PARTICIPATORY METHODS FOR A PEOPLE CENTRED HEALTH SYSTEM

Training workshop

MEETING REPORT

Training and Research Support Centre (TARSC),
The Ifakara Health Research and Development Centre (IHRDC)
with the
The Southern African Regional Network on Equity in Health (EQUINET)
and CHESSORE Zambia

Held at the Paradise Hotel Bagamoyo Tanzania
February 28 to March 4 2006

Report produced by TARSC
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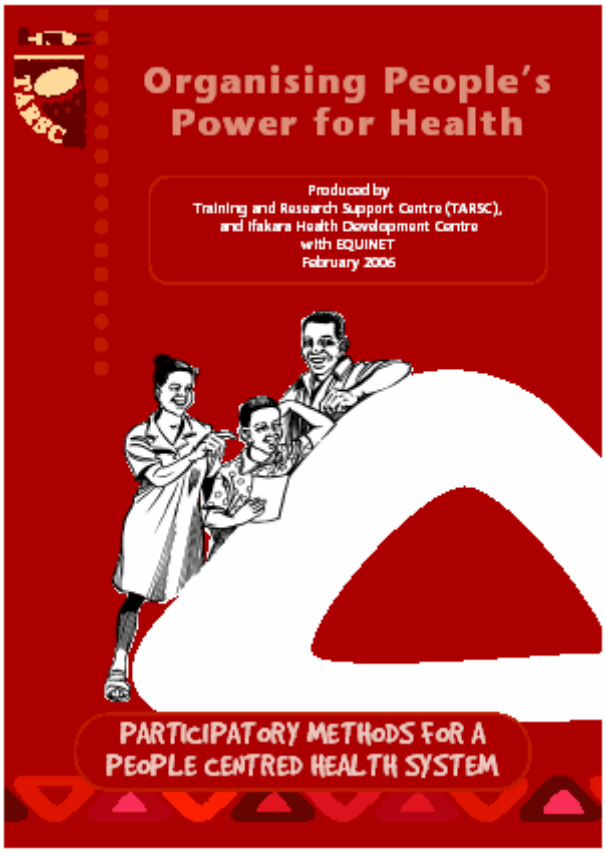
1. Welcome and introductions

The regional training workshop on participatory methods for a people centred health system was hosted by the regional network for equity in health in east and southern Africa (EQUINET) , TARSC, Ifakara and CHESSORE in Bagamoyo Tanzania from February 28- 3 March 2006. It involved 37 delegates from in east and southern Africa (See delegate list in Appendix 1) It aimed to build skills, share experiences and strengthen work on participatory methods for people centred health systems.

TARSC and Ifakara both have a history of work on participatory reflection and action (PRA) methods in health and worked together to write and produce a toolkit for the training which was being piloted at the workshop. EQUINET, with IDRC and SIDA, supported the production of the toolkit. CHESSORE provided peer review for the kit.



The meeting on PRA skills was held in the context of EQUINETs overall work on building people centred health systems, with features of:

1. Values of equity, social justice and the right to health.
2. Comprehensive, universal and integrated national health system.
3. People led, people centred health systems that organise, empower, value and entitle people.
4. Fair financing with debt cancellation, 15% govt funding to health, equitable mobilisation and deployment of resources.
5. Ethical and equitable human resource policies at national, regional and international level that recognise health workers concerns, and confront perverse south-north subsidies.
6. Fair global policy (just trade, reversing unfair flows of resources) with national and regional policy flexibility to exercise policies that improve health.

This report doesn't go into detail on EQUINETs approach to people centred health system as these can be found in other documents on the EQUINET website, such as Policy paper 15 and the report of the October 2005 Health civil society report.

The toolkit is separately available and provides the detail on the sessions and how they were conducted so this report doesn't record this detail. As a training workshop using PRA methods the meeting involved

- Exchange of experiences
- Dialogue
- Activity
- Reflections
- Discussions on follow up, and

many other activities. We don't aim in this report to provide all of the rich and diverse exchanges that took place in the meeting. We capture through quotes, pictures and some reports 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 Rene Loewenson, Barbara Kaim and Faith Chikomo from TARSC, Selemani Muyita, Ahmed Makemba and Charles Mayombana from Ifakara. TJ Ngulube from CHESSORE and Mwajuma Masaigana from TARSC Tanzania.

Thanks to TARSC and Ifakara for the notes for the report, to TARSC and to the participants for the photos and quotes! At the end of the meeting we agreed to set up a learning network with a mailing list called the *pra4equity* list to keep sharing experiences and learning in PRA for people centred health systems so we have called ourselves the pra4equity delegates!

The pra4equity delegates

2. Introduction to People's Centred Health Systems and PRA methods

We realised that our health systems are not that different in the way they are organised across the region, but how *people centred* are they?

We took the example of a young boy who had been burned by boiling water and rushed into the clinic. How would he be treated by the clinic? Would he be referred? How would the family and community support him and his mother? We made a human sculpture of how we think our health services *currently* respond.

For example,
The father was absent, at work far away….
The mother and child were bewildered….
The local health workers were commandeering but didn't have enough resources…
The resources were far far away in the IMF!

After this we moved the human sculpture around until it looked more like what we thought a people centred health system *should* look like.

There were many differences after we moved the sculpture

- The child and their mother were at the centre of a caring community
- The health workers were linked to, listening to and supporting the community
- There were resources at the clinic and good links to other levels of the health system
- The finance and health ministries were preoccupied with supporting the services on the ground
- The IMF was no longer the most powerful actor in the room!

We also realised that producing the difference was a social change process, and an outcome of the way people organise their services. Building a people centred health system is not simply a technical question, but calls for ways of work that build the power of individuals, communities, health workers, supporting institutions and others. Participatory methods provide a means for this.

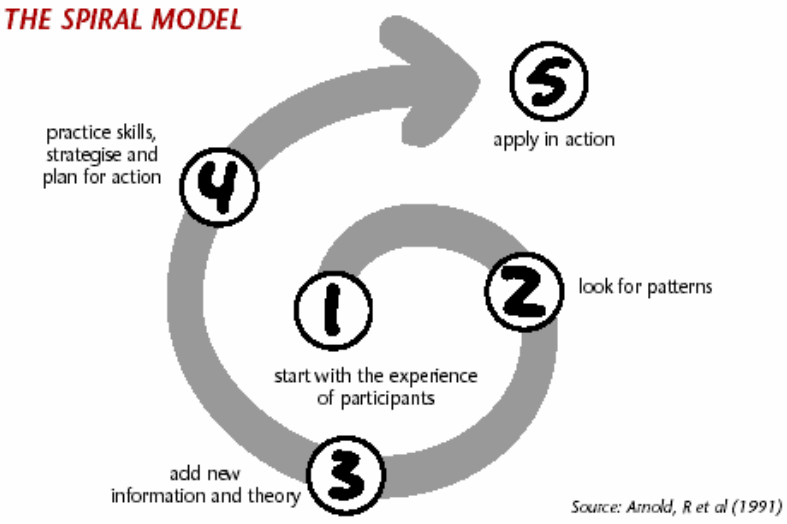
"We can't build people centred health systems without methods that build collective activity, capacity and power"

"Using participatory methods is not like eating a cake, where the more you share the more it is consumed. When you share knowledge and power, the more you share the more there is!" (Ahmed Makemba)

What do we mean by participatory methods?

Delegates in groups shared past experiences. From this there were some common features….

- *"People identify and explore their own problems and solutions… they are involved in every stage*
- *They stimulate action and lead to more fair outcomes in how resources are shared*
- *People drive the process, speak with their own voices and own the process*
- *They are transparent, give people power to express safely in non threatening environment and build mutual respect*
- *People listen, value the experience and the knowledge they have and critically reflect to use this to solve problems that they share and think are important*
- *Its exciting and fun!"*



We discussed 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.

3. Understanding community

We looked at the different ways of mapping and analysing communities. We discussed the different elements that make up communities, and how we understand the term 'community'. We drew a social 'maps' of a typical community and explored the type of features that these maps might include, and how they can be used to identify the different social groups and influences on health in an area.

Then we went on a transect walk! Mwajuma Masaigana and Selemani Mbuyita took us to different parts of Bagamoyo to look, listen and identify the different influences on health in the area. 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. Two of our facilitators knew the area well, and we talked to others who live and work in the area.

"The transect walk became a transect run when it rained- but we saw the usefulness of following up on a social mapping with a more detailed walk. We saw things with new eyes!"

The toolkit provides further information on the exercises carried out.

4. Understanding health

We put four pictures up on the wall, far apart from each other so that participants could easily move around looking at the pictures without getting crowded in. Under each picture we put up a sign which read **"Do you think this person is healthy? Why? why not?"**

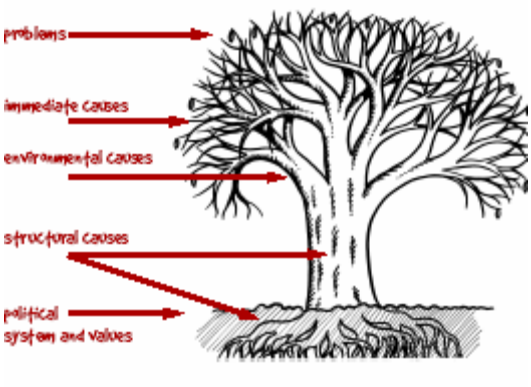
Then participants moved around the room, looking at the pictures, discussing what they saw and recording their views. We looked in plenary at the responses and used them to agree on the features of a shared definition of 'health' An example of the discussion is shown below.

Do you think this person is healthy?, why?, why not?

Yes –he so happy and excited with what's happening (watching and eating)
Yes –because the child is developing properly, capable of controlling the TV- fine motor skills well development
Yes there is no place like home
Yes –the person has a choice of a life style

Not healthy
Not healthy because he is living in dangerous environment alcohol, water on the floor, eating junk food
No –spoiled environment and behaviour
No –bad lifestyles contributes to poor health and chance of diseases of smoking, diabetes, HT and obesity is a couch potato who gets everything from TV and substances
Child neglect
Not healthy because is he is exposed to risk factors which can lead to conditions such as obese, liver, cirrhosis
Not health healthy because of bad eating habits
A happy child is a healthy child
No –overfeeding
No –proper supervisor

The following sessions explored how to identify health needs in communities, how to prioritise these needs and look at the causes of ill health.



The priorities for health we identified included food, water, health services, employment, freedom from violence, shelter and anteretrovirals.

We used the problem tree to look at a number of the health problems prioritised, asking *but why does it occur* for each problem to get more deeply into understanding the causes of the causes of these problems.

For example, taking the problem of food security for women
"Why does it occur?
Lack of money
Why does this occur?
Low income/unemployment
Why does this occur?
Inaccessibility of land + credit systems/gender based discrimination
Why does this occur?

- *Lack of policies + programmes addressing gender based issues*
- *Lack of programmes empowering women"*

The coconut energiser was a pick up when we had been sitting for too long!

"What! Poor provision of health services
Why! Inadequate funding to health sector from the budget
Why! Parliamentarians have insufficient knowledge on health/services priorities
Why! They don't ask for advice from professionals
Why! Politicians are more committed to ensuring their re-elections than tackling the real issues!"

5. People centred health systems

We used a wheel chart as a way of exploring and discussing the different levels of participation by communities in different aspects of the health system. The toolkit provides further information on this. The wheel chart was used to explore views on reasons for areas of poor participation and what could be done about these.

"Communities need to know budget priorities and ask for expenditure reports. There should be laws that empower communities to scrutinize expenditures and where those laws already exist communities need to get a quarterly budget performance report. This means that village committees should be established to take on these roles"

After lunch we divided into three groups.

One group looked at how health workers and communities need to and can work together to solve health problems through the 'stepping stones' method.

In the picture: trying to reach a goal only stepping on actions by health workers OR communities is very difficult When you combine and can stand on both you have enough 'stepping stones' to make it easy!

One group used a role play to explore how health workers and communities interact with each other in joint planning.

"The health centre is not the employer of the community, it's the partner. We need to have a better balance of power in taking up issues"

The third group looked at how resources are distributed across the different health providers in a district using 'resource pockets'.

"Clinics and community health facilities have more contact with communities but less resources than the district hospitals. We cant improve their resources by taking away from other levels- we need to use taxes on companies and levies on private care to raise additional funds"

A slide presentation by EQUINET (RL) presented the wider context to building a people centred health system. Poverty related diseases vary by country and income group. Against a background of significant resource flows out of Africa and economic and trade policies that weaken public health, many countries in the region face challenges in implementing the public sector, redistributive health systems that respond to health needs and redistribute resources to provide health care in accordance with need. EQUINET's goals of reclaiming the state is based on the understanding that addressing our health challenges needs as a precondition an effective public sector, able to exert leverage over the system as a whole. Various areas of work in EQUINET are aiming at supporting this, through research, knowledge, capacity building, promoting dialogue, policy support and social activism. The EQUINET website at www.equinetafrica.org has many of the publications of this work and the EQUINET newsletter provides monthly information on the work taking place in the region on equity in health.

We used PRA tools in the toolkit to explore options for improving communication between health workers and communities, and to include community priorities in health budgets. The 'market place' offered a means for people to explore different aspects of health budget processes and how community roles and power could be strengthened.

6. Launching TARSC and Ifakara materials

The Bagamoyo district Commissioner, Hawas Ngulume; the director of Ifakara, Dr Hassan Mshinda and colleagues from the district council, the district health services, the Ministry of health, the Tanzania Social Action Fund, and social partners including WHO, GTZ, IDRC, SDC, Youth Action Volunteers and TEBA joined us during the workshop to hold a launch of the Ifakara Community Voice Tool for support of participation in district health planning; the TARSC Auntie Stella PRA kit for adolescent reproductive health; and the joint TARSC/ Ifakara PRA toolkit for health.

We also launched and welcomed TARSC Tanzania.

The District Commissioner challenged us having held the meeting in Bagamoyo to follow through with concrete activities to implement new skills for encouraging community participation.

"Honourable Chairperson, the event of launching new participatory tools for community involvement in the health sector is another evidence of efforts that our country, and other countries in Africa are doing in identifying health needs of our people, planning on health services delivery strategies and implementation of various health programs. The Health Sector and Local Government Reforms in Tanzania stress the importance of community participation and involvement in all development activities. Steps in the reforms mention several principles towards achieving the reform objectives. Some of them include, autonomy of local authorities, capacity to mobilize and rationalize resources use, effectiveness and efficiency in service delivery, democratic process focusing on rights and obligations and community participation.

In our country, this is not a new phenomenon. The basis for good governance and community participation was laid down by the Arusha Declaration and other declarations that followed under the Socialism and Self reliance ideology. Unfortunately, the spirit and determination on these issues could not be sustained due to the global change of political and economic ideologies over time. It is really encouraging to see, with regards to the political and economic ideologies and philosophies of the world, the community participatory approaches are improved to match with the times we have before us. It is also encouraging to see that, such efforts are not only found in Tanzania but also in other African countries and particularly in our Southern, Central and Eastern Africa."

***"**Honourable Chairperson, the challenge that faces the Ministry of Health and Social Welfare as well as to everyone of us who are present here today is on the practical and useful application of these tools that we are about to launch. How we can we ensure that these tools reach as many users as possible in our region and how can we ensure that the tools do not end to be like story books? We need to identify strategies that will ensure that the tools are used to improve our people's health and lives."*

District Commissioner Bagamoyo

During the workshop we also saw videos of PRA approaches and of the Community voice tool.

7. Proposal development and next steps

After the launch we worked on concept notes that delegates had brought for follow up work in their home countries. Delegates and facilitators worked together to review the concept notes based on the skills learned and identify possible areas for follow up work including through EQUINET support.

Delegates flagged various concerns relating to follow up, including

- Communication and exchange after the meeting
- Taking projects forward
- Supporting capacities and learning after the workshop
- Using PRA approaches
- Follow up training and review

We addressed these on the follow up discussion.

Revising the toolkit

The toolkit will be reviewed after the workshop and a revised version produced (and provided to delegates). Participants made substantial comments on the toolkit and recorded these in a master copy. These inputs would be acknowledged and taken into account in the review of the tool kit. TARSC and Ifakara will finalise the toolkit and all the institutions involved in the workshop: Ifakara, CHESSORE, and TARSC will continue to support the follow up work on PRA methods.

In the mean time participants were advised to use the tool kit but to wait for the final version before circulating beyond themselves. The tool kit should also be seen as a resource file which will be constantly updated.

Participants with relevant and interesting PRA material and references were asked to share these with institutions working on the tool kit

Building skills as facilitators

There was a follow up discussion on the role of the participants as 'facilitators' of follow up processes. As facilitators participants are expected to

- allocate tasks, explain the objectives of the discussion, as well as the whole exercise to the group/community and prepare all required equipment and materials.
- guide activities through probing (provide explanation when required); stimulate discussion, and bring attention to motivate full participation by all.
- diplomatically control dominant participants and guide the group members so that they remain focused to the matter at hand.
- adhere to the time allocated and avoid long tiresome discussion.

This means that facilitators need particular characteristics:

- To be cheerful, patient, attentive, quick to learn people's names and quick also to change the direction of discussions as appropriate.
- To be capable of instilling self-confidence among other people in order that they are encouraged to contribute their ideas.
- To be constantly aware that facilitation is neither teaching nor instructing, but guiding people through the PRA process
- To be consistent, follow up and evaluate together with the community members the whole process and the plan.

This means that participants should continue the process after the workshop:

- read further and get into the debates about the advantages/disadvantages, strengths and weaknesses of PRA
- practice! Learn from experiences, and mistakes.
- if possible, try to find a more experienced PRA facilitator to work with the first few times using PRA
- avoid being overly ambitious. Keep things simple and clear; plan programmes carefully and be flexible. Listen to the needs and experiences of the people you are working with.
- If possible put together an interdisciplinary team: perhaps one person who is knowledgable in the subject you are researching, another who is an experienced PRA facilitator, a third person from the community you're working in, etc. In this way, each team member brings in a different perspective, different strengths.
- level the ground ie while people are using a PRA tool, be aware where you are in relation to them. Don't stand above them - best to sit with them. Watch your body language. Your attitude and behaviour is key.
- 'interview the map' . We did an exercise on what this means during the final session. While poeple are doing a map or a spider diagram or whatever, ask questions, probe. Make sure one person in your team plays this role while another writes down the information.
- Don't throw away what you're already doing in favour of PRA (unless you think it's not worth keeping!). PRA is designed to complement, rather than replace, other methodologies. It's the philosophy behind PRA - the focus on respectful participation of all people - that is important to infuse in whatever you are doing.

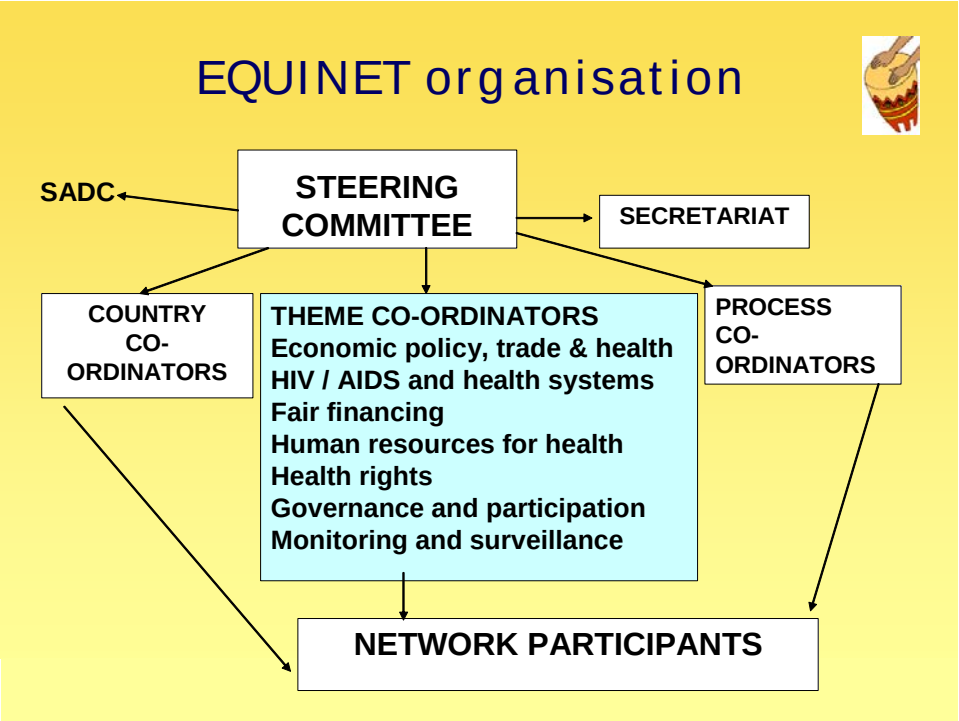
Proposals for future work

Participants were requested to revise 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 - dissemination plan. The revised proposals would be resubmitted a week after the training and reviewed by EQUINET for its grant process. The EQUINET grants aim to support participants to carry out work on PRA and people centred health systems, but also to learn and build skills in the process. Participants were encouraged to apply for other resources as well and to make contact and work with in-country PRA practitioners. The workshop facilitators were also available and willing where this was not possible.

Networking within EQUINET

Finally the ongoing networking with EQUINET was discussed. The structure of EQUINET and its theme, country and process work presented. This workshop was hosted with the theme co-ordinators of the work on participation and health, CHESSORE, and future work on PRA will bring in other theme areas of work such as the work on human resources for health; fair financing; treatment access and so on.

EQUINET resources provide support to the ongoing learning network on PRA that will come from this workshop and from PRA work in other themes, processes and country work in EQUINET.



Towards supporting this ' Learning network on PRA for people centred health systems' EQUINET will set up through the secretariat at TARSC an email list, the **pra4equity** list, for delegates from the workshop and others working on PRA in health in east and southern Africa.

This list will be used to share information on materials and debates; to share information on people with skills and experience in PRA and to provide various outputs from learning processes, meeting reports and other communications on PRA. The 'pra4equity' learning network will be a learning experience for the network as well, so feedback, discussion and ideas is encouraged! !

At the end of the training workshop we used the 'ballots in the hat' method set out in the toolkit to assess the usefulness of the workshop with three questions:

- What did you like about the workshop? What was the most relevant and useful aspect for you?
- What would you like to change or do differently in future workshops?
- What questions or knowledge gaps do you still have?

What we liked about this workshop……

"*We liked the dialogue of experience, we made new friends, networked. The workshop was well organized.*

We liked the content, we understand better why we need a people centred health system and how to build it and the areas of community actions for this. We see community differently and understand that there are different social views in coimmunities. We learnt different ways of encouraging participation, and the role of PRA methods for health for this.

We leant many approaches to dealing with communities, ways to prioritize health work. I learnt the logic behind equity work through illustrated explanation and discussion.

The driving force in the whole workshop was community drive, augmenting forces and activities that have relevance to that particular community through constructing, evaluating and reconstruction of a shared problem, taking reflection to planning, acting, monitoring and evaluation.

The facilitation was good, we learnt many new, brilliant and practical participatory approaches to work with communities that I can apply in the work I do. The pictures in the toolkit were useful.

Ive learned that PRA needs to be guided by the community you are working with and this tells you what methods you should use. Ive learned that PRA skills require patience and participation I understanding that as a facilitator in the process I have power and need to share the power (hand over the stick) with the group. I also understand that I need to plan carefully, be flexible and document well.

Ive been involved in PRA but I think the toolkit has made all of them clear - everything in it relevant. I appreciate the depth of the methods and the potential of the process to bring transformation.

I learned that learning PRA starts with three days and takes three decades"

What we would like to change or do differently in future workshops?

"We wouldn't do anything differently in this workshop.

Its important in this course to be informed of the participants backgrounds to ensure that when the session starts we are all at the same level. There could be didactic introductory lectures either at the beginning or end of the activities to put issues into context, such as what is PRA and people centred health systems.

We would want more of this and to have more time for it. We would suggest 7days because some activities were not covered and we would need more time to do all the PRA methods. Some activities, like the first, felt rushed and we needed more time for them

We want more focus on the area of the health system to have more link to content on what is meant by people centred health systems.

Some of the method session was frustrating because we were trying to do the method without a real content as we came from different countries and situations. We had to make things up. Obviously a methodology training has this problem, but it could be useful to try using a single real case story all the way through – in this case Bagamoyo.

We need time to practice methods ourselves - how to use them as research tools directly that we can measure; a component of practical examples. At the end of the workshop it would be good to have time to have individuals to come present what they feel about the whole project and to have sections of role playing as facilitators. It would also have been great to have made space for all to briefly present on their work and organisation/institution through their concept notes.

When individual project notes were being developed, we lost the momentum as a group. Setting time for this at the end or beginning of the day might have helped to hold the group together more. Some people were very passive and sleepy.

The toolkit could give more power to the community by asking them to come up with their own examples, methods of ranking so that the kit may be enriched and be socio culturally relevant. The problem tree needs to be revised as it is confusing as it stands.

We could in future include video scripts to depict follow ups and changes can be sampled from country to country on PRA methodology success."

What questions or knowledge gaps do we still have?

"None

How does action actually take place

Some methods are still not clear in what they will do or how to use them –

- *Joharis window?*
- *How to divide communities into social groups for problem identification. Whose priorities within the social groups should be taken up –what criterion?*
- *What methods work best for communities to make their voice heard and advocate for their concerns?*
- *Can we cover more methods?*
- *How do we mix methods and how do we analyse and report back (thus combined findings from the set of methods/activities) to the community?*
- *How do we continue to build and sustain the transformation stimulated and initiated by PRA*

We did not touch on some areas

- *How to influence change of policy in the health systems using PRA tools*
- *How to move from local to national to global level building PRA into organizational approaches*
- *I would like to get sharper on how to argue the globalization inequity debate*
- *How acceptable are PRA approaches to health providers?*
- *How can some of the activities be modified when working with profession, or people in government posts*

- *How do we persuade politicians/ policy makers/ managers that may not see the value of the approach (ie in medical model concept of research)*

We would want to know more about how we as a group will follow up

- *Can we translate this into French*
- *How will we pass on our findings? It would be highly appreciated if those implementing the tool can meet and share their experiences, barriers , challenges etc*

Lets go and practice and we will let you know more when we've tried using it!"

We closed the workshop with thanks to Ifakara and TARSC for their organising of the workshop, to the facilitators and participants and to the hosts in Bagamoyo. We said goodbye temporarily- until we say hello on the pra4equity mailing list!

Appendix 1: Participants list

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Appendix 2: Programme

EVENING – TUESDAY, 28TH FEBRUARY

TIME	SESSION	FACILITATORS
WELCOME, OPENING, OBJECTIVES, INTROS and registration		
6.30pm	Welcome Introductions - of facilitators - of participants Workshop objectives, logistics Participant roles and materials	Ifakara, TARSC CHESSORE, TARSC Ifakara TARSC
	DINNER	

DAY ONE – WEDNESDAY 1ST FEBRUARY

TIME	SESSION CONTENT	ROLE
8am	Intro	Selemani
MODULE ONE: INTRODUCTION TO PEOPLE CENTRED HEALTH SYSTEMS AND to PRA METHODS		
8.15am	What do we mean by a people centred health system?	Rene and Selemani
10.45am	What do we mean by PRA?	Barbs and Ahmed
12.30pm	**LUNCH and free time**	
MODULE TWO: UNDERSTANDING COMMUNITY		
3pm	What do we mean by community?	Faith
4.30pm	What are the different ways of looking at social groups in a community?	Mwajuma and Charles
5.15	Does the power of different social groups matter?	Barbara and TJ
6.00	End of day two Delegate feedback	Rene and delegates

DAY TWO – THURSDAY 2ND FEBRUARY

TIME	SESSION CONTENT	ROLE
8am	Review	All
MODULE THREE: UNDERSTANDING HEALTH		
8.45am	What do we mean by health?	Charles
9.30am	Identifying health needs / problems and their causes	Faith
10.45am	Identifying health needs / problems and their causes *ontinued….*	Selemani
MODULE FOUR: PEOPLE CENTRED HEALTH SYSTEMS		
11.45	Do health systems put people at the centre?	Faith
12.30	**LUNCH AND RELAX**	
3pm	How can health systems give meaningful roles to communities?	Gp 1:Albert and Barbs Gp 2:TJ and Charles M Gp 3: Rene and Faith
6pm	END OF DAY TWO Delegate feedback Videos on PRA and Health (optional)	Charles and Faith

DAY THREE – FRIDAY 3RD FEBRUARY

TIME	SESSION CONTENT	ROLE
8am	Review	All
8.30am	Health systems in east and southern Africa: what is the context for people centred health systems	Rene
MODULE FIVE: COMMUNITY ACTIONS IN PLANNING AND ORGANISING HEALTH SYSTEMS		
9.30am	Improving communication between communities and health services	Barbs and Selemani
10.30	Using different sources of power to improve health	Rene and Ahmed
11.15	Including community priorities included in health budgets	Faith

TIME	SESSION CONTENT	ROLE
12.15pm-230pm	**TARSC, IFAKARA launch session**	
PREPARATION AND FEEDBACK ON OWN PROPOSALS		
230pm- 4.30pm	Preparing/revising concept notes	Delegates
4.30pm	Review of concept notes	All
5pm	Presentation of concept notes	All
6pm	End of Day Three Delegate feedback	Charles and Faith

DAY FOUR – SATURDAY 4TH FEBRUARY

TIME	SESSION CONTENT	ROLE
8am	Review	
MODULES SIX AND SEVEN – OVERVIEW		
8.30am	Introduction on Modules 6 and 7	Rene
FOLLOW UP WORKPLANS		
10.30am	Final discussion on proposals	All
CLOSING SESSION		
11.00	Where to from here?	Selemani, Charles, Rene, TJ
11.45	Evaluation of the workshop	Barbs, Faith and Ahmed
12.15	CLOSING EQUINET TARSC IFAKARA and CHESSORE Participants	
12.30	**LUNCH**	