for this.

3.2 Health systems in east and southern Africa: the context

Following the 'human sculpture', Barbara gave a slide presentation for EQUINET on the wider context of regional developments and associated challenges to building people-centred health systems in the region. Drawing on the Regional Equity Analysis of 2012[3] published by EQUINET and a background paper presented by Loewenson and McIntyre presented to the ECSA Health Community[4], the presentation showed that improved growth has occurred in countries in ESA with falling human development, increased poverty and widening inequalities between the rich and poor. There is evidence of inequalities in health, in access to household resources for health and in access to health services within and across ESA countries. For example, in relation to maternal and child health:

- under 5s in poorest households in some countries (eg Mozambique, Uganda) have more than double the rates of under 5 mortality compared to the wealthiest groups in those countries;

---

[3] Available on the EQUINET website, divided into two parts URL: Regional EW 2012 Part 1w.pdf and Regional EW 2012 Part2w.pdf

[4] Loewenson R, McIntyre D (2012) Equity gains from investing in primary and community levels of health systems in East and Southern Africa: a review of survey evidence, Presented to the ECSA DJCC and Best Practice Forum, August 2012, Tanzania

- a child in the poorest household in Mozambique has 7 times the risk of dying in his/her first 5 years of life compared to a child born in the wealthiest group in Namibia;
- children of mothers with lowest education are 5 times more likely to be under-nourished than those with highest education, and those living in the poorest households are three times more likely to be undernourished than those living in the richest households;
- global inequalities are also wide: low income countries have 78 times the level of maternal mortality, compared to women from high income countries.

The presentation noted that there is much evidence in the region post 2000 to show the positive effects of bringing sexual and reproductive health and maternal health services to primary care level, thus suggesting that improved equity in health needs to come about through increased investments in primary health care (PHC). There is already wide policy support at national and regional level for this, but the challenge is to move from policy commitment to action. 9 out of 16 countries in the region already have essential health care packages or entitlements, but these are not always known or successfully implemented. Health worker and medicine availability is a key issue, as is the need to remove user fees and to control unofficial charges for supplies, transport and other needed resources.

To do all of this, calls for a more active citizenry who are given the space, skills and authority to have a say in how their health services are organised, financed, provided and reached by communities. There also needs to be mechanisms (such as health centre committees or community/health worker meetings) and resources in place to provide for dialogue with sections of the health system to ensure these rights are met. In this context, communities have an important role to play in monitoring progress and enhancing accountability in the interests of improved health and social justice in the region. Health systems organised around social participation and empowerment create powerful constituencies to protect public interests in health. This is the motivation behind the focus of this workshop.

3.3 Accountability and the Right to Health

Following from this presentation, Robinah Kaitiritimba from UNHCO and Adah Zulu hosted a simulated TV show called 'Who wants to be accountable?' There were four guest panellists, namely:

- Geoffrey Opio – GOAL Uganda
- Tatenda Chiware - Doctors for Human Rights Zimbabwe
- Zingisa Sofayiya - Health Network for Health and Human Rights, South Africa
- Josphine Kinyanjui - HERAF, Kenya

The remainder of the participants functioned as a studio audience and were given opportunities throughout the 'show' to interact with the panel and ask questions.

To start with, the panellists were asked to describe briefly the work of their organisations and what their views are on the right to health. It became evident early on in the TV show that the four organisations had a wide range of experiences on this issue, ranging from a legal and advocacy perspective, to a more community-focused approach, with two of the organisations specifically focusing on ways to strengthen community-front line health worker dialogue. Participants agreed that the right to health was much more than access to health services but also included the social determinants such as adequate housing and more.

Importantly, people's rights are not only about our governments signing up to specific international treaties or the development of country policies, but are also about ensuring that rights holders have the information and skills to be able to claim their rights, and duty bearers have the capacity to deliver.

Participants spoke at length about this last point, noting that it was a real problem in their countries when there is a disconnect between what rights holders are demanding and the ability of duty bearers to respond. Ultimately, the government, through the Ministry of Health is the duty bearer. But at facility level, the person-in-charge is the primary duty bearer with every facility staff member also responsible during direct patient contact. The problem is that the health system itself does not give any authority to frontline workers, and it then becomes difficult for the same workers to respond to communities. Decentralisation of power and resources within the system to local levels, together with the capacities for it, is thus necessary if people at community level are to be effective in providing input to the organisation of services. The health system needs to make clear what entitlements people have, and what obligations service providers have, and to communicate this widely to health workers and the public as a prerequisite for delivering health rights and building social accountability.

At the same time, people need to be empowered:

> "*We must know our rights and claim them. We must not sit back and take things lying down, we need to take ownership of our facilities and of our health. If I know that the clinic is open from 7.30am – 4pm, I should not have to wake up at 4am and risk my life to get a place in the queue. The duty bearers take advantage of the fact that most people who make use of primary care facilities are poor and uneducated, so they do whatever they like."* (Zingi Sofiyiya).

But, as one of the audience members, asked: *"how do we motivate communities to claim their rights and to own the process?"* The panellists responded in a number of different ways – saying that this is why it was so important to make sure people had access to information coming out of their health facility in relation to indicators of health, policy developments, etc; others agreed, but went further to emphasize the importance of developing health centre committees (called by different names in different countries) in which community reps and health workers worked together in defining community health priorities and action plans. Geoff Opio reported on a randomized control trial on community-based monitoring of public primary health care providers in Uganda that showed how social accountability mechanisms led to large increases in utilization and improved health outcomes.[5]

The TV Show highlighted a number of barriers to realising people's right to health. In addition to acknowledging that health centre committees often don't function well and have problems of legitimacy, there were also barriers in relation to:

- inadequate funds in the health care sector, and funds allocated for the primary level are often difficult to track or leaked to other uses often higher up in the health system;
- poor communications between clients and health workers, and between different levels within the health system;
- ineffective utilization of limited resources;
- lack of accountability of the private sector, including the pharmaceutical industry.

[5] Björkman, M. and Svensson, J., 2007, "Power to the People: Evidence from a Randomized Field Experiment of a Community-based Monitoring Project in Uganda.

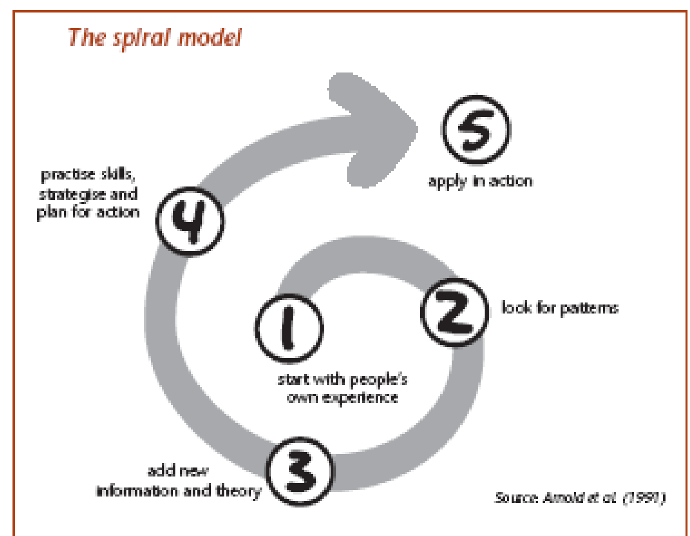
4. The PRA Process

What do we mean by participatory methods? asked Adah Zulu and Clara Mbwili, the facilitators of this session.

Participants were divided into 4 groups to brainstorm on this question, reflecting on their own work and what made it participatory. During our plenary report back, we came up with some common understandings:

- Participatory approaches aim to empower communities, recognise skills that reside in a community, operate from the principle that people are important.
- The work is participatory if the community is encouraged to be creative, to draw on their own experiences, share their opinions and contribute to decisions or plans being developed.
- Facilitators of participatory processes are good at listening and probing, try to find solutions to power inequalities, uses resources prudently, encourages communities to look for their own solutions, provide support
- Participatory approaches are not only relevant at community level, but can be used at all levels in the system.

We then went on to discuss the basic principles of PRA methods, why they are central to people centred health systems, and the way they support transformation. We also discussed that learning about PRA is not achieved in a four day workshop! It means building skills to listen, facilitate and work in ways that are a constant process of learning. It has a theoretical basis that people were encouraged to read more about.



The PRA process is like a spiral. Often the first plan of action will solve some aspects of the problem but will not go deeply enough to deal with the root causes of the problem. By setting up a regular cycle of reflection and action, communities can draw lessons from their experiences and continue to find better solutions to their difficulties. Each cycle moves them closer to achieving positive change in their lives.

Participants concluded this session by debating over 6 statements about PRA and trying to decide whether each of these statements were true, false or that they were undecided. After much discussion, they agreed to the following:

- ✓ PRA is just a set of fancy methods-*False*
- ✓ PRA has no theoretical basis-*False*
- ✓ PRA approaches are quick and easy to use - *False*
- ✓ Anyone can use PRA approaches successfully in their work – *False*
- ✓ Findings from the use of PRA methods do not reflect reality – *False*
- ✓ People involved in using PRA are neutral – *False*

5. Developing Follow-up Work: Defining the Change

Barbara explained that this training wanted to allow for as many opportunities as possible to ensure that learning coming out of these four days is put into practice. Thus, this session aimed to help participants reflect on what they've learnt so far and how they can use this information in their own work settings. As a first step, she encouraged people to think about the set of changes they want to achieve, especially in relation to:

- changes in duty bearers so they are better able to deliver
- changes in rights holders so they are better able to claim
- mechanisms for claiming entitlements/holding the health system more accountable.

Before breaking up into smaller groups for discussion, we explored how these set of changes could potentially impact on ways to strengthen the resourcing and functioning of our health systems at primary health care level. We noted that improving the responsiveness of the health system to make them more accountable to community health needs is one of the key ways in which to strengthen our health systems at primary level. The key question to ask, however, is what we need to do to ensure that the substantial resources that flow to and in health systems reach the primary care and community level. Defining what changes we specifically want to see to make this happen is the first step in this process.

Group work elicited the following information in relation to what changes were needed:

Changes in Duty Bearers (health workers, policy makers)	Changes in Rights Holders	Mechanisms for Holding the System Accountable
• Willingness to engage in dialogue and joint planning with community reps • Improved attitudes, skills and knowledge of duty bearers in relation to people's rights • Decentralise power and resources to local level • Share more information on health entitlements and ensure implementation • Improve transparency and end corruption • Ensure citizen participation in policy making • Ensure minimum of 15% allocation to health	• More informed and able to make choices and decisions that will improve their own health outcomes • Improved understanding of their entitlements • Improved skills and confidence to be able to assert their rights • Better able to prioritise health needs • Willingness to engage in dialogue and joint planning with health workers	• Set up and strengthen platforms for dialogue, feedback and consultation at community level in ways that can also impact decisions higher up in system • Ensure clinic staff hold regular meetings with community reps through, for eg, Health Centre Committees • Secure the inclusion of doubly marginalized representatives at these meetings • Institutionalize community monitoring, including use of community score cards

Each participant was then asked to use this exercise to clarify what changes they wanted to aim for in their own work and how this information could be used to develop proposals. Barbara noted that there would be time closer to the end of the meeting to work on their proposals, with mentoring from facilitators.

6. Understanding Community

(See Module 2 of the PRA toolkit)

Participants noted that the training had clearly shown so far that people's knowledge of their environment is an important source of information when developing and monitoring policies and programmes that affect their health. Building on this understanding, this session explored how we understand the term 'community', that communities are not made up of homogenous groups of people and that this needs to be taken into account when referring to the term. We looked at different ways of mapping communities, including surveys, photographs, questionnaires and interviews.

We then went on to look at how we can use social mapping to identify existing social groups and to show their distribution on a map (Activity 4, page 16). We divided into four groups, by gender and age, with each group drawing a map of a typical community (either rural or urban) showing major landmarks (such as schools, clinics, water points, etc) and how social groups are distributed on their map.

The findings from the social mapping activity were most insightful. Even working on fictitious maps (since this is a training of a mixed group of people, and not a real situation), we saw the differences in the way young and old, men and women, drew their maps and what they included in them. For example, one of the diagrams below shows a map of a rural community drawn by young men. The second map, to the right of the first, is drawn by a group of young women. As the pictures show, while there are some similarities in the landmarks identified (church, school, homesteads,, youth centre), the young men showed us where the bars and football fields were located in their community, while the young women placed more emphasis on the boreholes, orphanage and where the cattle graze.

"*I worked in Liberia for some time. Cholera was endemic there. I used social mapping to find out where there were toilets and, when not available, where people defecated. I explored how far these areas were from the beach and other water sources. It was a very useful tool.*" (Lisa Woods)

Participants then went on to discuss other ways of mapping our communities, including the transect walk. During a transect walk, key informants or other community members knowledgeable about their area join the team in going for a walk around the community. Transect walks can be used to triangulate (or double-check) information garnered from the social map. Both of these tools can be used as a reference point throughout a PRA process.

We also noted that both these tools require focus, time and patience to implement which reinforces our understanding from the previous session that PRA approaches are not quick to use!

6.1 Identifying different types of power in a community

The inequalities in health systems are not just inequalities in relation to resources, or in access to services. There are also inequalities in power: within the community itself, between service providers and communities, between different kinds of health personnel and between different levels of the health system. This is an issue that is largely invisible but, nevertheless, has a major impact on the participation in and use of health systems by more marginalised groups. We looked back at the human sculpture we'd done earlier in the training to reinforce this. Then, to explore this further, we used a spider diagram (see Activity 8, page 24) to list the different types of power that exist in our communities that can influence people's health – these range from the power of friends and family, wealthier and more educated members of the community, teachers, health workers and others with positions of influence, as well as institutions, policies and people of influence outside the community itself. Power can also be played out between people of different ages, religion and by gender. Power is not always bad – for example, a teacher can either use his/her power to encourage positive health behaviour, or as a way to engage in risky sexual behaviour.

We concluded this session by noting that it is essential that we use mechanisms and processes to address power imbalances when they are negative and reinforce inequalities. One of our challenges in the remaining days of the workshop is to explore whether participatory approaches can assist in this process.

7. Understanding Health

(See Module 3 of the PRA toolkit)

7.1 What do we mean by health?

We looked at four pictures and, for each picture, we asked the questions: **'Do you think this person is healthy? Why or why not?'** (See Activity 11, Page 33). For example:

- Is the man with the pay cheque, who is sweating in the factory healthy or not?
- Is the elder telling a story to a group of children in a state of health or not?
- Is the young girl with a baby on her back begging at the traffic lights in a state of health or not?
- Is the obese boy watching TV and eating fast food in a state of health or not?

The different issues raised by participants indicated that health is a combination of

- physical well-being
- psychological and mental well-being
- social well-being
- being disease free, and
- being well nourished

which fits in well with the WHO definition of health.

While health workers often focus on the physical aspects of health, we agreed that the pictures reflected how important it is not to ignore the social and economic aspects.

7.2 Identifying health needs and their causes

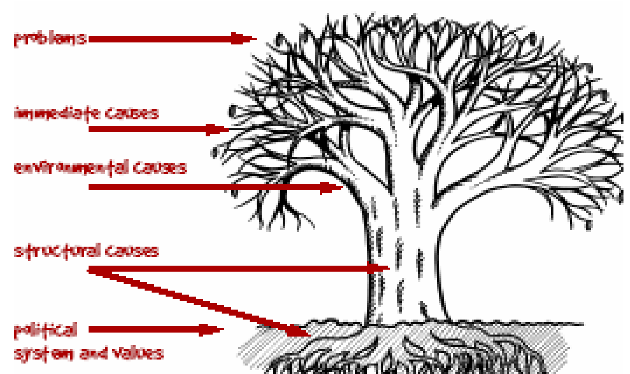
The following session explored how to identify health needs in communities, how to prioritise these needs and look at the causes of ill health (see Activities 12, 14 and 15).We divided into four groups to explore and prioritise health needs, using the ranking and scoring system. Participants grouped themselves by whether they were older or younger men, and older or younger women. We then brought the different groups together, and combined the top 3 priority health needs for each group to come up with a composite of 3 top priorities, that is: poor sanitation, malaria, and HIV and AIDS. We noted how, in some cases, it was easy to cluster the problems. For example, one group said that the problem was poor sanitation, another that it was diarrhoea.

Two issues came up during our discussions on use of this tool.

The first related to how the ranking within groups is done. It was observed that giving each person counters to make their own choices of priorities enables even less powerful groups to have a say. Having a collective discussion on what comes out and reorganising the priorities is useful in building a collective view, but it is also important that the voice of the most vulnerable groups is not lost in the process.

We also tackled the issue of how to deal with differing views. In a situation where different social groups see things differently, it is useful to focus on those areas they share views on, and then allow each to explain their different views and listen to the reasons given. It isn't necessary to always reach consensus: the differences if fully discussed can build greater understanding between groups of their differing perspectives, so that these are taken into account in future work.

We reviewed different approaches to explore the causes of health problems. The problem tree is a useful tool for looking beyond individual or biological causes for ill health to exploring some of the environmental, and underlying structural or political causes. Another is asking 'But why?' for each problem to get more deeply into understanding the causes of the causes of these problems. Others mentioned were picture codes, line ups, case studies and the spider diagram.



Show time!
One evening, we had the pleasure of watching two DVDs – one by TARSC, LDHMT and MoH Zambia on the Health Literacy programme in Zambia being implemented by the Lusaka District Health Management Team in the Ministry of Health, available at http://vimeo.com/72914294 and the other on community monitoring work being done by the Uganda National Health Consumers/Users Organisation. Both DVDs generated some important discussions, showing how PRA and social accountability work can be put into practice.

8. Strengthening Community-focused Approaches to Social Accountability

This was the stage of the training when we began to pull all our learning together! After a quick recap of what we meant by people-centred health systems and social accountability, we reviewed a list of questions that we felt needed to be addressed in our quest to strengthen community voice in building a stronger, better resourced and people-centred primary health care system. We summarised these questions as follows:

1. **What are our priority health problems?**
   Mapping our community and identifying the different social groups
   Identifying our top priority health needs

2. **What do we expect to see at primary care level to solve our priority health problem/s?**
   What health facility services and resources?
   What community roles?
   What interactions between the two, including mechanisms for claiming entitlements?

3. **What do we currently have?**
   What gaps exist compared to Q2 above?
   Who is most affected by these gaps?
   Which gap/s do we want to address as priority? Why?
   What change do we want to bring about?

4. **What will we do?**
   What actions will we take? By and with whom?
   Over what time period?
   How will we implement the reflection-action-reflection cycle?

5. **How will we know we are making progress towards the change?**
   What changes in the duty bearers ability to deliver?
   What changes in the rights holders ability to claim?
   Changes in services delivered?

Each group of questions would need to be explored at community level using a set of participatory tools and strong participatory facilitating skills. This led us into a number of important sessions in which we explored what type of participatory tools we could use to address specific issues. This included:

- identifying gaps and barriers to strengthening health service delivery and resourcing at community level - Where's Wadzai? , the Pie Chart, ranking and scoring and community score cards;
- identifying ways of improving communication between communities and health services – Margolis wheel and Johari's Window;
- identifying ways we can measure progress toward our goal – progress markers and the wheel chart.

8.1 Assessing health service delivery and resourcing at community level

We identified a number of ways in which facilitators can help communities to assess and critique the functioning of their health systems and to define priority areas for action. This included

- the use of picture codes and pie charts to reflect on what services we expect to see at primary care level (see photo);
- 3-pile sorting to map current services available and to identify barriers to strengthening health services at community level;
- ranking and scoring to prioritise which barriers to work on; and
- community score cards to monitor and evaluate health service provision.

In addition to these, we also reviewed other tools discussed in the toolkit, including

- resource pockets (Activity 22, page 66) to explore how health resources in the community can be shared;
- the Rifkin Diagram (Activity 24, page 74) to discover the extent to which local mechanisms, such as social power, have the power to influence decisions in health; and
- community exit interviews (Activity 26, page 78) as another tool for communities to monitor the effectiveness of their health services.

Robinah gave an interesting overview on the use of **Community Score Cards** (CSCs) as a tool for monitoring health services. The score card brings together rights holders and duty bearers to jointly analyse issues underlying service delivery problems and agree on shared responsibilities to address common concerns. The information collected through these CSCs provide policy and decision –makers with relevant information on community perspectives and concerns which, in turn, can influence policy choices and improvements in service delivery. It is a tool that many of the participants to this training use to hold health facilities accountable, and to encourage community participation in health facility decision-making.

Robinah made it clear that this tool is NOT about blaming health providers, nor is it designed to settle personal scores. Instead, it aims to foster dialogue and improve relations with health providers, monitor progress and service quality, expose corrupt officials, and promote accountability of funds and transparency of processes. Participants reinforced this argument by giving examples from their work situations of how score cards have realised changes in service delivery in a number of ways. For example, the National Taxpayers Association (NTA) in Kenya has used CSCs to track management of resources at local level health care facilities in selected districts. As Martin Napisa from NTA said in his presentation: *"NTA's experience with the citizens report cards have shown that such participatory efforts have the potential of deepening social capital by galvanizing communities around issues of shared experience and concerns".*

Robinah's presentation generated a discussion on what type of conditions need to be in place for a CSC to be effective. Drawing on an article written by Wild and Harris in 2011[6], we agreed that there are two key strengths in the use of CSCs:

- Scorecards appear to work best when they facilitate forms of collective problem solving by actors across the supply and demand side. Provision of information is only one part of this; equally important is the *process* for identifying who the key stakeholders are and bringing them together to devise joint action plans to tackle service delivery problems, and to follow up on these plans. This is where the PRA process, of moving between periods of reflection and action as outlined in the Spiral Diagram, becomes of value.
- Scorecards have worked particularly well where they have reignited communities' own capacity for self-help, alongside encouraging greater state responsiveness. Implementation of scorecards has the potential to serve as an important reminder of the roles and responsibilities of citizens themselves.

8.2 Improving communication between communities and health services

This session was facilitated by Adah Zulu, herself a health worker within the Ministry of Health in Zambia. She began the session by acknowledging that communication barriers do exist between people and health workers. This is not surprising, considering the different expectations, roles and power dynamics between the two groups. Nevertheless, it is essential that these barriers are addressed. If our health systems are to become more people-centred, health workers need to not only develop skills, knowledge and procedures around technical issues, but also need the skills, knowledge and procedures to facilitate meaningful community engagement and involvement, including in decision making. Fortunately, there are a number of PRA tools that can be used to unblock communication barriers, many of which are discussed in the toolkit. This includes Johari's Window (Activity 27 Page 80), Stepping Stones (Activity 18 Page 54) and the Margolis Wheel, as well as focus group discussions, transect walks and others all of which can build better understanding, respect and joint action between the two groups.

We decided to use the **Margolis Wheel** in our training session. This involved dividing participants into two groups – one representing health workers and the other community members. The two groups formed two circles, facing each other. The health workers then went round asking for advice from the community reps on problems they face in their work. This gave community reps the opportunity to act as advisers to the health workers – a situation they are seldom involved in. When reflecting on this exercise later on, both groups acknowledged that it was an empowering process to be given the chance to resolve problems between them as a team. The health workers thought that some of the suggestions they received were very useful and it raised their respect for the role community members can play at the health facility.

[6] Wild, L and D.Harris (2011) The Political Economy of Community Score Cards in Malawi. Overseas Development Institute, UK

It was also noted that both community reps and health workers need to be willing to listen to and use each other's language, for health workers to avoid jargon and community members to learn key terms from health workers. Participants noted that each needed to understand the constraints, challenges and goals of the other. Building such dialogue can be a challenge, and it was observed that it needed to be stimulating, interactive and visual through forums that provide equal opportunities of contribution of ideas.

> Opio's Story – Uganda
> *"I needed a malaria test. I went to the lab. The lab technician had no gloves. I asked why they were not wearing gloves, for both my protection and their protection. The lab technician looked at me with cold eyes. But the gloves were right there in the room. I said to myself: if this can happen in a place where I am paying, what about a free place?"*
>
> Tendai's Story - Zimbabwe
> *"I am the mother of twins. When I got home after work, one of the twins had a sore throat. I decided to take this child for treatment. The other twin started crying and wanted to go with me. I struggled to take two babies to a healthcare provider on my own. When we got there, the facility was very full and there was nowhere for me and the twins to sit. One of the babies wanted some water to drink, but there were no clean glasses, which made me worry about infection control. I was so frustrated I ended up shouting at my kid. There was a problem being served. There were no free rooms and we ended up being served in the corridor."*

8.3 Measuring Progress

Clara Mbwili presented options for measuring progress at community level. She noted that quantitative measures of change can be gathered before and after the intervention through:

- Pre and post test baseline questionnaires. This is a quantitative approach that is used to measure how the communities involved perceive, know or report practices before and after the intervention. It is administered to exactly the same group of people before and after, using a set of questions that measure conditions before and after (using a ranking scale from 1-5 for example) with exactly the same questions asked to see how things have changed after the intervention. It gives a quantitative assessment of change.
- Using data from facilities or surveys to measure the situation before and after the intervention on the area where change is expected (for example mothers attendance at ANC, or compliance with treatment).

Further, participatory methods can be used to review programmes before and after. The outcome mapping strategy can be implemented after the problem has been identified, as you are developing your action plan. **Progress Markers** are set to indicate

- ✓ The things people feel they MUST achieve
- ✓ The things people feel they would LIKE to achieve
- ✓ The things people feel they would LOVE to achieve

These can be defined by community members during the planning process, and then reviewed periodically to assess progress against these markers and to plan how to overcome problems. Reviews can also be done through monitoring visits undertaken by facilitators.

A further approach is to use **a wheel chart** (Activity 19 Page 54) to measure where people feel they are at different stages of a process (such as how well local committees are known in communities; how friendly services are and so on.). The method is shown here, focusing on levels of community participation. Wheelcharts can be used at the beginning and end of a process to assess change.

Frederick Okwi – Uganda:
"The wheel chart tool provides an opportunity to assess progress made in specific tasks. It's a tool that, if well utilized, can help to make a breakthrough in participatory monitoring and evaluation."

Activity 19:

TO ESTABLISH LEVELS OF COMMUNITY PARTICIPATION IN DIFFERENT AREAS OF HEALTH SYSTEMS

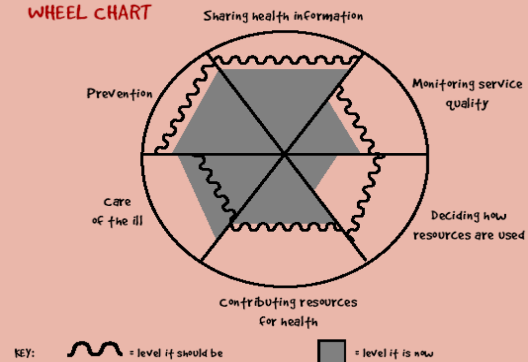
METHOD: WHEEL CHART

Time: 30 minutes

Materials: flipchart paper and pens or, if doing this activity on the floor, charcoal or chalk

Procedure:

1 Ask participants to list the areas of community participation.
2 Divide participants into groups of about 10 and ask them to draw a wheel on a piece of flipchart paper with about eight spokes (the number of spokes is determined by the number of participation areas identified). Areas of participation could include: sharing health information, monitoring service quality, deciding how resources are used, caring for the ill, and so on. Label each segment of the wheel with one of the participation areas.
3 Explain that the group has to decide how much the community participates at present in relation to each area of participation and note the level on the wheel chart. For example, a high level of participation in health resource allocation means a lot of the segment will be shaded, a little means only a small part of the segment will be shaded.
4 Ask participants to make a line with a different colour pen on the wheel chart to show how far communities feel they should be involved in each area (the line should be at the top if they want to be more involved and lower down if they don't).
5 At the end of this exercise, ask the different groups to show their wheel charts. Discuss what you have learnt about community participation in health.



Source: R. Loewenson (2001)

9. Follow up Work and Next Steps

9.1 Development of Proposals

During the training, participants had numerous opportunities to work on their proposals for follow-up work, including time for group mentoring and feedback. Barbara now explained the process forward, outlining how participants were encouraged to develop their proposals and access resources for follow up work to use PRA approaches in building community roles in accountability and action. The work aimed to build new knowledge, skills and evidence on strengthening the resourcing and functioning of PHC through use of these participatory approaches.

Thanks to support from Open Society Foundations, COPASAH is in a position to give two or three small seed grants to add to institutions current budgets. These grants are awarded for follow up work, with peer review and some mentoring. Barbara noted that, even if participants do not receive funding, mentoring would be on-going via the COPASAH and PRA mailing lists. Participants were also encouraged to work as country teams and to identify in-country PRA practitioners to support implementation and monitoring of their PRA work.

Barbara distributed a set of guidelines on the outline of the proposals. Participants were requested to write their proposals with particular attention paid to (a) The problem at hand, (b) the change process they

wished to bring about, (c) which PRA tools and methods they planned to use, (d) the steps they intended to take to implement their proposed work, and (e) how they proposed to report and/or use the information generated.

Feedback will be given on the first draft of the proposals. The final draft will need to be submitted by end of November. Selection of proposals for funding will be done by TARSC in COPASAH through a second peer review process.

9.2 Opportunities for networking

Both Robinah and Barbara encouraged participants to stay in touch through the COPASAH e-list and through the EQUINET mailing list at pra4equity@equinetafrica.org. Robinah gave a short description of COPASAH plans for the coming year. She noted that, in addition to the proposal process outlined above, COPASAH will also be providing technical support and opportunities for exchange visits within the region.

10. Reflections on the Workshop and Closing

At the end of this training workshop, we asked participants to give feedback on the workshop. This is what they said:

The evaluations mentioned that there were many things about the training that were relevant and useful:

On specific methods and tools:
"*The Spiral model provided me with the whole picture… The wheel chart and progress markers for monitoring… I was pleased to learn new techniques such as the problem tree… the 'but why? method that got is digging deeper into the causes of the causes… the wonderful progress markers and the link between entitlements and rights… I appreciated the two DVDs that we watched… I learnt about power dynamics, especially through the spider diagram… Ranking and scoring, progress markers and community scoring… Pie chart seems to be a less adversarial approach… Engaging community members in mapping out their social challenges... This helps in establishing community ownership of PRA projects and outcomes… I really liked the exercise where we looked at the 3 questions on health services, engagement and community. Made me think how I could use this in my work with health workers…Group work is the best method ever! I learned so much from my colleagues, had so much fun, especially when doing the human sculpture."*

Generally:

> *"I learnt that there are some things that I cannot change… Health is more than the physical; it is also the mental… The only thing that limits us is our own creativity… That the health-worker's point of view is important… Bridging the gap between the duty bearers and the rights holders…Think beyond communities to influence the larger system…"*

There were also some questions and requests:

- *"Please add a module on community monitoring to the PRA toolkit… Are we going to be able to share all our experience with TARSC and get feedback? Can we call on you?…Will you be able to*

provide enough mentorship on the proposals?... Are there any plans beyond 2013 besides the grant?... More reading and resources needed…"

And issues of concern:

"I am concerned about how I will get buy-in once I return to my organization to implement this new learning… What happens when the community voice is ignored by the policymakers?"

In terms of the training itself:

"The facilitators were great…. The workshop has given me hope. I really was battling with how to mentor the health committees. I am now confident about my job…Please one day more…. Add a session on how to build engagement with government… Have a session near the beginning that defines concepts like accountability and entitlements… More time for country work and mentoring… Opportunities to use these tools in a real community setting… Please provide certificates to the participants…"

And, finally, there is still much to do after the training:

"I am ignited to go back home and spread the gospel about PRA and accountability!"
"We want to… try our hand at applying PRA tools in our community… strengthen ties with health workers…finish writing our proposal….keep our network alive… "

We closed the workshop with thanks to TARSC, UNHCO and LDHMT for organising and facilitating the workshop; to COPASAH and EQUINET for sharing their knowledge; to OSF for funding the training; and finally to everyone for sharing their experiences and contributing to the discussions with such commitment and energy. We said goodbye, until our next exchanges on the COPASAH and pra4equity e-lists.

Appendix One: List of Participants

No.	Name	Organisation	Country	Email Address
1.	CHEGE Milkah Nyambura	Health Rights Advocacy Forum (HERAF)	Kenya	chegemilkah@gmail.com
2.	KINYANJUI Josphine Nyambura	HERAF	Kenya	josephine@heraf.or.ke
3.	NAPISA Martin Nyongesa	National Taxpayers Association (NTA)	Kenya	mnapisa2003@yahoo.com mnapisa@nta.or.ke
4.	SOFAYIYA Zingisa Patience	Learning Network for Health and Human Rights	South Africa	zsofoyiya@yahoo.com
5.	MDAKA Kanya Sakhiwo	Learning Network	South Africa	kanya.mdaka@gmail.com kanya.mdaka@uct.ac.za
6.	SCHAAY Nikki	University of the Western Cape – Community Medicine	South Africa	schaay@mweb.co.za
7.	WOODS Lisa Nicol	South Sudan Health Action Research Project (SHARP)	South Sudan	l.woods@kit.nl
8.	MACHA Jane Liberaty	Ifakara Health Institute (ITI)	Tanzania	jmacha@ihi.or.tz janetmacha@yahoo.co.uk
9.	BARAKA Jitihada Ramadhani	ITI	Tanzania	jittybaraka@gmail.com jbaraka@ihi.or.tz
10.	MUTASHOBYA Greysmo	Health Promotion Tanzania (HDT)	Tanzania	gmutashobya@hdt.or.tz
11.	KIRIGWAJJO Moses Nsaire	Uganda National Health Consumers' Org (UNHCO)	Uganda	mkirigwajjo@unhco.or.ug
12.	OKWI Frederick	UNHCO	Uganda	fokwi@unhco.or.ug fredokwi@gmail.com
13.	KAITIRITIMBA ** Robinah Kitungi	UNHCO	Uganda	rkitungi@yahoo.com
14.	BEINOMUGISHA Annet	Coalition for Health Promotion and Social Development (HEPS)	Uganda	a.beinomugisha@yahoo.com
15.	SERUNJOGI Francis	Centre for Health, Human Rights and Development (CEHURD)	Uganda	rc.seru@yahoo.com
16.	KILANDE Esther Joan	Action Group for Health Human Rights and HIV/AIDS (AGHA)	Uganda	jkilande@yahoo.com
17.	OPIO Geoffrey	GOAL Uganda	Uganda	gopio@ug.goal.ie
18.	SIBUCHI Getrude Miyanda	Lusaka District Community Health Mgt Team (LDHMT)	Zambia	gsibuchi@gtmail.com
19.	Munkombwe Barzlar	LDHMT	Zambia	smartbm83@yahoo.com

20.	MBWILI ** Clara	LDHMT	Zambia	adahzulu@yahoo.com
21.	ZULU ** Idah	LDHMT	Zambia	adahzulu@yahoo.com
22.	CHIBUYE Denis	Treatment Advocacy and Literacy Campaign (TALC)	Zambia	dennischibuye@gmail.com
23.	MAKANDWA Mevice	Training and Research Support Centre (TARSC)	Zimbabwe	info@tarsc.org
24.	MARIMA Stephen	TARSC	Zimbabwe	info@tarsc.org
25.	KAIM ** Barbara	TARSC	Zimbabwe	barbs@tarsc.org
26.	MUGUSE Joseph	Zimbabwe National Network of People Living with HIV (ZNNP+)	Zimbabwe	jmuguse@gmail.com
27.	MBENGERANWA Tendai Mhaka	ZNNP+	Zimbabwe	tfmhaka@yahoo.co.uk tendaifmb@gmail.com
28.	CHIWARE Tatenda	Zimbabwe Association of Doctors for Human Rights (ZADHR)	Zimbabwe	chiware@live.com
29.	MATAMBANADZO Isabella ***	Freelance	Zimbabwe	zvinemazuva@yahoo.com

** Facilitators
*** Rapporteur

Appendix Two: Training Workshop Programme

DAY ONE – MONDAY 7TH OCTOBER

TIME	SESSION CONTENT	SESSION PROCESS	ROLE
8am	Registration		MM
8.30am	Opening session	Welcome and introductions Objectives of the workshop and programme	BK/RK
INTRODUCTION TO PEOPLE CENTRED HEALTH SYSTEMS AND SOCIAL ACCOUNTABILITY			
9.15am	How do communities and the health system interact with each other? How does this impact on processes of accountability?	Activity 17 Human Sculpture: PRA work on current interaction and then vision of a people-centred health system	CM/AZ
10.30am	TEA		
11.00am	Health Systems in ESA: what is the context for Primary Health Care services	Presentation by EQUINET drawn from the Equity Watch work and Regional Equity Analysis 2012	BK
12.00	Accountability and the Right to Health	TV show with 4 presenters to explore issues of accountability and the right to health	RK/AZ
1.15pm	LUNCH and RELAX		
REFLECTIONS ON PRA APPROACHES, IMPLICATIONS FOR DEVELOPING FOLLOW UP WORK			
2.15pm	What do we mean by PRA?	Activity 1: What do we mean by participatory methods? Guided discussion on PRA and why PRA methods are central to people-centred health systems. The spiral model	AZ/CM
3.30pm	TEA		
4.00pm	Developing Follow up work: Defining the Change	Overview of expectations for follow up work. Followed by group work and plenary discussion	BK
5.30pm	END OF DAY ONE	Evening reading: Module 1 and bring any queries to the first session of Day Two	

DAY TWO – TUESDAY 8TH OCTOBER

TIME	SESSION CONTENT	SESSION PROCESS	ROLE
9.00am	Review of Day One	Day 1 feedback – ball game Questions and discussion on Module 1	CM
UNDERSTANDING COMMUNITY			
9.30am	Tools for mapping and understanding communities	Reflections on what we mean by community and social groups. Activity 4: social mapping Other tools eg transect walk	AZ /BK
11.00am	TEA		
11.30am	Understanding how power relations influence health	Activity 7 on identifying the different types of power that exist in most communities.	CM
UNDERSTANDING HEALTH			
12.15pm	What do we mean by health?	Activity 11: To understand how health is defined across	RK/AZ

		different social groups (Health pictures)	
1.00pm	**LUNCH AND RELAX**		
2pm	Identifying and prioritizing health needs / problems	Activity 12: To identify and prioritise health problems in communities (ranking and scoring)	AZ/BK
3.15PM	**TEA**		
3.45pm	Identifying causes of health problems	Identifying causes of problems Activity 15: 'But why?' and problem tree. Outline other options: Picture code, spider diagram, line ups, case studies	CM/AZ
4.30pm	**END OF DAY TWO**	Participants to read Modules 2 and 3 overnight	
	EVENING	Viewing of DVD on Health Literacy in Zambia and Community Monitoring in Uganda	CM/AZ

DAY THREE – WEDNESDAY 9TH OCTOBER

TIME	SESSION CONTENT	SESSION PROCESS	ROLE
8.30am	Review of Day Two	Review of materials read and Day 2 feedback	AZ
UNDERSTANDING SOCIAL ACCOUNTABILITY IN PEOPLE-CENTRED HEALTH SYSTEMS			
9.00am	Reflections on what services we expect to see at primary care level	Review on what we mean by people-centred health systems. Identifying actions that should be happening within the community, the health system, and in the interaction between the two. (Where's Wadzai? Poster and pie chart)	CM/RK
10.15am	Mapping current services available and identifying barriers/gaps	To map whether health entitlements listed in previous session have been delivered or not (3-pile sorting)	BK/AZ
11.00am	**TEA**		
11.30am	Mapping current services available and identifying barriers/gaps (continued)	To identify and rank the barriers to strengthening health services at community level (spider diagram, rank and score)	BK/AZ (contd)
12.45pm	**LUNCH AND RELAX**		
1.45pm	Additional reflections on the status of our health systems	1. Community exit interviews and score cards (RK) 2. Wheel charts (CM)	RK, CM
3.00pm	**TEA**		
COMMUNITY ACTIONS IN PLANNING, ORGANISING AND MONITORING HEALTH SYSTEMS			
3.30pm	Developing an Action Plan	Methods for developing a community action plan	AZ
4.15pm	Preparation for group or individual work on concept notes	Review Module 4 with the group Plenary discussion on participants' concept notes	BK
4.30pm	**END OF DAY THREE**	Game drive. Participants to read Module 4 and 5	
	EVENING	Delegates work on their own or in country groups to integrate what they've learnt during the workshop into their concept notes/proposals for future work. Facilitators available for consultation.	

DAY FOUR– THURSDAY 10TH OCTOBER

TIME	SESSION CONTENT	SESSION PROCESS	ROLE
8.30am	Review of Day Three	Review of materials read and Day 2 feedback Summary of what we have covered so far and where we are going	BK/RK
9.00am	Improving communication between communities and health services	Identifying barriers to overcome communication between health workers and community (Margolis Wheel) Activity 26 - How do people and health workers communicate with each other? (Johari's Window) Review of other tools – stepping stones	AZ
9.45am	Ways in which we can measure progress toward our goals – progress markers	Use of progress markers Other ways of assessing and discussing progress: baseline and post intervention surveys, wheel chart	CM
10.30am	TEA		
11.00am	Presentation and discussion of concept notes/proposals	Delegates present their concept notes in working groups. Summary comments in plenary	all
12.30	Summary session on PRA approaches	Concluding activities on facilitation and approaches	BK
1.00pm	**LUNCH and RELAX**		
FINAL COMMENTS AND TIME LINES			
2.00	Review of the toolkit	Walkthrough of the toolkit. Overview of Modules Six and Seven. Other sources of information and resources. Questions and discussion	BK
2.45	Time Frames	Time frames, proposal submission, feedback, etc Communication channels	BK
3.30	TEA		
4.00	Opportunities in COPASAH and EQUINET	Discussion of opportunities and activities for networking and engagement around community monitoring, social accountability and participatory approaches.	RK and BK
4.45	Evaluation of the workshop	Activity 33: Evaluation – Ballots in the Box	AZ
5.30	CLOSING OF WORKSHOP	Brief closing comments Braai dinner, music, dancing, singing!	