

**CREATING NURSE STUDENT AWARENESS ON COMMUNITY
KNOWLEDGE ON HEALTH IN “ONTEVREDE” (UNSATISFIED)
INFORMAL SETTLEMENT, NAMIBIA**



A PRA PROJECT REPORT



**Produced by University of Namibia and the
Onteuvrede community
With the Regional network for equity in health
in east and southern Africa (EQUINET)**



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Creating Nurse Student Awareness On Community Knowledge On Health In “Ontevrede” (Unsatisfied) Informal Settlement, Namibia

EXECUTIVE SUMMARY

The nursing curriculum of the University of Namibia is based on Primary health care approach. However nursing students do not have the skills for a participatory approach to communities and perceive that communities do not know or need to be consulted on their health needs. Communication breakdown between communities and nurses is not in the interest of either. This study aimed to create awareness among the student nurses to help them view the communities as partners in health, and at the same time to empower the communities to be more responsible for own health.

The work used participatory research (PRA) methodologies to achieve these goals. It was implemented in the context of the EQUINET programme on PRA training for people centred health systems. It drew support from EQUINET institutions in the region, namely TARSC Zimbabwe, Ifakara Tanzania and CHESSORE Zambia. Through PRA a better understanding was sought of the health needs of the community, and which actions could be taken to address health issues by the community and other role players.

Eight nursing students of the University of Namibia, randomly selected from the student list, participated in this study, together with the community of “Ontevrede” informal settlement area around Katutura. Permission was obtained from the community leaders and community participants. The students completed an attitude checklist before and after their work on the community. Students and communities separately identified their perceived health needs and proposed health actions through PRA approaches including transect walks, social mapping, brainstorming, discussions, ranking and scoring, the “Problem Tree” and “But Why” method and stepping stones exercises. These views were then synthesized, and the different and common views across both groups identified. The two groups then discussed the findings, and the areas of shared perceptions and differences.

The students identified clinic, toilets, health education and electricity as priority health needs, while the community identified the need for a clinic, plots, tar roads and toilets, both in order of priority. There were thus a number of shared priorities. The students identified unhygienic conditions as the main cause of health problems, while the community identified lack of secure land and accommodation.

In the combined meeting of the two groups, these priority health needs and the actions to be taken to address them were discussed. The major difference was in

the actions to be taken to address lack of toilets. The community did not see the need to build toilets when they did not have their own plots, while the students felt that shared toilets could be built as an interim measure. In the meeting through PRA approaches the community worked out a systematic plan of action to deal with the toilets, and through this resolved to build one toilet for every four households. They also realized through the local dialogue the steps they could take as a community to move these health actions forward.

The work through a PRA approach brought about two important changes. Firstly, it created a change within the students' attitude towards the community knowledge. Thirty one percent of the students in the first attitude test felt that the community was not able to identify their own health needs. After the PRA work, 100% of the students who participated in PRA indicated that the community was able to identify their own health needs. Prior to the exercise, 57% of students felt that the community was able to act on their identified health needs. After the exercise 100% of the students now felt this. The students learned that the community, as insiders, know their health needs and problems often better than the outsiders who are coming and going. They also realized that the community was able to act on their health issues

Secondly, the community was empowered to act on their problem of toilets, which they never thought to work on. The community realized their own strengths to initiate action, while also strengthening their collective dialogue on how to approach authorities to support their action.

The facilitator learned that the participants have more control than the facilitator in PRA research, and that the use of PRA tools paves the way for concrete community outcomes that cannot always be planned.

As a way forward in this community our PRA team will now work out approaches to consolidate the changes in the community and in the students. This includes continuing the process of community dialogue, including with authorities, and of integrating PRA approaches and community health interaction in the nursing curricula.

Creating Nurse Student Awareness On Community Knowledge On Health In “Ontevrede” (Unsatisfied) Informal Settlement, Namibia

1. INTRODUCTION

Prior to independence, the health sector in Namibia was structured along ethnic lines and was curatively biased. After independence in 1990, the Ministry of Health and Social Services adopted Primary Health Care approach. The nursing curriculum at the University of Namibia is based on this approach. However nursing students do not have the skills for a participatory approach to communities and perceive that communities do not know or need to be consulted on their health needs. A breakdown in communication between communities and nurses is not in the interest of either. Communities who feel their issues are not taken seriously may not act on health issues, and nurses may ignore priority health needs identified by communities.

Following training in Participatory reflection and action (PRA) methods for people centred health systems by Training and Research Support Centre (TARSC) and Ifakara Health Research Development Centre in EQUINET the delegate attending from the University of Namibia suggested that the use of PRA approaches could be used to change this situation. The approaches could be used with 3rd year nursing students, pursuing Diploma in Comprehensive Nursing and Midwifery Science Program and in the “Ontevrede” informal settlement area in Katutura. The latter was targeted because of their vulnerability for ill-health due to number of factors such as unemployment, lack of basic services including health care.

The study reported here thus aimed to change perceptions of community roles in health in student nurses to help them to view the communities as partners in health and to realize the importance of mutual understanding and dialogue in their daily interaction with communities. It was felt that this partnership could empower the communities to be more responsible for own health.

The work aimed to use PRA methods to find out

- Priority health needs and health actions in “Ontevrede” informal settlement area identified by communities and student nurses
- Perceived shared contributions of communities and health services in addressing the priority health problems

By using PRA approaches it aimed to change the mindset amongst nurses towards listening to and communicating with communities in planning local health interventions

2 METHODS

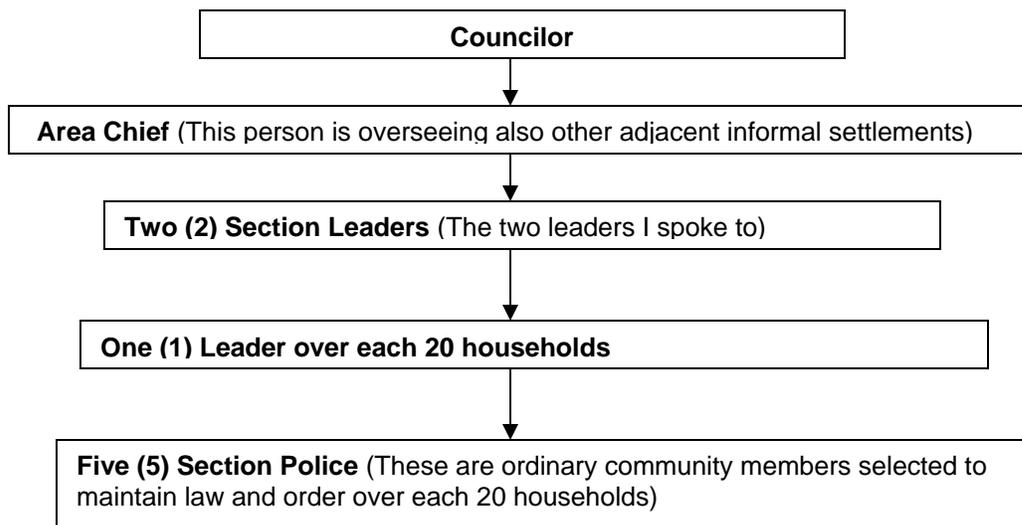
The research used a mix of qualitative and quantitative methods.

A brief questionnaire was given to all (77) 3rd year nursing students in the beginning to assess attitudes towards community knowledge on health needs. The same questionnaire was administered to the selected students who participated in the PRA exercise after the exercise to see whether their attitude towards community knowledge on health needs and responses was different to this baseline. The questionnaire reviewed nurse perceptions of whether communities were able to identify their own health needs and able to act on them.

Eight 3rd year nursing students from UNAM (Males = 2 and Females = 6) were randomly selected, and informed consent was obtained. The number was defined by available resources. The gender balance reflects that in the 3rd year student group.

An initial community visit was made to introduce the work with community leaders in the area, to introduce the process, agree on dates, and to assure that the purpose was educational and avoid undue expectations.

The leaders were very excited about the initiative, more than expected. They were very keen to be part of this project. They narrated a scenario where the Windhoek municipality previous week installed four pre-payment water meters without consulting the community. Issue that annoyed them and also resulted in some threats to remove the meters from their premises. They commended the researcher with the way she decided to introduce this project through the existing channels and pledge cooperation. They indicated participation and promised to first address the community. A time was agreed for meeting the community. It was made very clear that all the sections of the community need to be involved in the intervention such as youths, elderly, women, orphans, etc., although a smaller group of the community could act as secretariat or reporters, which they completely agreed with. The channels of communication in the area for both top down and bottom up communication were:



After the meeting with the community leaders, a meeting was also held with the selected students to inform them on the project and its education role and to secure their agreement.



The excited eight students for PRA exercise before entering the community

This was followed by a **Transect walk** and mapping with the students accompanied by a section leader. The eight students were taken to “Ontevrede” informal settlement area. The first day was used to create a rapport with the community through the section leaders and the transect walk was done the following week. In the first introduction the students directly observed the area and identified issues during the transect walk and informally map the area individually, and then by combining all the individual maps, as a combined map.



Social map of “Ontevrede” settlement area

The students were provided with an observation guide on some of the issues to look for during the transect walk in the living environment, community environment, economic activities, infrastructures and services.

On the day of transect walks, the community leader introduced us to the community in their homesteads.

After the transect walk and social mapping, the students and the community separately held meetings using **PRA methods** to identify their health needs, the causes of these needs, the four priorities amongst the needs identified and the health service and community actions for these identified health needs.

The student nurses and community held a **joint meeting** to discuss their separate findings, why any differences occurred. The PRA tools allowed both for dialogue on the differences and a PRA exercise to look at community and health service roles in acting on a priority problem. Each group discussed lessons learned from the exercise.

After the end of the whole PRA intervention, the students were given the same attitude checklist provided in the beginning, to assess any difference in their perceptions regarding community knowledge after the exercise.

EQUINET (TARSC, CHESSORE and IFAKARA) facilitators provided backup support on the methods and on the draft reports. The notes were taken by the PRA team (community secretariat, students and facilitator). The full programme was implemented between 23 March 2006 and 31 May 2006. Dr Käthe Hofnie-//Hoëbes, University of Namibia, led the research team and others involved were third year nursing students of the same University namely:

Ms Sarafina Erastus

Mr. Sakeus Nairenge

Ms Leena Shavuka

Mr. Walinyando Linyando

Ms Omagano Amwaanyene

Ms Lourencia Muinjo

Ms Josephina Shikukutu

Ms Hilya Uukongo

Findings were synthesized and **report compiled** on the outcomes and possible way forward from lessons learned. Both groups participated in this step for the ownership. This final report was compiled by University of Namibia (K Hofnie-//Hoëbes) with technical edit from TARSC/EQUINET (R Loewenson).

3. FINDINGS

3.1 Student attitude pre-test

The student attitude pre-test generally indicated that students felt that community knowledge of their health needs was weak, and that even those able to identify their health needs needed assistance from health workers through health education and advice. A large share felt the community were uneducated and from a remote area. A minority (7% of the students) indicated that the community has good knowledge of their health needs, in the case of one student because he/she lives in that community and knows the community well (See Table 1).

Table 1: Student attitude pre-test results

Attitude Assessment	Pre –Test	Results
Do you think that community has the ability to identify their own health needs?	Yes	61%
	No	31%
	Don't Know	7%
How would you rate their knowledge on identification of their health needs?	1. Poor	22%
	2. Fair	28%
	3. Satisfactory	43%
	4. Good	7%
To what extent do you think the community is able to act on their identified health needs? The community will...	1. do nothing	7%
	2. do something at household level	57%
	3. refer to the community worker	17%
	4. refer to the health worker/facility	19%

3.2 Transect walk

These results are reported in relation to the living environment, the community environment, infrastructures and services

Community history: The City of Windhoek (municipality) relocated this community in 2000 from other areas such as Okuryangava and Ongulumbashe because the City of Windhoek wished to extend those areas. Some of the community members were brought from other settlement areas such as adjacent Okahandja Park. The City of Windhoek argued that Okahandja Park was overcrowded. The community informed us that they were not stable. According to them, every time the City of Windhoek wanted the piece of land back for their extensions, they would have to relocate.

Shortly after relocating to this area, they were told to move to Otjomuise. They were very dissatisfied and mobilized against this decision. They informed the municipality that it was too much work for them to clear the bushes every time for constructing new houses. According to them, their items were also being broken during these movements as they were constantly on the move. It was at this junction that the name of “Ontevrede” comes, which means unsatisfied. Initially

this area could be seen as extension of Okahandja Park. The City of Windhoek then agreed and promised them plots in the area where they are now living.

Generally, this community is a youthful community, with few older people. One old woman was observed, although they indicated that there was also one old man. The older people were living with their children, as they were from the Khomas region. Of the younger generation, some were out of school youths, mostly school dropouts, with young men in the majority. We were informed that some of the youths ran away from homes and squatting with friends in this area. These community members came from all over the country, with the majority from the Northeast. According to the community, the majority of the children under the age of five years were attending kindergarten in the adjacent settlements, although there was none in the area of study. One physically disabled woman and a school going boy in a wheelchair was observed. The boy was dressed in a school wear and driving in his wheel chair to the nearby school in the area.

We were informed that the majority ethnic groups living in this area were Okavango, Oshiwambo, and Damara>Nama. The majority of the community members were unemployed, while others who were working earning low salaries, ranging from N\$100-00 to N\$500-00 per month. (= US\$16.6 - \$83.3). The majority were security guards, while some of the women were doing domestic work. We came across one police officer, which also lives in this area. The majority of community members were unmarried, but cohabitant with children.

According to our observations, the interactions between men and women appeared to be good, as was the interaction across ethnic groups. They understand each other and appear to live in harmony. However, the community raised a concern of rape cases, due to lack of streetlights and alcohol misuse. We were also told that lots of fighting and housebreakings were taken place. Serious crimes were not common, but rape and common assaults were reported.

Living conditions

The **houses** were constructed with different temporary materials, such as corrugated iron, thatch, wood and hardboard with no ventilation. Many houses had only a door and no windows. Some used caravans for houses. During the rains, roofs leaked. The rooms were small and overcrowded. In some homesteads up to ten people were living. The houses that looked bigger were those combined with the businesses (shebeens). The rooms were divided by curtains. Some houses looked dirty and dusty, while others were managed well. It was observed that some utensils were not properly clean, such as container in which fish was prepared. The majority of houses were in poor condition.

The **bathrooms** were erected from boxes, plastics, old carpets and corrugated irons. Dirty water from the bathrooms drained down the streets, where other people were walking, including young ones. The community had no toilets, and

used bushes and the nearby river. One pit latrine was observed in the yard of one of the community members, although not an ideal one. Faeces were observed in some walkways. When raining and the area wet, the smell of faeces was obvious. Three proper pit latrines with fans on top were observed between the border of “Ontevrede and Okahandja Park”, but were not used by the community, partly they indicated as they were not consulted on them. Secondly, the community believes that those toilets will never help, as they are few and will contribute more to the spread of diseases. Some believe that nobody will be responsible to clean it and will just cause fighting among them. Others indicated that if the toilets were full, it would create more bad smell. Some men were observed urinating in the bushes within the vicinity of the homesteads. One big orange municipal refuse bin was observed at the border of Babylon and Ontevrede settlements.

Infrastructures

Very dusty gravel **roads** were observed. Although there was no official taxi rank in this area, taxis were available, although not enough. The road to the Government school transects the study area (Ontevrede), and taxis were running through the area. According to the community, taxis were scarce and charging extra money because the area was very far from the city center as well as from Katutura township, with its health and other facilities. Although not within the community itself, municipality buses were available only for morning hours from Babylon, (adjacent settlement to Ontevrede). Security guards were transported with company transport. Some people own cars in this community, although few. We were informed that around ten people have own transport.

No **electricity** was observed in the area, but Shebeens were using fridges and deep freezers. The community used candles, paraffin, firewood and power generators as sources of light, fuel and for refrigeration. There was also one house, which was using solar panels for power, with two houses generating power with power generators.



The community used piped **water**. Four water outlets were observed, with water coming from the reservoir in their area.

Large water reservoir within the settlement area, which also caters for the surrounding settlements

Each household was currently paying N\$20-00 (\$3.3) per month for the water. In December 2005, the City of Windhoek erected four taps for pre-paid water meters without consulting the community. This caused dissatisfaction among the

community. Of the four taps, only three were operational. These water outlets were placed strategically to accommodate all the households.

Community environment

No formal shops were observed. **Shebeens** were all over the place, within the normal households, and not as stand alone entities. Some shebeens were combined with mini markets selling items ranging from groceries, braids, condoms, and some medications such as panados, grandpa powders, aspirin, eno, and medlemon. None of the shebeens played noisy music. In fact only one was playing music, but not loud or disturbing. One pickup was loaded with meat, but people were not buying. The meat was covered with bags, and appeared fresh. A car full of firewood was also observed, and people were not buying this. There were also mobile businesses that were selling items (see photograph). These people were walking and selling their items.



Men selling clothes to community members

Some people had small huts or shelves in front of their homesteads where they sell groceries, fruits and vegetables. Others were selling traditional foods, vegetables, fruits and dry fish on the streets.



Food sold on the street corners

People **cultivated** maize, mahangu, sorgham, beans, tomatoes, pumpkin and cabbage. The majority of the households planted tomatoes, as the house in the picture. They do not water their plants much and depend on the rain. Outside the rains, some people use tap water for gardening. A few households planted shade trees, but these were still young. Some community members had tall grass around their houses, as this was a raining season. Others have cleaned their yards nicely and planted flowers in their yards.



This household had cleaned their yard and planted tomatoes

Children were doing normal house chores, such as washing dishes, cleaning houses and fetching water from the three taps in the area. Some of them carried containers that were a bit heavier than their age and build, while others carried smaller containers. Children carrying beer were also observed. On closer enquiry, it was noted that their parents or other older people sent them to buy from the places where drinks were being sold.

Social services

No **health facilities** were observed in the area. The community was attending Okuryangava clinic, Katutura Health center, or Katutura State hospital when in need of health services. Hence, the vaccination passports of those children under the age of five years who were reviewed, as well as those of women of childbearing age for Tetanus Toxoid were up to date.

'Ontevrede' is an extension of bigger Okahandja Park, which borders many other bigger informal settlement areas. The government built a **school** in front of this study area, even before this community settled in this area. We were told that there were also kindergartens in the neighboring settlement areas, but not directly in the community of study.

We were informed that orphans once received clothes from different **churches**, especially, the Catholic and Lutheran churches. No formal work is been done by any other non-governmental or church organization in this community. According to the community, the majority of deaths in this area are due to Tuberculosis. However, we did not come across bedridden or sick people in the homesteads. The area leaders inform us that they do not have people for home-based care. People who are not well are going to the clinic and are only for some few days in bed. According to the community, there are orphans. Of them, some were legally registered, others not.

There was a big church building closer to the school at the border of Ongulumbashe and Ontevrede. The church was constructed of wood and corrugated iron. One house between other homesteads had a cross on the door. We were informed that it was also one of the church buildings.

There were two **soccer fields** across the highway in front of the settlement area. It appears that one is not in use for some time and is full of grass. We were told that both fields were being used only if other teams of neighboring settlements are being invited. However, these were open spaces that were used by the community for recreation, and not official designated soccer fields. The municipal **playground** was observed for children at the border of Babylon with 'Kilimanjaro', which was very close to 'Ontevrede'. This playground was meant for the inhabitants of all the neighboring settlement areas. The people do not have a community hall, and gather in an open space, even without a shade tree for meetings and other activities of common interest.

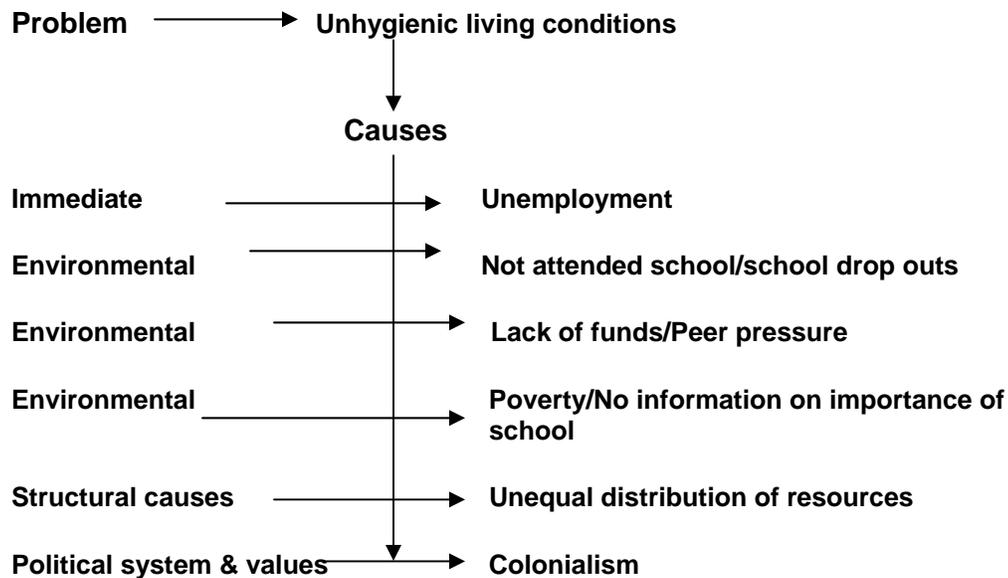
3.3 Health needs and actions identified by the students

The students' initial list of health needs identified during the transect walks were:

- **Living environments:** Toilets; Provision of mosquito nets; Ventilation in the houses; Building of proper bathrooms
- **Infrastructures:** Tar roads; Electricity; Safety and security
- **Services:** Clinics; HIV/AIDS awareness campaign; Traditional Birth attendant for emergencies; Provision of community home-based care; Environmental health inspectors for pest control and inspection of food sold in markets; Health education on:
 - Hygienic conditions
 - Family planning
 - Construction of houses
 - Visual aids

There was a thorough discussion on how each of above could impact on the health of the community. Using the “But why” and Problem tree” tools, the students identified “Poor living conditions” as the main problem they observed, as this had impact on community health. The causes for this were identified as in Figure 1 below:

Figure 1: Causes of poor living conditions



The students in two groups collectively ranked the top four health needs as:

Table 2: Priority health needs identified by two groups of students

Group 1: Priority health needs	Group 2: Priority health needs
<ul style="list-style-type: none"> ○ Toilets ○ Clinic ○ Electricity ○ Health education 	<ul style="list-style-type: none"> ○ Clinic ○ Health education ○ Toilets ○ Electricity

The two groups separately came up with the same health needs! They then jointly used PRA dot ranking methods to rank these priority health needs according to their importance:

Table 3: Jointly identified four top priority health needs by students

Four Priority Health Needs	Ranking by students
Clinic	1
Toilets	2
Health education	3
Electricity	4

The students were convinced that a clinic was first priority as the clinic would provide personnel to educate the community to maintain healthy practices, and to cater for emergency treatment during day and after hours. The health education that could be provided from the clinic will address the issues of unhygienic conditions according to them. For some, health education without a clinic was not a possibility. They noted that the communities were trying to cope without a clinic by attending other health facilities. They observed this from the up-to-date health passports of under five's and mothers of child bearing ages.

The students proposed a range of health actions for these priority needs:

At community level

Ventilation

- ✓ Make window-like openings when constructing houses.
- ✓ Fewer people in one room

Hygiene

- ✓ Maintain personal hygiene
- ✓ Keep kitchen utensils and water containers clean
- ✓ Clean houses inside and outside
- ✓ Organise refuse dumping sites

Toilets and bathrooms

- ✓ Dig pit latrines. (communal toilets, bathrooms at strategic places for now).
- ✓ Build bathrooms away from the streets to avoid dirty water running down the streets or in the gardens

Construction of houses

- ✓ Build bigger rooms, those who could afford, to prevent overcrowding.

Safety and security

- ✓ Create a neighbourhood watch
- ✓ Educate children on the dangers of highway transecting the settlement
- ✓ Watch dogs for thieves

Traditional Birth Attendants (TBA)

- ✓ Identify experienced person that could be trained for emergency deliveries

Health education

- ✓ Community has already some knowledge on the treatment of common colds. Sell already panados, aspirin etc. in their shebeens.
- ✓ Give first aid treatment of wound, burns, accidents, tepid sponging for children who develop fever
- ✓ Education on proper preparation of food to reserve nutrients
- ✓ Community based worker could give information on family planning and HIV/AIDS
- ✓ Identify busiest time of the day for speeding of cars and close windows, to minimize dust coming into the houses
- ✓ Community to visit clinics for regular check up for possible Tuberculosis, cause by dusty streets

Community home-based care (CHBC)

- ✓ Community should be responsible for CHBC, with the guidance and training by others in the district or area with the necessary knowledge.

HIV/AIDS campaign

- ✓ Have HIV/AIDS trained persons for sustainability of information from the community in bringing education to the community members.

At district level (through NGOs, community support groups, students from UNAM, Health workers, safety and security units, environmentalists etc)

Provide training and support to the community on:

- ✓ CHBC
- ✓ HIV/AIDS campaign
- ✓ Health education
- ✓ TBA
- ✓ Safety and security
- ✓ Constructing of houses, toilets, bathrooms
- ✓ Provide mosquito nets

By government

Regional and local government should provide:

- ✓ Clinic and health inspectors
- ✓ Tar roads and Electricity
- ✓ Launch HIV/AIDS campaign on national level
- ✓ Maintain safety and security
- ✓ Mosquito nets
- ✓ Health education on national level

- ✓ Supervise building of houses and bathrooms even if the community uses temporary structures.
- ✓ Pit latrines

3.4 Health needs and actions identified by the community

The community selected a committee of ten members from different ethnic groups and gender. This committee went around other community members and asked what they perceived as health needs in their area. The following health needs were identified:

- Clinic
- Tar roads
- Toilets
- Plots
- Spray lights
- Police station

The community members justified these identified health needs as below.

Clinic: According to them, the clinic is essential to take care of their health. Currently, other clinics are very far, and they have to travel by foot. Sometimes while they reach the clinics, the numbers given out have already be taken and finished (In Namibia, the clinics handle certain numbers of clients per day, according to the capacity of health workers. Thus if somebody comes at the clinic (not emergency) and those numbers have been given out to those who queued earlier, others coming late have to come back next day, but also early enough to get a card.

Tar roads: This is needed for public transportation such as bus stop and taxi ranks. Currently, taxis are very expensive, as this area is outside taxi operation area. Some community members only go to town for shopping once a month. Others said that the roads are very dusty, as some other roads are transecting their area to link up to the high way, which is in front of their settlement. They feel the dust is contributing to the cases of Tuberculosis commonly experienced in their area. One person said, "We need tar roads so that we could at least inhale God's fresh air and not this polluted dust".

Toilets: Currently, the people are using bushes and nearby river. According to them, when the wind is blowing, the organisms come back to them through dust. "The grass is now tall and most people are just sitting closer to houses". According to them children are stepping on the faeces, causing health problems. Some people said, "During raining season such as this, the faeces is also smelling too much". The community indicated that other people from other areas do not support them when they have events such as death and hold memorial services, due to lack of toilet facilities in their area.

Plots: The community needs plots. According to them, if they have plots in their names, it will be possible for them or municipality to build proper toilets. Some believe that if they have plots, electricity, which they need so much, will be also easily provided by the City Council. Others said that it would be also possible for them to control the pre-paid water meters municipality installed in their area.

Spray lights: As with the toilets, the community said that they do not get enough support from other members during sad times, such as memorial services, as their area is very dark and people do not feel safe. People are also fighting and crimes are escalating due to lack of streetlights. Directly connected to health are possible rapes and assaults committed in the darkness.

Police station: The community said that they are very far from other police stations. When they once reached those police stations, the police stations also have their problems of shortage of transport, and while waiting for transport, the perpetrator escapes. The common crimes committed in their area are house breakings and common assaults. Serious crimes such as rape and murder occurred in the past, but are not common. Crime is perpetrated by people coming from other areas, more than the inhabitants of the area. Domestic violence is kept secret, as it is regarded as a shameful thing if others hear of it.

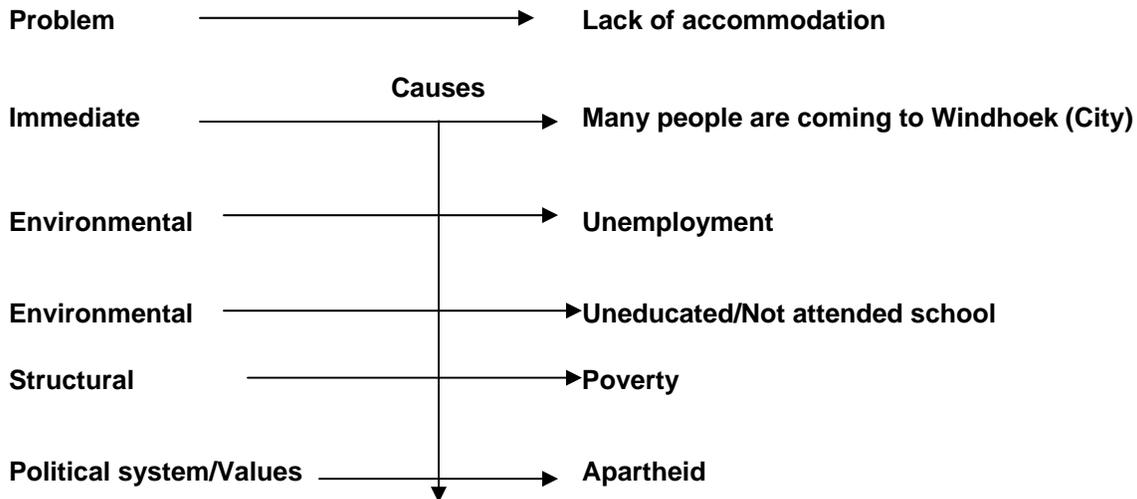
Community members were divided in two groups according to gender. This was to see whether gender preferences exist or to avoid possible male or female dominance in convincing each other to agree to needs not prefer by others. Ranking was done through discussions and consensus agreement and not through scoring. The priority health needs identified were :

- Clinic
- Plots
- Tar roads
- Toilets

It seems that people of this area hold regular meetings and had pinpointed their health needs before. One of the section leaders said that they have also taken these priority needs to the City Council and that the City Council promised to look into the issues of plots, clinic, toilets and roads. Thus according to them, those people who are in the homesteads already know what they need.

The community was asked why they found themselves in this area “Ontevrede” with all these problems. What could be the main problem and the causes? “But Why” and Problem Tree exercises were introduced to identify the main problem and its causes. The following were mentioned.

Figure 2: Causes of lack of accommodation



Given these causes the community looked at which problems they could act upon with the limited resources they have and which needed inputs from government or other national institutions.

On the Clinic:

The men were rather quiet and women started to talk. The women indicated that they are trying, although very far to attend clinics in other areas to maintain good health. Some said that they are treating minor ailments such as small burns, cuts, wounds and common colds with menthol ointment, clean wounds with salt water and use clean cloths as bandages when children have small cuts or wounds. One woman said that if the child has fever, they are giving tepid sponging first. They indicated that if somebody gets ill during nighttime, they are praying that the condition would not become worst until morning hours so they walk to the health facilities outside their area. They have also an option to go to the fire brigade officials who are in the adjacent settlement area to be taken to the hospital, but they are charging N\$ 450-00 = \$75, which they cannot afford.

Some community members indicated that welfare organizations such as Red Cross and church groups could visit them and assist with some food items, clothes and medications when sick. Others mentioned that even UNAM students could visit them and provide them with necessary health education. According to them, they have also considerable number of orphans and vulnerable children in their area, aggravated by unemployment. Some women indicated that they need assistance to be educated in income generating projects to assist themselves and their households. One woman said, “ We need to be empowered by others to feel as people, as the unemployment let us feel worthless”.

The community would like to be supported by government or government agencies in income generating projects and building of clinic in their area. Some community members asked that the clinic in Babylon (neighboring informal settlement area) be reopened in the mean time while awaiting on their own clinic, as this one is apparently closer to them than the rest in other suburbs.

On Tar roads

Currently communities are spraying water in front of their houses so the dust will not enter the houses too much, but this has also little effect. The community could not think of roles for others but suggested that the City of Windhoek should provide a truck with water to spray the streets at least once a day. One community member suggests street booms, to enable cars to reduce speed. However, another member counteracted this that the truck that is scrapping the roads will have difficulty and others agreed. The community finally agreed that they could call upon the assistance of city traffic corps to patrol the area and give penalty cards to those who are speeding and causing extreme dust. The community also indicated that if the roads were tarred, they could have been able to have public transport in their area.

On Toilets

The community view toilets as being very difficult without own plots. One man said, "If we talk of toilets, than we talk of erven (plots)". "Public toilets will not solve the problem, the diseases will still spread. If government gives us erven, everybody will keep his/her toilet clean". Some argue that if they are awarded plots, the government will build toilets, even without the houses that they will struggle to build themselves. The community believes that nobody will take responsibility for public toilets and people will only fight each other over keeping them clean. They say that they will just use bushes as they are doing currently as public toilets will be also few. After almost half an hour discussion, one woman suggested that everybody could dig a hole and cover with corrugated iron in their own yard and only use disinfectants for smell. One person agreed that he has done that. The majority did not agree with this idea of the previous speakers. They said that there would be too much bad smell in the air if many people dug holes and it will worsen the situation. For them they only view plots with proper flushing toilets as only solutions. The community thus indicated that government should give them plots and build for them toilets as lasting solution.

Erven/plots

The community is mobile. One woman said, "We are constantly on the move, you build your house now here, but should move again. This is wasting our building material and our material is getting old". Others suggested cleaning houses inside and outside although not having own plots. Other community members mentioned that they couldn't put in floors, as it is not their own plots. One man suggests that if possible, to put a piece of carpet to reduce dust in the houses. As curtains are often dirty, due to massive dust, one man suggests washing the curtains twice a month. Another man supported this view. The problem of some

community members who put rubbish near others houses was raised. The general feeling was that the plot is not demarcated and thus difficult to know where your territory starts and ends, particular where the houses are build too close to each other. One man suggested to build houses not too close to each other to prevent that string of houses burn down when one caught fire. They felt that "Government should demarcate even to us". The leadership requested big orange refuse removal bin, but are still waiting, as the municipality only removes refuse in black plastic bags, that are put at strategic places along the roads.

Spray lights

The community is currently using paraffin lamps and candles for lighting. Some are using fires and torches. The power generators we observed during our transect walks were not mentioned. Maybe those are only for the businesses such as shebeens. The community at least requested one or two spray lights. They were not in favour of requesting streetlights, as these could be many and expensive, but only spray lights that good also enlighten the neighboring Babylon informal settlement area.

Police station

People were already elected to do community policing. The election was apparently done in collaboration with the City police and Namibian police. However, the police promised to first do fingerprints on the elected persons to make sure that they were not previously involved in criminal activities. Thus the community is still waiting on the police to do this so that community policing can be implemented. Government "should build the police station and implement community policing".

3.5 Joint dialogue on health needs and actions between community and students

The student nurses and community held a joint meeting on the weekend to discuss the findings from the two groups. Fifteen community members (9 males and 6 females) met with the students outside one of the committee member's house. The facilitator introduced herself and the students, explained the purpose and the expectations that there would be no right or wrong answers; every person should be free to contribute to the discussions, as far as they will not talk at once as the facilitator and students will jot down issues discussed. The community secretariat was also encouraged to take notes of the discussions for the final report. It was finally reiterated that other's views need to be respected during the discussions to facilitate understanding. As half of the 15 community members had not participated in the earlier discussions the facilitator again explained the whole purpose of the exercise in all languages.

Except of the facilitator, nor students neither the community knew each others identified needs. The facilitator read out all the needs identified by the students, and thereafter those by the community. There were lots of smiles as there were

some similarities. The four priority health needs were read out. There were also two similarities, i.e. the clinic which was number one for both groups, as well as toilets, although the rating for toilets was not the same. The groups were asked to justify their ratings of the four priority health needs.

Priority two: Toilets or plots? The students rated toilets as second priority, while the community rated erven/plots as their second priority. The main argument of the students was on the hygiene and health hazards due to unhygienic conditions. The students suggested use of common pit latrines, while the community was waiting on the proper structures from the municipality. However, the community did not think that building of pit latrines was a good idea. They felt that toilets without erven will never work. Their argument was that the municipality tried to build four toilets, without consulting them. Currently, they are not using those toilets. According to them, those toilets pose more health hazards if many people use them and no one is responsible for them. One community member said that they are now better off using bushes. There was a very strong opposition of building toilets. Students tried to explain to do something for time being, as they were waiting on their plots for so long and still do not have 100% guarantee when exactly the plots will be allocated to them. This argument was not well taken by the community and they preferred to stay as they are now if not allocated erven first. This issue of toilets was discussed for almost an hour, until we decided to proceed to the next point. We did not reach consensus on this point of toilets versus erven. However, discussions took place in a orderly manner, where every speaker acknowledged others point of view and argue his or her case forward in an orderly manner.

Priority three: Health education or tar roads? The community argues out their case why tar roads should come third. They see toilets and spray lights within the context of erven, thus see tar roads as the only different issues with the exception of police station. The same reasons previously indicated were again used in defence of this rating. Students did not see any problem with that as they also have similar issues in the health education. Thus consensus was easily reached.

Priority four: Electricity or toilets? The community was first to defend electricity as spray lights, toilets and electricity are part and parcel of erven according to them. They felt spray lights will come together with electricity.

As toilet issue was discussed without any satisfactory consensus, the facilitator opted to use it for a PRA exercise on how to solve problems through the contribution of different actors, called **Stepping Stones**.

The scenario of a certain informal settlement area, similar to the community of Ontevrede was used. In this scenario the facilitator drew a river between the two settlement areas. The other area did not have own erven, electric power or toilets but they have overcome the public health problems their own way. What could

the community of Ontevrede do to overcome their toilet problems such as the other community?



The chart used to map the stepping stones exercise

They were told to plan issues in the sequence how they will do things to cross the river to be like other community. For time being, there was a silence. Everybody was looking on the flap chart in the middle in front of them and deeply thinks what to do. One community member starts spontaneous to say that they will first **(1)** call a community meeting to discuss the issue. Another one said that they would **(2)** elect a committee. After these contributions everybody was free to come in easily. Following contributions were made: **(3)** Community to pledge cooperation in what ever they are planning to do; **(4)** find out cheaper and easy way to construct pit latrines. *(This was a very interesting moment. It seems that they quickly forgot of heated debate of toilets and erven. When they actually started to mention calling of meeting and election of committee, I did not know what they want to discuss until this end);* **(5)** consult municipality first for permission, as this land is not ours; **(6)** provide feedback from municipality to the community, as only few members will go for permission; **(7)** agree on rules and regulations with regards to cooperation among the community members throughout the whole project; **(8)** four household to build one toilet; **(9)** pledge contributions such as corrugated iron or piece of wood not currently utilized by the households and lying around, cement bag etc, for the construction of toilets among four households; **(10)** solicit cleaning material among households and later from Ministry of Health on monthly basis; **(11)** health education regarding maintenance of hygiene; **(12)** general maintenance of the whole project regarding responsible households, how often to clean etc.

This was a major breakthrough. After this exercise, the facilitator asked the community members to indicate with red marker, which activities they could perform alone as a community without the assistance of others. At this point in time, almost everybody stood up to participate eagerly. Students were just observers as seen on the photograph.



Community members discussing the actions they would take, while two students observed

They only left out health education and encircled cleaning material, which they want to contribute initially, but requesting the Ministry of Health at the later

stage. At this junction, the facilitator asked them whether they realize their own strengths in this project. There was a silence and facial expressions of disbelief on what they marked in red on the flip chart.

After the same question was repeated, one man said in a very soft voice, that he never thought of this. "I never thought of this. Now that I saw on this paper, it became a reality". Other man said that he too never thought of that. "We always ask government to do things for us, but I never thought that we can plan things ourselves" A woman, who expressed very strong views that building of pit latrines would never work without even in the previous discussions, mentioned that she learned a lot. According to her, she also realizes how much they could do, without the help of others if they plan well. She further said that she also learned a lot from the discussions among them and the nurses when they were explaining each other's identified health needs. Other community members nodded heads in agreement when previous persons spoke. In final analysis, this exercise of steppingstones was an eye opener for the community. By visualizing what they were able to achieve without the help of others, was a reality and a method of empowerment. One community member could also proudly say that they could use this plan they drew up for further action.

4. DISCUSSION

4.1 Comparison between community and student perceptions

The students and communities shared most health needs identified, except for the plots. Two of the priority health needs out of four were also the same for both groups, with the clinic being identified by both groups as priority number one. Toilets identified by the students as number two, was rated number four by the community (See Table 4).

Table 4: Four priority health needs on both sides

Community	Student nurses
<ul style="list-style-type: none"> • Clinic • Plots • Tar roads • Toilets 	<ul style="list-style-type: none"> • Clinic • Toilets • Health education • Electricity

Both sides indicated a clinic as important for all the health problems identified in the area, as noted below.

Table 5: Discussions on clinic as priority number one

The Community argued that	The students argued that
<ul style="list-style-type: none"> ✓ They needed clinic to take care of their health. ✓ Other clinics are currently very far and they are not seen if they arrive too late to get a number. 	<ul style="list-style-type: none"> ✓ With the establishment of a clinic, health education will be given to promote health, ✓ Emergency treatment for those who are sick at all times, which is currently lacking

The students rated toilets as second priority, while the community rated erven/plots as they second priority. The students and community differed in their discussion of this.

Table 6: Discussions on toilets and plots as second priority health needs

The Community argued that	The Students argued that
<ul style="list-style-type: none"> ✓ No toilets without erven ✓ Municipality will build proper toilets for us, and also provide us with electricity. ✓ If we don't have plots for whom will the toilets be built, as we are always on the move? ✓ Pit latrines will cause more health hazards than ever before; smell will accumulate. 	<ul style="list-style-type: none"> ✓ plots were not one of their health needs at all. ✓ Toilets are important for hygiene and to avoid health hazards ✓ Dig communal pit latrines, through combined efforts at strategic places for time being ✓ Build bathrooms away from streets to avoid dirty water running down the streets

<ul style="list-style-type: none"> ✓ Better to stay in the current conditions where we are making use of bushes. ✓ Nobody will take responsibility for cleaning, as these will be nobody's properties. ✓ It will only cause unnecessary quarrels during waiting when other person is busy in the toilet ✓ Our building material is also getting old, as we are building and breaking over and over. 	<ul style="list-style-type: none"> ✓ Cover pit latrines with sand when moving away. ✓ Reuse temporary material e.g. corrugated iron again at another area were community is moving to
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One woman tried to turn around the discussion and tried to convince her fellow community members that they could think of building pit latrines for each households and only use disinfectants, to avoid bad smells. While one of the men supported her, more community members opposed the idea. At this junction, the students again tried to come in with communal toilets and the community also turned this down. Earlier, the community mentioned that people were defecating in the walkways and closer to riverbeds and that the organisms were coming back to them through dust, when wind was blowing. They also mentioned the smell of faeces as troublesome, especially during the raining season. Interesting how the community dynamics work. The woman who proposed building of toilets during these discussions, did not contribute to the final stepping stones exercise, where the community took part and plan their way forward. In contrast, others who initially opposed the idea aggressively were those who actually designed the plan of action on toilets.

The students and communities both recognised the health risk of dusty roads and the need for good transport to health services.

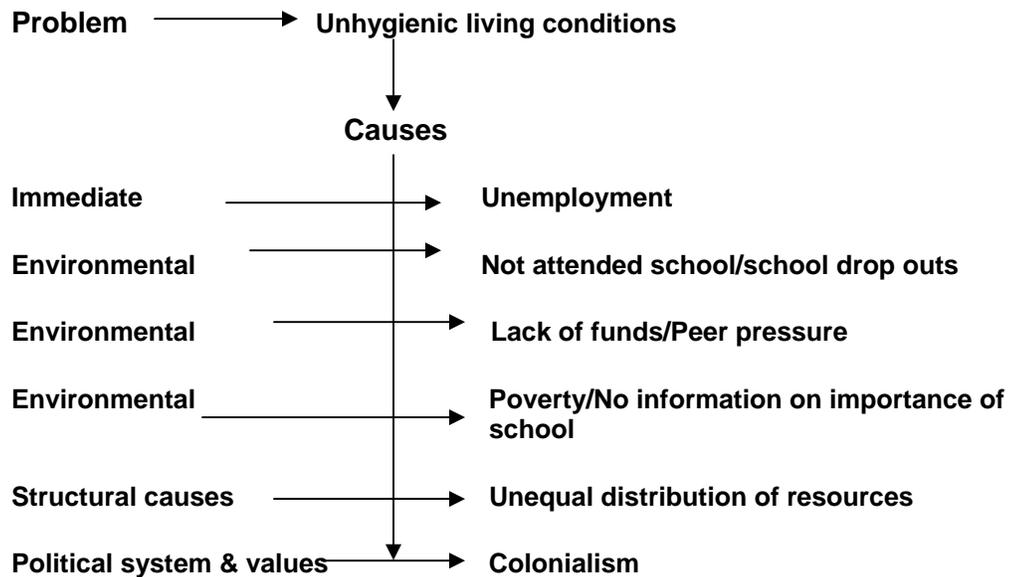
Table 7: Discussions on roads and health education as third priority health needs

Community	Students
<ul style="list-style-type: none"> ✓ View roads and police station as only different issues from plots, Meaning that toilets and spray lights are included in plots ✓ If roads are tarred, public transportation will be available ✓ Currently, public transportation expensive and scarce as we are outside taxi and bus operation zones ✓ Gravel roads very dusty ✓ Dust is contributing to Tuberculosis 	<ul style="list-style-type: none"> ✓ Gravel roads are very dusty and pose health risks to the community ✓ Public transport will be available when roads are been tarred ✓ Community to regularly visit clinics for Tuberculosis check up ✓ Identify busiest time of the day for cars and close windows to minimize dust

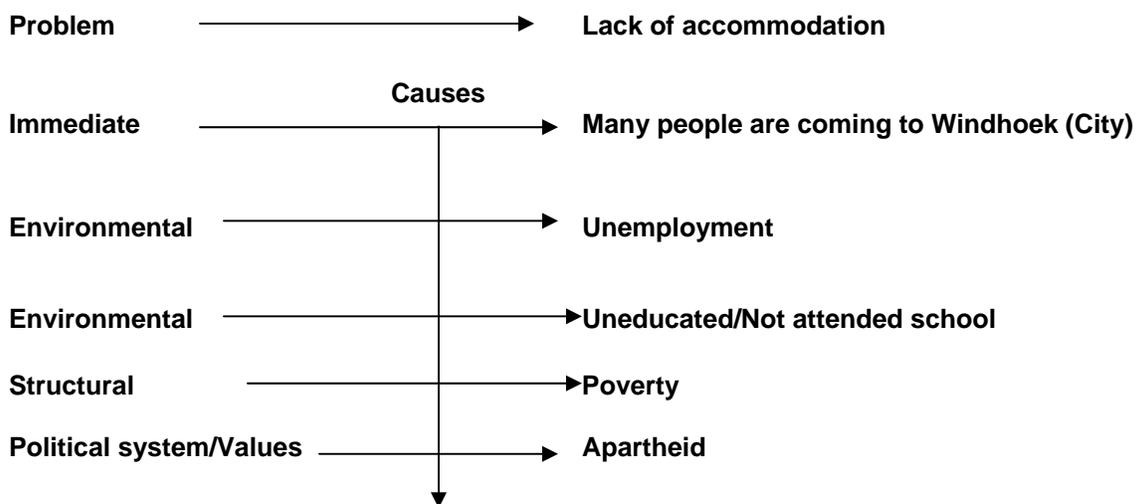
On the fourth priorities (toilets or electricity), the students understood that lighting was also linked to plots, although some were not very happy with how the community clustered many health needs into one. This was not mentioned during the discussion, but voiced during lessons learned at the end.

The PRA tools of “Problem tree” and “But why” exercises were used to explore **causes** of health problems by both groups

□ *Causes of health needs by the students*



□ *Causes of health needs by the community*



Looking at above diagrams, one could easily see the views from insider and outsider's perspective. Unhygienic living conditions identified by the students were not necessarily those indicated by the community. Contrary to student's view, the community regards lack of accommodation as their main problem. After both groups identified main problem and immediate causes, all the environmental, structural and political system/values were similar, directing to the root cause, as colonialism and apartheid, which means the same thing in the current context.

Actions to be taken

The actions are reported in the tables in the previous section. Many of the actions proposed by the community related back to getting security of tenure over their plots, which they felt to be essential for other actions. On the other hand the students proposed interventions that would be done at a more immediate level. It was evident that the community wanted to go deeper into the causes of the causes of their health problems than the students solutions.

To some extent this reflects their different educational and social backgrounds. It however also possibly reflects the communities past experience having been moved several times in trying to deal with such problems, and their desire to seek more lasting solutions.

The resolution of tenure is a matter that needs to be dealt with by the relevant authorities. In the meantime, it is clear that community is currently making considerable efforts to prevent ill-health and promote health without the assistance of others. From the stepping stones experience, it appeared that the community did not collectively realize their strengths and use this to work on their challenges. The exercise generated this realization, and made it clear that certain actions can be taken at community level, by others in the area or district as well as those by the government. It indicated the interdependency of all the actors in the health care. It is a challenge for the health sector to take the community onboard at the management level, where they could take part in all decisions that concern them.

4.2 Lessons learned from the experience by the community

The community leaders were grateful for the way this intervention was initiated, in contrast to other organizations that do not consult adequately and impose issues on them. (Example of pre-paid water meters installed and pit latrines build in their area was cited). They indicated that they were part of the whole exercise and free to argue out their cases, an issue made them strong as the students listened to them and agreed with their views.

The information sharing in a relaxed and safe environment facilitated learning. They could assimilate health workers views and compare with theirs. A better understanding has empowered them in the health issues they were not familiar

with. The community has realized that they are powerful and could plan and take decisions alone with minimal help from others. They came to realize that it was not needed to sit back and always wait for the government to initiate actions and that they also have the capabilities to initiate projects for the improvement of their public health.

It was an eye opener for the community to stand up and initiate own plans or something that could be complemented by others. One of the community leaders said the following: “We were actually sleeping. I think change is needed in our situation. As community leaders, we did not know what to do and how to direct the community. But now we have learned a lot. For us, this exercise was an eye opener. It has become clear to us that we can plan according to our needs and also go and convince other people in good faith. Now we can write letters to the municipality to propose things we want to do and come in negotiations on the whole issue of our situation, not only the toilets, because we are suffering for too long. Our children are also growing now under these circumstances. This plan we came up with the other day, is a very important one for all of us who were present, and particularly for us as leaders. We will call a meeting to discuss it with the whole community”.

4.3 Lessons learned from the experience by the students

The students reported learning from the direct observations and transect walks.

They noted that observations are incomplete without communication and asking questions to clarify what you observed. Some thought that the community will be rude or unhappy if asked questions regarding their living conditions in the area.

Some students were very surprised of poor living conditions in which the community lives and survives. They wondered whether the children are attending school, how the community operate at night without electricity, how they cope if one falls sick during the night without a clinic. The students were part of the community the very specific day when the rain showers fell and could experience how some houses leak during raining season.

During the transect walk “Contrary to the first day’s experiences, the community was friendly, cooperative and open to talk to us”. “Some of the community members were curious and wants to know what we were doing. Some thought that we are offering jobs”

Some of the community members wanted to know where the information is going; others complained of people coming to their area and asking questions without any feedback. Some complained that even though people are coming and asking questions, that there is no difference in their lifestyles for example no toilet facilities. The student felt that

“It was a good experience to see the reality of the hardship faced by the communities in the informal settlements. This is very good for integration of theory into practice”.

“ My biggest lesson is that people although living in this harsh conditions, try to go forward. They want to make change. I mean the way they started is not where they are now. For example they are trying to move from a small house build from hardboards to the one of corrugated irons, or starting selling maybe only few things and having after time a bigger place with many items”.

“The bottom line is that the people are trying very hard to cope with their circumstances. The majority of vaccination passports viewed for children under the age of five years and those of the women of child bearing ages (Tetanus Toxoid) was up- to- date”

They noted that interaction between different ethnic groups is very good. Maybe they are bound by same circumstances in which they are living. The community was noted to be living in a high-risk area. Some of them were their patients.” I mean high-risk of malaria and having children at shorter intervals. I nursed some of them in the maternity wards that is why I think they lack family planning education”.

Generally, the students could better understand the observations they did on the first day after asking questions from the community for clarification. Thus they concluded that communication is important to avoid misinterpretations between what is being observed and the reality.

After the joint discussions the students felt that the community knows what their needs are. They realized that the students and communities came up with very similar priorities. They also understood how communities prioritized issues that they did not see, like plots. They realized that the community analyses their problems differently: “Community has a different way of identifying their health needs, contrary to what we did. They clustered their needs so that one need includes many other needs in one e.g. plots, where they included toilets and electricity, where we pinpointed each need on its own”

”I came to realize that the community is very eager to get the plots to move forward with their lives. They want to own some land and build their houses and toilets to improve their standard of hygiene”

“ I realized that that the community can identify their health needs better, because they live there”

They also realized that the Stepping stones exercise was a way for the community to work out for themselves steps to build their toilets and solve problems.

“I came to realize that the community has such a wonderful, good thoughts and is capable of doing many things for themselves with little or no assistance from someone from outside the community”

“It was a good learning experience. It was my first time I conducted this type of serious (In-depth) research and learned such different problems of the communities”

They found the research an amazing experience. It was the first time for them to work directly with the community members in solving problems of the community e.g. identifying health needs. “The part I enjoyed most was when we met the community committee members and discussed the most important four priority health needs. It was really nice and I enjoyed it”

“ Our research was a qualitative type of research. There was no fixed method of doing the research, but it was flexible and research went on depending on the situation. For example, when we did our transect walks in the community, we asked them questions from the standpoints of the community members. These questions were not structured or pre- formulated, but they came from the situation we found there. We really tried our best to understand the situation and identify the health needs of the community. We came up with more than 20 health needs, and from those we have to choose four health needs, which we thought, were most critical. It was a good learning experience”

“I learned how to conduct a community entry process in a practical situation, which I only learned in the class”.

They also learned to see the community differently:

“The most important lesson I learned was that even though how much you try to put yourself in the shoes of others, (empathy), you cannot never feel like them (community). I am saying this because when we came up with our own four health needs, the community also came up with wonderful different four health needs. So I learned that if we were implementing partners, and have to implement these health needs of ours, without consulting the community, we could have been wrong. So it is really important that community members must always be involved when something about the community need to be done”

After the exercise a second attitude questionnaire was administered.

Table 8: Student attitude pre- and post-test

Attitude Assessment	Pre –Test	Results	Post-Test	Results
Do you think that community has the ability to identify their own health needs?	Yes No Don't Know	61% 31% 7%	Yes No Don't Know	100% 0 0
How would you rate their knowledge on identification of their health needs?	1. Poor 2. Fair 3. Satisfactory 4. Good	22% 28% 43% 7%	1. Poor 2. Fair 3. Satisfactory 4. Good	0 0 25% 75%
To what extent do you think is the community able to act on their identified health needs?	1. They will do nothing 2. They will do something at the household level 3. They will refer to the community worker 4. They will refer the health worker/facility	7% 57% 17% 19%	1. They will do nothing 2. They will do something at the household level 3. They will refer to the community worker 4. They will refer the health worker/facility	0 100% 0 0

The findings were very interesting. After initially rating that communities would not be able to identify their health needs, as reported earlier, the responses completely changed after PRA exercise. All felt that communities knew their health needs, and seventy five percent (75%) of the students indicated that communities had good health knowledge. As one student said, “They are capable. They know their health needs as well as the causes of the problems such as flocking of people to the urban areas which created all these problems”. Contrary to the initial attitude test where only 58% thought that the community was able to do something at the household level, all (100%) of those subjected to PRA intervention indicated that the community could do something at the household level. It appears that the exercise had completely changed the student attitudes towards the community.

4.4 Lessons learned from the experience by the facilitator

I learned through trial and error, as I was not an expert in PRA work and applying it for the first time. Probably, the main thing that helps me to cope was the principles of qualitative research, which enabled me to allow the process to flow freely with no or very little interference. My personal experience is that the use of PRA does not only empower the community, but the facilitator as well. The participants have more control than the facilitator in PRA research. This is a challenge to the traditional researchers such as myself. Good listening skills and showing respect to other’s views are very useful tools in facilitation of PRA. Above are not only useful to the facilitator, but build confidence in the community

or others who are participating in helping them to realizing that their views are being heard and taken onboard. This aspect foster feelings of ownership of the project, in those who are participating as clearly indicated in the Stepping Stones exercise. The following were experiences and lessons learned:

On the role of the community

- Given power, the communities will grow in confidence in what ever they are doing
- Correct community entry process facilitates cooperation and active participation. However, undue expectations are some of the challenges. It was needed to over and over explain what the purpose of our visit was, as some community members expect us to change their problems with the municipality.
- Feedback, which is an integral part of PRA process counteracts the notion of lack of feedback in general community work. Many community members were complaining of people coming and asking questions or doing work in the community and do not come back for feedback.
- PRA encourages involvement of all sectors of community, i.e. men, women, youths, elderly etc. However, it is a challenge to get women and youths involved. I had to urge the community leaders, who are male in majority to involve more women and youths in the working committee for these PRA activities so that their voices could be heard as well. Contrary to the notion that women may not speak up in the meetings with men and that they need to form different groups, the women were vocal in this group. This could be maybe due to the common nature of the issues under discussion, and perhaps that women are more at the receiving end of all these health related problems.
- The communities can participate in planning of health related activities. The Stepping Stones exercise was a clear testimony that if the community is empowered and involved they could be able to make own decisions on issues related to their health and social welfare.
- Before engaging with the community, one will never know the community's mental strengths. It was very clear that the community knew their situation better than the outsiders (Students) and defended their ratings, even if the students initially do not want to agree, students were brought to the point to understand the arguments used by the community at the end. The community also knows why they are in these unstable informal settlements.

On using PRA approaches for the students and communities

- The use of PRA empowered the students. It was an eye opener that the community was able to systematically argue their case, contrary to the student's initial perceptions. One student was overwhelmed by the reasoning and knowledge of the community and wondered where the community acquired this knowledge.
- PRA develops and strengthens observational skills during transect walks

- PRA enabled community and students to be engaged in in-depth two-way process of communication in a relaxed and safe environment on the community health needs and actions to be taken, which empowered community at the end to give a second thought to their initial negative attitudes towards construction of communal toilets.

On using the PRA tools as a facilitator

- The use of PRA tools paves the way of outcome. It is difficult to have an expected outcome according to my experience of the final Stepping Stones exercise. I initially wanted Stepping Stones exercise to demonstrate the relationship and interdependency of the community and the health workers, but the situation of no consensus on the actions to be taken regarding the lack of toilet facilities was turned into stepping Stones and created unplanned result of empowering the community to act on that issue.
- The flexible nature of PRA creates relaxed atmosphere and better cooperation among those involved. It is always a fun and not stressful. Active listening and respect of different views are the key components in facilitating learning.
- PRA methods do not need formal education. Available means are used and the community can follow and participate. Community involvement is important for consensus in issues concerning them, which PRA are advocating.

On the PRA tools themselves

- Visualization creates sense of reality and better understanding of what is under discussion. Thus next time we will use more of it, including role-plays.
- Use of different tools that are correctly selected guide the whole process and lead to successful outcome that would be beneficial to the community. Multiple tools and combination of methods, ensure trustworthiness at the end.
- PRA methods need time. If you spend enough time and explain issues needed to be addressed and allow also time for discussion (although sometimes time consuming, particularly, where different language groups are involved and translation necessary), you will get valuable results at the end. One must not rush the process.
- The outside appearance is not always true. During our transect walks; it appeared that the community had very good working relationship in their area. However, during the combined meetings, it became clear where the issue of public toilets were discussed that they do not cooperate well, to the extent that such an initiative was argued not to be successful.

5. CONCLUSIONS

Students, community and the facilitator all learned from each other in this exercise. If this had been an ordinary training exercise, it would not have borne similar fruits. Using the PRA approach brought about important changes in student attitudes towards the community in terms of their knowledge and ability to act on health problems. This may transform the way they work with the community. It also brought about second thoughts within the community on their collective ability and strength in taking action to improve their own health, while defining those deeper causes that need to be tackled by government. The PRA exercise produced the unexpected outcome of change in the attitudes of the community to act on their identified problem of toilets, while still engaging the City of Windhoek to allocate plots to them.

The community is eager to move on with their plan of action. A feedback meeting was held on the process and at this the community pledged support for their own plan of action. They defined the next steps. These will be, first, call a meeting with their immediate head and area councilor. They requested the presence of the students and facilitator to present the findings of the research so that they could use this to discuss with these leaders to pave the way forward for implementation of their plan of action.

The University was requested to support the community with necessary health education, which is part of the action plan and also support them in negotiations with the authorities (Health and City council) for material support to complete their plans.

From the findings on the changes in student attitudes it also appears that PRA methods that bring students and communities together in ways that increase their understanding of each others roles, experience and capacities has a positive impact on both groups. It will be important to explore how this ad hoc exercise can now be more systematically included in the nurse training programme at the University.

6. THE WAY FORWARD

In follow up therefore we propose to give feedback on this work to

- High ranking community leaders to serve as links to the City council and Health authorities for negotiations in support of community initiatives
- The University especially in relation to nurse training
- The Health sector, especially the Ministry of health

We propose that the University assist the community in health education. We propose to work with EQUINET support to continue the positive dialogue and planning through the PRA process with this community, while also engaging with

local authorities and sponsors to obtain seed funding to support the community plan of action.

Following dialogue with the University in the findings and how this type of work can be integrated within the University training, we propose to hold small workshops on PRA methods for the lecturers, with a practical component in the community to empower them on PRA approaches. PRA approaches are useful for nursing training, thus need to be integrated in the curriculum. However, lecturers need to be trained to support the initiative. If more lecturers are empowered, they will be able to teach their students.

We propose that the eight students who were part of this current PRA will remain involved in the follow up and monitoring of the project in “Ontevede” settlement area, until its completion.

Finally, we propose to share our learning experience of PRA work in Namibia with colleagues in the regional network (EQUINET, and the network of those working with PRA approaches for people centred health systems) so that we can build collective learning on how these approaches work in the health systems of east and southern Africa, and so that we can strengthen our ability to support future work.