PARTICIPATORY METHODS FOR A PEOPLE CENTRED HEALTH SYSTEM

Training workshop

MEETING REPORT

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

Held at the Paradise Hotel Bagamoyo Tanzania
February 14 to 17 2007

Report produced by TARSC
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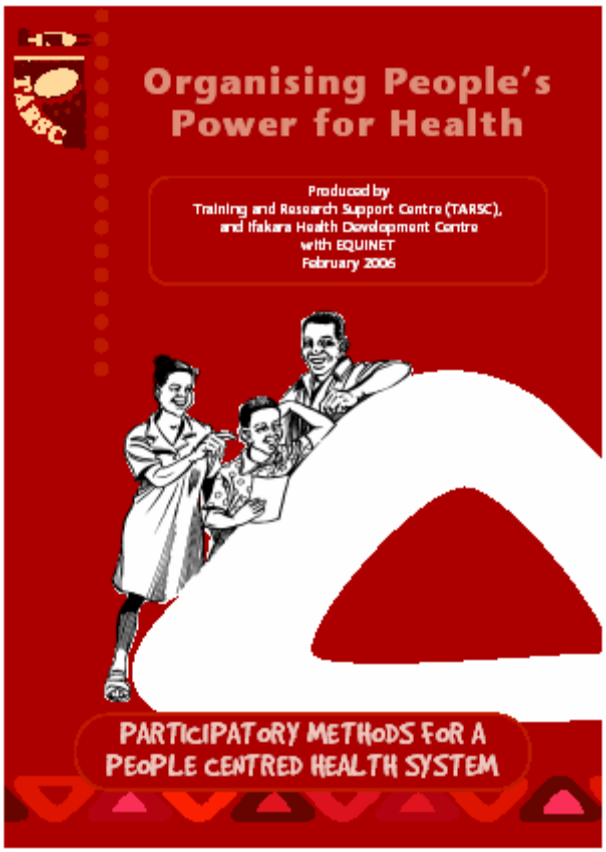
1. Welcome and introductions

The second regional training workshop on participatory methods for a people centred health system was hosted by the regional network for equity in health in east and southern Africa (EQUINET) , TARSC and Ifakara HRDC in Bagamoyo Tanzania from February 14-17 2007. It involved 35 delegates from in east and southern Africa (See delegate list in Appendix 1) It aimed to build skills, share experiences and strengthen work on participatory methods for people centred health systems.

TARSC and Ifakara both have a history of work on participatory reflection and action (PRA) methods in health and worked together in 2005 to write and produce a toolkit for the training which was being piloted at the workshop. EQUINET, with IDRC and SIDA, supported the production of the toolkit. CHESSORE provided peer review for the kit.

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

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



This report doesn't go into detail on EQUINETs approach to people centred health system as these can be found in other documents on the EQUINET website www.equinetafrica.org.

The toolkit is separately available and provides the detail on the sessions and how they were conducted so this report doesn't record this detail. As a training workshop using PRA methods the meeting involved dialogue and exchange of experiences, activities to encourage reflection and discussions on follow up, exchange on work done in 2006 and the lessons learned and many other activities(See programme). We don't aim in this report to provide all of the rich and diverse exchanges that took place in the meeting. We capture through quotes, pictures and some reports some of these exchanges and the major agreed areas of action and reflection arising from the meeting.

The setting changed a bit from the beginning (see picture left) to the end of the meeting (see below) ! We were given a venue for the usual formal workshop– but by the end of the meeting we were a group of people who were closer and using the space quite different;y!!!

The 2007 training focused on the relations between communities and frontline health workers.

It was targeted at researchers, health workers, academics, civil society organisations, NGOs, community leaders and workers and others who are involved in work with communities and health workers who are doing or involved in work on strengthening positive community - health worker interaction. The training gathered delegates from the 2006 training who had implemented PRA programmes under the EQUINET umbrella to share their experiences and to review their own future work. These delegates were Kathe Hofnie //Hoebes Namibia, Clara Mbwili Zambia, Ashraf Ryklief South Africa, Jimmy Wilford Zimbabwe and Sibusisiwe Marunda/Bhebe Zimbabwe.

In addition to the inputs from the 2006 group, the facilitators for different sessions of the meeting were Rene Loewenson, Barbara Kaim and Fortunate Machingura from TARSC, Selemani Mbuyita and Ahmed Makemba from Ifakara. Mwajuma Masaigana from TARSC Tanzania gave input.

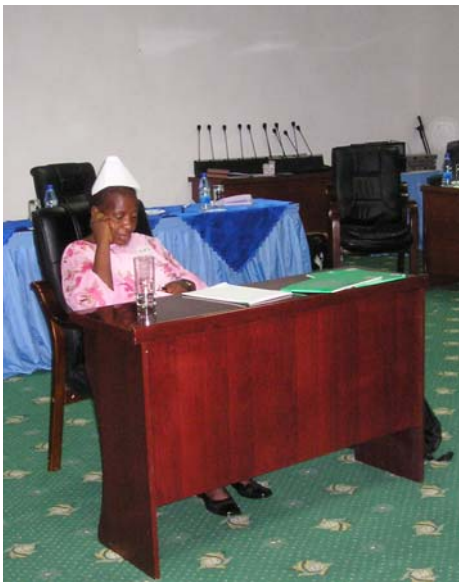
The 35 participants that came were from 10 countries in Eastern and Southern Africa bringing with them a rich diversity of skill, experience and knowledge. There were community health workers, volunteers, health rights activists, nurses, doctors, academics, people working within state health departments, community based organisations and NGOs. The participants engaged actively in workshop processes, lively debate and sharing of experiences to make for a truly participatory workshop.

Thanks to all participants for the notes for the report, photos and quotes! The report is compiled by TARSC from all these inputs. The 2007 delegates have now joined with those from the 2006 process in the PRA learning network and the *pra4equity* mailing list to keep sharing experiences and learning in PRA for people centred health systems.

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

We shared some experiences of how communities and health workers interact from our own countries, some positive, some less so.

We took the example of a young adolescent girl, who had a health problem, coming to a clinic to seek help. How would she be treated by the clinic? How would other community members be treated? How would the health worker relate to her? Would she get the care she came for? Who else was important for this, in and beyond that community? Participants made a human sculpture of how we think our health workers *currently* feel and respond to communities.



The heal;th worker was distant, with her own troubles of too little pay, worrying about her family, with too much to do and not well equipped for her work…

The patient was powerless, hardly noticed, patients stood in long queues waiting, while more influential people bypassed queues…

People added actors to the sculpture and moved the figures in the scene around, drawing on their experiences. The scene that participants created emerged out of this. Some patients in the sculpture were resigned to the wait and supported each other. One at the back was angry about an influential person going to the front of the queue. Key figures of support, like the District Medical officer (DMO), the Ministry of Health officials and non government organisations were not paying attention to this setting, and were involved in their own work. The DMO was overworked, and the health ministry seemed focused on national and international level actors, and paid little attention to this primary care level.

We discussed this current interaction, and agreed that in this situation, no-one wins. The patients do not feel well treated, and neither do the health workers. The Ministry is not getting the best services at local level. All are stressed and the most vulnerable are least able to secure their health needs.

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

There were many differences after we moved the sculpture

- The young girl was now at the center of a caring community, with health worker, community members, NGOs supporting her
- The Nurse was also surrounded and linked to a supporting community from the community leaders, DMO and NGOs. She was happier, ready to attend to the community needs, with resources enough to make her work.
- The clinic was being supported by different players and linked to other levels in the health system
- The health and finance ministries were now preoccupied with issues concerning the development of the clinic and community, and communicating with the DMO about how best to support this level
- The local NGOs were now interacting with the clinic, the community and other players in the health system

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

2.1 The Zambia PRA experience of strengthening health worker- community interaction

The work built on Zambia's Health Reform Vision 'To provide equity of access to cost effective quality health care as close to the family as possible'. Zambian health Reforms were introduced early 1990s aimed at enhancing leadership, accountability, partnerships and sustainability at all levels. This implied enhancing community participation in health service delivery. However experience indicated that there was a mismatch between policy & practice, the expected health outcomes were not achieved and people were not

satisfied with their health services. There were misunderstandings between health workers and community members, people had poor knowledge about availability and use of health resource, and were involved in health services, but not in planning, budgeting and activity implementation. Analysing this the team felt that health worker training led to attitudes that health providers "knows better than patients", and that there were inadequate advocacy & communication skills in community members. Some community health structures and groups felt powerless and unappreciated.

The PRA Pilot Intervention was aimed at addressing these problems, to strengthen health worker and community interaction towards improved health services. It was aimed at health workers (HW) and community members (CMs) at Health Centre level to:

- Reduce existing misunderstandings
- Reduce information gaps
- Enhance community voice
- See positive change in health provider attitude towards community members involved in health activities

PRA process in Zambia

The PRA tools were used in two areas, Lusaka urban and Chama rural involving health workers and community members. The full report of the work can be found at www.equinetafrica.org. The health workers themselves reported an improvement in their situation

"The PRA orientation has brought a new approach to planning and changed our attitudes about planning. We have been able to share the new skills in planning although some health workers have a very negative attitude toward planning"

Community members felt their working relationship had improved with health staff taking their opinions into consideration and with joint activities implemented, like the Child Health Week. Community members were given responsibilities to handle cash during this week, showing increased confidence in them by HWs. They also reported greater skills building activities and greater community involvement in health activities. This was appreciated by all. Participants felt they had changed perceptions of and behaviours in planning and were more aware of the constraints related to resource allocation from district & central level.

There were constraints, such as in time for this process, lack of formal recognition of such work as important for the health system, resource constraints, competing commitments and adequate preparation for budget processes and skills for the work, but in general people felt this should be sustained and extended to other areas.

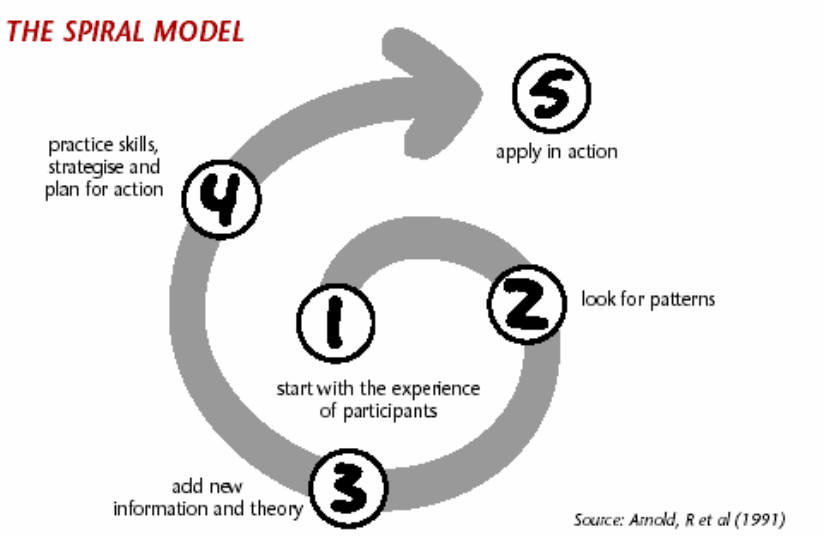
In the next session the 2006 group held a parallel session on the experiences of the 2006 work. This was implemented at different points in the meeting and is separately reported in later in the report.

What do we mean by participatory methods?

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

- *"With participation there is community involvement at all stages"*
- *"There is interactive learning"*
- *"All community voices are heard especially the marginalized"*
- *"Communities provide solutions to their own problems"*
- *"Its interesting"*

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



The PRA process is like a spiral with a regular cycle of reflection and action, from this a community can draw lessons from their experiences and continue to find better solutions to their difficulties, this continues to move them closer to their positive change in their lives. We discussed the basic approach of reflection and that it gives communities opportunities to share their opinions and contribute to decisions or plans being developed and that this encouraged a bottom-up approach.

Clara Mbwili from Lusaka Health Board outlined the experiences of their team in using PRA to promote communication and partnership between health workers and communities in urban Lusaka and rural Chama districts Zambia in 2006.

3. Understanding community

We looked at the different ways of mapping and analysing communities. We discussed the different elements that make up communities, and how we understand the term 'community'. We explored what a family was, how families form social groups and then communities and what determines a society. We looked at the different ways of mapping and analyzing communities. Participants brought forward methods like surveys, photographs, questionnaires and interviews. We explored different participatory

approaches. An example was shown of social maps that had been drawn by the 2006 PRA work done in Zimbabwe by TARSC, the Community Working Group on Health (CWGH) and Zimbabwe Health Portfolio Committee in parliament on district resource allocation in health. These maps were used to discuss how social maps could be used to explore community features relevant to health.

The delegates drew social 'maps' of a typical community and explored the type of features that these maps might include, and how they can be used to identify the different social groups and influences on health in an area.

We also discussed the role of transect walks. During a transect walk, key informants or other community members knowledgeable about their area join the team in going for a walk around the community. The toolkit provides further information on this.

3.1 Namibia experience with transect walks

Kathe Hofnie //Hoebes presented the experience of using a transect walk in PRA work in a community in Namibia. The report of this work is on the EQUINET website (www.equinetafrica.org).

The transect walk was introduced after the initial exercise to build rapport, and Introduce the PRA team to the community. It was done by nursing students who used a guide and recorded their findings, thereafter discussing it and drafting a shared report. The observations are well documented in the report of the work and were shared with the delegates at the meeting. Kathe shared some lessons from the experience: She noted that observations incomplete without communication with community members. Students better understood the observations after asking questions from the community for clarification. The students had been surprised by poor living conditions and fascinated by how the communities are trying to cope with the hardship. It offered a good integration of theory into practice. The students gained a lot from the transect walk and it already began to shift their attitudes towards the community.

3.2 Understanding the power relations that influence health

Elisauth Mmanyi (District AIDS Cordinator, Bagamoyo District Council) and Mwajuma Masaiganah (TARSC Tanzania) presented an outline of the needs and support of orphans and vulnerable children in Bagamoyo.

OVC are children whose biological parents are both dead or children who are vulnerable and are under their care due to HIV/AIDS, born by teen-mothers and abandoned and or those who are sexually abused or have undergone any other form of violence. Universally, relatives and friends provide up to 90% of care for people with AIDS and their families within the home of the sick person; but most initiatives often come with few links to public health services Vs Community approaches especially around rural areas. Bagamoyo district is on the highway (coupled with poverty; the movement of tourists, the flow of people from and to Dar es Salaam, Zanzibar and other up country regions aggravates the problem). It is estimated that by the year 2010, 15 per cent of all children in the worst affected countries will be orphans. In 2005, Bagamoyo district with poulation 247,847 had 5,035 orphans and vulnerable children (2,714 males and 2,321 females under 18 years) mostly due to HIV/AIDS . 43% of the households with orphans are female headed and most of these are female grandparents.

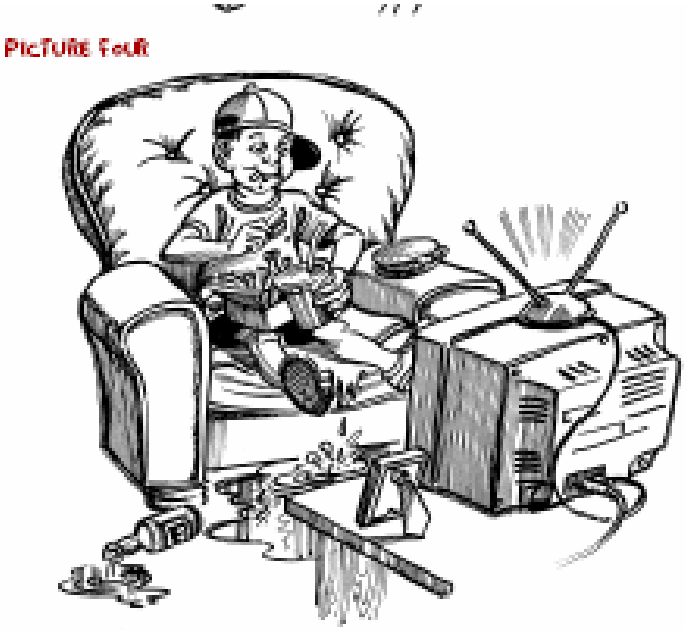
OVC need bereavement suport including counselling to reduce stigma, as well as nutritional support, education, health care, shelter. They also need information and training on what to expect of AIDS, how to care for their dying parents and siblings. The goal in Tanzania is to provide hope to OVCs and Care givers through good quality and appropriate care to maintain their independence and have the best quality of life. However this faces a number of challenges, in terms of community capacities, resources at local health facilities and community mechanisms of OVC support. Caretakers also face community challenges in relation to stigma and resources for support. It is proposed to conduct PRA in Zinga Ward as a pilot for effective OVCs/Care takers support area that can be emulated by the whole district. This work aims to strengthen communication between communities and the district to foster inclusion of OVE needs identification through PRA into the district planning and to identify areas of initial support to OVCs and care takers.

Delegates then used a spider diagram in groups to explore how to analyse the support for OVC, with each ‘leg’ of the spider representing a different group OVC interact with and the impact they have on OVC. This tool was discussed, to see how useful it is in drawing out what is happening in the community, and exploring how to orient health interventions to support these actions.

4. Understanding health

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

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



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

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

While health workers often focus on the physical aspects of health, delegates comments on the pictures reflected how important people felt the social aspects to be.

The following sessions explored how to identify health needs in communities, how to prioritise these needs and look at the causes of ill health. We divided into three groups to explore and prioritise health needs, using the ranking and scoring system. Delegates grouped themselves by whether they were health workers, NGOs or those coming from community level. We then brought the different groups, and the priority health needs identified, together and explored how they compared with each other. There were some similarities, but also some differences. For example

Those working with community level identified as priorities

- trained health workers;
- sanitation (toilets); recreation facilities;
- access to health centers;
- decent clothing;
- access to medication

Those who were health workers identified as priorities

- Good working environment;
- sanitation;
- IEC/Health promotion;
- access to good nutrition

Delegates discussed two issues.

- *How was the ranking within groups done?* It was observed that giving each person counters to make their own choices of priorities enables even less powerful groups to have a say. Having a collective discussion on what comes out and reorganising the

priorities is useful to build a collective view, but it is also important that the voice of the most vulnerable groups is not lost in the process.

- *How are differing views dealt with?* In a situation where health workers and communities see things differently, it is useful to focus on those areas they share views on, and then allow each to explain their different views and listen to the reasons given. It isn't necessary to always have consensus: the differences if fully discussed can build greater understanding between groups of each others perspectives, so that these are taken into account in future work.

Various approaches useful to explore the causes of health problems were discussed. The problem tree can be used to look at a number of the health problems prioritised, asking *but why does it occur* for each problem to get more deeply into understanding the causes of the causes of these problems.

Picture codes are a further way of exploring problems. The toolkit provides examples of picture codes, and these were used as examples to discuss the causes of the problems, using the "but why approach".

For example, taking the problem of food nutrition
"Why does it occur?
Lack of money
Why does this occur?
Low income/unemployment
Why does this occur?
Inaccessibility of land + credit systems/gender based discrimination
Why does this occur?
Lack of policies + programmes addressing gender based issues
Lack of programmes empowering women"
And so on….
We discussed PRA approaches to link action to these causes.

4.1 IHRG experience in using PRA to promote workers health

Ashraf Ryklief presented the 2006 experience of the IHRG around how health workers in South Africa used PRA to identify the causes of their health problems at work and the actions they could take. This is captured in the IHRG poster overleaf.

Raising Our Voice, Breaking Our Silence

Health Workers' Experiences and Needs around Occupational Health Services in Cape Town, South Africa

A Participatory, Reflection and Action project facilitated by the Industrial Health Research Group (IHRG) with support from the Regional Network for Equity in Health in East and Southern Africa (EQUINET) and IDRC Research Matters, June 2006

The participants in this project came from the following public health sector trade unions:

Denosa
Hospersa
Nupsaw
Pawusa
Sadnu
Samwu

"Here we are allowed to participate. We come with our experiences from our workplaces. By coming here we can get a distance from it and see its reflection. With participation we come up with action. The resolutions or answers that we come up with are actually based on problems that we experience at our workplaces."

Health workers are not recognized as a community that requires health care. The link between the health and well being of health workers and the quality of health care that they are able to provide to the community needs to be recognized and positively developed.

In this PRA project, participants carried out investigations of occupational injuries and illnesses in their workplaces. This allowed them to use their own real experience of case work as the material for reflection, learning, and planning improved action.

Research findings on Occupational Health Services

- There is a range of procedures and role players that make up the system of OH services, but this system does not function effectively, and certainly not in the interests of health workers.
- As a result, health workers do not get proper diagnosis, treatment or management for workplace injury and illness.
- Employer opposition to workers' health and safety rights, their negligence, disinterest and obstructionism is an important factor in blocking health workers' access to an effective OH service.
- Health workers' experiences of medical practitioners not complying with proper diagnostic and reporting procedures encourage them to see these services working in the interests of management.
- Employers are not using workplace injury or illness information and stats to develop preventive approaches.

A dysfunctional OH service for health workers means that:

•Cases are not recognized or they are neglected, causing huge physiological, psychological, emotional, and social hardship on affected health workers.

•Occupational injuries and diseases are left as isolated individual problems and are not seen as collective issues. As a result workers are often stigmatized.

These participatory learning and research projects are an important tool for stimulating and facilitating learning inside trade unions.

It is important to sustain these networking and learning activities in order to contribute to that organizational development.

As health workers we must equip ourselves and our trade unions!

Workers are really not aware of hazards or health and safety rights at the workplace. They only become aware when they get injured or become ill. Trade unions are not paying proper attention to health and safety and shop stewards don't have a clue. The unions are also not putting pressure on the employer to comply with the General Admin Regulations regarding the the election of health and safety reps. We must take steps to change this. We must make shop stewards aware of health and safety issues. We must encourage our unions to network and collaborate so that each one is not reinventing the wheel. We must also get our unions to ensure election of health and safety reps and enforce our rights to access to health and safety information in our workplaces.

PRODUCED BY THE INDUSTRIAL HEALTH RESEARCH GROUP Richard.Jordi@uct.ac.za

Ashraf presented the needs, opportunities, and resources for continuing the case work, the networking, and the learning activities of this group. He noted that there is a strong need to continue the work, following and learning about case work and developing skills for investigation. There is also a need for OH&S skills training and for this kind of forum for networking and sharing. There are resources and opportunities within the participating institutions for this that will be tapped, starting with monthly PHS Forum workshops.

5. Building people centred health systems

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

We then went to the open area near the sea to look at how health workers and communities need to and can work together to solve health problems through the 'stepping stones' method. This activity explored the several steps that communities could engage in to reduce the prevalence of HIV and AIDS. We discussed how communities and health workers are supporting each other in health systems. We discovered that in some instances communities and health workers work in parallel when they are supposed to compliment each other's work.

We went on to discuss how stakeholder mapping could be used to map the different institutions, individuals and different stakeholders in the communities and how their relationships could be used to strengthen and enhance delivery mechanisms.

In a session the following day we discussed the barriers to overcome to improve communication between health workers and communities, using the Johari window as a tool to facilitate this discussion and identify how to unblock communication barriers.

A slide presentation by Rene Loewenson EQUINET presented the wider context to building a people centred health system. Drawing from the regional equity analysis being prepared by EQUINET, the presentation showed that improved growth has occurred in countries in east and southern Africa (ESA) with falling Human Development increased poverty and widening national inequality in wealth. There is evidence of inequalities in health, in access to the household resources for health and in access to health services within and across ESA countries. Longstanding commitments to equity have sought to overcome unfair differences in health, and to allocate more resources to those with greater health needs. To do this we will need to reclaim the resources for health for poor households to access a fairer share of national resources; for the health services used by these communities and for countries to meet obligations to health. Against a background of significant resource flows out of Africa and economic and trade policies that weaken public health, many countries in the region face challenges in implementing the public sector, redistributive health systems that respond to health needs and redistribute resources to provide health care in accordance with need. EQUINET's goals of reclaiming the state is based on the understanding that

addressing our health challenges needs as a precondition an effective public sector, able to exert leverage over the system as a whole.

Reclaiming the resources for health systems and households for health calls for adequacy of health financing, progressive means of resource mobilization within a framework of universal coverage, and needs based resource allocation. Experience from the region suggests that steps towards this calls for

- Recognition of the real costs of financing a health system of about $60 in the public sector, with additional demands from AIDS and the MDGs
- Governments to increase their own financing to health so that this reaches at least the 15% commitment made in Abuja, *excluding donor resources*

Without health workers there is no health system. Strengthening national health systems cannot be done without valuing and "reclaiming" our health workers. Equity also includes the power and ability people (and social groups) have to direct resources to their health needs, particularly for those with worst health. Addressing equity thus means relooking at health systems: overcoming longstanding blocks in administrative systems, health worker attitudes and health system processes that disempower people. This calls for mechanisms, resources, participatory reflection and action approaches and civil society and parliamentary contributions that facilitate analysis and action. Health systems organised around social participation and empowerment create powerful constituencies to protect public interests in health .

Rene outlined the various areas of work in EQUINET aiming at supporting this, through research, knowledge, capacity building, promoting dialogue, policy support and social activism. The EQUINET website at www.equinetafrica.org has many of the publications of this work and the EQUINET newsletter provides monthly information on the work taking place in the region on equity in health.

6. Integrating PRA approaches into ongoing work

We integrated the approaches discussed in the workshop into ongoing work in a number of ways.

- By exploring how to strengthen facilitation skills for PRA
- By listening to the experiences of the 2006 group and the lessons learned, and
- By carrying out mentored work and discussing in groups how to apply these approaches within areas of work identified by participants

6.1 Strengthening facilitation skills

A discussion on facilitation skills examined was aimed the expectations of facilitators on the follow up work, with delegates raising issues such as stimulating discussion, motivation of participation of all the participants, being clear of what the aims of discussion will be as well as staying focused.

The agreed characteristics of a facilitator were identified as to

- Show respect
- Establish rapport
- Abandon preconceptions
- Hand over the stick
- Watch, listen, and learn
- Learn from mistakes
- Be self-critical and self- aware
- Be flexible
- Support and share
- Be honest

"Don't rush, lecture, criticize, interrupt, dominate, sabotage, or take yourself too seriously!"

As facilitators participants are expected to

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

This means that facilitators need particular characteristics:

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

It was suggested that participants can continue the process after the workshop:

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

6.2 Learning from the 2006 experience

Two rounds of discussion were held with the 2006 group to examine what had been learned from this experience, and the group then related these experiences to the wider meeting.

Kathe Hofnie-//Hoëbes presented her experience as a facilitator

"I learned through trial and error, that PRA empowers the community, and the facilitator as well".

She observed that in PRA, participants have more control than the facilitator, making it a challenge to the traditional researchers. It calls for good listening skills and respect, while for communities it builds confidence and helps them to realize that their views are being heard and taken onboard. This aspect fosters feelings of ownership of the project, in those who are participating. Once the community is empowered their confidence grows.

The process is important. The correct community entry process facilitates cooperation and active participation and feedback is an integral part of PRA process. This means carefully selecting tools that will guide the whole process and lead to successful outcome beneficial to the community. This needs time.

The 2006 group discussions raised a number of shared lessons. The group agreed that priorities (needs and actions) could differ between facilitators and participants/ community. This means that it is necessary to clarify roles and responsibilities of facilitators and community and use the PRA method and appropriate tools to confirm community's needs & priorities. The PRA process is iterative not linear. The process should drive use of tools, not tools drive the process.

It is important that dialogue was developed. This is done through sharing of experiences, in which the power of the community is recognized, community voices heard and mindsets and attitudes change. Participation creates respect for each other, links and networks are created and it strengthens the facilitator and community partnership.

This relationship needs to be built on in a meaningful way for change. Feedback is important for accountability to community. Powerful people need to be brought on board to influence change and community processes organised.

The group discussed how to build exit strategies – to address the issue "What happens after the round of innovation using PRA"? Monitoring should be in-built to validate process and mechanisms built in to objectively measure change or monitor outcomes (such as process markers and pre-test & post-test questionnaires) to add confidence to the groups involved. Continuity and change was felt to have been enabled or disabled by a number of key factors:
Facilitator factors
Participant factors, and
Institutional factors
In any new PRA process it was felt that these factors should be thought of both for how they will influence the process, and for how positive elements will be sustained.

The 2006 group identified a number of follow up steps that they felt would consolidate the work done and assist in the newly trained colleagues advancing their work. These are summarised in the table below.

SAYWHAT, from the 2006 group, presents their work to the meeting.

Process	Activity	Responsibility
Raising the Profile of the work done	Publishing of PRA work done so far. Can be done as combined publication.	EQUINET 2006PRA Group
	Take advantage of presenting PRA project work at various fora eg national or local conferences, meetings etc.	2006PRA Group
	Apply to participate in upcoming EQUINET Writer's Workshop.	EQUINET 2006PRA Group
Horizontal Networking	Reach out via e-mail to 2006 PRA trained group still practicing PRA, in an effort to support, encourage & deepen understanding of PRA process and enhance dialogue. Also lookout for opportunities for regrouping or reunions.	2006PRA Group
	Exchange visits to neighbouring countries undertaking PRA projects either to observe or act as resource persons for some steps within projects.	2006PRA Group EQUINET
	Actively participate and contribute to the PRA e-mailing network.	2006PRA Group
Mentor Support	Linking members to other PRA resources on topics of interest, and these could be either persons or possible financing sources.	EQUINET
	Support in editing and publishing of work in various formats eg posters, policy briefs, reports etc.	EQUINET

6.3 Development of PRA proposals

Delegates worked individually with mentoring and then in groups on concept notes that they had brought for follow up work in their home countries. Delegates and facilitators worked together to review the concept notes based on the skills learned and identify possible areas for follow up work including through EQUINET support. Delegates also worked in groups to review each others proposals.

Participants were requested to revise their proposals with particular attention paid to (a) The problem at hand, (b) the change process they wished to bring about, (c) which PRA tools and methods they planned to use, (d) the steps they intended to take to implement their proposed work, and (e) how they proposed to report and/or use the information generated -

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

Feedback would be given from EQUINET on the proposals. It was noted that while proposals could still be submitted later than February / March, delegates were urged to complete proposals to ensure that grant funds were available.

7. Reflections on the workshop and closing

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

- What did you gain from this workshop?
- What would you like to change or do differently in future workshops?
- What do you most want to do next?

What we gained from this workshop……

"We gained a lot of facilitation skills and free interaction on issues….. new ways of interacting with different social groups in different on different issues…. and the PRA toolkit, which is a rich resource in participatory approaches."

"This was a real potential for network. We gained from the networking and sharing of experiences from the different countries that did follow up work from the PRA 2006 group. We gained collective learning from group discussions, especially the 2006 group reports"

We gained skills in PRA… in developing a PRA proposal and we appreciate the mentoring …. And in helping Health workers and community work. I learnt how to resolve conflict without alienating other people. PRA approaches built confidence, if you don't know you keep asking the participants 'the causes of the causes of the causes'"

"I gained a deeper understanding of PRA as a process and not just a set of tools. I have gained ways of gathering information for different people using different tools. Use of participatory tools is really fun, I liked the social mapping and the spider diagram"

"Culture is dynamic in Africa it was interesting to note the different cultures that exist in Africa"

What we would like to do differently in future workshops?

"The program was too intense. We want the organizers to add more days so that the we cover all the tools in the Toolkit, in future workshops organizers should not facilitate activities that are meant to take long time in a short time"

"We need a more friendly conference room; in future we should not sit on the same chairs that are squeaky, heavy and very annoying. You should remember that not all of us are fast English speakers, instead of giving us instructions give us more handouts on activities. Also move the next workshop to another country"
"The presentation on building people centered Health system, perspectives, evidence and challenges from EQUINET should be done in the early sessions at the beginning of the workshop as they orient participants and give them a clear picture of what EQUINET is, what it does and how the work on PRA fits in the whole picture"

"Do not overlook other countries in invitations"
"Avoid plenary sessions on proposals"

"Nothing wrong!! Carry on. The workshop was good! Hakuna matata"

What do you most want to do next?

"We want to

- *find out if we can apply PRA methods in a real community.*
- *follow up and start the work in our respective districts. (many people said this)*
- *Continue working with communities, now applying PRA tools and exchange ideas in the pra4equitylist.*
- *Use PRA in our daily work … and see how effective they can be. Practice the PRA techniques in tackling community problems.*
- *Help bridge gapes between health workers and vulnerable communities.*
- *Pass on the PRA stick to other people who will do the same in future.*
- *be facilitators of equity*
- *Involve communities /target groups and value their existence.*
- *Conduct PRA workshop in the orientation for stakeholders in communities.*
- *Develop our PRA concept note and send it to EQUINET*
- *Form health center committees in communities."*

"We want to incorporate and intensify the use of the PRA processes within the communities we work with in order to strengthen their capacity to participate and determine the establishment of health systems of their choice"

We closed the workshop with thanks to Ifakara and TARSC for their organising of the workshop, to the facilitators and participants, to IDRC and SIDA and to the hosts in Bagamoyo. Mwajuma Masaiganah representing the EQUINET Steering committee in Bagamoyo wished delegates safe travel and reminded them to use the dynamic potential of PRA work to improve the health system. Dammas Kathuku, one of the participants, relayed the appreciation of the delegates on the meeting and their own exchange and thanked those involved on behalf of all participants. We said goodbye-until our next exchanges on the pra4equity list.

Appendix 1:Participant list

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Appendix 2: Programme

DAY ONE – WEDNESDAY 14TH FEBRUARY

TIME	SESSION CONTENT	SESSION PROCESS
8am	Introductions and welcome	Registration. Introduction to objectives of the workshop Delegate introduction
8.30-10.30am	*COMBINED* How do communities and health workers interact with each other?	PRA work on health worker and community interaction (Activity 16) Changes in health worker- community interaction through PRA: experience from Zambia PRA in Lusaka and Chama
10.30am	**TEA**	
11.00am	*DELEGATES* What do we mean by PRA?	Activity 1: What do we mean by participatory methods? Guided discussion on PRA (Activity 13) Summary of skills built in the course
12.30pm	Delegate proposals	Discussion on proposal themes and goals
12.45pm	**LUNCH and RELAX**	
11.00am	*2006 GROUP* Experiences of PRA work done	Presentation of work done in ◆ Zambia ◆ Namibia Guided discussion Summary of agreed points. Discussion of support roles to 2007 participant proposals
12.45pm	**LUNCH and RELAX**	
2.00pm	*COMBINED* Tools for mapping and understanding communities	features of communities that affect interactions with health workers Tools for mapping and analyzing communities Experience of using the transect walk in Namibia Discussion
345pm	**TEA**	
4.00pm	*DELEGATES* Understanding how power relations influence health	Introduction on OVC in Bagamoyo. Strengthening health worker links with vulnerable groups: Summary: Identified changes In health worker, community interactions; useful tools
5.00pm	*DELEGATES* Work on proposals	Time for mentored work on proposals ◆ Specific aspects of community-health worker relations in focus ◆ Changes aimed at – what, in who, why? ◆ Who will sustain the changes? ◆ How feasible is this?
4.00pm	*2006 GROUP* Experiences of PRA work done	Presentation of work done in ◆ South Africa ◆ Zimbabwe youth ◆ Zimbabwe OVC Guided discussion Summary of agreed points.
6.00	**END OF DAY TWO**	Evening reading: Delegates: Modules 1 to 2 and bring any queries to the first session of Day two.

DAY TWO – THURSDAY 15 FEBRUARY

TIME	SESSION CONTENT	SESSION PROCESS
8.15am	Review	Questions and discussion on work to date; Framing PRA processes and proposals; Lessons learned from first round of PRA work Discussion
9.15am	COMBINED How is health understood and prioritised?	Different understandings of health, Activity 11 Prioritising health needs: Activity 12 Comparing community and health worker views; methods for dialogue across the groups on health needs
10.45am	**TEA**	
11.15am	COMBINED Identifying options for acting on health needs / problems	Identifying causes of problems – using picture codes Discussion on how communities and health workers see causes Use of case studies to discuss causes Discussion
12.45	**LUNCH AND BAGAMOYO VISIT**	
3.45pm	*COMBINED* How participatory are our health systems?	Levels of community participation in different areas of health systems. (Activity 18) Use of the PRA tool to strengthen participation
4.45pm	*COMBINED* How can health systems give meaningful roles to communities?	Health worker and community reflection on how they are supporting each other Acting jointly on health problems (Activity 17) Discussion (Activities 20 and 21)
6.00pm	*DELEGATES* Short group activity	Group work on facilitation skills
4.00pm	*2006 GROUP* Next steps on PRA work	Future work and networking ◆ Focus areas for future work ◆ Methods and approaches ◆ Other actors to be involved- local, national, regional ◆ Communication, the pra4equity list and networking ◆ Report writing and dissemination Summary of agreed points.

DAY THREE – FRIDAY 16 FEBRUARY

TIME	SESSION CONTENT	SESSION PROCESS
8.15am	Work on proposals	Preparation of proposals; Mentoring by facilitators, 2006 group
10.00	**TEA**	
10.15am	*COMBINED* Facilitating PRA processes	Feedback on the short group activity Discussion on facilitation skills Experiences of facilitation
11.15am	*COMBINED* Improving communication between communities and health services	Barriers to overcome in communication between health workers and communities Health worker and community communication with each other? (Activity 26) Summary discussion
12.15-230pm	**LUNCH**	
230-3.15pm	Group work	Delegates work on proposals and work integrating learning.
3.15pm	**TEA**	
3.30pm	*COMBINED* Plenary	Presentation of concept notes Discussion Summary comments Question and Answer on facilitation methods

DAY FOUR – SATURDAY 17TH FEBRUARY

TIME	SESSION CONTENT	SESSION PROCESS
830am	Review	Queries and feedback on modules in the toolkit
9.00am	*COMBINED* Presentation and discussion of concept notes / proposals	Presentation of concept notes Discussion Summary comments Nest steps
10.00am	**TEA**	
10.15am	*C0MBINED* Building people centred health systems: perspectives, evidence and challenges from EQUINET	Presentation on the regional equity analysis Debates on challenges (Activity 28) Discussion
11.30am	Summary session on PRA approaches	Concluding activities on facilitation and approaches.
12.30am	Next steps	Time frames, proposal submission, feedback etc Communication channels Suggestions for the next workshop
1.00pm	Evaluation of the workshop	Evaluation: (Activity 33)
1.30pm	CLOSING	Brief closing comments
1.45pm	**LUNCH**	