SESSION REPORT

Skills building on methods and tools for learning from action in participatory action research: Building action learning within affected actors and communities

Vancouver, Tuesday 15 November 2016

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With the EQUINET pra4equity network

1. Summary

This three hour participatory skills session discussed methods/ tools to build *learning from action* as a key element of participatory action research (PAR) and briefly the implications for what this means for an understanding of 'resilience' in health systems. It was held as a satellite session at the 2016 Global Symposium on Health Systems Research. The session drew on approaches and experience from Africa, Latin America and participants globally to discuss the methods/tools, their application and their integration in health systems. It integrated input from two rounds of moderated discussion on these questions held on the pra4equity list prior to the Global Symposium, moderated by Therese Boulle and Rene. The EQUINET,TARSC, AHPSR, WHO, IDRC Methods Reader on PAR was also distributed. The session was attended by 62 delegates from all regions (in a 50 person meeting room!).

2. Proceedings

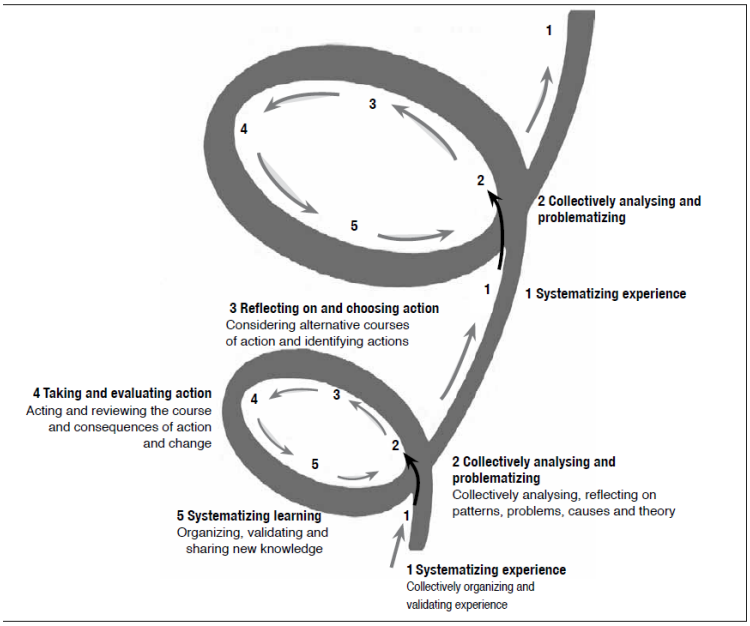
2.1 Overview

Rene Loewenson, TARSC/EQUINET introduced the aims of the session, introduced the co-facilitators and acknowledged the prior input of the pra4equity network members and the support from IDRC Canada for the venue. Rene noted that this session builds on and does not aim to repeat more basic skills on PAR that were covered in prior sessions in Montreux and Cape Town and referred those seeking information on this to the methods readers and colleagues working with PAR in their regions. The session was focused on methods and tools for building *learning from practice and change,* responding to demand from prior symposia sessions on PAR, as these methods for learning from action were identified as weak in PAR practice. She noted that PAR, like other research approaches, reflects underlying paradigms of how knowledge is understood and built. She presented the range of paradigms in a table (below) and noted that in PAR reality is understood to be subjective, captured by lived experience. Knowledge is thus socially constructed and PAR seeks to capture this through an organised inquiry and analysis of shared lived experience, including in through the learning from action.

	Positivist	Post -positivist	Critical theory	Construc-tivist	Participatory
What is real?	Single observable reality exists	Reality exists, can only be imperfectly captured	Reality is shaped by SE values, clarified over time	Reality is local, Socially constructed	Reality is subjective Captured by lived experience
What is knowledge?	Obtained through impartial observation	Impartially observed, but need perceptions to interpret	Subjective, value mediated, context specific	Socially constructed	Socially constructed, self-awareness of reality
How can knowledge be produced?	Experiment-observation; verifying hypotheses	Experiment-Observation Test hypotheses	Dialogic-testing subjective meanings	Dialectic-Shared meaning. Social construction	Participatory inquiry of shared experience; from action

She noted the broad steps in PAR shown in the adjacent figure (taken from the PAR reader) and that PAR

- Transforms those participating from research object to active researchers and agents of change- 'no delegation'
- Organises local experience, reflection, collective validation and analysis on relationships between problems and their causes to generate knowledge
- Develops, implements and reflects on action to produce change and generate knowledge
- Is emancipatory- aiming to shift power as control of the creation of knowledge shifts towards those directly affected, and
- Generates counter-narratives to dominant characterisations that hide realities.



In PAR, research seeks to understand and transform reality, reflecting the values and contexts of those generating it. Research and the knowledge generated is understood to be a source of power, building a consciousness that reality can be changed.

She outlined examples of methods used at different stages of the PAR process (covered in more detail in other sources):

- Methods for drawing out, accumulating and collective review of individual observations – eg picture codes, social mapping, collective questionnaires, seasonal calendars, narratives
- Methods for collective validation – eg ranking and scoring, pairwise ranking, transect walks/observational surveys (to validate social maps), human sculpture
- Methods for analysing cause and relationships – eg problem trees (cause), pocket charts (distribution), venn and spider diagrams (relationships)

In relation to methods for building knowledge from action she noted that the methods involve those directly affected by a situation collectively identifying priorities and strategies for change together with methods for reviewing the strategies used and change achieved. These methods seek to build strategic understanding of change, and the power, processes and institutions that affect it. Hence while it may involve revisiting the same maps and other tools used in earlier steps for concrete changes in conditions and relationships, it also involves processes and methods to review analysis of causes and relationships and assumptions about power, including the change in social power within the group involved. She noted that with such reflections often being built over many cycles of PAR and over time, in many cases the continuity is built by PAr being embedded within wider social processes, such as trade union, social movement, civil society and local state processes.

2.2 Initial reflections on methods for learning from action

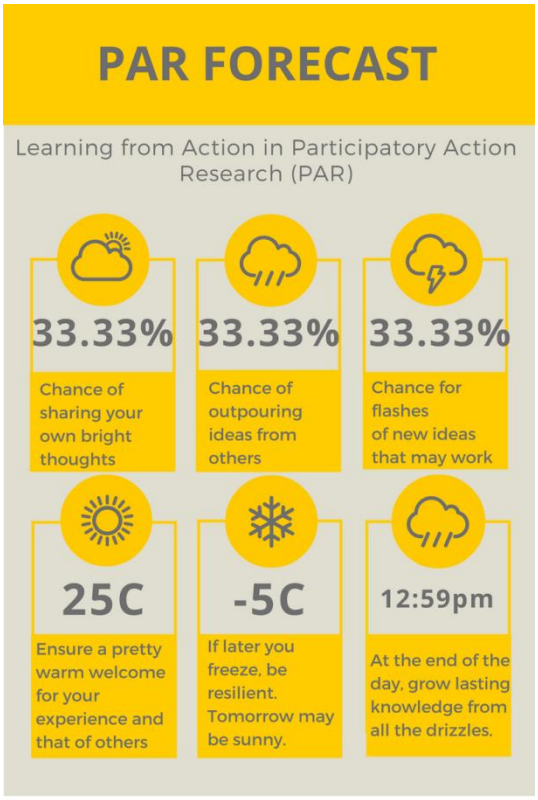
Rene briefed on the prior moderated discussions held on the pra4equity list, and noted that the issues raised in those discussions by many people who could not come to Vancouver would be included in the session. They were captured on the two flip charts that were provided for delegates to add their own views, experience and inputs in a 'market place' session on:

- CHART 1: What PAR methods / tools have successfully supported collective learning from action and change in health systems ?
- CHART 2: What factors have enabled or disabled their effective use?

The information on the charts is shown below, with the information in blue the points raised in the pre4equity list discussion and the inputs in black font those raised in the skills session. (More information on any of the methods flagged can be found in the Reader and other sources).

CHART 1: What PAR methods / tools have successfully supported collective learning from action and change in health systems ?

- There are a range of methods for this: the 'but why' method allows for understanding of what caused changes, while the 'wheel chart' and 'progress markers' are methods that enable mapping of how far things have changed against the expected or planned changes
- Further methods that can be used to present evidence for discussion of whether conditions have changed as planned include the 'community scorecard', collective maps, stories, and ranking and scoring changes
- We can use PAR forecasts to assess the conditions for and possibilities of change
- Appreciative inquiry as a method seeks to engage stakeholders in self-determined change, by asking questions that explore the vision or potential direction of change or future and then exploring how to get there.
- Quadrant feasibility and priority setting and explicit modelling are methods to test change theories and options and their feasibility
- Photo journalism; mapping can be used to share and more widely discuss and review changes
- Theatre for development, stop theater and theatre of the oppressed also engage on visions of change and how to get there, and on what could be done differently
- Public hearings facilitate wider discussion on and review of actions, particularly when smaller subgroup processes are included to discuss issues more deeply within homogenous or mixed groups



Across all these methods it was noted that

- The methods should facilitate discussion and collective validation of the strategic possibilities, contexts, social actors to assess the best approach for actions
- The methods should always seek to be based on the experience of those directly involved in the conditions and actions
- The processes may yield emotions and there need to be prior provisions for support for such consequences
- The methods need to be aimed at building not simply a measurement of change but to facilitate discussion, and collective understanding and validation of our hypotheses or theories of change
- Systematic documentation is important to capture the evidence
- Meta-analysis across sites, such as in network dialogue, facilitates the wider sharing of such insights from learning from change

The factors that enable or disable the application of these methods were discussed and recorded on the charts, shown below, with the information from discussions in prior PAR work shown on the slide. The points raised in the pre4equity list moderated discussion held prior to the symposium are shown in blue overleaf, and the inputs in black font are those raised in the skills session.

Enablers and barriers to learning from action

Enablers	Barriers
Organised communities able to use or extend political / institutional space to influence policy and practice	Individualised actors, poor social cohesion and / or closing of political and institutional space
Effective and sustained partnerships between communities, local professionals and academics	Technical/ policy actor resistance to social power, different forms of knowledge, and sustained process.
Catalysts with understanding of PAR methods	Poor understanding or communication of PAR methods
Policy and planning processes that use multiple forms and sources of evidence; social change seen as an outcome	Centralised planning; social outcomes not rewarded; PAR knowledge seen as locally specific
Time for PAR; embedding PAR in institutional work	Unpredictable time frames, tracking stopping too early given demand for several cycles over time
Resources for PAR; embedded within system budgets	Limited, project defined resources

CHART 2: What factors have enabled or disabled their effective use?

As enablers:

- Time and a sustained process is needed as it can take several PAR cycles for meaningful change to be implemented. The length of engagement is important for learning from action, as are the existence or creation of spaces for participation.
- The methods used should be accessible and understandeable to the community involved. PAR as process takes into account power imbalances/inequalities within those involved and its methods provides a means to address inequality.
- The confidence, self-efficacy in those involved and in the facilitators, the knowledge of the diversity of methods and the presence of health champions encourages (and should be embedded) in the application of PAR.
- Good channels for communication between communities and health workers, authorities and others supports the application.
- There is growing recognition of different types of knowledge, of PAR as an effective method for building knowledge and understanding complexity and of why and how change takes place.

As barriers:

- Prior 'phantsi' or data raids by researchers in communities may create distrust around any research, and PAR should derive from communities holding researchers accountable and retaining control of the process throughout
- The resources and process may stop too early for the tracking of effective change
- Lead organisations may lose attention and researchers may not be able to sustain their own involvement
- The organisational culture and processes of many institutions is different culture to that of PAR and its cycles and bureaucratic systems and a struggle for legitimacy (such as in universities) can undermine application of the methods.
- Health workers are often reluctant to give power to communities and have weak understanding of PAR.
- The methods for recognising and assessing change in confidence, consciousness in those involved are less well developed and used than those for assessing change in concrete conditions

There was some discussion of whether social media facilitates PAR- it was noted that digital access has been a vehicle for combatting inequality, but it depends on access and how it is used. In general it was noted that there are a range of potential methods for learning from action. *It was suggested that it would be useful to compile information on these methods and their use, including links to existing good outlines, to share these more widely.* However the contexts, spaces, processes, capabilities, political, organisational culture and strategic issues raised are as important for the learning from action in PAR as the specific methods.

2.3 Case study discussions

The delegates divided into four groups to explore these issues more deeply through the lens of specific and diverse PAR case studies. The four case studies were

i. GROUP 1: Facilitated by Walter Flores, Center for the Study of Equity and Governance in Health Systems, Guatemala, discussed their work within indigenous communities in Guatemala, documenting and engaging on rural health service deficits, including with national authorities and parliaments, and how the evidence and process affected power relations and responsiveness to community demands.

ii. GROUP 2: Kelvin Koffa Kun New Kru Town/International Rescue Committee, Liberia with Lara Ho, International Rescue Committee discussed their work in New Kru Town engaging pregnant women, community midwives and birth attendants , local leadership and health workers on learning from improving the maternal health system post Ebola in Monrovia, to review experience, build communication between the stakeholder groups identify impacts of the Ebola epidemic and identify and take actions to improve the system.

iii. GROUP 3: Leslie London University of Cape Town, School of Public Health and Family Medicine, Health and Human Rights Programme, South Africa discussed their work in developing evidence for and engaging in provincial policy review of health centre

committees, showing how the methods addressed differences in perceptions and relations between health workers and communities in policy engagement.

iv. GROUP 4: Ana Amaya UNU CRIS Belgium discussed work in Southern Africa and Latin America monitoring implementation of prioritised areas of regional health policy and agreements, showing how the methods strengthen problem solving and accountability across stakeholders and countries by involving regional, state and non-state actors from the Southern African Development Community and the Union of South American States.

The case study facilitators presented their work, the key features, the purpose, what was done and changed, what learning and insights were derived from the process and actions. Case study leads facilitated participant discussion on the process and methods and on issues from participant own experience on applying PAR and the learning from action. Each group recorded points from the discussion on the process/methods for building learning from action and on issues to take into account in applying the methods.

2.4 Learning from the case studies

The rapporteurs put their charts for all groups on the wall and we had a 'walk through' discussion of the findings from the case study groups on the methods used for participatory learning from action, and the issues in applying the methods. We explored also what this means for PAR practice; and for institutionalising these approaches in health systems at local/national/regional level.

Points raised on the process/methods for building learning from action

The work in GUATEMALA raised the methods and processes used by an indigenous community in its engagement with authorities. The methods used were highly visual to communicate evidence, take and review actions on the health services: photography and media evidence, narratives, radio broadcasting, videos, infographics and community bulletins. The methods supported dialogue and the building of collective voice and action within the community. They also provided a means to engage with authorities, such as using smartphones to gather evidence for complaints on service deficits and holding monthly meetings with authorities.

In LIBERIA, the power imbalances between pregnant women, health workers, community leaders, community and traditional midwives meant that some processes divided the different groups involved in making their diagnoses of the problems and their causes and proposing actions, but that identifying strategies for change brought these diverse perceptions together in a way that managed the imbalances and integrated the different views, to identify shared priorities, strategies and joint actions. In this they noted that the facilitator plays a key role in managing disagreements and diverse views, and that the methods need to enable this. They organised a collective mechanisms and responsibility across all the groups for the actions and reviewed them collectively. Bringing these different social experiences in the same situation meant that the change process needs to be sustained, to allow for different voices in the shared meetings, and to use different techniques and take time to build the trust and local connections needed for change.

In SOUTH AFRICA the health clinic committees [HCC] provided a space the work, given their formal role in increasing community participation, and the learning was built on influencing policy change on their functioning. The change process was built around claiming and using this space and there was some discussion on the relative merit of using a claimed space versus an invited space in changes over time and of the HCC as a dynamic space that can be used in this way. Structured approaches (score cards, mapping) and a rights focus were used to collectively organise and analyse evidence, supported by mentorship and skills building. However, as important were there the measures needed to sustain and shift power within the space to give enough time to build the change and the learning on the work. This included, for example ensuring representation by democratic election. The group saw further that such processes need to plan for sustainability from outset.

For the work in UNASUR and SADC, demystifying concepts, and using simple language was important for power equalisation, being explicit issues such as gender. As in other case studies, the methods for trust building were key for building learning across diverse groups, as were approaches to avoid dominance of particular influence, such as by shifting places for meetings.

Points raised on factors/ issues in applying the methods, and institutionalising them in health systems.

Many of the same issues raised in the earlier discussion on enablers and barriers were raised in the case studies, including enablers such as:

- Time and resources for the processes to sustaining the PAR process to be able to take advantage of windows of opportunity for change.
- Communication channels, public interests and support,
- The capacities and confidence of the facilitators and of those involved, and the skills, information, training and other inputs needed to support this, and

Barriers such as:

- Undemocratic culture, weak institutional support.
- Time and the intensive demands of the process;

The deeper discussions in the case studies however raised that learning from action in PAR is not only dependent on the creative tools, methods, competencies and time. It was noted to demand virtuous and continuous cycles, that create support and progressively strengthen voice and power, feed into processes of resource provision. It is inherently a strategic process – and not a project - that integrates other inputs:

- Careful mapping and identification of the participants, what may sustain or impede involvement over time and what may affect their ability to act on their evidence;
- Identifying the power relations and bottlenecks within the group and in their interaction with the wider context.
- Understanding of contexts that may affect the work, including turnover of personnel, leadership capacities and roles, legal and political conditions, the current mechanisms for feeding into policy, the attitude and capacities of authorities and influential individuals, how conflict is resolved, and the policy space for change, and
- Exploring and identifying the invited, claimed or created spaces for locating the process, and assessing their potential for participatory processes, or what needs to be done to facilitate this,
- Identifying the potential risk of structural, systemic problems that remain unsolved, and the ethical issues this raises and
- Providing for the documentation, communication and media resources and skills needed to facilitate these processes.

The case studies highlight that the specific tools raised earlier also need to be located within wider processes to support building analysis to inform action and learning from action:

- Processes that facilitate sharing of experience and analysis within separate groups where there are power imbalances, but that also bring together groups that need to build shared analysis and engage collectively to produce change.
- Rights based approaches
- Mechanisms for representation, feedback, engagement, that meet regularly for monitoring, follow up and review of actions and feedback to wider communities.

Participants noted that these features of learning from action imply that rather than seeking to institutionalise the 'methods' for learning from action in health systems, we should be institutionalising the conditions and spaces for it within diverse contexts.

2.5 Implications for the concept of 'resilience'

In the concluding discussion we reviewed what these participatory efforts to transform and build knowledge on health systems imply for the understanding of 'resilience'.

Rene noted that the discussion on the pra4equity list has raised questions on the use of 'resilience' as a concept in work on health and health systems (See adjacent slide).

What it means for resilience?

GSHR website: "Health systems must be resilient – able to **absorb the shocks and sustain the gains** already made...."	Topp et al: "'building resilience' rarely seems to involve a **direct.. challenge to the structural conditions** that contribute to overarching health system dysfunction...
Env sciences: the **stability of a system against interference** from external disturbances	pra4equity: in a situation of injustice **disruption may be healthy**
General: **flexibility, ability to recover** from setbacks; **spring back into shape**	Other Env Sciences: flexibility and the **ability to self-reorganize into a healthier state** which may differ from the existing
pra4equity: **Command-control emergency responses** that neglect to build community capacity and systems to prevent	pra4equity: PAR a process for **transformation**- draws in **learning from action** on a system **by those directly affected.**
	pra4equity: either remove the term from our lexicon, or **reclaim what it means, from the bottom up"**

One participant commented that resilience was one of the features of systems, rather than a unidimensional attribute. The pra4equity discussion noted that some use it to talk about the ability to self-organise into a healthier state. However it was also noted and that many responses to emergencies that seek to restore stability do not build capacity of local communities to control or transform conditions.

The discussion observed that with different 'meanings' being ascribed, as raised in the discussion on the pra4equity list, we need to question and understand explicitly how the term is being used, and why it is given focus over other attributes of systems. Participants questioned why 'absorbing shocks' and 'stability' were being given significant focus when unjust and structural inequalities lead to shocks and undermine health. In this context disruption not stability may be necessary, particularly given that PAR seeks to confront inequity and build capacities to transform.

Appendix 1. Delegate list

Name	Institution
Rene Loewenson	Training and Research Support Centre /EQUINET
Walter Flores	Center for the Study of Equity and Governance in Health Systems
Lara Ho	Senior Technical Advisor for Health Research, International Rescue Committee
Kelvin Koffa Kun	International Rescue Committee, New KruTown
Ana Amaya	UNU CRIS Belgium
Leslie London	University of Cape Town, School of Public Health and Family Medicine,
Zakaria Belrhili	National School of Public Health
Douglas Glandon	Johns Hopkins Bloomberg School of Public Health
Grang Tharh Lory	Nat'p Elon Univ Vietnam
Kaittin Atkinson	UBC Digital emergency medicine
Grace Bongololo-Mbera	REACH Trust, Malawi
Kingsley Rex Chikaphupha	Reach Trust
Guillaume Labrecque	Technical Advisor, Governance | International Rescue Committee
Chiara Bodini	Centre for International Health, University of Bologna, Italy and PHM
Paul Bossyns	Belgian Technical Cooperation, Brussels
Martina Riccio	Centre for International Health, University of Bologna, Italy and People's Health Movement
Sarah Simpson	EquiACT
Mauricio Torres Tovar	Peoples Health Movement (PHM)
Erick Kambale	PHM
Prasana Saligram	Public Health Foundation, India
Soumya Alva	John Snow Inc (JSI)
Fran Baum	PHM/Flinders Uni Austria
Kassim Kwalamasa	REACH Trust Malawi
Godelieve van Heteren	Rotterdam
Karen Mathias	EMA/ Umea Univ Sweden
Anuj Kapilashrami	Univ of Edinburgh UK
Linda Gibson	Nottingham Trent Univ UK
Loubna Belaid	Univ of Montreal, Canada
Lorena Ruano	CEGSS
Fernando Jerez	CEGSS
Astrid Escrig	VOFT
Sumiyo Okawa	Uni of Tokyo Japan, Harvard Sc PH
Jessica Spagnolo	School of Public Health, McGill Univ, Canada
Gail Webber	Bruyere Research Institute, Ottawa Canada
Sian Fitzgerald	Health Bridge, Canada
Maeve Conlin	Management Sciences for Health, USA
Janice Lan	School of Public Health, Hong Kong
Bosco Turyamureeba	Makerere University School of Public Health. Uganda
Bruno Meessen	ITM, Belgium
Maarten Kok	Erasmus/Tutu, Netherlands
Mulumba Moses	CEHURD-Uganda
Nicole Gailits	McMaster University, Canada
Kaaren Mathias	Emmanuel Hospital Association and UMEA, India
Dhananyay Kakde	OSF
Lucy Ramirez	Mozambique
Lei Alfonso	EV4GH
Stefanie Gregorius	LSTM/ UK
George Jobe	Malawi Health Equity Network
Ramjith Babu	The Union
Werner Soors	ITM,Antwerp
Nicolas Oitiz	Universidad de Valle, Spain
Damian Perez	Universidad Veracruzana
Nestor Cabiera	Universidad Veracruzana
Gina Teddy	UCT, South Africa
Anais Tuepkr	VA USA /OHSU
Chad Swanson	Revolutionize Health
Chantal Inyabire	MRC- Rwanda
Sergio Chicumbe	INS-Mozambique

Name	Institution
Jahmena	JPASPH, Bangladesh
David Wallar	CSC Consulting Group
Anadne Nebot	ITM, Belgium
Moses Tetui	Makerere Univ, Uganda