

Organising People's Power for Health



PARTICIPATORY METHODS FOR A
PEOPLE-CENTRED HEALTH SYSTEM



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Produced by
Training and Research Support Centre (TARSC),
and Ifakara Health Development Centre
with EQUINET
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PARTICIPATORY METHODS TOOLKIT

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Source: CHESSORE, Zambia: Community health meeting

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MODULE 1

Why a toolkit of participatory methods in health?

AIM: This module gives the background to why we developed this toolkit. We outline the toolkit objectives, who can use it, and the people and institutions involved in producing it. We also explain how users can find their way around it.



MODULE 1

Why a toolkit of participatory methods in health?

Section 1.1 Background

For some time now, people working in the field of health at community level have expressed the need for a toolkit specifically focusing on participatory approaches to working on health. This toolkit was produced in response to this need, drawing on the experiences and knowledge of individuals and institutions working in this field. The toolkit shows how participatory methods can be used to raise community voice, both through health research and by training communities to take effective action and become involved in the health sector.

This toolkit supports our shared goal of building strong, people-centred national health systems. We discuss this in more detail in module 4.

While the principles of participatory methods are essentially the same, the specific tools and how they are used differ. We designed this toolkit using the participatory methods that our field experiences have proved to be useful in raising the voices of communities in issues of health. The activities we describe have been shown to empower communities.

Participatory approaches also generate relevant knowledge and information that is crucial to community-based programmes.



Source: CHESSORE Zambia – community meeting on health

There are so many participatory methods that it is beyond the scope of this toolkit to list and describe them all.

For example, when programmes talk about using rapid rural appraisals (RRA) or participatory action research (PAR), they are often using participatory methods. Many methods emerge from the participatory rural appraisal (PRA) approaches used over the last few decades. These PRA approaches are now also referred to as participatory reflection and action and this is the sense of PRA as we use it throughout this toolkit.

What do we mean by participatory methods?



Activity 1:

WHAT DO WE MEAN BY PARTICIPATORY METHODS?

To identify participatory methods people have used in health programmes and to develop a shared understanding of the key characteristics of participatory approaches.

METHOD: GROUP WORK AND TRUE/FALSE STATEMENTS

Time: 75 minutes (30 minutes group work and discussion; 45 minutes placing of statements and discussion)

Materials: flipchart paper and pens; four headings printed on the wall (True, False, No consensus, Not sure) and four copies of the following six statements, with each statement written on a separate piece of paper:

- 1 PRA approaches are quick and easy to use.
- 2 Anyone can use participatory approaches successfully in their work.
- 3 PRA is just a set of fancy methods.
- 4 PRA has no theoretical basis.
- 5 People involved in use of PRA are neutral.
- 6 Findings from the use of participatory methods do not reflect reality.

Procedure:

- 1 Divide participants into four groups of about eight people. Give each group a piece of flipchart paper and pens.
- 2 In groups, participants discuss the following questions:
 - What were your experiences in using participatory methods? Tell your stories about what you did and why.
 - What made your work participatory? Develop a group list of the key features of a participatory process.
- 3 After 20 minutes, put all four groups' flipchart sheets on the wall (or floor) and collectively identify the key features that made their work participatory.
- 4 Participants then go back into their groups. Give each group a copy of the six statements and ask them to decide as a group which heading each statement should go under: true, false, no consensus (they cannot agree) or not sure (they can't decide).
- 5 After approximately 30 minutes, ask one group to put their six statements under the headings they chose. Then, discussing with the whole group, go through each statement, one by one, asking whether they agree that the statement is in the right place.

If groups have different opinions about a statement, ask them to argue their case until all participants reach consensus. If they cannot reach consensus, put the statement under the 'no consensus' heading. (Make sure you return to this statement later on in your workshop to reach resolution.)

During discussion of the true/false statements in activity 1, participants develop a greater understanding of good PRA practice and gradually realise that all six statements are FALSE, representing different facets of the various myths surrounding PRA.

6 Summarise on a flipchart the key features identified by participants that made their work 'participatory' and discuss these.

Source for the True/False Statements: Pretty et al (1995); PLA Notes Number 24 (October 1995)

Training tip!

To help facilitate the following session, here are some notes on each of the six statements used in activity 1:

'PRA approaches are quick and easy to use'

These methods are appealingly simple. However, developing a rapport with a community takes time. Encouraging dialogue, joint analysis and learning can be time-consuming and challenging.

'Anyone can use participatory approaches successfully in their work'

Anyone can help make a map or do a matrix scoring. But this does not mean that learning takes place or changes occur. PRA facilitators need to move beyond the tools to deal with wider issues such as organisational change, attitudes and behaviour, ethics and responsibilities. To use these approaches successfully, you need, for example, good communication skills, the ability to facilitate and resolve conflict, and flexibility.

'PRA is just a set of fancy methods'

Participation is not just mechanically applying 'techniques' or methods, it is part of a process of dialogue, action, analysis and change.

'PRA has no theoretical basis'

Participatory methods have drawn on many well-established traditions, including activist participatory research (Paulo Freire), action research, applied anthropology and the theory of adult education – all aimed at empowering people.

'People involved in using PRA are neutral'

PRA seeks to work with diversity, rather than to simplify complexity. This recognises that different individuals and groups evaluate situations differently, leading to different actions. Everyone's views (including the facilitator's) have a perspective and bias. PRA draws this out and explores it rather than pretending to be neutral.

'Findings from the use of participatory methods do not reflect reality'

PRA research tests the reality of findings by gathering the experiences of a group of people and allowing them to 'check' their findings collectively. PRA researchers can also triangulate evidence, in other words, compare findings from different sources or approaches, including quantitative studies. The extent to which PRA findings reflect reality is also a measure of the extent and/or intensity of interaction with various groups of people and how far differences of experiences and views are captured.

Most people have some understanding of what using participatory approaches in health means but we don't always know how to make it happen. Firstly, there are some basic principles to using participatory methods. These are:

- Local people are more knowledgeable about health problems in their own areas.
- Local people are creative and capable of undertaking their own investigations, analyses and planning.
- Field workers have a role to play as facilitators of this process.
- Local people can and should be empowered to solve their own problems.

In PRA, these principles are put into practice by recognising three inter-related components. These are called the 'three pillars of PRA'. Specifically they include:

- the positive attitudes and behaviour of facilitators;
- sharing between facilitators and the community; and
- using a wide range of participatory methods.

Just as a three-legged stool cannot stand if one of the legs is broken, so all three pillars are essential in implementing a participatory approach.

The three pillars of PRA

'We'

unlearn, sit down, listen, learn, respect
use our judgment at all times, relax,
embrace error, hand over the stick,
facilitate, ask them

BEHAVIOUR AND ATTITUDES



METHODS

'They'

map	model
estimate	compare
score	rank
draw	count
analyse	plan
present	act
monitor	evaluate

Teach us things we often
thought only we could do

SHARING

Both 'us' and 'them'
share our knowledge,
experiences, ideas, skills
and analysis

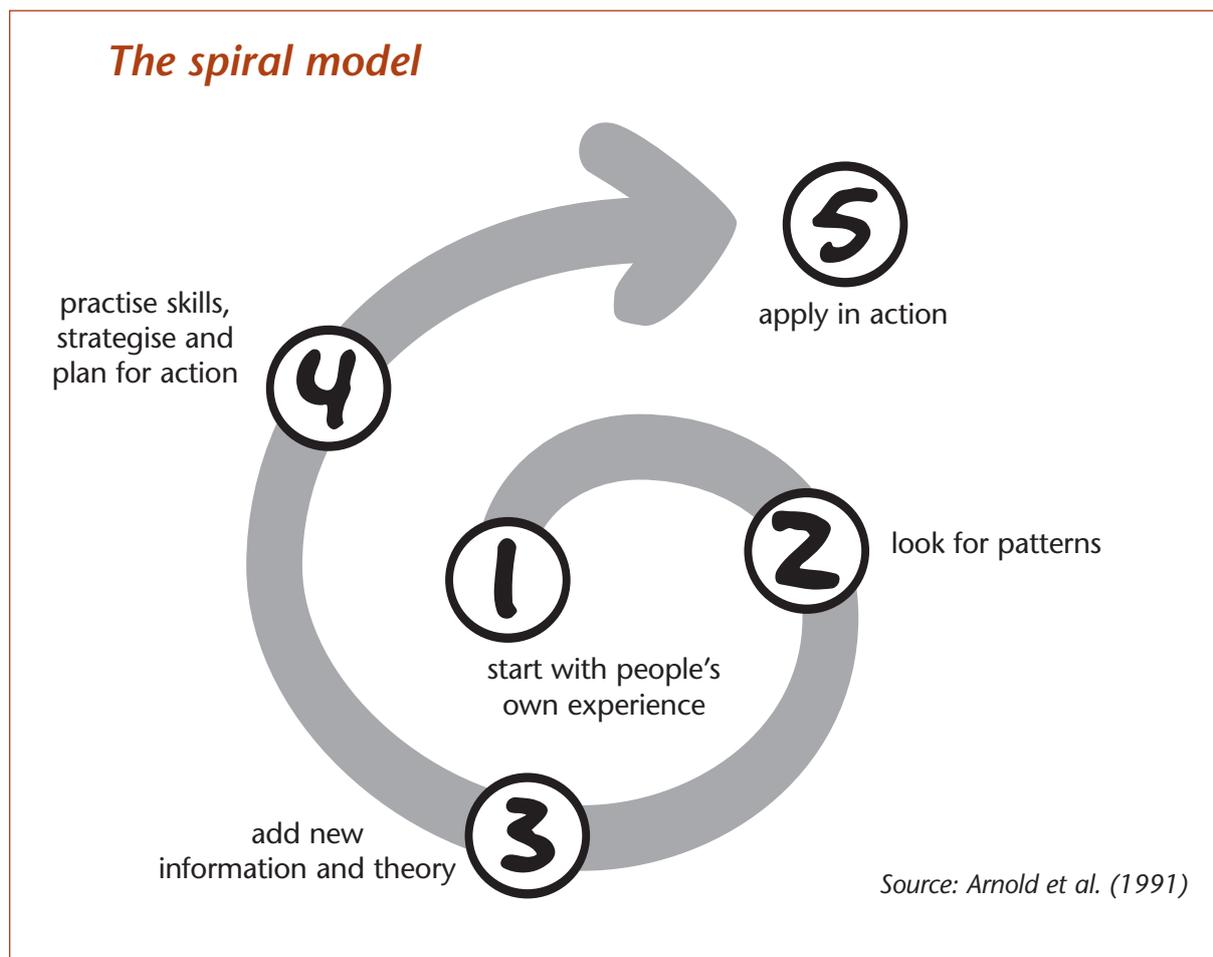
Most real learning and change takes place when a community becomes dissatisfied with some aspect of their lives and wants some things to change. When this happens, a facilitator can assist the process of change by providing a situation where community members:

What does this imply for the way we implement participatory approaches in health?



- Reflect critically about what they are doing, drawing on their experiences and knowledge;
- Look for patterns to help analyse their experiences (what is common about all our experiences? what is different? what are the common social, economic and political conditions affecting our experiences? and so on);
- Identify and obtain any new information or skills they may need; and
- Plan for action.

This process is like a spiral. Often the first plan of action will solve some aspects of the problem but will not go deeply enough to deal with the root causes of the problem. By setting a regular cycle of reflection and action, communities can learn from their successes and continue to find better solutions to their difficulties, thus moving closer each time to achieving positive change in their lives.



How do such participatory approaches that build reflection within communities differ from top-down participatory approaches?

A reflective approach gives the communities opportunities to share their opinions and contribute to decisions or plans being developed. A top-down approach, on the other hand, is more prescriptive – everything is decided and worked out from the top without involvement of those at lower levels. People only become involved at a relatively late stage when issues have already been finalised.



Activity 2:

WHEN IS PARTICIPATION NOT TOP-DOWN?

METHOD: ROLEPLAY

Time: 5 minutes for each roleplay; the total exercise should take about 40 minutes.

Procedure:

- 1 Participants do two role plays of the same scenario to reflect the two approaches. Both scenarios involve communities wanting to build pit latrines through a programme supported by a district council or a non-governmental organisation.

Scenario one

In this programme, officials design the pit latrines and decide where they should be built. They then train community leaders to encourage the community to take an interest and insist that community members become involved in the programme.

Act out this scenario. The roleplay can be of any stages of the work you choose. After the roleplay, discuss whether you think this is top-down or bottom-up planning. Why?

Scenario two

Discuss what would make the approach bottom-up, noting how this would involve social, economic, cultural and technical factors that affect the building and use of pit latrines in the community.

- 2 Ask participants to roleplay what the different scenario might look like to reflect the areas they discussed. The roleplay can be of different stages of the work so it first involves the district officials and the leaders and then the leaders and community members.
- 3 After acting out both situations, hold a final discussion on what type of participatory approach you are aiming for and when it is important and relevant to use it.

Training tip!

Look at the pictorial case study in section 2 of module 3, activity 13, as another example of a top-down approach to working with communities.

A final note on participatory methods

Participatory, reflective approaches are primarily qualitative in nature. The tools we use in this manual aim to gather people's knowledge based on their opinions and experiences. By definition, much of this knowledge is not scientifically measurable. Nevertheless, it is vital if communities and outsiders are to work successfully together in improving the health and well-being of individuals, communities and the nation.

At the same time, this does not mean that participatory research and action ignores quantitative data (data that is counted or measured). There are examples of participatory methods for research in health in this manual that provide quantitative evidence. We can use participatory methods in health research to produce averages and other quantitative information.

Drawing on secondary sources – such as published and unpublished studies and reports, sentinel surveillances, national surveys, project documents, films or videos – is also essential to any participatory approach. We recommend that users of this toolkit take advantage of these additional sources of information in order to get the most out of the participatory methods introduced in the manual.

This introduction doesn't tell you everything you need to know about participatory methods. A list of further resource materials appears in module 7 where we discuss ways to strengthen your skills as a facilitator of participatory research and training.

Section 1.2 Who produced this toolkit?



This toolkit is a product of the the Training and Research Support Centre (TARSC) (Dr Rene Loewenson, Barbara Kaim and Faith Chikomo – Zimbabwe) and the Ifakara Health Research and Development Centre (Ifakara) (Selemani Mbuyita and Ahmed Makemba – Tanzania). Graphics were provided by Mashet Ndlovu and editing by Margo Bedingfield.

It was produced under the umbrella of the Regional Network on Equity in Health in East and Southern Africa (EQUINET), with support from IDRC (Canada) and SIDA (Sweden) in the programme of work on participation and health.



TARSC is a non-profit institution that provides training, research and support services to communities and their organisations to develop capacities, networking and action, and to interact with the state and private sector on areas of social policy and social development (see www.tarsc.org).



Ifakara is a non-profit, independent, district-based health research and resource centre, generating new knowledge and relevant information regarding priority problems in health systems at district, national and international level through research, training and service support aiming at better health and community development (see www.ihrdc.org). TARSC and Ifakara wrote the toolkit.

The Centre for Health, Science and Social Research (CHESSORE) (Dr T. J. Ngulube – Zambia) peer reviewed the toolkit. CHESSORE is a non-profit research institution working in four districts of Zambia to promote community voice and participation in health, and to generate new knowledge and information relevant for policy and implementation in health at local and national level (see www.equityinhealth.org/chessore).

What does this toolkit and course aim to do?

Generally, this toolkit aims to strengthen capacities in researchers, health workers and civil society personnel working at community level to use participatory methods for research, training and programme support. At the end of the course, we hope that the users of the toolkit will have learned and be able to use various methods for participatory approaches to research and training within various areas of work aimed at building people-centred health systems. The toolkit uses experiences from different countries in the east and southern African region.



The toolkit is aimed at those who work with communities in health rather than directly at communities. In this toolkit we are talking to health workers, health researchers, leaders and workers in community organisations and community leaders who work with communities.

Activity 3:

WHAT ARE PARTICIPANTS' EXPECTATIONS AND BENEFITS FROM THE TOOLKIT AND THE COURSE?

METHOD: GROUP DISCUSSION

Time: 30 minutes

Procedure:

- 1 Ask participants what they hope to get out of the course and the use of the toolkit. Discuss and list their responses on a flipchart.
- 2 Ask participants who will benefit from their having taken this course or used this toolkit. Discuss and list their responses on a flipchart.
- 3 Revisit these expectations in a discussion at the end of the course.

How to use this toolkit

The toolkit is organised into seven modules. Each describes the issues that are important for community voice and participation in different aspects of health and health systems. The modules give examples of participatory methods to raise issues with communities, organise evidence and views from communities or raise the voice and capacities of communities within health systems.

We try to be as concrete and practical as possible in sharing knowledge and skills about participatory methodologies. The tools or techniques provided are not prescriptive but suggest possible approaches and can be modified for different environments. A key characteristic of PRA is its flexibility. People can adapt PRA tools to meet the specific needs of communities and situations. Facilitators are encouraged to be creative and adaptable and to use their best judgement in applying these approaches.



Source: Petty et al. (1995)



MODULE 2

Understanding Community

Section 2.1 What do we mean by 'community'?

The terms 'community' and 'participation' appear to have many meanings to different people.



What do they mean to you?



The term 'community' is used to describe a group of people who live in the same area or who join together for a common purpose.

Communities are made up of *individuals*. These may be people with and without particular health conditions. They may be pregnant, well-nourished or have diabetes; they may be children, spouses or partners, family members, parents, care givers, co-workers, and so on.

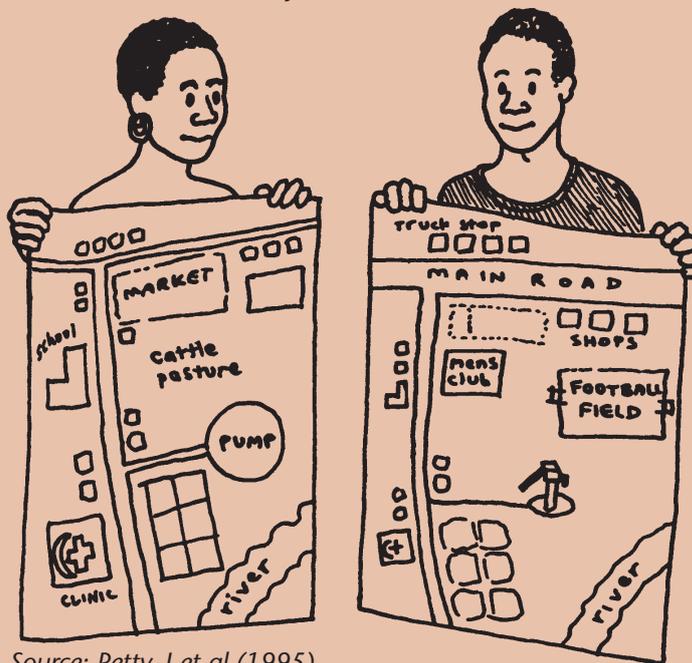
Individuals come together in communities to make up *families and households*. Although used inter-changeably, these terms have very different meanings. A *household* can be defined as a group of people, living together, who usually depend on each other economically. *Families* in traditional societies typically involve a much larger network of connections among people. They go beyond the household in relationships that include many generations, extend over a wide geographical area and are based on mutual rights and duties. The term *extended family* places special emphasis on the role of relatives outside the household in providing economic and social support. Extended families, for example, have been important in supporting people from AIDS-affected homes.

Beyond the immediate networks of household and family, there are *social groupings* within *communities*. These social groups share a common experience or situation. For example, they may have the same social class, income level, gender, geographical area, age, ethnic or religious group, political status or other social and economic factors. Health workers are a social group who share a common occupation. These factors can influence how they are exposed to disease, how healthy they are and how much they are affected by ill health. It can also influence how well they are served by health services or how they access those services. For example, disabled people as a social group face particular difficulties in getting to health services and need specific attention in the planning of health services so that their disabilities do not disadvantage them.

From this we understand that a community may be a group of people who live in different areas but have shared interests. When people describe their experiences of working with communities in health it often seems that they are talking about groups of people who are all the same. Within a community living in the same area, however, there are a range of different social groups – for example, men and women, young and old, rich and poor, teachers and farmers, and so on. To understand the causes of good health and ill health and to organise community roles in health we need to understand these different groups and levels in a community. Only then will all groups have a fair chance of being involved and of having their needs met.

Procedure:

- 1 Ask participants to get into groups of not more than 10 people. Groups can be divided by age, gender or any other category participants prefer. Give each group a few minutes to decide on a name for themselves.
- 2 Discuss with participants what they understand by the term 'social groups'. Let them give some examples. Discuss how these social groups influence health and health systems within their community.
- 3 Then tell each group to draw a map of their community on the ground (using sticks, stones, leaves, and so on), on the floor or on a large piece of paper. Instruct them to show the following on their maps:
 - major landmarks, such as schools, clinics, shops, where people live, water points, vegetable gardens;
 - how social groups in their community are distributed on the map. For each social group ask participants to come up with a symbol. The map should be clearly labelled with a key describing the symbols used.
- 4 Ask participants also to map wealth distribution within the community. Symbols can be used for different wealth levels.
- 5 Each group then nominates one person to present their map to the plenary. After each group has presented their map to the other groups, have a general discussion focusing on the similarities and differences between the maps. Discuss whether there was a difference in the maps based on age or gender. What do the maps show about social groupings and wealth?
- 6 If the maps were done on the ground, ask a volunteer from each group to copy the map onto a piece of paper.
- 7 After the presentations identify four or five key informants who will follow up on the wealth distribution exercise (Activity 5).



Source: Petty, J et al (1995)

A research tip!

You can use these maps later in research activities to compare how the distribution of social features like wealth or access to water, relate to the distribution of health issues like nutritional status of children or the number of cases of diarrhoeal disease in the past month.

Section 2.2 What are the different ways of looking at social groups in communities?

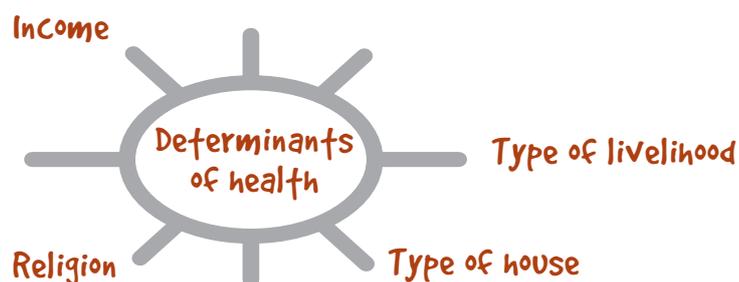
When we describe communities we need to understand what factors have an impact on health. Take the case of HIV and AIDS, for example, where individuals may acknowledge their infection themselves but hide it from their partners and families. This means that we need to know how both different individuals and different families are responding. While household and family responses may be caring and supportive, particular groups, like young people or widows, may not receive the same level of care and support. Some social groups have joined together at the wider community level to protect vulnerable individuals within their groups. Women's groups have, for example, called on the state to intervene with laws and social measures to require partners to tell each other their HIV status.



What situations can you describe that show how the features of individuals, households, families or social groups influence health?

Knowing how inputs to health are distributed across different social groups in communities is important and helps you understand who is more at risk of ill health and what different health service needs people have.

One of the most obvious characteristics in a community that is important to health, for example, is wealth. We often use income to define wealth but it is just one of the determinants of wealth. There are a number of other variables that contribute to how wealthy people are. For example, wealth may be affected by the type of livelihood (what the household or individual does for a living, for example, keeping livestock, farming crops or other employment) or what assets they own. More land and livestock, for example, shows how rich or poor a rural household is. Other surveys have found that households judge wealth from their housing structures. Others may use the health status of their family members to determine their wealth status. Others may believe that political power determines their wealth.



There is no single answer and these determinants of wealth vary from one community to another. Livelihood patterns in a community are diverse; people have different ways of raising income, different lifestyles, different asset ownership, different homes and different health needs.

We know, however, that wealth and poverty influence health and that health has an impact on wealth. When households cannot afford to pay for their health needs, they become more unhealthy. When people are ill they cannot earn a living or produce food and they spend more money on health care, so they become poorer.

We therefore need approaches to examine how communities understand wealth in their communities and how it is distributed across different social groups in the community. We can use these approaches for both research and training.

Activity 5:

To IDENTIFY WEALTH GROUPS, THEIR CHARACTERISTICS AND DISTRIBUTION WITHIN THE COMMUNITY

Method: WEALTH RANKING

Time: 45 minutes

Materials: paper and pens

Procedure:

- 1 Ask four or five key informants to identify the different wealth categories in their community. They need to develop a set of criteria or indicators for each wealth category (for example, what do the poorest or richest people in their community own? what work they do? and so on).
- 2 Ask the key informants to complete the table below, giving each social class a name (for example, very rich, rich, average, poor, very poor) and description, as well as an estimated percentage distribution within the community.

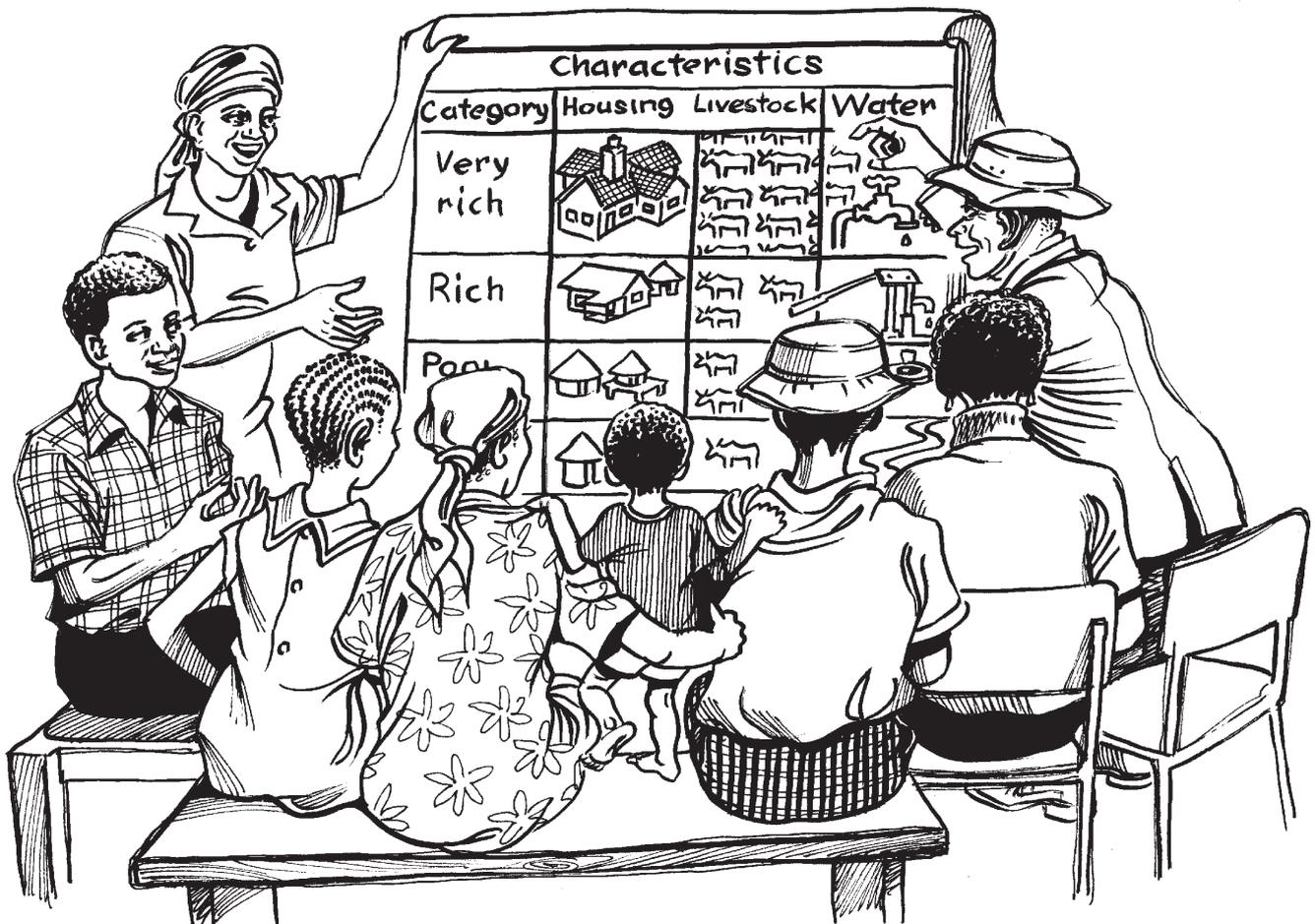
Social class	Description	Estimated distribution within the community (%)
1		
2		
3		
4		

- 3 After completing the table, ask the key informants to discuss the following questions:
 - What influence does each of these groups have in determining their well-being or health?
 - How do the poorest or worst off groups cope in relation to health?
 - How does gender influence a person's wealth?
 - What are the implications of this activity for health planning in your community?

Identify a volunteer from the group to record all responses to the discussions.

A research tip!

Wealth ranking can be done in a number of different ways. The one shown in Activity 5 is the easiest – but also probably has the widest margin of error. If you want a more accurate participatory approach to wealth ranking, look at some of the many PRA training manuals available (see suggested reading in module 7). You can also verify information obtained through key informants by going back to your secondary sources (see the discussion in module 1). Participatory approaches work well in combination with quantitative data – it's not a matter of using one or the other but of mixing the two in the most creative way in the interests of increasing the community voice.



Facilitators can follow up on the information communities generate through mapping by doing 'transect walks' through the communities. These try to relate people's perceptions of their communities to what is really going on in practice. Transect walks are systematic walks across the community allowing participants to see a range of features, resources and conditions in the area. The word 'transect' is used because of the need to cross an area when walking around observing. A cross-section of the area is used to ensure that the area observed represents the whole community. Generally transects are done after map drawing and are used to verify information gathered from maps. The walks rarely follow a straight line, often zigzagging through different areas. During a transect walk, key informants or other community members knowledgeable about their area join the team walking around the community.

Activity 6:

TO ESTABLISH DISTRIBUTION OF WEALTH IN THE COMMUNITY AND VERIFY INFORMATION THAT PARTICIPANTS HAVE SHOWN ON MAPS AND KEY INFORMANTS HAVE PRESENTED

METHOD: TRANSECT WALK

Time: 1–3 hours, up to a whole day

Materials: small notebooks, pens, a camera (optional)

Procedure:

- 1 Identify the key informants and other community members who will go on the transect walk. Give them some time to plan their walk – where they want to go and what questions they will ask. Make sure the group identifies a volunteer to keep notes of issues discussed during the transect and a good photographer if a camera is being used.
- 2 During the walk participants observe and verify information and issues raised in the mapping exercise and in key informant interviews.
- 3 At the end of the transect walk the rapporteur presents his or her notes in plenary so everyone is kept informed about the whole process. Allow some time for discussion and points of clarification. During this discussion, ask the question:
 - What did you discover that was new, especially in relation to the different social groups' access to health? What are the implications for your work?



Section 2.3 Does the power of different social groups in communities matter?

Yes! Experience has shown that differences in health between different social groups relate to how much power the groups have. The term 'power' denotes their ability to control and direct resources for health to ensure that they benefit the groups and reflect their priorities.

Can you think of an example of this for individuals at community level?



Can you think of an example of this for social groups at national level?



The health of individuals, households and social groups depends on the resources they are able to access. This depends partly on how they voice their interests, how they engage with political, economic and administrative authorities, how they claim their rights and exercise their obligations, and how they influence the distribution of the economic and social resources for health.

This in turn depends on the power they have and on how the family, state and other sources of power intervene on their behalf. For example, young children have little personal power but parents, adults, schools, health services and others intervene to make sure that they are fed, clothed and treated fairly. Orphans are more vulnerable because they lack one source of power.

Power is a dynamic force that has different levels and influences. Power is not possessed, it is exercised. Power can be used productively. It may be exercised from the top down but in some circumstances, such as when communities organise collectively to address issues, it can emerge from the bottom up.

What are the different sources of power at community level?



Individuals may have power due to: their economic or political status; their role in the family; the way the law gives them power; the knowledge and education they have; and for many other reasons.

Different social groups in communities organise in different ways to increase their power and to access the resources they need for health. This is partly what we mean by participation in health. For example, people may form networks or associations around shared interests to increase their power. These networks or associations represent **civil society**, an independent sphere of social interactions. Civil society associations and networks formulate and articulate their interests, negotiate conflict, and provide and use services. It is a sphere where people engage in activities with public consequence. Civil society provides the norms and networks of trust to improve the efficiency of society by coordinating public action. Although civil society organisations emerge from civil society, they sometimes have state or corporate links. They generally draw their authority from community, neighbourhood, work, social and other connections. They provide the institutional vehicle, beyond the ties of immediate family, to satisfy shared necessities or interests and to collectively relate to the state.

Institutions also have power. The state has power and authority through laws, information and services. Businesses have economic power to employ and provide goods and services.

Participation as a concept relates to how involved people are in health actions. It also concerns the relative degree of control in decision making over resources for health within different groups in communities and between communities, businesses and authorities. We will discuss how power is organised and used for health in the next modules.

First, let's try to understand better what forms of power exist within communities and how they are distributed. To do this you first identify the different types of power (Activity 7) and then rank them according to their influence on health (Activity 8). If you are short of time, you can leave out the roleplays in Activity 7 and move straight into the ranking exercise once you have identified the different types of power in your community.

Activity 7:

To IDENTIFY THE DIFFERENT TYPES OF POWER THAT EXIST

WITHIN A COMMUNITY

METHOD: ROLEPLAYS

Time: 60 minutes: 10 minutes discussion; 15 minutes to prepare their plays; 15 minutes to present all their plays; 20 minutes discussion and round-up

Procedure:

- 1 In plenary, brainstorm on the different types of power that exist in most communities or societies, like influential people such as chiefs or politicians, certain organisations and influence according to age or gender.

For example, you could look at the power that a male teacher has over a 12 year old schoolgirl. This could be used to encourage positive health behaviour or to lead to risky sexual behaviour. You may think of the power that a doctor has in relation to a sick patient. It can be used to encourage the trust that a patient needs to use health services when needed or it may lead to patients being scared to ask questions and play a role in their own health.

Ask for a volunteer to capture the responses on a flipchart.

- 2 Participants then break up into groups. Assign one of the different power dynamics to each group and ask them to prepare a short play to show how this power can influence health issues (positively or negatively) within their community.
- 3 Call all the groups together to watch each group perform the plays and have a general discussion after the performance, focusing on the following questions:
 - Did most of the plays portray positive or negative influences of power in the community?
 - What did you learn about the way power can be used (or abused)?

Different types of power within a community have different influence and impact on health issues. This influence may or may not be significant.

Activity 8:

TO RANK THE DIFFERENT TYPES OF POWER THAT EXIST WITHIN A COMMUNITY ACCORDING TO THEIR INFLUENCE ON HEALTH

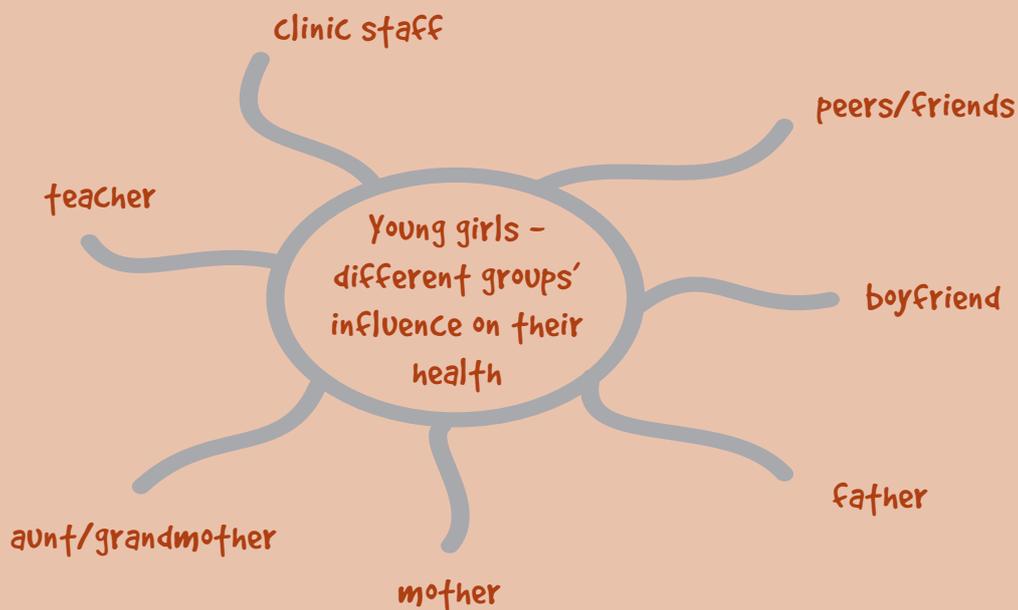
METHOD: SPIDER DIAGRAM; RANKING AND SCORING

Time: 30 minutes

Materials: counters (stones, seeds or anything quantifiable), flipchart paper and pens

Procedure:

- 1 Participants go back into their groups. They think of a particular social group, like young girls. They draw a spider diagram as shown below with each 'leg' of the spider representing a different type of power present within the community that has an influence on this group.



- 2 Give each participant an equal number of counters (10 or 20 small seeds each, for example) and ask them to distribute their seeds between all the 'legs' of the spider. The more seeds they put on a leg, the more they think this type of power has an influence on the health of the group selected, whether positively or negatively. When everyone in the group has distributed their seeds, count how many there are on each spider's leg and rank them. The more seeds, the higher the ranking.
- 3 Groups then present their findings to the others. Lead a discussion on the differences and similarities among the groups and the reason for their findings. Reach a whole group consensus on the power dimensions within the community and their influence.

A research tip!

You can use a spider diagram in many ways to see how communities rank issues, like the most serious health problems affecting a group in their community, the factors that make people healthy, the reasons why people don't report back for their results after voluntary counselling and testing, and so on.

Section 2.4: How do we ensure that all social groups are involved in and reached by health activities?

How do we classify social groups for health activities in a community?

Earlier we saw that a community is structured by different social groups. We also saw that social groups can be classified in different ways, such as age, gender, wealth, power, occupation, ability and disability, and so on.

Are there clear lines differentiating membership in the identified social groups?

The answer is no. There is a lot of overlapping and interlinking in membership. For example, a simple conclusion that *women* (using a gender classification) are the most vulnerable in accessing health care might be wrong, as some of the women might be *better off* than most *poor men* (classifying by wealth).



In one country, people aged over 60 years were involved in an exemption scheme for user fees for accessing health care. It was later realised that there were more people able to pay in this social group (as many were still working, recently retired with sufficient savings and so on) than among youth who were facing a critical problem of unemployment. Sometimes, too, an individual can qualify for a benefit more than once because of having more than one social feature (for example, being disabled and being unemployed).

How do we make sure that all groups are fairly involved and reached by our health activities? How could this be achieved?

Coming up with agreed ways of understanding social groupings is one starting point. Understanding how the social grouping we use affects the health activity in question is a further important point. We need to ask ourselves how different social groups influence health activities, or how different groups are affected differently by a health activity. In many cases, when we look at health activities and interventions, we divide people into social groups based on wealth, gender and age. Are there other ways of grouping people in our own settings?

Activity 9:

TO IDENTIFY WHICH SOCIAL GROUPS MIGHT BE INVOLVED OR LEFT OUT IN A GIVEN HEALTH ACTIVITY

METHOD: CASE STUDIES AND GROUP DISCUSSION

Time: 45 minutes

Materials: flipchart paper, pens

Procedure:

- 1 Ask three participants to give examples of a health activity or intervention taking place in their community. If possible, ask the volunteers to prepare their case study at least a day before. They can present the case study in any form they want – as a narrative, a play or a picture, for example. Each case study should take no more than 5 minutes to present.
- 2 While each volunteer is presenting, ask the other participants to list the social groups involved. This list should then be put on flipchart paper, using one piece of paper per case study.
- 3 After all the case studies have been presented, lead a discussion on what participants learnt about the influence of particular social groups in relation to health programming. Use the following questions to guide the discussion:
 - Which social groups were included in these health activities? Which were left out? Why?
 - Do you think the health activities discussed in these case studies would have been more effective if those excluded from the programme had been included?
 - What strategies can you suggest to ensure all groups are reached and involved?



A research tip!

Statistics of the population and of the existing social groups are important so you know the size of each group. Use community government records. If these are unreliable you could conduct a village census to establish actual and reliable figures. A village census is a count of every person and household and also includes information on important social features like age or sex.

How can we improve involvement and participation?



For the different social groups identified, several strategies are needed to generate interest so they become actively involved in health activities. Firstly, people need to be aware. **Information is power.** A community that is well informed about existing health activities stands a better chance of raising their voice, debating and demanding inclusion and participation. In the design of any programme we need to include components that create awareness, listen to inputs from communities and feed information back to communities. There are a range of ways of keeping communities informed – community meetings, postings and special communal announcements. There are also ways of giving feedback to communities on the issues they raise. We discuss this further in module 4.



Does it mean that we work with everybody in the community?

It is practically impossible to work with everybody through all stages of implementing a health programme or activity. Different stages of a programme involve different people in the community. For example, during the introduction, awareness creation and sensitisation stage of the health activity, preferably all community members would be involved. However, at the planning stage, for example, representation is important as it is not possible to include all community members in a planning meeting. Here again the usefulness of knowing about the various social groups that exist in the community is evident. True representation is more likely if you know the different groups that need to be represented and can ensure that all their interests are addressed. If you are clear about the social groups that are directly or indirectly affected by or have an impact on the health programme, you can more easily support representatives of these groups when working in smaller groups.

The challenge is how best to select the representatives. Social groups that have a formal structure and existence (for example, a society of disabled people in a community) pose a less challenging task when it comes to identifying representatives. Other groups like the *poor* or *aged people* in the community are not organised in a formal and known structure. This can pose a challenge in how to identify and appoint representatives from these groups.

Activity 10:

DEVELOPING CRITERIA FOR SELECTION OF REPRESENTATIVES FROM VARIOUS SOCIAL GROUPS

METHOD: STORY WITH A GAP

Time: 30 minutes or more, depending on the discussion

Materials : two pictures, shown below

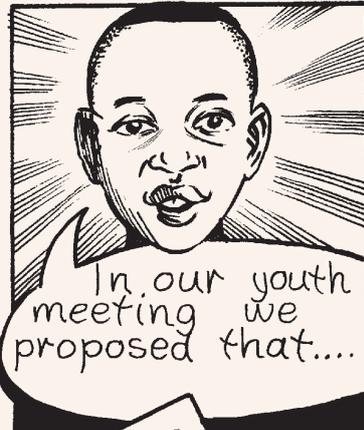


PICTURE ONE

PICTURE TWO



We represent 200 youths from 5 youth groups in our community who come together to discuss these issues.



...and that's why we've come to you today.



Masket/Ahlovu. 05

Procedure:

Show the two pictures to all participants and ask them to discuss the following:

- What do you see happening in the first picture? What do you see happening in the second picture? What do you think happened to get the youth from picture 1 to picture 2 (the 'gap' in the story)?
- How do you think the youth representatives in picture 2 were chosen by the larger group of youth? What criteria do you think they used to choose those two representatives?
- What do you think happened at the meeting in picture 2? And what happened afterwards? How do you think the two youth representatives reported back to the larger group?
- What lessons can you draw from this story in relation to group participation and representation?

In Summary:

This module outlined some key concepts in understanding the use of the term 'community' and provided some tools for how we look at these with communities.

Communities are not homogeneous but are made up of individuals, households, families and social groups with different features. This is important to health.

We need to understand how the resources for health are distributed across the different social groups in communities to better understand their opportunities for health, the types of health services they need and how they will use these services. The distribution of resources depends in part on how power is distributed and organised within communities and on how it is used to promote health and for whom.

MODULE 3

Understanding health

AIM: This module aims to develop an understanding of health and the systems that promote and protect health. It explains how health is not the same as disease and health systems are not the same as medical care services. We describe how to understand and present health needs and what causes good health or disease.



MODULE 3

Understanding health

Section 3.1 What do we mean by health?

People often think the term 'health' relates to diseases like tuberculosis and malaria but while diseases are a health issue, health is about much more. Health is about the absence of illness and disease. It is about whether people are stressed or mentally disturbed in ways that harm their lives. It includes whether individuals have physical disabilities or whether their social relations, spiritual lives and conditions support their lives. The World Health Organisation (WHO) states in its constitution that being healthy is not merely the absence of disease but a complete state of physical, mental and social well-being. You may add your own understanding of what it means to be healthy through the activity below.

What is your understanding of health?

Activity II:

To UNDERSTAND How HEALTH IS DEFINED ACROSS DIFFERENT SOCIAL GROUPS

METHOD: HEALTH PICTURES

Time: 40 minutes

Materials: four pictures as shown on pages 32 and 33 – if possible, enlarge these pictures on a photocopier; flipchart paper and pens

Procedure:

- 1 Stick the four pictures up on the wall, far apart so that participants can easily move around looking at the pictures without being crowded in. Under each picture put up a sign which reads '**Do you think this person is healthy? Why? or Why not?**'
- 2 Let participants move around the room, looking at the pictures and discussing what they see.
- 3 After about 10 minutes (or when you can see they have finished), bring everyone together to discuss the following questions:
 - When looking at these four pictures, who do you think is the healthiest? Who is the least healthy? Why?
 - What characteristics make for a 'healthy' person? Based on these characteristics can you now put together a definition of what it means to be healthy?
- 4 Note this discussion on a flipchart. After participants have given their definitions, read out the WHO definition of health and ask for comments. Compare the WHO definition with the groups' ideas – what is different and why?

'Health is thus not merely the absence of disease but a complete state of physical, mental and social well-being' (WHO Constitution, 1948).

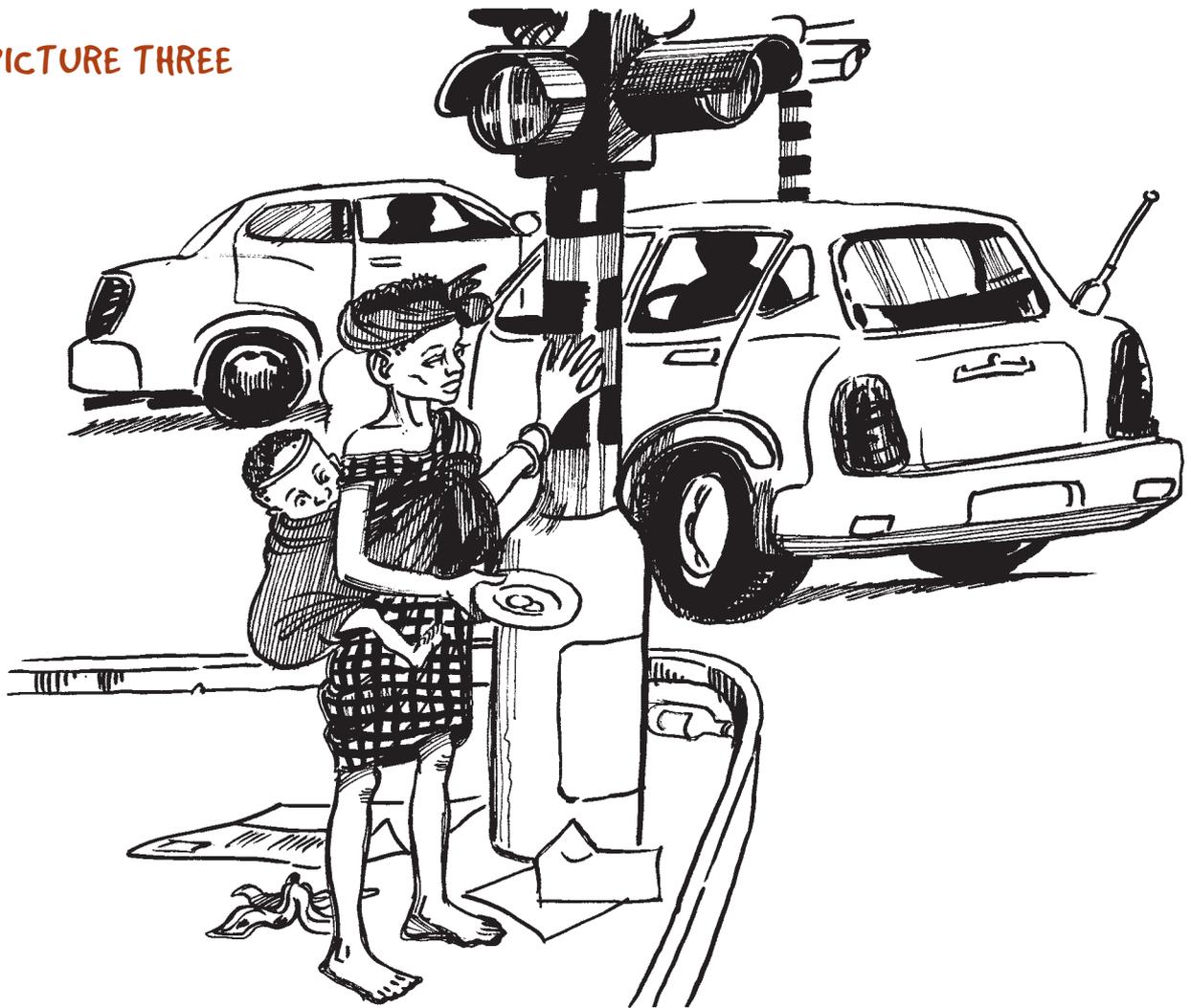
PICTURE ONE



PICTURE TWO



PICTURE THREE



PICTURE FOUR



Section 3.2: Understanding health problems and needs in our community

How do we assess our health problems?

Health problems and needs vary in communities and among individuals. Communities experience a range of health-related problems. For example, people may lack access to safe water, good sanitation and food. These living and working conditions could result in health problems, such as diarrhoea and parasitical infestations. Communities need the health services to understand the challenges they face through problems like poor nutrition, malaria or measles. These services would then be aware that the community could achieve positive gains in health through social support, employment and good living conditions.

Communities can gather information about their health-related problems in a range of ways:

- Through informal discussions among community members;
- From formal gatherings at places like churches, schools, clubs and so on;
- By mothers or other people visiting health centres to get information from health reports;
- Through community-based health workers – traditional healers, village health workers and traditional birth attendants are pivotal in gathering and disseminating health information;
- Through print and other media.

They can also make their needs known in a number of ways, including:

- Through local meetings organised by influential people like chiefs, church leaders or politicians;
- By talking to community-based health workers – traditional healers, village health workers and traditional birth attendants;
- Through reports to health centres or police, depending on the issues;
- By visiting and talking to community groups and meetings, including those of community-based organisations.



What do we mean by health needs?

Health needs in communities are not simply a list of common diseases. Health needs include the inputs to health, like water, food and shelter. They include health care and other services that improve health. They may include political and social issues, like participating in planning and monitoring health activities and in implementing health actions. We need to understand how communities see their needs and report on these needs to services and authorities.

How can communities organise information on health needs?

Activity 12:

To IDENTIFY HEALTH NEEDS IN COMMUNITIES

METHOD: RANKING AND SCORING /MULTI DOT SYSTEM

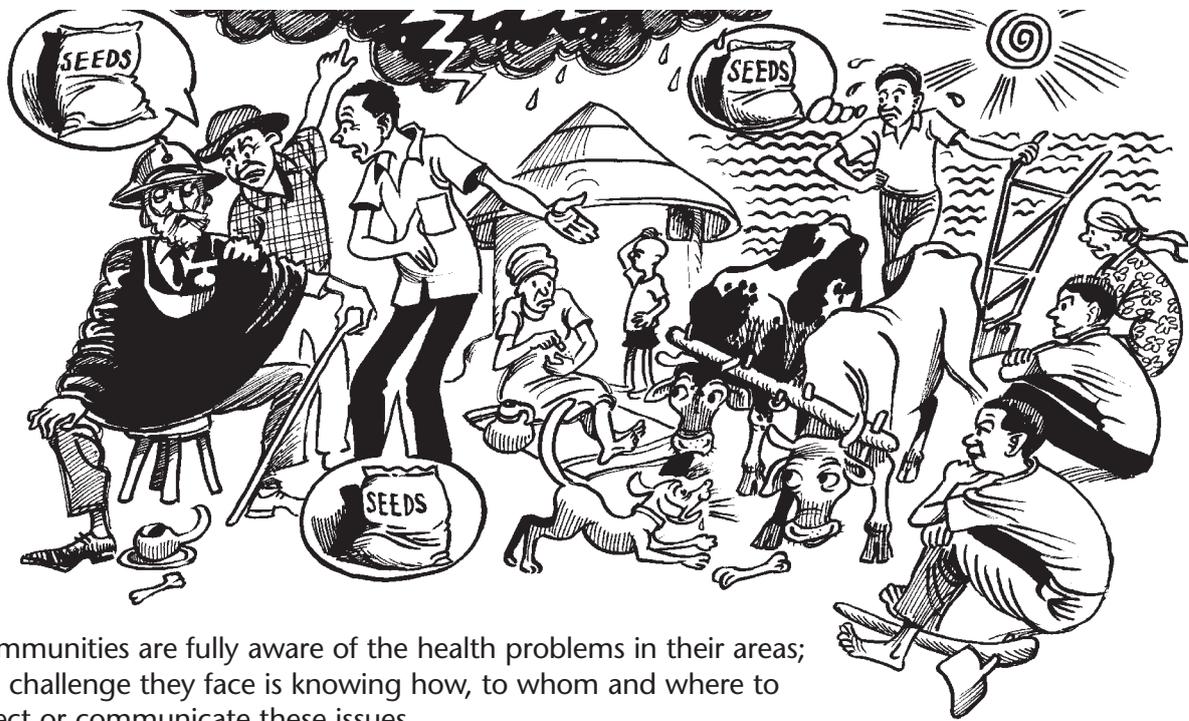
Time: 40 minutes

Material: pen and paper, counters (stones or seeds)

Procedure:

- 1 Divide participants by gender and age. This division is important since some health needs are gender or age specific, for example, women may want easier access to clean water or young people may want a soccer field, and so on. It is important to identify these different priorities for wider discussion later on.
- 2 In these groups, ask participants to list the health needs in their community. They can do this on a chart or on the ground.
- 3 When the lists have been developed, give each participant three stones, beans or any other counter available. Ask them to distribute or place their counters against the three health needs they think are the most important and need the greatest attention.

Count the total counters for each item listed and write the totals. Each group now has a list of three top priority health concerns.
- 4 Bring the four groups back together to share their findings. During report back, ask each group to justify why they thought these three health needs deserve most attention.
- 5 Then discuss the following:
 - What were the differences between the four groups' health priorities? How can you explain these differences? What do they tell us about the different needs of men and women, youth and adults? And how does this impact on health programming?
 - Do these findings reflect the views of everyone in the community? If not, how can you ensure that other community members' views are taken into account?
 - How can we make sure these needs are met? Who should hear about these findings?



Communities are fully aware of the health problems in their areas; the challenge they face is knowing how, to whom and where to direct or communicate these issues.

For community voice these needs must be brought in through bottom-up approaches in which authorities use scientific and technical information together with indigenous and community knowledge and views. When communities identify their health needs and set priorities, they share their insights into how these problems can be tackled. The experience, information and views from communities combined with that from technical people can be used at all levels of health responses, from village, ward, division, district, national and regional up to international levels.

Activity 13:

IDENTIFYING HOW AND WHERE INFORMATION ON COMMUNITY NEEDS AND PRIORITIES IN HEALTH SHOULD BE USED

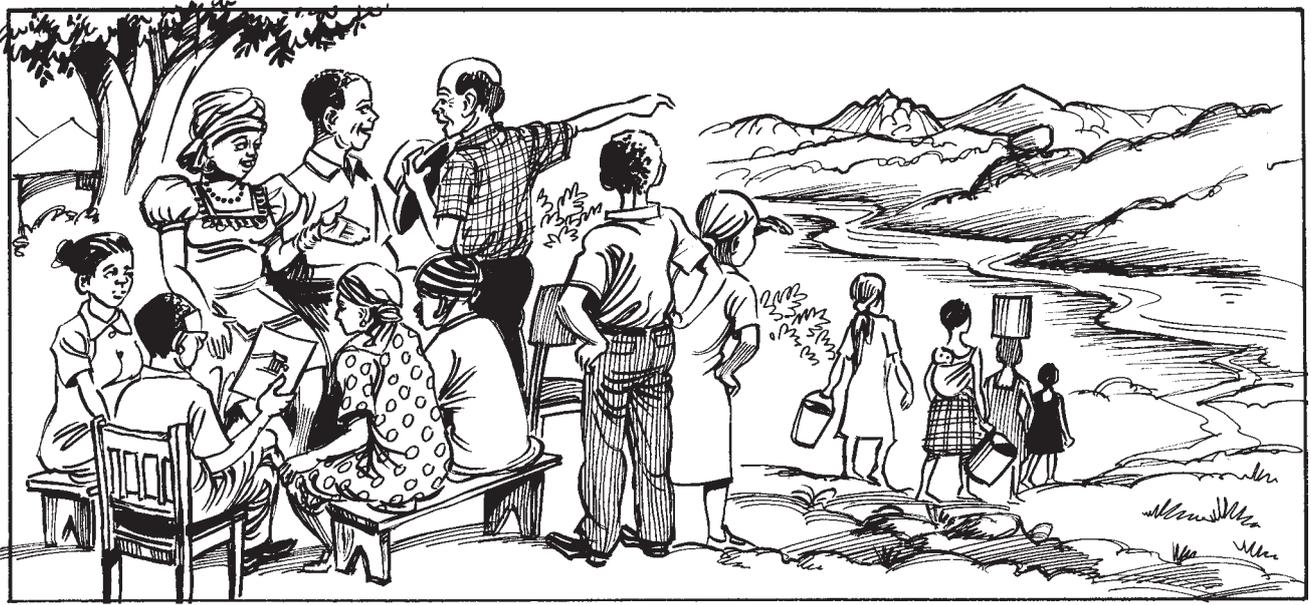
METHODS: PICTORIAL CASE STUDY AND BRAINSTORMING

Time: 40 minutes

Materials: three pictures in the case study

Procedure:

- 1 Distribute a series of pictures showing the following story to participants
 - People in a community meeting ask their MP to help solve their water problem;
 - Technicians construct a water well close to a burial area;
 - People bypass the water well and continue to fetch water from the river far from the village. The MP and technicians are puzzled, and don't understand why the women are not using the newly built water well.
- 2 Let the participants brainstorm and discuss:
 - What happened in this story? Why?
 - What could have prevented or alleviated the situation?
 - Have you had similar experiences?
 - How can communities ensure that their information is taken into account?



Section 3.3: What causes health problems and what can we do about it?

There are many causes of health problems. Some we can act on but others are beyond the control of individuals, communities or families.

At the most basic level health problems are caused by changes in our bodies (ageing, wasting of muscles, tooth decay, infections, depression) that make us unhealthy. We may be differently affected by these changes depending on whether we are old or young, male or female, well or poorly nourished. These are individual factors that lead to ill health.

However, underlying these individual factors are social and environmental causes. These may relate to the immediate conditions in which we live, work and socialise.

These environmental factors may include, for example, poor housing, unsafe or inadequate water, high food prices, overcrowding, lack of schooling or the poor status of women.

There are reasons for these more immediate environmental issues that cause health problems. These are the structural causes of ill health. They relate to the following:



Can you think of health problems caused by these environmental factors?

- *How the wealth in a society is distributed and what incomes and assets people have.* People living in small rural centres, for example, may have limited opportunities for formal employment compared to those in large urban areas. When women have no legal rights to land they can be left in a difficult situation when their partners die.
- *Social and cultural factors* that influence whether people can access wealth, affect how they treat each other and determine whether they have access to health services. Some religious teachings, for example, forbid their members from having blood transfusions or being immunised. In some communities, social practices ensure that orphans and vulnerable groups are looked after and are given food.
- *How the laws provide for rights to health*, for example miners are required by law to have regular medical examinations to ensure they are protected from dust-related diseases caused by the work they do.
- *How the policies of a country direct public sector resources to address health problems, such as through state health services.* For example, charging user fees for health in many countries in southern Africa has been a barrier to poor people accessing the health services they need, while making tuberculosis treatment free has encouraged people to seek and complete the treatment.

Can you think of how health problems are caused by these structural factors in your community?

These structural causes arise because of deeper factors, for example, from political beliefs and practices and the values defining what rights individuals and communities can claim or expect from society. Also how the society's resources are used to address community needs. Political systems based on equity and solidarity are more likely to collect and use taxes to look after ill people than those that prioritise individual liberties over social welfare. These values are defined nationally but increasingly global values are having a strong effect on national systems.

In Zambia the government supported communities to construct 'waiting mothers shelters' as a way of encouraging women to have assisted deliveries at health facilities and to reduce maternal mortality. Traditional beliefs and values dictate that aunts or grandmothers accompany a pregnant woman and play an active role at the delivery. The shelters provided for in national policy had to accommodate these traditional assistants, especially for young women.

In many countries in southern Africa user fees for health services were increased as part of their economic structural adjustment programmes. National policies had stressed the values of equity and access but user fees were brought in on the advice of finance institutions like the World Bank to promote efficiency and cost recovery. When poor people began to drop out of services some national governments revised these policies to protect their original core values of equity and access.

Activity 14:

WHAT DO COMMUNITIES THINK ARE THE MAJOR CAUSES OF THEIR HEALTH PROBLEMS?

METHOD : PROBLEM TREE

Time: 30 minutes

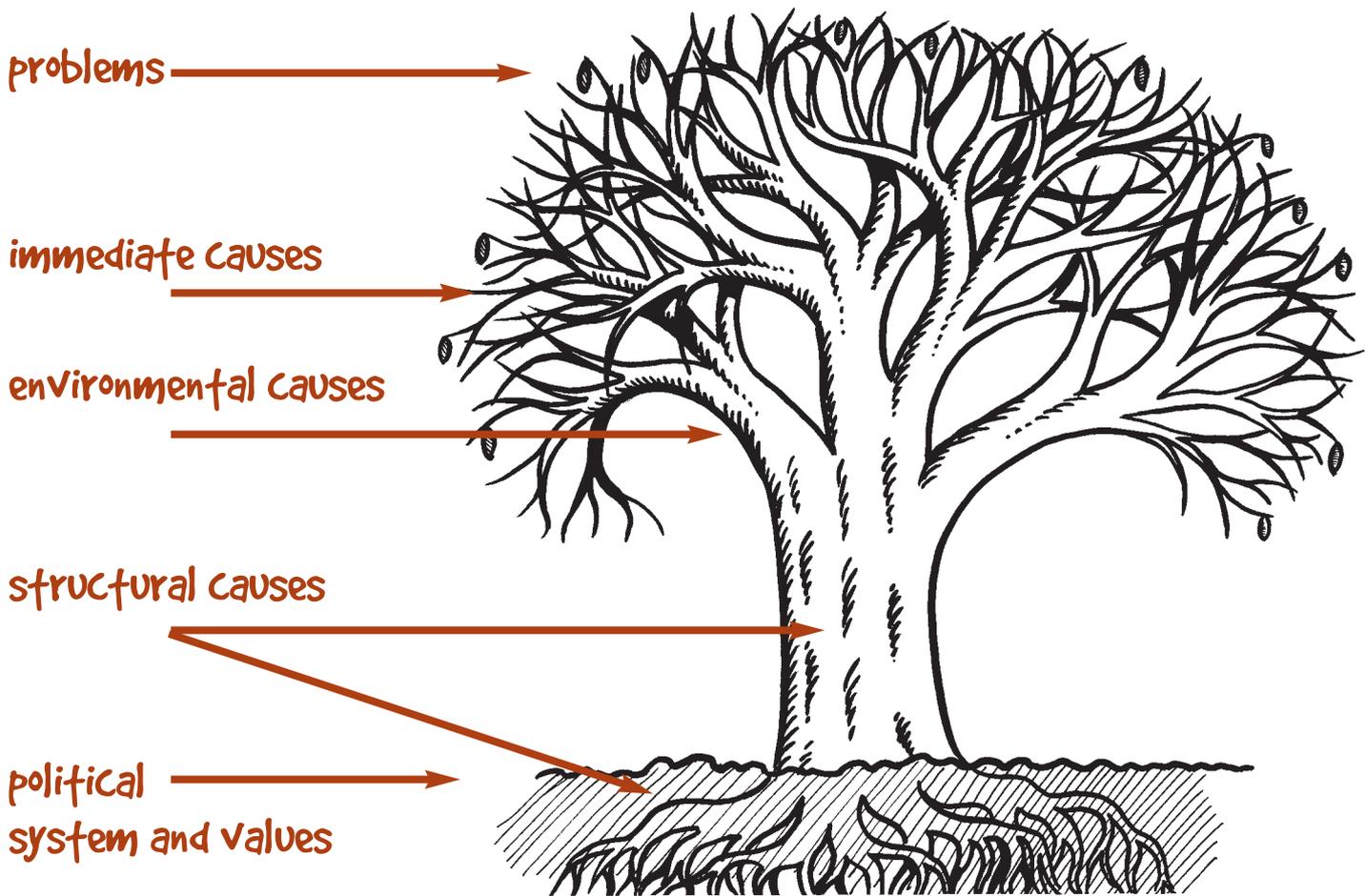
Materials: a copy of the 'problem tree' (see page 42) or ask participants to draw their own

Procedure:

This activity helps participants explore the root causes of an identified health problem. The problem tree offers a structured way of getting at the various levels of a problem. The 'but why?' method that follows in activity 15 is more fluid. Choose the activity most appropriate to your group's needs.

The problem tree

- 1 Participants choose two priority health problems. They then break into two groups with each group focusing on one of the health problems selected.
- 2 Using a picture of an ideal tree, participants analyse the causes of the identified problem.
 - The pods are the problems;
 - The branches that hold them are the immediate individual or biological causes;
 - The large branches are the environmental causes;
 - The trunks or roots are the underlying structural causes;
 - The ground is the political systems and values that are the context for the structural causes.
- 3 Look at the causes identified and discuss the following:
 - Which causes can communities act on with the resources they have? How?
 - Which ones need to be acted on by others within their own district or area? Who do communities need to influence to make these actions happen?
 - Which ones need to be acted on by governments or other national institutions? Who do communities need to influence for these actions?



When looking for causes we can explore different levels of causes. Aim to go beyond the immediate causes and find the 'causes of the causes'. When addressing these we can solve problems for a wider number of people.

Look at this example of Mr Khumalo who has tuberculosis:

Mr Khumalo has tuberculosis because he was infected by someone in his family.
(This is an immediate cause.)

He was infected because he lives in a single room with five other people and it is easy to contract an airborne disease in an overcrowded environment.
(This is an environmental cause.)

He lives in a one room lodging because although he has had his name on a waiting list with the council for housing for over ten years, he has not yet been given a stand.
(This is a structural cause.)

He has not yet been given a stand because.....

And so on.

Each cause has a different level of solution, all relevant for Mr Khumalo's tuberculosis.

Activity 15:

EXPLORING THE CAUSES OF HEALTH PROBLEMS

METHOD: THE 'BUT WHY METHOD'

Time: 5–20 minutes, depending on how much discussion you want it to generate

Materials: flipchart paper and pens; or sticks to draw in the sand

Procedure:

The 'but why?' method can be used at any time during the community research process to help participants deepen their understanding of an issue. It is especially useful when participants are not making progress in analysing a problem and need a quick exercise to help them see things differently.

- 1 Either in pairs, small groups or as one large group, one participant asks a question or makes a statement related to a specific problem arising in their community.
For example, 'Why are so many people getting malaria in our community?' or 'People don't go to the clinic any more when they are sick.'
The others ask 'but why?' and the person answers.

Keep going, asking 'why?' and letting that person answer, until you think it's gone far enough.
- 2 Follow up with a discussion on what new insights arose out of doing this activity and whether it identified any potential solutions

Here is an example of how the 'But why?' method can be used to get to the root causes of a problem:

'The child has a septic foot.'
'But why?'
'Because she stepped on a thorn.'
'But why?'
'Because she has no shoes.'
'But why has she got no shoes?'
'Because her parents can't afford to buy her any.'
'But why can't they afford to buy her shoes?'
'Because they are paid very little as farm labourers.'
'Buy why are they paid so little?'
... And so on

Source: Hope and Timmel (1984)

You can see from this example how causes move from the immediate to structural and, as we dig deeper, to the underlying political systems and values of our societies.



What can communities do about these causes?

Communities play a pivotal role in addressing their health problems at each level but they need partnerships with those who have the power to act at different levels.

To start with, the problems need to be recognised and made visible. The work discussed earlier of organising information on community health needs is part of this. By using participatory tools for research we not only make these problems visible to experts but communities can also gather evidence of how health problems affect them. By repeating investigations at intervals we can monitor how the situation changes over time. Interviewing elders in the community (using *oral history*) helps to see the different health problems that have arisen at different times in history so we can discuss and try to understand what may have caused current problems.

We have other ways of making health needs visible:

- National health information systems gather information on health needs. Regular reporting on what these systems are collecting is important;
- Disease surveillance systems that monitor particular conditions at clinic or community level can report on health issues. These systems use sentinel sites that are selected or sampled or community monitors which regularly provide information;
- Surveys such as nutrition surveys or surveys of vulnerable groups can report on particular health problems.

Communities themselves need to know about and act on the problems that exist, and to work with other authorities and levels of the health system to address these needs. We discuss some of the options for this later. We also need the national space and authority to respond to community needs at the global level. We explore this further in a later module.

Our health systems are an important entry point for organising these responses to health needs and leveraging action from other sectors. If the health system is organised to raise and respond to the causes of health problems it is a vital starting point for making sure the other key institutions and policies do so as well.

The next module discusses how to improve community involvement and raise community voice in the health system.

In Summary:

Health may be differently defined from different groups' perspectives, for example from the viewpoints of scientists, communities, doctors, pharmacists, ministers and many other different groups of people.

Health is defined by WHO as a state of complete physical, mental and social well-being, not simply the absence of illness and disease.

Health problems arise due to causes at immediate individual, underlying environmental and deeper structural and socio-political levels. Communities can make their health problems, needs and the causes of them more visible. They can act on the causes of health problems and influence action in others, particularly within their health systems.

We hope that at the end of this session you are better informed about how to work with communities to identify their health issues and needs and the causes of the health problems they are experiencing.

MODULE 4

People-centred health systems

AIM: This module describes how health systems are organised and the different features of people-centred health systems. It discusses how health systems can draw in meaningful community voice and participation. It also explores what a people-oriented health system means for the way health workers and communities interact, and for the way resources are mobilised and used. These examples are chosen to highlight the way PRA tools can be used to explore and strengthen people-centred health systems.

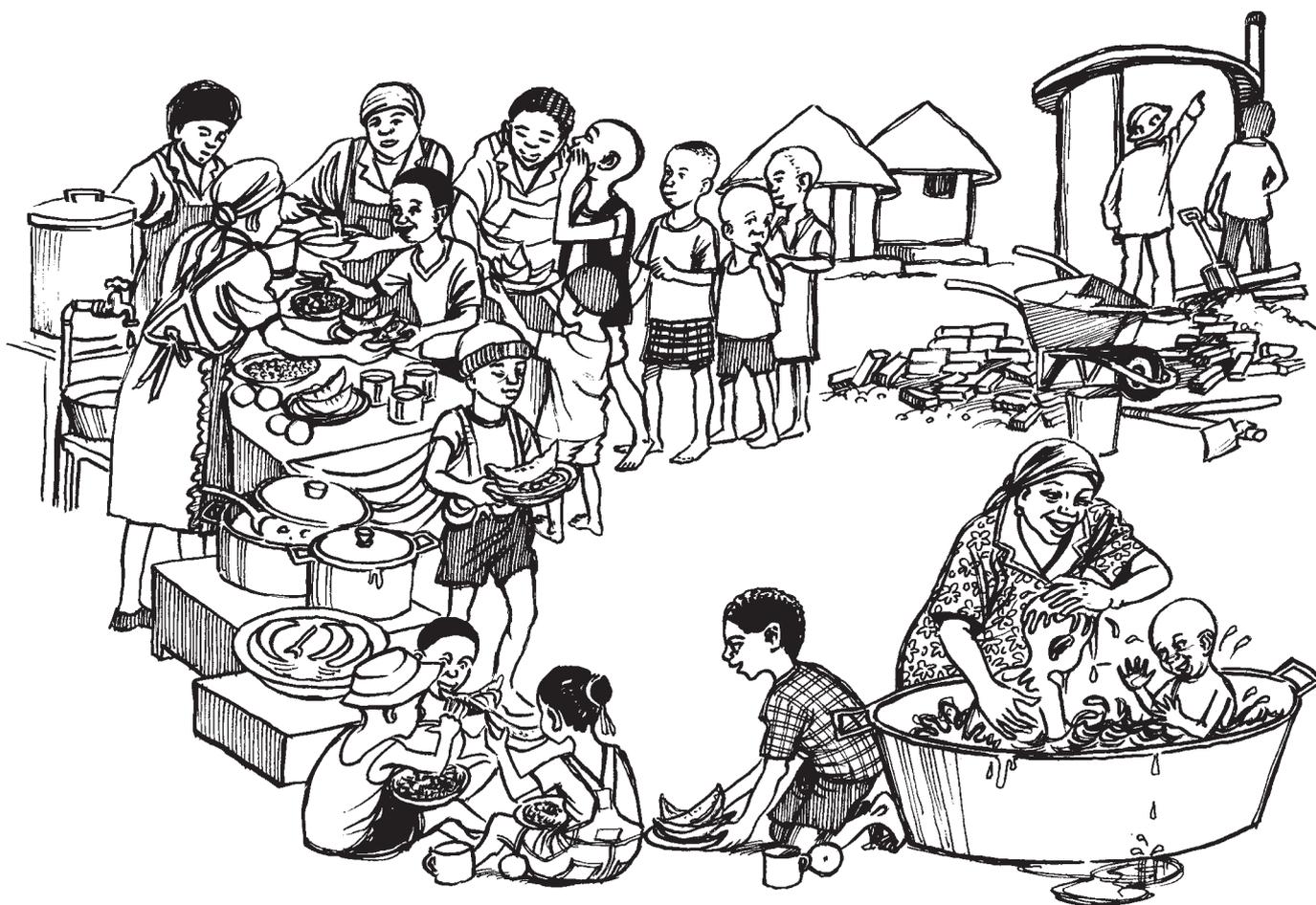


MODULE 4

People-centred health systems

Section 4.1: What is a health system?

A health system includes all the people, institutions and resources that take health actions. Health actions are actions whose main aim is to improve health. Hence a health action includes, for example, a mother giving her child oral rehydration solution. A community health worker helping a young girl answer a question about her health is also a health action. A man visiting a health service to treat a fever and a person giving home-based care to someone with a terminal illness are both health actions. Actions taken by other sectors also improve health. Hence when schools teach youth life skills, when farmers are encouraged to grow food crops or when businesses provide safe work or secure employment they are also taking actions on the social conditions that improve health. The goal of a health system is to improve people's health but health systems have other goals. They aim to respond to the needs of the people they serve and to ensure that people do not pay unfair costs for their health services.



Health systems do this through a range of actions:

- Public health actions protect and promote a population's health and prevent disease. For example, putting taps into people's homes makes it easy to access clean water for washing and cooking which are necessary for health.

- Relevant, quality health services care for people according to their needs. For example, making sure that clinics have adequate drugs to treat common diseases and that services are nearby and do not cost more than people can pay means that people will recover from illnesses more quickly and don't have far to travel for treatment.
- Health workers are trained and so have the knowledge and skills to deliver health services. Traditional healers have different skills and use a different body of knowledge from western medicine but they also play a significant role in health systems.
- Health systems collect, analyse, communicate and use information of different types to plan, deliver and monitor health and health care.
- The way the health system is organised reflects the measures that a society is taking to protect and ensure its social values, ethics and rights, including the rights to participation and involvement. Hence, for example, a health system that redistributes funds from richer groups to support the health needs of poorer groups reflects the values of solidarity and equity.

What are the different levels of the health system?

These actions and resources, and the values they reflect, are organised at all levels – from primary (community and clinic level) to secondary (district level), tertiary (provincial hospital level) and finally quaternary (central or referral hospital level). For communities, the entry point is at primary health care level. The efficiency of services at this level depends on the relationship between the communities and the health services.

Primary health care supports communities through the following approaches:

- Collaborating across sectors to address community health needs;
- Ensuring communities participate and are involved in planning and implementing health interventions;
- Using appropriate technology and local materials;
- Promoting health and preventing ill health;
- Allocating resources for health in accordance with community needs.



Source: TARSC Zimbabwe: Child health session in rural Zimbabwe

Primary health care empowers communities because it supports the actions that communities take to improve their own health and does not mystify health.

Health services are organised to support this community-level, primary health care system. The rural health centre is the focal point at community level while the district hospital coordinates health services at district level. At higher levels, provincial hospitals provide care to clients referred from district hospitals while central hospitals, special referral hospitals and the Ministry of Health head office provide a range of specialised services, including professional staff training.

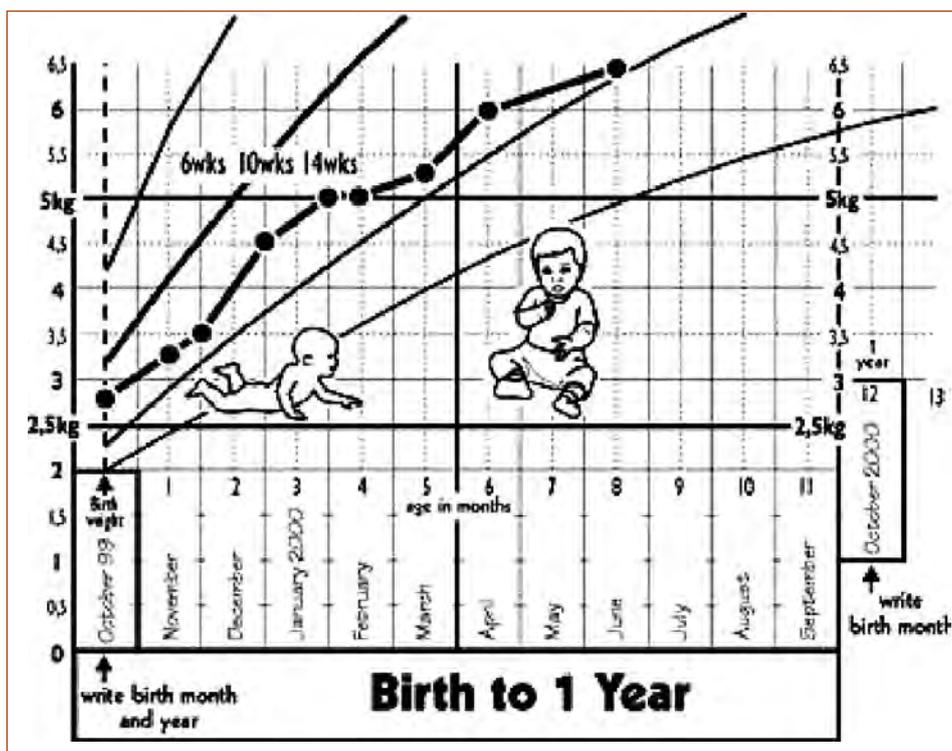
These different services are provided by a variety of providers, including:

- Government – primarily the Ministry of Health;
- Local government health services – district, rural, urban and town clinics;
- Army medical services;
- Health services provided by missions and faith-based organisations;
- Industrial medical services;
- Private medical sector.

Health services are not the only contributors to health. Farming activities can affect nutrition, the housing sector can reduce airborne disease by overcoming overcrowding and schools can improve education and literacy and promote social action for health. Many sectors play a role in health and need to be brought in to work with the health system.

Let's explore, as an example, how the primary health care system supports child nutrition. At the 'under 5 clinic' services, children are weighed regularly and their progress is recorded on a chart. This graph, also referred to as the 'road to health' chart, is a tool that parents and health workers can use to check that children are adequately nourished for their age. A drop in a child's line is an alert that the child may be ill and need treatment, may be dehydrated and need sugar and salt solution or may need high energy foods to catch up on growth and avoid malnutrition.

The primary health care system empowers communities to assess their health in many ways. For example, also on nutrition, a simple strip to measure mid-upper arm circumference can be used to determine whether children are malnourished. These simple tools allow communities to carry out their own assessments of health with local health workers.



A road to health chart

Activity 16:

IDENTIFYING ORGANISATIONS THAT SUPPORT HEALTH AT COMMUNITY LEVEL

METHOD: SPIDER DIAGRAM

Time: 45 minutes

Materials: flipchart paper, counters (coloured pens or paper), different types of seeds or leaves

Procedure:

- 1 Divide participants into groups of six to eight people. Each group is going to draw a spider diagram to identify the main health-related organisations in their community.
- 2 Groups start by drawing a circle in the middle of a piece of flipchart paper (the body of the spider) and labelling it 'Health services'. Using the same method outlined in Activity 8, ask participants to draw the spider legs, with each leg representing an organisation in their community involved in health, for example, clinic, youth friendly corner, traditional healer, school guidance and counselling, pre-school, and so on.
- 3 Broadly divide the community into five major groups such as by age or by income, and use different coloured pens to represent each group.

For example, by age it would be:

Children	– BLUE	Middle-aged adults	– GREEN
Youth	– RED	Elderly	– BROWN
Young adults	– YELLOW		

- 4 Next, go back to the spider diagram and for each 'leg' of the spider, add counters to show which groups are using each health service.
- 5 When they've completed this exercise, ask the following questions:
 - Which services support all social groups? Why?
 - Which social groups are left out of many services? Why?
 - How could this be changed to improve health?

How is your health system organised in your community?

Who are the actors and services in the health system and how do communities relate to them?

Communities can share their understanding of what a health system should be like and compare this with how it is. Then they can identify the improvements they would seek to make to bridge the gap and work out where they can be more involved in implementing these improvements.

Activity 17:

UNDERSTANDING THE HEALTH SYSTEM FROM THE COMMUNITY

PERSPECTIVE

METHOD: HUMAN SCULPTURE

Time: 90 minutes

Materials: a large space, pen, small pieces of paper to use as labels, sticky stuff or pins, a camera if possible

Procedure:

You need at least 15 people for this activity. Participants will position themselves in ways expressing power relations among major actors – in this case, the major actors in the health system. The result is a human sculpture that represents the group's understanding and knowledge of what is going on in their health system.

- 1 To start with, the facilitator sets the scene or asks one of the participants to describe a common situation at a clinic, noting the person and the problem they come with.
For example, a 16-year old girl in her third trimester of pregnancy comes to the clinic in a poor rural area. She arrives on a day when the clinic is busy with its usual line of patients waiting for treatment.
- 2 Before beginning the human sculpture, participants name the major actors that would be found in this situation. One facilitator writes the names of the actors on the flipchart; another facilitator writes the names on small slips of paper.
- 3 The facilitator asks participants to place the actors as they are named. Start with the person who comes to the clinic and whoever comes with her or him. Then add the clinic personnel and others named (family members, people in the community and in the health services, the state and international players, and so on).
- 4 If you use the pregnant teenager, for example, ask one of the participants to take her role and stick a label on her shirt. The group discusses how the teenager should be positioned in the middle of the room. Then invite the rest of her family to come forward and, again, the group decides how they should be positioned in relation to the girl, keeping in mind that we are sculpting the power relations between each actor (participants show the different power relations by placing people at different heights or distances from each other, using gestures, body movements, and so on).
- 5 The group continues to identify and place the other actors, leaving the national and international actors until last. Keep asking whether everyone agrees that the way people are placed reflects their status and links. This will ensure that the sculpture is an agreed outcome of the group.
- 6 When all the actors are in place, discuss what this sculpture says about power relations:
 - Are the teenage girl's needs being met? Why or why not?
 - What role is each 'level' of the health system playing ?
 - Who has power? Who does not?
 - Who is connected? Who is not?
 - Is this how things are in your health systems generally?
 - Is this how you think things *should be*?

- 7 If you have a camera, take a photograph of the sculpture.
- 8 Now ask the participants to move the actors to position them to solve some of the problems they raised or to show things they want to change to make the system more people-oriented.
- 9 Discuss the difference between this sculpture and the one before:
 - What has changed about the power?
 - What has changed about the relations between the people and the health workers?
 - What has changed within the community? And within the health services?
 - What is different about the local–national–international relations?
 - What do you think the characteristics are of a people-centred health system?
- 10 Give cards to people to write down the features they see or hear as the discussion is taking place on how the sculpture looks now and the features of a people-centred health system (for example, supporting the patient, better links between local and national health authorities, and so on).
- 11 Take a photo of this sculpture for comparison and then tell everyone to sit down. Ask the actors to join the others in a circle.
- 12 Lay the cards down on the floor in the middle of the circle and group them. What are the common features that people have identified of a people-centred health system? Write these as a summary on a flipchart. Does everyone agree with this?
- 13 Discuss in plenary how we would need to move from the current to the desired situation. Note the changes suggested and that this is a process of transformation.

Source: Arnold et al. (1991)

Look at the human sculpture made at an EQUINET meeting shown below:



Source: EQUINET from Tanzania workshop 2006

Training tip!

After the discussion on the changes needed to transform our current systems into more people-centred health systems, draw the link between the changes and outcomes we seek to achieve and the need to use participatory methodologies to achieve them. This is why there is such a close link between participatory approaches and people-centred health systems. Participatory approaches seek to empower people and our aim is to build health systems that make people and local health workers more powerful actors for health.



A health system covers the activities that promote health from the community level to the level of central referral hospitals. It has many actors, not all of whom are health workers. Communities relate differently to these actors and services. Our aim is to build a health system that puts people at the centre and makes sure that the services reach and provide support for health to all, and promote health action from all.

Section 4.2: Do health systems give meaningful roles to communities?

Communities are important in many aspects of health systems.

- People stay healthy by their understanding and awareness of health – parents are responsible for the health of their children, partners for each other's health, and communities should care for the elderly and poor in their communities.
- People share information with health services on the conditions in their community and on preventing and treating disease.
- People have local health knowledge to contribute to their health systems, including information on healthy foods and local health risks.
- People play a role in implementing health actions, including outreach of health programmes, caring for ill people and supporting health services.
- People contribute resources to the health system, including their time and labour, for example, even building clinics, waiting mother shelters and other services.
- People set priorities and make decisions on how health problems should be addressed and how resources should be allocated.
- Communities also monitor and make sure that their services are functioning in the way they expect. They give feedback to health authorities and discuss issues with health workers

Community participation can be seen as a process of empowering the community through promoting people's ability to improve and control their health. This means that people can take informed decisions and act on their priorities and needs. Community participation does not mean that people 'do it alone' but that they have effective partnership with authorities that influence health.

Exploring the various aspects of what a health system does will identify more clearly the different ways in which communities participate and have voice.

Activity 18:

To EXPLORE HOW COMMUNITY GROUPS AND HEALTH WORKERS WORK TOGETHER TO MEET COMMUNITY HEALTH NEEDS

METHOD: STEPPING STONES

Time: 30 minutes

Materials: large space on the floor, string or chalk, round pieces of paper

Procedure:

This exercise can be done as individuals or in groups. If you do it as an individual activity on paper, follow the same steps a group would take.

- 1 Identify a priority health problem, such as sexually transmitted diseases in women or tuberculosis
- 2 Imagine that you are on one side of a river. Where you are, the people have the public health problem you identified. On the other side of the river the problem has been eliminated or controlled. Mark a line on the floor (or on paper if you are doing it individually) for each side of the river, with some distance between.

3 What do you need to do to get across the river?

The measures you need to put in place are the stepping stones you use to cross the river. If you are working on the floor, use circles of white card to write the measures on. For example, using the health problem of sexually transmitted infections (STIs), you need STI drugs at the health centre; staff trained in syndromic management; people telling their partners about their STIs; people knowing the symptoms of STIs, and so on.

Put them in the order they need to happen for the management of the problem to work. Make sure you are happy that you can cross to control of the problem with the measures that you have. Note that you cannot get across unless you step on all the stones you have put down as essential.

4 Now use a red marker to mark those cards that depend on the health sector to carry them out and use a green marker to mark those that depend on the community.

5 Divide the group into two: health workers and community representatives. The health workers can only go onto cards with a green mark with someone from civil society. The community group can only go on circles with red marks if they go with a health worker. Try with the health workers alone – can they cross the river? Try with the community alone. Can they cross?

Can health workers and the community cross together?

6 What does this tell you?

- Can the health sector or community address major health problems without each other?
- If they need each other to succeed, how can the links be strengthened?
- What community organisations exist that can work with the health sector on the major public health problem you have chosen?



For more information on the stepping stones methods see <http://www.steppingstonesfeedback.org/>

Community participation in health systems is the involvement of the community in all health processes, like planning, allocating resources, delivering services, promoting health, monitoring and evaluating health systems.

How strong is community participation in health systems?



The level of participation varies depending on the issue or area. In some instances, communities provide information which might be used by other decision makers in coming up with programmes or interventions.

For example communities provide information on the needs in their community but may not make decisions in budget planning. Communities may be **consulted** on programmes designed by health providers. This is a higher level of participation than information sharing but still does not give communities authority. Communities might also act as **decision makers** and may take health actions directly. For example, in malaria control, communities may use traditional mosquito repellents to protect themselves from mosquito bites. They may organise the local materials to build their own waiting mother shelters at the clinics. These different levels of participation range from more passive approaches (such as through information sharing) to more active approaches, such as making decisions on health workers or new investments in health.

Let's see the level of community participation in our area

Activity 19:

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

METHOD: WHEEL CHART

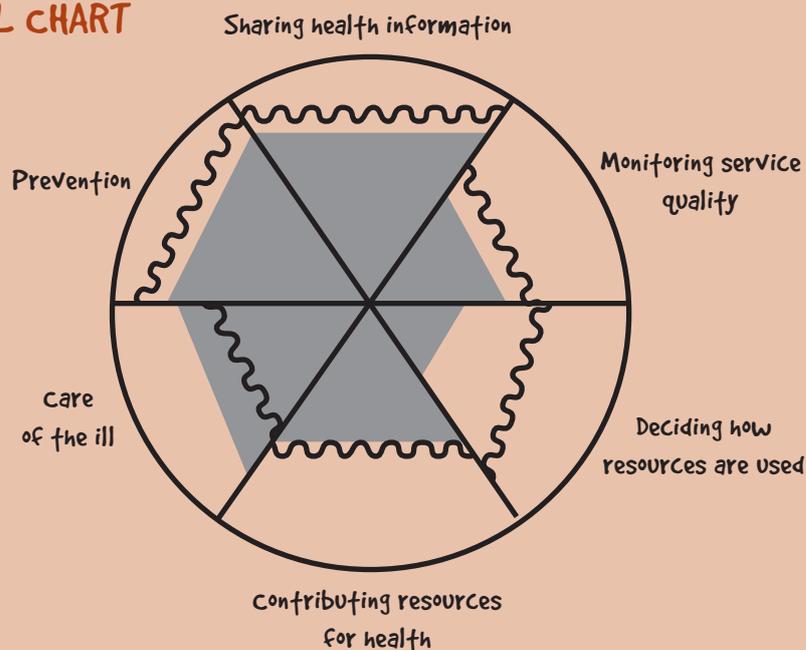
Time: 30 minutes

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

Procedure:

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

WHEEL CHART



KEY:  = level it should be

 = level it is now

Source: R. Loewenson (2001)



How do communities and health services interact in the health system?

The roles of communities and health services in health systems should complement each other. Health services that provide the sort of care that communities need and that reach out to communities support community action in health. For example, health services that provide antenatal

care for all women without cost barriers, use these services to refer women for treatment of illnesses, provide information on family health and advise on pregnancy and child care, give women the resources and information they need to take more control over their own health. There may still be additional challenges in this. Services that work well for older women may not work for adolescents who are pregnant, for example. If services only reach out to women when they are pregnant they miss all the needs women have before they become pregnant.

Social factors, such as how people understand disease, influence people's health-seeking behaviour and patterns of health care use. Services that reflect people's culture and use local materials may have greater acceptability than those that do not.



Source: Ifakara Tanzania Community members building a local waiting mother shelter

Even where health infrastructures are available, providing information in people's own language, ensuring culturally appropriate care or supporting community networks for prevention and follow-up of illness are all important factors in access to care.

It would be useful to see how public health interventions provide for both health service and community roles, and ensure that the technical, resource and social inputs are available to fulfil those roles. If the discussion of mutual roles were extended to prevention, there may be stronger motivation for collective action over healthy environments and practices. This would be much better than the practice whereby people wait until they fall ill before making any demands on the health services.

Communities and health services thus need to harmonise their ideas of what is expected of each to solve major health problems. Community health workers elected by communities provide one mechanism for doing this. Another way of doing this is through joint structures such as health centre committees. These committees involve both community and health service representatives.



Activity 20:

UNDERSTANDING AND STRENGTHENING COMMUNITY INTERACTIONS WITH HEALTH SERVICES

METHOD: ROLEPLAY AND DISCUSSION

Time: 15 minutes for the roleplay, 20 minutes for discussion

Procedure:

- 1 Ask some participants to volunteer to play the roles of the village chief, members of a village health committee (about four), the person in charge of the village health facility and a district health officer.
- 2 The health committee members convene a meeting. Their instructions are as follows (write these instructions on small pieces of paper for the committee members):
'There have been a few suspected cases of cholera in your community. Discuss the cases that have been reported, the possible causes for the outbreak and the measures to be taken.
'Of the measures, show what you can do on your own (for example, educating and sensitising the community on hygiene issues, encouraging households to build and use latrines, and so on).
'Arrive at a point where you recognise that you need assistance from the person in charge of your health facility (drugs, information on the disease, for example). At this stage, take the issue to a meeting of the health centre committee and invite the nurse in charge to come on stage.'
- 3 The nurse in-charge attends the meeting and responds to some questions from the committee members and together they plan what to do. The nurse in charge's instructions are:
'You've been invited to attend a health committee meeting. The members of this committee lead the discussion about what they want from you. Respond as best you can. Eventually, admit you can't tackle some of the issues without the help of the district officials. Go and report this to the district health officer and invite him or her to the village.'
- 4 The district health officer comes to the village and commits the district office to actions they are going to take to help the community (for example, provide additional support staff, drugs or transport).
You can use other health issues in the same format.
- 5 Once the play is over, the facilitator should lead a discussion with participants using some of the following questions:
 - What conclusions came out of the role play?
 - Whose concerns were met and whose were not met? Why?
 - What could the health committee members have done to make sure their concerns were met? How could the authorities have responded more effectively?
 - What are your own experiences of relations between communities and health officials in dealing with community health matters? Give a specific example. Who started the dialogue and how did it end? Why?

Section 4.3: Do health systems listen to people's views?

How do communities raise and discuss their issues with health services?

There are various ways in which information on health policies, issues and interventions is communicated between communities and the health systems.

- Health services can gather information on public needs and preferences through: information or opinion surveys; ideas competitions; key informants; the print and electronic media; PRA approaches; and participatory health appraisals.
- Health services can communicate information to the public on health profiles, policies or activities through: white papers, charts and posters in health or public facilities; discussion documents; mass publicity programmes; making official information accessible to citizens; agendas or minutes; public audiences on budget discussions; providing accessible policy or budget summaries to citizen groups; holding meetings, lectures or discussion sessions; joint committees; and through the print or electronic media.
- The public can be encouraged to give feedback to health planners by: advertising proposals with procedures for people to offer suggestions or lodge objections; carrying out public inquiries; holding public hearings; and organising public meetings, lectures and discussion sessions.
- Communities can include their proposals in health planning through committees, hearings, meetings and suggestion boxes.



Source: TARSC Zimbabwe: Community survey on health needs

All of these depend on what the community considers appropriate. What works in one community may not work in another.

One of the most important requirements is a common language between health professionals and communities. PRA approaches make this possible by organising community knowledge systematically. Civil society organisations also help to develop this common language by acting as intermediaries and combining public views with available data and technical information. Health services can organise health information using various forms of mapping and charts. Visual representations of trends and distributions make issues simpler. Medical terms can be simplified so that everyone can understand and take part in discussions. We need to recognise and take active measures to overcome the profound disempowerment communities can feel when trying to join in discussions with medical professionals and bureaucrats.

For many people, participating in formal committees may call for parallel processes to 'prepare for partnerships'. This way, groups have the opportunity to frame their ideas or issues, understand more about health information and specify clear positions and inputs to joint agendas before they meet with their professional counterparts. Likewise, health service providers can make sure they present health information and choices in an accessible form and develop their communication and negotiation skills.



How do communities present their issues to health authorities?

Let's review some examples of how communities can express their needs. We raised some of these in the previous modules. For example, in Activity 12 in module 3 we used a common PRA tool called 'ranking and scoring' where participants listed and then prioritised their health concerns. Many other participatory activities can also be used to highlight community health needs, such as roleplays, chapati diagrams or picture codes. As long as we are clear about the objectives of the activity, there are many ways of getting there.

In the equity gauge programme in Zambia, for example, community committees used drama to raise issues and concerns about how their health system was performing. Communities from different parts of an equity gauge district prepared sketches to illustrate their experiences and perception of service delivery. District health authorities were invited to attend these presentations which took the form of a competition between different areas in the district. The sketches were able to raise any negative experiences of the health system that communities were worried about. At first the director of health angrily rebuked people for the negative portrayal, insisting that it was a misrepresentation. On reflection, however, he accepted the messages conveyed. He promised to improve health workers' interpersonal skills as one way of improving relations in the health system.

It can be difficult for people to raise issues as individuals. Generally, PRA approaches succeed by working through and reinforcing community-level organisations. They strengthen organisations by using a collective approach to inquiry or training, and they work through community organisations to act on issues raised.

What organisations exist at community level to raise and take up community issues?



Communities organise themselves through various networks and associations, and through civil society organisations. These membership-based organisations are rooted in communities. Those that are based on genuine associations of people enable communities to take greater control in and responsibility for their lives, including their health actions.

The type and number of organisations that represent communities on their health issues vary from one country to another. There are community-based organisations, faith-based organisations and private institutions that represent communities on health issues. There are community-based groups that promote home-based care programmes and support people and groups living with AIDS.

If anyone is excluded it may be because they are unaware of the existence of such supportive groups. So we need approaches that make these groups and their purpose visible and known to communities. One of these approaches is called 'stakeholder mapping'.

Through stakeholder mapping participants learn about the institutions and people in their area that affect health issues. They find out about their activities and how they interact with each other. Stakeholder analysis identifies stakeholders to assess their interests, roles and influences on programmes.

This contributes to the design of projects or programmes by developing a logical framework for social group participation and helping to identify appropriate forms of participation. It is best mapped by a direct survey of the areas involved but can also be done through key informants.

There are two kinds of stakeholders:

- **Primary stakeholders** who are directly affected (positively or negatively) by the process or programme;
- **Secondary stakeholders** who are involved in the delivery process.

Hence, for example, in a malaria programme, organisations representing peasant farmers, women’s groups and youth in the villages may be included as primary stakeholders. The relevant non-governmental organisations and local government outreach health services are secondary stakeholders. They organise sprayers and chemicals, and facilitate community discussions on when, where and how the work should be done.



Stakeholder analysis includes all groups with an interest – both winners and losers, if they exist – and those involved or excluded from the decision-making process. In addition to noting who the possible stakeholders are, the analysis seeks to draw out the interests of the different groups at the beginning (and during a programme). It clarifies the social groups covered by those interests, relates these groups to the objectives of the programme and identifies any groups left out or areas of potential conflict of interests between stakeholders.

Such mapping also helps to identify relationships between stakeholders which can be used to strengthen mutual support networks, assess alliances, and enhance delivery mechanisms and the co-ownership of programmes.

Activity 21:

TO ESTABLISH ORGANISATIONS THAT EXIST AT COMMUNITY LEVEL AND WHO THEY INCLUDE

METHOD: INSTITUTIONAL /STAKEHOLDER MAPPING

Time: 40 minutes

Resources: large piece of paper, small (if possible, coloured) pieces of paper, scissors

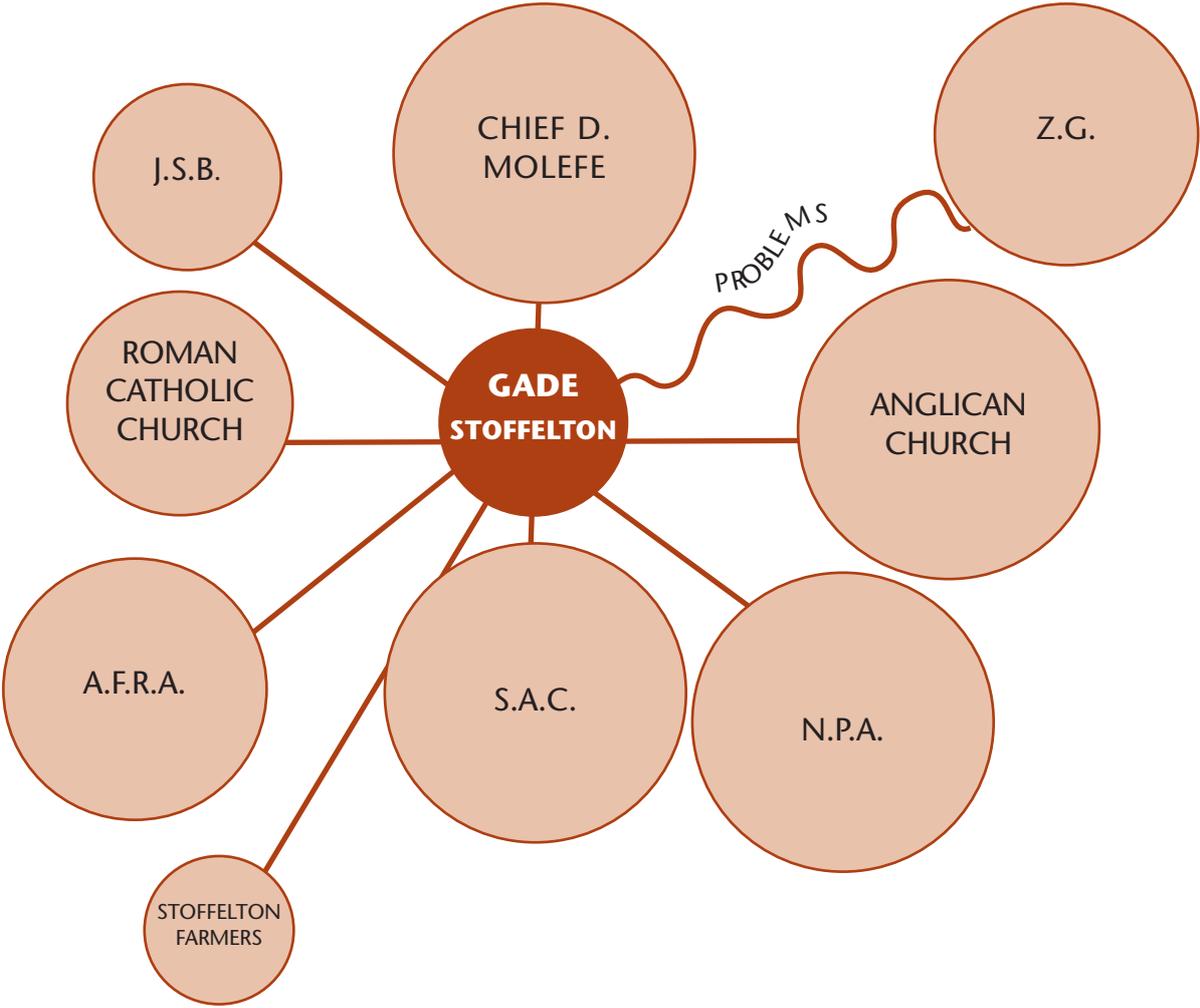
Procedure:

- 1 Working in groups, participants make a list of the main health-related institutions operating in their community.
- 2 Decide with participants what issue you want to explore, such as which institutions are important in supporting orphans or how one institution relates to the others in providing health education to the community. Make sure all members understand exactly what is being measured.
- 3 Participants cut out or draw circles to represent each institution, the larger the circle, the more important the institution.
- 4 Ask participants to place the circles on a bigger piece of paper showing their relationships and linkages – the overlaps indicate cooperation between or among institutions and separate circles show no links or that the roles or activities of the institutions are different. Participants can adjust the size or arrangement of the circles as they consider appropriate.
- 5 While participants are developing their diagram, explore with them why they are making certain choices. For example:
 - Why is this institution so far away from the others?
 - These two institutions are overlapping – what type of activities do they share? Document what they say.
- 6 At the end, ask the groups to exhibit their diagrams and do all or some of the following:
 - Identify common patterns in the way institutions relate to each other;
 - Analyse key differences between the different groups' diagrams and the underlying causes;
 - Look at whether certain kinds of people, for example, women, the poor or orphans, are excluded from participation in certain institutions. Suggest reasons why they are not represented and how they cope.



We can also use methods such as **chapati diagrams** (also called institutional analysis or venn diagrams) to show the links and strengths of relations between stakeholders in programme planning. Participants list the stakeholders in a programme (or related to an institution) and make a diagram as outlined in Activity 22. The chapati diagram below was done by a group of PRA trainees in South Africa (Towards Partnership in Development, 1993). Participants were identifying key partners to an organisation called GADE in Stoffelton. As you can see, some partners are closer than others, some more important – all reflected by the size and distance of the circles from the centre organisation.

Institutional mapping can be used afterwards to help identify possible entry points to be strengthened for community action.



Source: *Towards Partnership in Development: A Handbook for PRA Practitioners: South Africa. April 1993*

Section 4.4: Do health systems collect, share and use resources for health fairly and effectively for people's needs?

Resources are a cornerstone of any activity or programme. Resources include people and their skills, material resources like water points and drugs, and financial resources. Health resources refer to human resources as well as material, financial and infrastructural resources and these are drawn from:

- Finances, usually from government, donors, communities and individuals;
- Human resources, found in communities and in health centres, including community health workers, health personnel and administrative staff;
- Technical equipment, usually from government, donors and commercial enterprises. This usually includes medical equipment like x-ray and theatre machines;
- Infrastructure and capital resources come from government, donors, communities and the private sector.

In a people-centred health system it matters how these resources are raised, organised, managed and distributed for health. It also matters that the way resources are allocated is made known to communities and that they have some say in this.

This is not a course on fair financing for health but in a people-centred health system we need to focus on some aspects of how resources are mobilised, organised and used.



Let's put this in the form of some questions:

How relevant are the areas which resources are being directed to?

- Are resources going to the right areas? What is 'right'?
- What do communities think is relevant? What do health authorities think is relevant?
- What do powerful people think is relevant?
- Should public money from workers' taxes go only to workers' health programmes – or should they be spent on health needs of people who can't contribute, like orphans or vulnerable groups?

How effectively are the resources being used?

- Are the resources provided being used to provide quality services to the population which have an impact on health problems?

How fairly are the resources being distributed?

- This is **equity** which in health means that more resources go to those with greater need and less ability to contribute.
- We also talk about the **solidarity** in health systems. This refers how far the resources in the system are shared between different groups. For example, progressive income taxes and social insurance collect from people according to their income and distribute across groups according to their needs.

How sustainable is the approach to raising and using resources?

- Is it realistic?
- Will it be able to continue and grow or will it collapse?

By asking these questions at ALL levels of the health system we can find out whether or not the system is people-oriented.

There are many tools for carrying out research and raising awareness on how health systems mobilise and allocate resources. The most important equity and solidarity questions may be answered by analysing what takes place at national level between social groups and areas and even at global level between countries.

Look at the example in the box below of how resources are consumed in some parts of the world relative to what they could do for health in others. The figures show the estimated spending on the items shown in a year.

Basic education for all	\$6 billion
Cosmetics for the USA	\$8 billion
Water and sanitation for all	\$9 billion
Ice cream in Europe	\$11 billion
Reproductive health for all women	\$12 billion
Perfumes in Europe and the USA	\$12 billion
Basic health and nutrition	\$13 billion
Pet food in Europe and the USA	\$17 billion
Business entertainment in Japan	\$35 billion
Cigarettes in Europe	\$50 billion
Alcoholic drinks in Europe	\$105 billion
Narcotic drugs in the world	\$400 billion
Military spending in the world	\$780 billion
<i>Source: Human Development Report, 1998</i>	

You can find out more about these figures and how they were calculated at <http://hdr.undp.org/reports/global/1994/en/>.

Let's look a bit further at the PRA tools that we can apply at community level.

What resources does our community have and how are they used for health?

Activity 22:

To EXPLORE HOW HEALTH RESOURCES IN THE COMMUNITY ARE BEING SHARED

METHOD: RESOURCE POCKETS

Time: 40 minutes

Materials: hats, baskets, plates or any other materials which could be used as 'pockets'; counters such as seeds, small pieces of paper, coins

Procedure:

- 1 Choose one resource essential for the health of your community. This could be, for example, drugs (material resource) or health workers (human resource). Then list all the facilities where this resource SHOULD be available, for example, at clinics, district hospitals, provincial and central hospitals and also in the private sector.
- 2 Once you've completed this list, make a 'pocket' for every identified facility. A 'pocket' can be a cup, a hat, an envelope or any other container. Label each pocket.
- 3 Give each participant about twice as many counters (seeds or small pieces of paper) as there are pockets. For example, if there are six pockets, give each participant 12 counters.
- 4 Ask each participant to distribute their counters according to how the health resource is distributed between all the facilities. The more seeds you put in a pocket the more available the resource.
- 5 When everyone is finished, count how many counters there are in each pocket and discuss the following questions:
 - Which facility had the most counters? Which facility had the least? Why?
 - Who uses the different facilities? Who uses the facilities with most resources? Who uses the facilities with least resources? What are the different needs of these groups?
 - Is there a discrepancy between need and resource allocation? Why?
 - What does this mean in terms of health equity?
 - How would you allocate the resources to make the distribution fairer and more relevant to community needs? Who would get more? Where would this come from?

How can communities control their own resources for health?

Communities contribute a significant amount to the health sector through out-of-pocket payments (fees), taxes and other means. Yet this money gives them little power. Individuals who pay fees have far less power than organised communities who have a relationship with their states to provide services. The purchasing power of an individual is small. The social power of a community is much larger.

In some communities, local health committees with support from the local authority organise, manage and mobilise resources for health. These resources are not a substitute for international or state services and private sector contributions to health. They can, however, lever attention and draw in resources from other sources.

Read through the case study in Activity 23 below which describes how one community took charge of their own resources.

Activity 23:

To REVIEW THE FEATURES OF COMMUNITY RESOURCE

MOBILISATION

METHOD: DISCUSSION OF A CASE STUDY

Time: depends on the discussion generated by each group

Procedure:

- 1 Read through the following case study from Tanzania:

Through the Community Voice project, villagers at Fulwe village in Morogoro district, Tanzania, identified their community's three priority problems to be solved and the actions to be taken. These included extending their primary school, constructing a dispensary and establishing reliable water sources. After developing the action plans that were to be included in the formal district planning process, the villagers took initiatives to start some implementation activities that were within their capacity.

In undertaking these activities funds were required. The Community Voice project had no funds set aside to implement plans generated through the process. Although the plans identified various sources of funds, including the district council, the villagers did not wish to sit and wait for the district council to act. They sought other ways to augment their resources.

The village is easily accessible from Morogoro town, as a result of which many top government officials and other well-to-do people in the town had established farms in the village. The villagers organised a special meeting with all such 'absentee' farm owners living in town. Among these officials were the district executive director, the district water engineer and a well-known businessman in Morogoro municipality. In the meeting, the village leaders and the members of the village participatory planning body briefed the officials and other invitees about the Community Voice activities in the village, and the contributions that the villagers were ready to make. They then asked for their material and non-material assistance to enable the implementation of the action plans developed.

All the invitees applauded the idea and they gave their material support as well as ideas to enable more effective implementation of the plans.

- 2 Now talk about the following questions:

- What do you think of the Community Voice's activities on resource mobilisation?
- How relevant were they?
- How effective were they?
- How equitable were they?
- How much solidarity was there?
- How sustainable were they?



Source: Ifakara School construction, Tanzania

We need ways of measuring the winners and losers of current resource allocation for health. A number of the tools we have used in previous sections can be used for this.

- You may look at fee charges for health or other essential services;
- You may look at medical aid for private care;
- You may look at access to antiretroviral treatment for AIDS.

Choose an area of resource allocation. Then look at the PRA tools we have used so far in the training kit and see if you can develop a way of identifying who is gaining and who is losing in the way health resources are currently mobilised and allocated.

We have in this section discussed only some features of people-centred health systems. There are many others. The health civil society groups at the Southern African Social Forum in Zimbabwe in October 2005 raised a number of features that they felt were important. Read through their resolutions which are presented below.



RESOLUTIONS OF HEALTH CIVIL SOCIETY IN EAST AND SOUTHERN AFRICA MEETING Presented at the Southern African Social Forum, 14 October 2005

Health civil society groups in Zimbabwe and east and southern Africa, recognising the initiative of health civil society in the region met in Harare on the 13 October 2005 to discuss our struggles for health. We agreed on the following resolutions.

We are united, together with health civil society in the region, around the core principles and values of:

- The fundamental right to health and life;
- Equity and social justice;
- People-led and people-centred health systems;
- Public over commercial interests in health (health before profits);
- People-led and grassroots-driven regional integration.

To take these values forward we are reclaiming the state in health and have identified the following priorities:

- 1 Building a national people's health system;
- 2 Organising people's power for health;
- 3 Having adequate, fairly-treated health workers;
- 4 Sufficient and equitable funding of our health systems;
- 5 Global solidarity for economic and trade justice.

Within these areas we resolve that:

BUILDING A NATIONAL PEOPLE'S HEALTH SYSTEM

- 1 We are struggling to build integrated health systems underpinned by the principles of equity that address our lives, not just our illnesses and that keep us healthy.
- 2 We will link, network and foster strategic alliances with partners, inside and outside the health sector, to develop a unified voice.

ORGANISING PEOPLE'S POWER FOR HEALTH

- 3 We are organising people's power to amplify our voice, claim our right to health and control our resources for health.

HAVING ADEQUATE, FAIRLY TREATED HEALTH WORKERS

- 4 Our health systems need adequate, well-trained and fairly distributed health workers at all levels of our health systems in places where people need them most.
- 5 Health workers in the public sector need to be motivated through decent conditions, training, incentives, living wages and safe work environments, in a way that promotes gender-equity.

SUFFICIENT AND EQUITABLE FUNDING OF OUR HEALTH SYSTEMS

- 6 We demand sustained increased investments in the public sector in health. We expect our governments to meet their Abuja commitment to spend at least 15 per cent of government spending on health.
- 7 We demand an end to African wealth unfairly flowing out of the continent so that we keep the resources for our health.
- 8 We demand an end to unfair charges for poor people for health.

GLOBAL SOLIDARITY FOR ECONOMIC AND TRADE JUSTICE

- 9 We expect our parliamentarians to ensure our countries have the independence and sovereignty to protect our right to health.
- 10 We remind those who go to the World Trade Organisation (WTO) that: 'No deal is better than a bad deal.'

We as health civil society, together with all other progressive forces in society in the region, are taking forward the struggle. We call on our global partners to support us in this struggle!

In Summary:

This module has shown how health systems are organised. It has outlined some features of people-centred health systems and the roles communities can play in these. The module has explored how communities are organised to play these roles.

The module has outlined ways in which participatory tools can be used to strengthen the communication and relations between communities and health services, as a key feature of people-centred health systems.

It has also explored what a people-centred health system means in relation to sharing resources for health and how this can be examined through participatory methods.

MODULE 5

community actions in planning and organising health systems

AIM: This module describes how communities can act to build people-oriented health systems. In earlier modules we discussed how communities can be involved in health actions and information sharing. In this module we explore how communities can be involved in health planning, setting budgets, allocating resources for health and monitoring and giving feedback to services and health workers.



MODULE 5

Community actions in planning and organising health systems

There are mechanisms in health systems to involve communities in planning and delivering health interventions. These have been part of health systems for many years. During the post-independence periods in African countries health committees were set up to empower communities and mobilise social action to support primary health care programmes. They worked with community health workers to strengthen links between health services and communities.

Section 5.1: Mechanisms for participation in health planning

Health services have been through various rounds of health sector reforms since the post-independence periods in African countries. While many policy reforms gave support to community participation, in practice the mechanisms were often weak and lacked authority. For example, in theory, decentralisation promoted shifts in power to local levels. In practice, while lower levels took on more responsibility for planning and managing services, they lacked the resources and mechanisms to effectively hand over powers to local services and communities.

Decentralisation has thus had mixed effects. In some cases it has enhanced community roles and voice in health activities, while in others it has not. Evidence indicates that the impact of decentralisation on community voice depends on the level of resources that accompanied the authority given to local levels, the capacities in the district levels of health systems and whether decision making was participatory at district levels, amongst other factors.

This has led to research into whether social empowerment and participation in health actions have grown and how effectively a more sustained base for health programmes has been built.

Tools to assess participation range from survey questionnaires and key informant interviews, to specific tools such as the Rifkin diagram and more participatory methods such as the wheel chart.



Source: University of Namibia, Namibia: Community using PRA tools

The **Rifkin diagram** and its use is shown in Activity 24 on the next page.

Activity 24:

TO EXPLORE THE EXTENT TO WHICH LOCAL MECHANISMS
HAVE THE POWER TO INFLUENCE DECISIONS IN HEALTH

METHOD: THE RIFKIN DIAGRAM

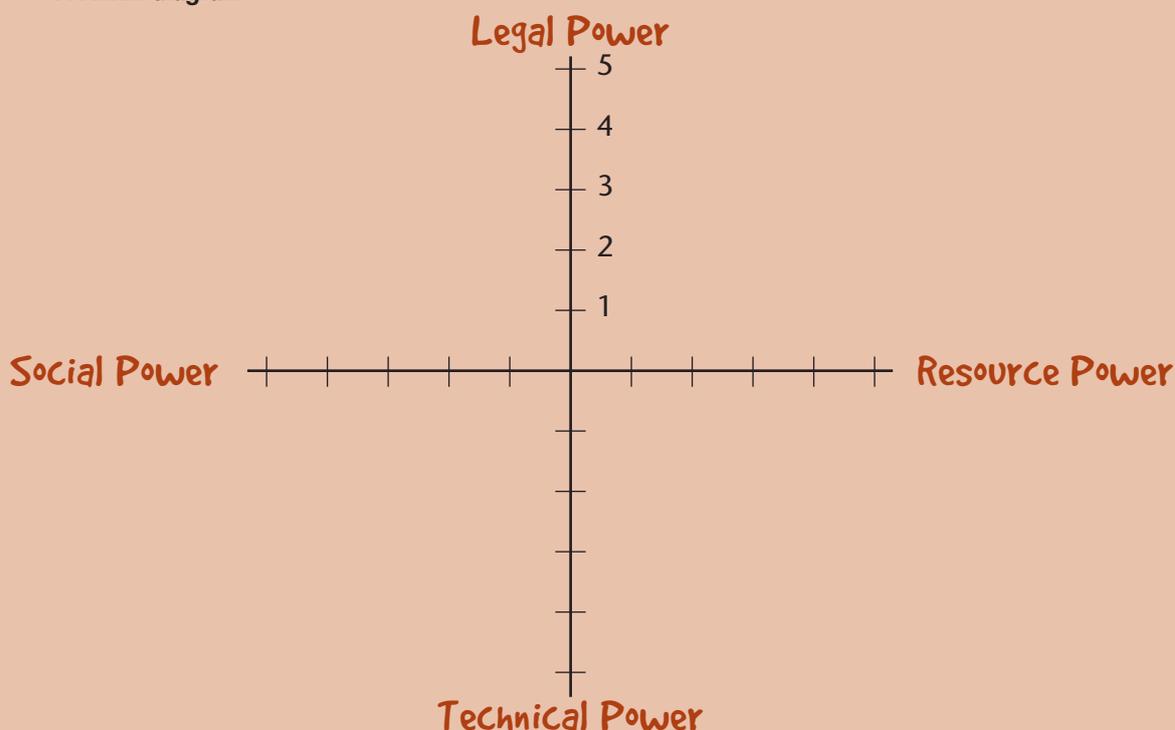
Time: 30 minutes

Materials: a copy of the Rifkin diagram, pens, paper

Procedure:

- 1 Copy the following diagram onto flipchart paper:

A Rifkin diagram



Explain to participants how the Rifken diagram works, as follows:

In the Rifkin diagram each factor that influences participation is shown as a line. The diagram above has four lines each 'measuring' the power that different sections of the community or local authorities have to influence decisions in an aspect of health services (such as district health budgets). You can have more lines if needed.

Each factor is given 5 possible points. If you think that the social group has a high level of that factor (such as legal power) you mark the line at point 5. If you think that it has a low level of that factor you mark the line at point 1.

You do this for each factor, discussing the rankings collectively. When you have marked the points for each factor, you can join all four points with a line. This tells you where that social group has most influence (or participation).

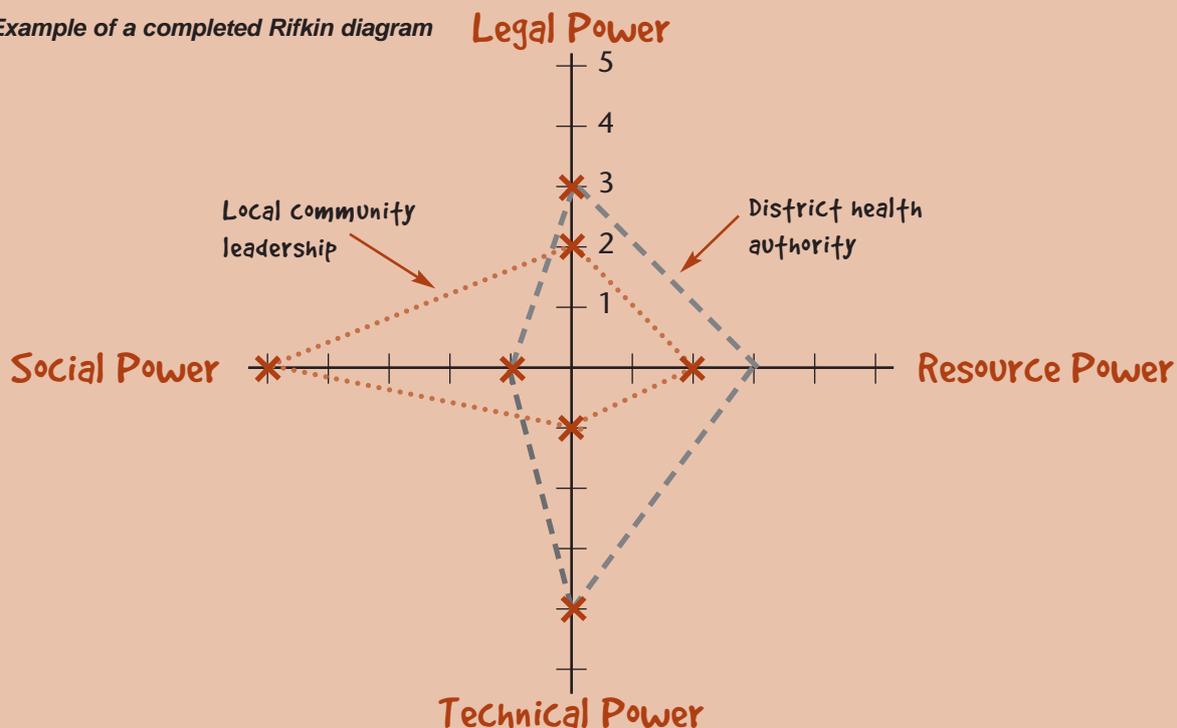
Source: Schmidt and Rifkin 1996

How do we use the Rifkin diagram?

We can use a Rifkin diagram to compare how people perceive the authority or power of different social groups or mechanisms for participation. Look at the example of a completed diagram below.

We can use it to compare how things have changed by doing it before and again after an intervention and discussing how the lines have shifted.

Example of a completed Rifkin diagram



- 2 Try it out! Divide participants into groups and ask each group to choose a different mechanism that has a role in health within the district (district health authority, district health board, health centre committee, local government council, village committee, women’s association, and so on).
Ask each group to fill in the diagram on a flipchart, marking each power line for their chosen mechanism. They need to make sure they can justify their ideas.
- 3 When participants have finished, each group puts up their diagram and appoints a representative to answer questions while the rest of the participants go around the room looking at the differences in all the groups’ diagrams.
- 4 Have a plenary discussion on what they observed:
 - Which structures appear to have the most influence and power? Why?
 - Which have the least? Why?
 - Which ‘power’ factors carry the most influence? Which carry the least? Why?

Training tip!

You can use other factors on the lines. For example, instead of different forms of power you can use different areas of participation (in planning, in monitoring, in setting budgets, in raising funds, in sharing information) and compare the roles of different groups or changes in these factors.

How can communities be involved in health planning?

Public health planning has often been top-down, based on experts identifying priorities and the strategies to address them. This is intensified by curative medical systems that are hierarchical, mystified and paternalistic towards their clients. Health workers can be influenced by this style and become distant from and confusing to their patients. Communities, on their side, often lack the 'language', information, cohesion, organisational structures and capacities to effectively engage and can end up disempowered and distrustful. Specific approaches are thus needed to ensure that health systems are responsive to communities.

For example, community organisations have used surveys of community or client satisfaction with health services. These surveys assess the following: access to services; speed of service delivery; attitudes of service providers; adequacy of information; and conditions of facilities. They have used these surveys in joint meetings between the health service and civil society to discuss measures needed to enhance health service performance in these areas.

In Zambia, for example, surveys of perceived quality have been used to solicit community views on how user charges link to health service performance. Communities assessed user fees in relation to service quality. Service quality was assessed in terms of availability of drugs, food for in-patients and the level of comfort provided for admitted patients. In response to this demand from health system users, the Zambian Ministry of Health incorporated guidelines for health workers that linked increases in user fees with identified quality improvements to be achieved (CHESSORE, 2005).

Community health workers have also supported this feedback link to services. In Zimbabwe, for example, the Zimbabwe National Family Planning Council responded to client demands communicated through community-based distributors on quality of care issues related to family planning.

This type of feedback and input to health planning from communities is also important for the design of health services. For example, in one district in Tanzania, communities living near Kilombero river were provided with free insecticide treated nets as a prevention strategy against malaria. Unfortunately, the nets were provided without community health education under the assumption that malaria was a big problem and 'its awareness is wide among communities'. These fishing communities did not believe in the nets for two reasons. Firstly, there were myths that the insecticides were poisonous to humans, particularly children. Secondly, they did not believe that there was any way to avoid mosquito bites as most of them spent their nights fishing. As a result, they used the nets for fishing rather than to protect themselves from mosquitoes.



Source: TARSC Zimbabwe: Community health meeting

Activity 25:

HOW EFFECTIVELY ARE COMMUNITY VIEWS USED IN PLANNING?

METHOD: INCOMPLETE STORIES

Materials: picture stories

Procedure:

- 1 Give participants a series of pictures such as those shown on the next page. They tell a story of a health intervention. In the first picture there is a problem in the community of young people drinking too much alcohol. In the second picture the health workers design an intervention to teach young people in schools about the dangers of alcohol. In the third picture the adults in the communities forbid young people from going to bars or drinking alcohol. The last picture shows a group of young people talking to each other.



- 2 Discuss the following questions:
 - How effective do you think the health workers' intervention will be?
 - How effective do you think the adults' intervention will be?
 - What do you think the young people in the last picture are saying?
 - What would have happened and how would the interventions have differed if all views had been taken into account?

How can we monitor the responsiveness of health services?

Communities can monitor their health services themselves and feed this information back to the health services for health planning. Look at one way of doing this in Activity 26.

Activity 26:

How Do COMMUNITIES MONITOR THE EFFECTIVENESS OF HEALTH SERVICES?

METHOD: COMMUNITY EXIT INTERVIEWS

Time: 15 minutes to interview; 30 minutes for discussion

Procedure:

- 1 Ask participants the following questions to assess the effectiveness of their health system:
 - Who uses the services and who does not?
 - Does this differ by type of service?
 - What do people think of the services?
 - What improvements would they want to make?
- 2 We can demonstrate this by roleplaying the interviews. Participants work in groups of three or four.
 - One or two people will be interviewed about the effectiveness of their community's health services.
 - One person is the interviewer.
 - Another person is the observer who takes notes on what she or he observes during the interview process.

The interviewer takes about 15 minutes to ask the two community representatives questions that address the issues above.
- 3 At the end of the interview, the observer comments on the process of interviewing:
 - Did the interviewers manage to get useful information from the people being interviewed? How could they have done better?
- 4 Back in plenary, discuss what is meant by 'community exit interviews':
 - How could they be used effectively at community level? By whom and to what end?

Patient rights charters

One way that services have been monitored is through 'patient rights charters'. National health policies usually set out the obligations to and responsibilities of patients, and in some countries these have been consolidated into patient rights charters. Health workers also have rights and obligations which are provided for in these charters. Charters promoting the rights of health care users have been adopted in Zimbabwe, South Africa and Malawi.

The Malawian Patients' Rights Charter came from a meeting of health civil society in the Malawi Health Equity Network. Professional associations for doctors, nurses and midwives, the National Association of People With AIDS and the Consumer Association of Malawi took part in the discussions. The charter originated from participatory research with key stakeholder groups, including patient lobby groups, to develop its content. It was completed in 2000 and presented to the Portfolio Committee on Health in the Malawian Parliament in 2001. Parliamentary briefing sessions helped build up trust and rapport between the legislature and civil society.

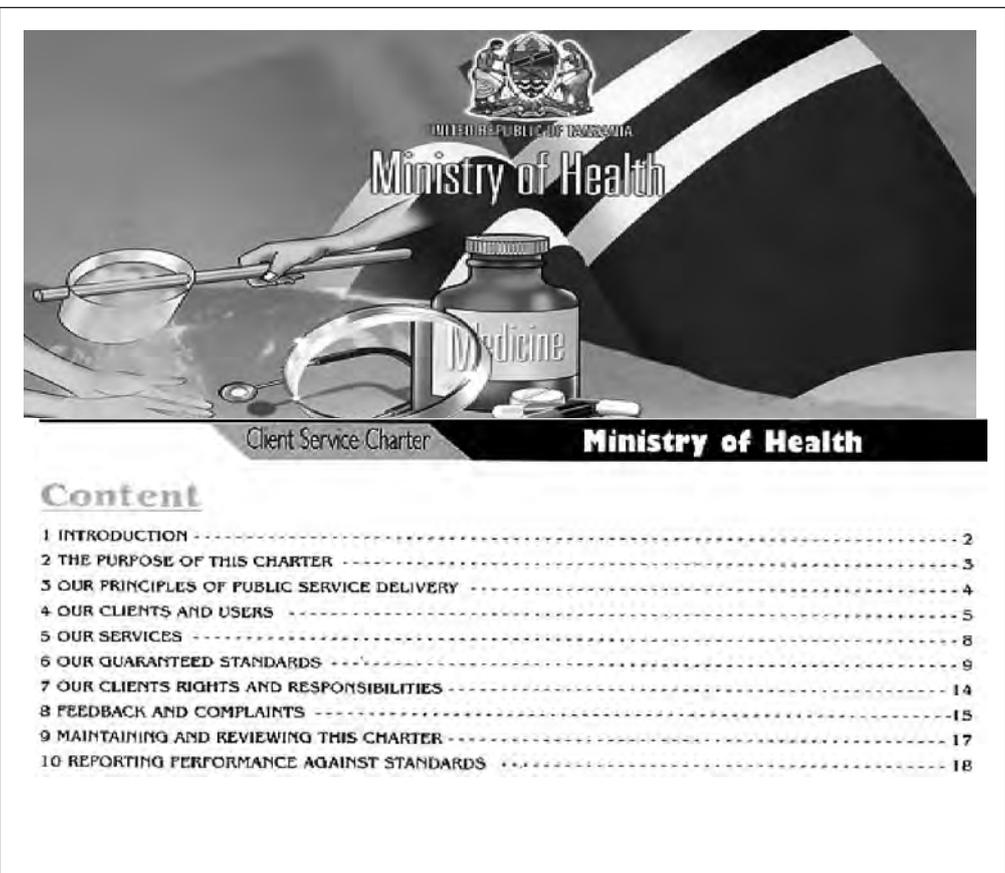
In both Malawi and Zimbabwe civil society was active in helping to disseminate information on patient rights to communities, and in promoting dialogue on patient rights and responsibilities.

We will treat our clients fairly; respect their privacy and dignity; be helpful and courteous; and pay particular attention to those with special needs



A quote from the 'Client service charter', Ministry of Health, Tanzania

The patient rights approach provides an important 'rights-based' approach in health but this often depends on individual willingness to take legal or other remedies. This is less likely among poorer groups who may fear being victimised if they take up disputes with the health services. Also, this action may focus attention on individual services or health workers when the problems raised actually relate back to decisions on health systems and resource allocations taken at much higher levels. So communities may need more social and institutional approaches to assess whether they are fairly treated.



Tanzania client service charter

Patient rights charters give some clear criteria for communities and health workers to use in assessing how well their services are performing. There are other tools to help communities monitor their health services but, initially, the following issues need to be addressed:

- How well do health workers and communities communicate about these health service issues?
- What opportunities and mechanisms do they have to do this in a way that doesn't threaten either and is able to solve problems?

Communities may feel disempowered by the language and environment of health workers and the health services. Health workers may also become defensive when communities raise issues about their health services.

Section 5.2: Communicating about health services with health workers

How do people communicate their feedback on health services to health workers?

If not carefully done, community feedback on health services can be regarded as unfair criticism and may create hostility between people and their health workers. So how can communities communicate with providers when they encounter problems in the services delivered to them?

Activity 27:

HOW DO PEOPLE AND HEALTH WORKERS COMMUNICATE WITH EACH OTHER

METHOD: JOHARI'S WINDOW

Time: 30 minutes

Materials: picture divided into four images or windows; two versions of Johari's window (you can draw these on flipchart paper)

Procedure:

- 1 Show participants the picture divided into four sections, called Johari's window, which is shown at the top of the next page. Ask them to discuss the picture, using some or all of the questions below:
 - What do you see happening in each picture?
 - Why do you think the nurse or the young man are sometimes blindfolded and sometimes not? What do you think the blindfolds symbolise?
 - Which of the four boxes represent most closely the type of communication that exists between the health system and community members in your area? Give some examples for each box.

During the discussion, encourage participants to look for examples which illustrate communication (or lack of it) between community representatives and health personnel in relation to community actions in planning and organising health systems.

- 2 At the end of the discussion show participants diagrams 1 and 2 (see opposite page) taken from Johari's window. Explain these two diagrams as follows:

Johari's window is a way of explaining different styles of communication.

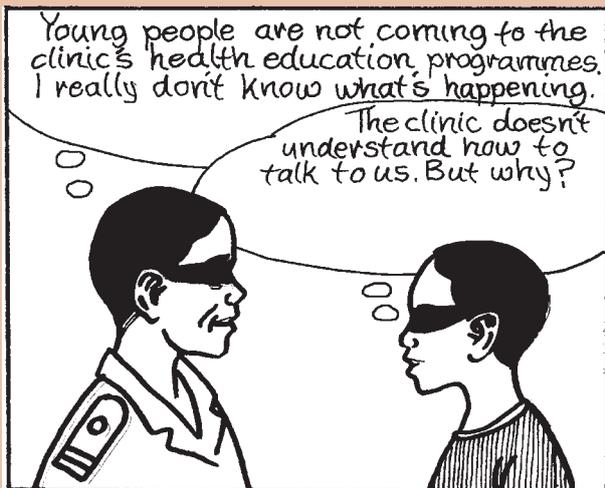
Diagram 1 shows the four different 'windows' of communication.

- Outsiders or people with authority (like the nurse in the pictures) generally relate to the community from window 2. They feel they have all the right answers to community problems, while the community is considered ignorant or blind.
- In window 3 the outsider is as good as blind when working with community members without first getting to know their true feelings, beliefs and values.
- Window 4 is the most effective way of communicating.

Diagram 2 shows that our goal is to make this window as large as possible. The way to do this is through a process of reciprocity and horizontal relationships by which the community's rich experience, knowledge of customs and beliefs, and intimate understanding of the local situation, can be integrated with the outsider's technical know-how.

JOHARI'S WINDOW

Window 1



Window 2



Window 3



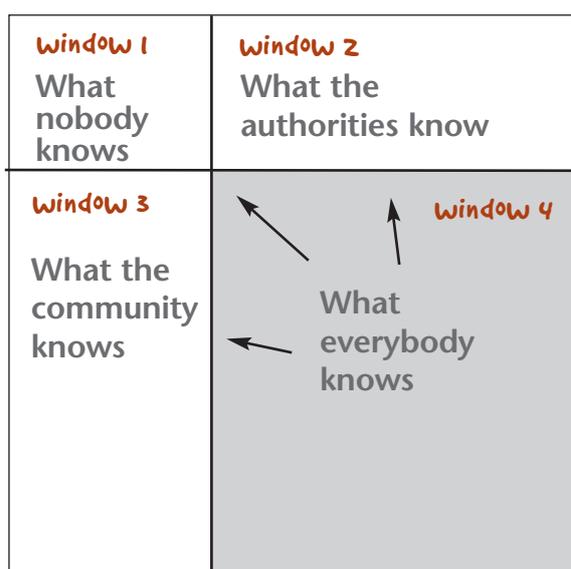
Window 4



DIAGRAM 1

<p>Window 1 What nobody knows (unknown)</p>	<p>Window 2 What the authorities know (blind)</p>
<p>Window 3 What the community knows (hidden)</p>	<p>Window 4 What everybody knows (open)</p>

DIAGRAM 2



Source: Srinivasan (1990) Tools for community participation: A manual for training trainers in participatory techniques

Section 5.3 Building community priorities into district planning and budgets

It is easier for communities to raise issues when they have a continuous presence in health planning and budgeting.

To ensure communities effectively participate and become involved in health services, community roles need to be built into health plans and budgets. This way, communities can introduce their health priorities into initial processes that allocate resources for health.

Earlier we discussed how communities organise and make their priorities known to health systems, and suggested mechanisms for joint planning. To take a closer look at community involvement in health planning, we now focus on district budgets and suggest how communities can bring their priorities and plans into this process.

The health budget is distributed into different areas of spending and across different levels of spending, from clinic to national levels. Practically, each level compiles its cost plans which are built into the next highest level. For communities, their influence may come in at national level through dialogue with the Ministry of Health and other health providers, through issue-based research and campaigns or through advocacy and dialogue with parliaments in the budget process. It may come at district level through the district health budget planning process. However, communities often have little knowledge of or influence over the budget process that allocates resources for health.



What do we mean by a district budget?

A district health budget is a cost plan for the health system for the year. It is usually divided into budget lines, such as administrative, curative services, preventive intervention services and research.

A district budget is the plan or forecast of activities and the related costs for their implementation. We distinguish two main components of a district budget, namely, the capital costs and operational or recurrent costs. Capital costs relate to physical infrastructure such as buildings, vehicles and durable equipment. Operational costs are concerned with maintaining and operating services. Operating costs recur regularly and are needed to carry out a programme of activities.

Budgets have different structures depending on their nature and scope. Household budgets, for example, vary from one household to another and will be different from health facility budgets. In general terms, budgets are plans of expenditure. They are a forecast rather than a definitive statement of costs and prices. Two characteristics are common in any budget – itemisation and costing.

It is not difficult to understand how a district budget works, especially when we realise that budgeting is central to all our lives.

Activity 28:**DEMONSTRATING A SIMPLE BUDGET****METHOD: QUESTION AND ANSWER****Procedures:**

- 1 The facilitator asks for two volunteers, one male and one female, to roleplay experiences of family expenditures at home.
Start by asking the female volunteer and later the male volunteer to explain the expenditure patterns of the roleplay family. Ask them to imagine they have just received their monthly salaries (both being salaried workers). Encourage them with leading questions, such as 'What else do you spend your money on?'
- 2 Ask another participant to list the breakdown of various expenditures mentioned by the two volunteers
- 3 After the budget has been exhausted, ask the volunteers to prioritise the items of expenditure and to explain why they give higher priority to some items than to others. Also ask them what criteria they used for costing.
All the responses should be put down on the flipchart.
- 4 At the end of this exercise let the larger group discuss the following:
 - What was different about the way this couple made their household budget compared to how district or national budgets are put together?
 - Was there any difference between the way the woman and man wanted to spend their salaries? How did they reconcile (or negotiate) their differences? Do you think district budgets are negotiated in the same way?



Items of expenditure or budget lines of district health budgets may vary from country to country depending on priority issues addressed in the budget. However, the basic features are the same.

Below is an example of how a district health budget is structured. Have you ever contributed to the development of a budget like this? How was this done?

Discuss the case study of anyone in the group who has participated in a budget process. Map the steps of the process and examine them:

- At what points in the budget planning process could communities make their voices heard?
- How did communities contribute to the budget preparations in the steps outlined?
- Did community inputs impact on the way the budgets were finalised?

A: Specific expenditures

Sheet 1 of 2: Tanzania District Health Accounts - Rough Work Sheet for Government and Donors

District Council _____ Fiscal Year _____ Matrix for: _____ Fiscal Year _____ Matrix for: _____

1. Use calculator and pencil to accumulate the sum of the total contributions to each line item from these various sources and write them into these cells
2. Enter the totals from this work sheet into the same cells in the computer using the District health Accounts Tools

LINE ITEM	Source of Funds									
	Govt & Local Block Grants	Council Own Funds	National Health Insurance	Community Health Fund	Community Contribution	Cost Shearing	Bilateral (Specify)	Multilateral (Specify)	NGO (Specify)	Private/ Parastatal (Specify)
Minimum Essential Health Interventions										
Integrated management of Childhood Illness (IMCI)										
Immunisation (EPI, NIDs & Vitamin A Days)										
Malaria Prevention (eg. ITNs)										
Malaria Case Management (for Adults & 5+)										
Safe Motherhood - Ante/Postnatal & Obstetric Care										
Safe Motherhood - TBAs										
Safe Motherhood - Family Planning										
All Other Safe Motherhood Initiatives (Maternal/Perinatal)										
HIV/STD Control										
TB DOTS (including TB drugs, Leprosy)										
School Health										
Health Promotion										
Environmental Management										
Essential Drugs (by EDP, Indent, Donation, Capitalisation)										
Essential Drugs (by IMCI Supplement)										
Other Health Interventions										

B: Non-specific expenditures

Non-Specific Delivery Support	Source of Funds									
	Govt & Local Block Grants	Council Own Funds	National Health Insurance	Community Health Fund	Community Contribution	Cost Shearing	Bilateral (Specify)	Multilateral (Specify)	NGO (Specify)	Private/ Parastatal (Specify)
Salaries, Wages and Payroll (PE)										
PE Related Allowances (eg. Housing)										
Supervision Allowances										
DMO and CHMT Office Running Expenses										
Training (Domestic, General, Non-Intervention)										
Supplies and Consumables (Health Facilities)										
Minor Repairs and Maintenance (Health Facilities)										
Transport (for supervision & all other fuel, fares, maintenance)										
Inpatient Costs and Catering										
Emergency Preparedness										
Capital Expenditure (Buildings)										
Capital Expenditure (Vehicles)										
Capital Expenditure (Equipment)										
District Health Systems Analysis & Planning										
Council & Health Facility Boards										
Other General Support										

Source: MOH-Tanzania Essential Health Interventions Project – District Cost Information System (2003).

How are community priorities included in health budgets?

Communities have an opportunity to influence budgets through the following:

- Identifying and prioritising their health needs (see earlier module);
- Appointing health teams and structures at local level to draw up health plans for their neighbourhoods, clinics and districts;
- Contributing to the plans for and use of local government health budgets;
- Making inputs into the plans for and use of non-governmental organisation budgets;
- Mobilising and planning for their own community level resources for health.



Source: Ifakara, Tanzania: People discussing district health priorities in Tanzania

Before the current phase of the Zambian health reforms, for example, rural health centres had been regarded as purely for out-patient services. The ongoing health reforms introduced and formalised the concept of community partnerships in the health services. Without clear guidelines on the roles and responsibilities of community representatives, most of the community committees embarked on activities that added value to their health centres. The most commonly added features were maternity shelters. These were sleeping quarters for patients, post-natal mothers and tending relatives. The value (in terms of coverage, use and performance) of these locally-constructed shelters to the health system was so compelling that both district and local health managers from then on allocated budget lines for such shelters as well as running costs in terms of furniture and food for its clients. They did this despite national level guidelines that omitted such provisions.

Activity 29:

BRINGING COMMUNITY PRIORITIES INTO HEALTH BUDGETS

METHODS: MARKET PLACE

Time: 30 minutes for the market place; 40 minutes report back and discussion

Materials: flipchart paper, pens

Procedure:

- 1 Prepare four sheets of flipchart paper, each with one of the following questions at the top:
 - Why do district health budget priorities sometimes differ from those of communities?
 - How can communities influence health budgets to include their priorities?
 - How can differences of opinion between groups on health budget priorities be resolved?
 - How can communities monitor health spending so it is in line with agreed budget priorities?

- 2 Pin the pieces of flipchart paper on different walls around the room, relatively far away from each other. Put a marker next to each piece of paper.
- 3 Give participants about 20 to 30 minutes to walk around the room discussing the questions posed at each 'station'. The discussion should also raise practical issues which, from experience, are barriers to the community roles in the question and how they are overcome.

To help the discussion, ask for four volunteers to act as station monitors. Their role is to take notes of the discussion, NOT to facilitate.

Everyone else can move between stations in their own time; entering or leaving a discussion when they want.

Major points in the discussion are noted on the flipchart paper by any member of the group – this makes it easier for any newcomer to the discussion to know what has already been discussed.

Remind participants that, just like in a market place, it is not rude to come or go as you please. There should be a lot of noise as people debate the issues addressed on each piece of paper. There should also be a lot of movement between stations. By the end, everyone should have visited all four stations at least once.

- 4 After about 20 to 30 minutes, tell everyone to sit down. Ask each station monitor to come forward to summarise the discussions. Allow for group discussion on the issues raised and note any recommendations on actions to be taken forward after the meeting.



MODULE 6

Bringing community voice to national and global levels

AIM: This module aims to explore the options for communities to raise issues, have dialogue with and influence important actors in health at national and global levels.



MODULE 6

Bringing community voice to national and global levels

If communities want to play an effective role they need to make their voice heard at all levels of the health system – not just at the community level. Communities need to participate in and monitor any health actions. Their role is to advocate for their interests and influence public and private health systems at national, regional and global levels.

This module briefly introduces some of the ways communities make their voices heard at these different levels. More detailed discussion on this topic can be found in some of the resource materials listed in module 7.

Community inputs at national, regional or global levels may be made in different ways:

- Community representatives may be invited into structured forms of participation, such as through citizen bodies with defined functions, advisory or consultative councils, community forums, public health boards or through processes formally structured into programmes;
- There may be less formal mechanisms of open participation, where an open invitation is made to groups to make inputs into processes, policies or debates, for example, through inquiries, hearings, community meetings, public surveys, internet discussion forums and ad hoc consultations;
- Inputs may be obtained through ad hoc exchanges, such as by making officials accessible to citizen-initiated comment and by advocacy through media reports or in one-off campaigns.

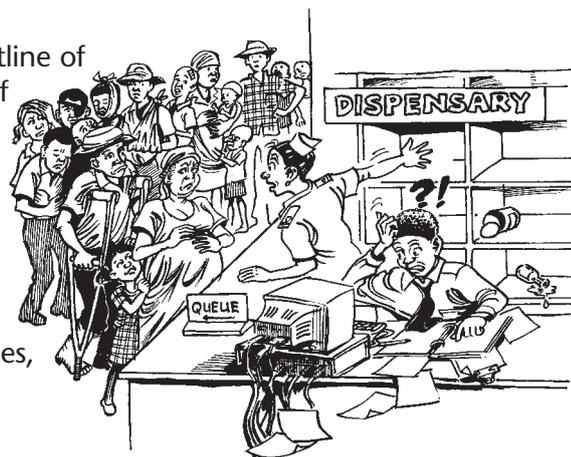
As these processes rise to regional and global level, they may become more complex. Different types of community interests and issues may arise, making the direct link to community voice more difficult to achieve. At the same time, connections between many social groups on a wide geographical scale and in larger numbers can increase the influence of community inputs in decisions affecting health systems. This is especially important when decisions that influence health systems are made nationally or globally.

Section 6.1: Who makes the decisions at different levels of health systems?

Policy development is complicated. It involves a number of players with different interests. Policy interests at local level may differ from those at global level.

Using the issue of medicines, for example, the following outline of the priorities at each level gives some idea of areas of potential conflict of interests:

- At community level the interest is to make sure that people have medicines at the nearest health facility when they fall ill.
- At district level, decision makers may balance their priorities for drugs for treatment against spending on prevention, water supplies, improving antenatal services, and so on.



- At national level, there may be issues about how much foreign currency is spent on drugs, compared to fuel and other essential goods.
- At global level, there may be trade rules to do with protecting patents for large companies that may limit the options of what countries can do.

How do communities influence all these levels?

Activity 30:

To SHOW INTERESTS AFFECTING HEALTH FROM COMMUNITY

To GLOBAL LEVEL

METHOD: PICTORIAL CASE STUDY

Materials: large copies of pictures 1, 2 and 3, as shown opposite

Procedure:

- 1 Copy the pictures shown so they are poster size. Pin the three pictures up on the wall and give a short background to the case study, as follows:

In South Africa in February 2003, 'Johannesburg Water', a management company, introduced a programme called Operation Gcinamanzi (conservation) in an area in Soweto, Johannesburg. The programme was promoted as part of the free basic water policy but involved raising charges on water based on consumption, through pre-paid water meters. The programme had a number of effects:

- *Women who did not have the money for water at home walked for up to an hour to and from home to fetch water from friends and family in neighbouring areas or to carry laundry to wash, affecting their health in the process;*
- *People stopped using water for essential tasks like washing hands; and*
- *People began stealing water from outside taps, begging for water or being charged exorbitant rates for water from neighbours.*

The pictures tell a story of how the privatisation of water affected different interest groups at community, national and international levels.

- 2 Ask participants to walk around looking at the pictures and discuss
 - Who are the people in picture 1? How do you think they were affected by the privatisation of water services? Did it bring harm or benefit to them?
 - Who are the people in picture 2? How do you think they were affected by the privatisation of water services? Did it bring harm or benefit to them?
 - Who are the people in picture 3? How do you think they were affected by the privatisation of water services? Did it bring harm or benefit to them?
 - Who do you think makes the decisions on water provision in the community – the people in picture 1, 2 or 3? Why?
 - How do you think the people in picture 1 can get their problems and issues heard by the people in pictures 2 and 3?
- 3 Discuss what this case study says about whose interests and voice influences decisions on health. How do communities ensure their voice is heard?

Picture ONE



Picture Two

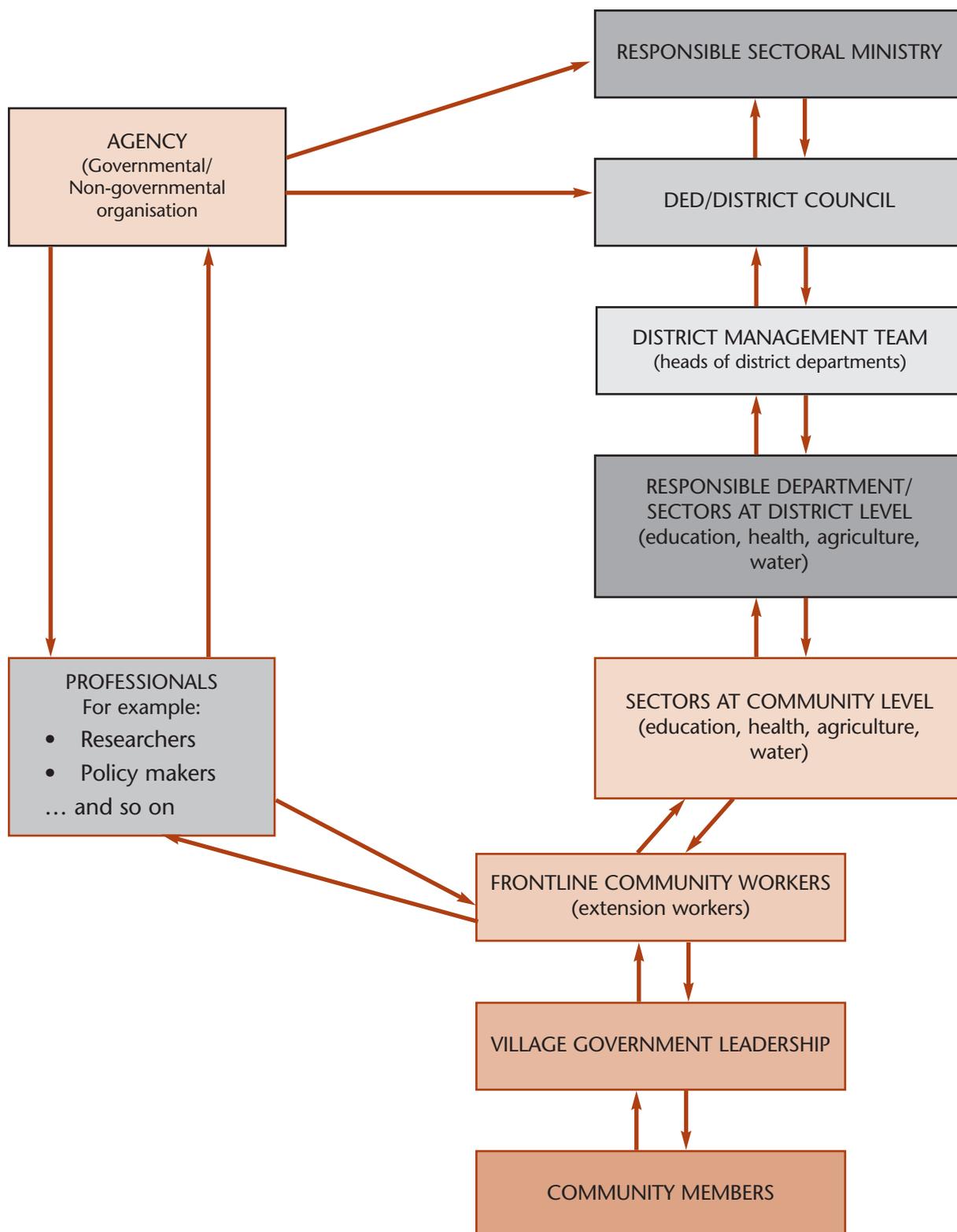


Picture THREE



If communities want to effectively work with, engage or influence institutions at different levels they need to understand how these institutions are organised, their roles, how information flows between them, and what their authorities are. An example of these different levels in Tanzania in the government system is shown in the diagram below:

Administrative and technical information flow in Tanzania



Source: *The Community Voice, Tanzania: Getting community needs into district development plans*

The diagram shows how, in Tanzania, discussions at community, village, and district level are fed upwards and linked to structures of the state, technical institutions and others at national level. Different countries have different mechanisms for structuring participation in planning from community to national level. They also have different degrees of two-way communication up and down the system. Theoretically, it is possible for an idea or activity to be initiated at any level and communicated either way to reach any level. In practice, whether and how this is done differs across countries.

It can be difficult for individual communities to influence all these levels. This may require civil society organisations that operate at different levels, or alliances of organisations who can bridge the links between community, national, regional and global levels.

Hence, for example, the Community Working Group on Health in Zimbabwe is an autonomous registered trust. The approximately 25 organisations now in the trust include national membership organisations that have branches across the country. Other members are area-specific. The trust has established local committees at district level in 25 districts. These committees coordinate local activities, including education and health actions, and link civic groups with all health providers. The national Community Working Group on Health takes up issues with government and parliament – at national level. It also interacts in regional and international platforms through alliances such as, EQUINET, the health civil society platform and the People’s Health Movement.



Source: CWGH Zimbabwe: District meeting of the CWGH

It is thus important for communities and civil society to engage local, district and provincial authorities, parliaments, regional and global institutions, and to make connections across civil society groups as they do this. The next section presents one example of this type of interaction.

Let's take a closer look at one example of this type of interaction.



Section 6.2: Engaging parliaments in health

Parliaments are important structures in health policy, particularly at national level. Many people know what parliaments are but they don't always understand exactly what they do.

Parliaments have a range of representative, legislative, and oversight roles that have an impact on equity in health:

- They pass laws;
- They review national budgets;
- They monitor the performance of government;
- They raise and debate issues relevant to the people.

Experience shows that when parliamentarians are given the information and technical support they need, they can effectively carry out these responsibilities, with a positive impact on health. Despite this, professionals and civil society organisations working in health seldom take advantage of this. They do not fully understand parliamentary processes so do not offer the support parliamentarians need or work with them on health issues. Likewise, parliaments may not be adequately linked with professionals and networks working on health equity.

In a meeting of parliaments and health equity organisations in August 2003, parliamentarians noted some of the areas where they are having an impact on health, as shown below:

COUNTRY	AREAS OF IMPACT
KENYA	Advocating for appropriate policies and increased resources to health
MALAWI	Monitoring and overseeing
SOUTH AFRICA	Overseeing budgets, especially to ensure equity
TANZANIA	More attention now being given to rural areas, especially in budgets and particularly to pro-poor budgets
ZAMBIA	Overseeing budgets, advocating for appropriate policies
ZIMBABWE	Advocating for appropriate policies and increased resources to health

Portfolio committees responsible for health in the parliaments of South Africa and Zimbabwe have influenced the process of reviewing and enacting health-related laws. Committees have been given powers to study bills, conduct public hearings and engage experts on any subject matter under investigation. They can also support amendments to bills to promote health equity. In the budget process, parliamentary committees have held public hearings. These are held with stakeholders and provide a national level forum for interest groups (like the health and treatment activists shown in the photograph) to share their views on laws and policies, review how policies are being implemented and hear views on new priorities.



Source: Pieris 2005: Young people in Zambia in a campaign for treatment access

In Botswana, for example, the Botswana parliament's HIV/AIDS committee sensitises the public, promoting and leading campaigns against the spread of HIV/AIDS in partnership with the National AIDS Council. Members of Parliament, as representatives of the people, make use of other tools such as motions and questions to ensure that constituents' needs are addressed.

Parliamentarians also have the duty to ensure that international treaties serve the interests of the people. In South Africa, any requests for approval of treaties are referred to the portfolio committees who carry out investigations before reporting to the House.

Parliaments now offer space for stakeholder input through the use of public hearings, parliament constituency centres and on-site visits. Parliaments provide an opportunity for pro-equity legislative analysis by allowing stakeholders to participate in analysing bills during committee scrutiny.

The challenge now is for communities and civil society to work effectively with parliaments!

Activity 31:

To DISCUSS OPPORTUNITIES FOR EFFECTIVE COMMUNITY ENGAGEMENT WITH PARLIAMENTS

METHOD: FROM THE HORSE'S MOUTH

Procedure:

- 1 Invite a Member of Parliament (MP) to come and discuss issues raised by participants and respond to their questions.

The MP can give information on:

- how a parliament works;
- its health committee (if any) roles, powers and processes;
- what it has done in the past year;
- what opportunities exist for communities to work with parliaments in health.

- 2 Delegates can find out what their MPs have done to bring their constituents' views and concerns about health to the attention of parliament. They can also find out how MPs inform communities about health policy issues and ask for practical examples.

Delegates can prepare for the meeting by doing some background fact-finding on these questions and also research questions to ask at the meeting with the MP.

- 3 After the meeting, discuss how successful participants were at raising community voice. Discuss how their voice could be strengthened.

Note: The arrangement to invite the MP should be done during preparations of the workshop.



Section 6.3: From community to global level

We have just begun to open the possibilities for national, regional and global engagement on community issues. At higher levels, communities, through civil society organisations, have played an important role in advocating for health rights and public health standards, and on the needs of special groups and other aspects of how the health system works.

This takes place at regional level, in east and southern Africa, through networks like the regional Network for Equity in Health (EQUINET) and the Southern African Social Forum. At the Africa continental level, organisations like the Pan African Treatment Access Movement engage in Africa-wide consultations.

This engagement by communities at regional and global level is growing as wider social movements focus on issues such as: trade and health and public health; HIV/AIDS treatment access campaigns; poverty and health; and so on. Global policies and the global economic system have had, and continue to have, a strong influence on people's lives and health. For example, transnational companies influence the food produced and marketed, what medicines are available and the prices these goods are sold at. Global agencies set policies, trade agreements and economic conditions that influence how many health workers are employed and what they are paid. Global agencies can contribute resources for health to help address health needs but they can also have a powerful influence on health policies. You can read more about these influences in some of the resources listed in module 7.

At the same time, communities and civil society organisations have become more organised globally. The People's Health Movement have, for example, prepared a 'Peoples charter for health' as a way of raising voice globally on civil society priorities for health. These advocacy activities complement health goals and benefit from more information, technical expertise and other inputs.

Many approaches have been used in health campaigns:

- Shareholder resolutions;
- Consumer boycotts;
- Direct negotiations;
- Monitoring and exposing abuses;
- Winning media attention and using films and documentaries;
- Monitoring and gathering data;
- Building coalitions;
- Lobbying strategies using simple slogans and clear messages;
- Direct action, by which we mean taking visible actions to draw attention to an issue or claim, like building a wall of remembrance for victims of landmines;
- Recruiting highly visible, well-known people to speak on the issue.



The 'People's charter for health'



Source: PHM Tanzania: Peoples Health Assembly in Cuenca

Advocacy skills are important for participation. Taking ideas to national and global levels involves lobbying and advocacy. The skills for advocacy are not included in this toolkit but there are organisations who provide these skills. You can find out who offers this support in your country. The activity below gives some insights into the issues people and organisations face in taking on advocacy.

Activity 32:

DEVELOPING AN ADVOCACY PLAN

METHOD: 'MEETING THE CHALLENGE'

Time: about 1 hour

Procedure:

- 1 Explain to participants that they have been invited to assist a women's organisation in developing a national campaign. They want to get the courts to pass a law providing for the rights of women to terminate pregnancy before 16 weeks. The women's organisation has a strong grassroots membership. At the organisation's last annual general meeting, members agreed that the organisation campaign for this in the coming year.
- 2 Divide participants into groups of about eight and give them 30 minutes to draw up an advocacy plan.
 - Who should the organisation lobby?
 - Who are their allies and how can they partner with these groups or individuals? (Think about allies from community to global level.)
 - What strategies should they use?
- 3 After 30 minutes, bring the groups together to discuss their experiences of planning for advocacy:
 - Did people agree on who was the target to lobby? If not, why?
 - Did the plans include many targets to lobby? What effect will this have on the strategy? And on the organisation?
 - Did groups find it easy to identify allies at community level? At national level? At global level? What effect would this have?
 - Did choosing some allies mean that you had to lose others?
 - Did people agree on the strategies? What choices did you have to make in choosing some strategies over others?
 - What do you think are the characteristics of a successful advocacy plan for a community-based organisation?

In Summary

This module explored issues facing communities in raising health issues at national or global level. It introduced decision making on health at national and global level, and the many interests that influence these decisions.

We explored how civil society organisations and parliaments may be helpful in making the link between community, national and global issues.



Communities can track and compare the way health services spend their budgets against their priorities. We have suggested a number of tools for looking at health service spending and for looking at community priorities. How would you use these tools in a process that:

- Draws out community priorities;
- Draws out information on how budgets are spent;
- Compares and discusses the differences;
- Explores the reasons for the differences?

You may use three or more different tools and discussions in between to draw out this information. This builds up a participatory research approach out of different tools. Doing participatory research is never a matter of using just one tool. We build the research inquiry and discussion and the cycles of inquiry, reflection and discussion of action out of different tools in sequence.

How might you combine two or three of the methods in this toolkit to explore how community priorities compare with how health budgets are spent?

In Summary

For effective community participation, it is important for people to be involved in and contribute to the planning of health systems.

In this module we explored the mechanisms that communities can use to strengthen their involvement in health planning.

We examined how communities can raise their views with authorities in health systems and communicate their priorities to them.

We explored how budgets are constructed and what a district budget might look like.

The module discusses the way communities can monitor the performance of their health services, and shows how patient rights have been used for this.

Finally we discuss options for reviewing community roles in health budgets so that the priorities that communities have are reflected in them.

MODULE 7

Lessons learned and next steps

AIM: This final module summarises some of the learning on how participatory methods can support community voice in health. It suggests some next steps, and provides information on resources and places to obtain further support.



MODULE 7

Lessons learned and next steps

The discussions in this toolkit highlight some of the ways we can use to build people-centred health systems. We also provide examples of participatory methods which help communities reflect and act collectively using these approaches. Although the toolkit doesn't cover all approaches and experiences or all aspects of a people-centred health system, we hope you now have a good sense of the issues to be considered and the potential of participatory approaches in helping communities meet their shared goals. The material presented was drawn from the experiences of the organisations that developed this toolkit – it is not exhaustive. We look forward to receiving comments and information based on your own ideas and experiences too!

Section 7.1: What have we learnt about using participatory approaches for people-centred health systems?

PRA is about facilitating change. If it is used effectively, it can lead to major shifts in the way people and organisations think and act. If we want our health systems to be people-centred, to respond to community needs, inputs and values, and to involve the community, then they need to be transformed.

Using PRA approaches, whether in research or training, makes a closer link between the change we seek to produce and the methods we use to do this.

This has many consequences. The first is for the facilitators. When using participatory approaches, PRA practitioners are encouraged to move away from the concept of 'us and them' and recognise that the issue of health affects us all. The facilitator's attitude and behaviour is central – listen to people's own knowledge, create dialogue, and involve people and institutions at all levels in decisions and activities.

Everybody can learn about participatory methods but we don't automatically have the skills to implement them. Especially in PRA, skills are not acquired by learning alone but by doing. So PRA skills grow through practice and through feedback from colleagues and communities.



Source: EQUINET Ifakara TARSC PRA workshop Tanzania 2006

There are also consequences for how we work with communities, health workers and others in the health system. PRA entails a shift of emphasis from:

Dominating	to	empowering
Closed	to	open
Individual	to	group
Verbal	to	visual and verbal

We do not want to make the false assumption that communities are a homogeneous group of people. Genuine participatory approaches take into account the conflicting interests in communities and never try to force consensus. In the context of a people-centred health system, we have suggested a number of ways of listening to different views and of tapping different types of power to achieve shared health goals.

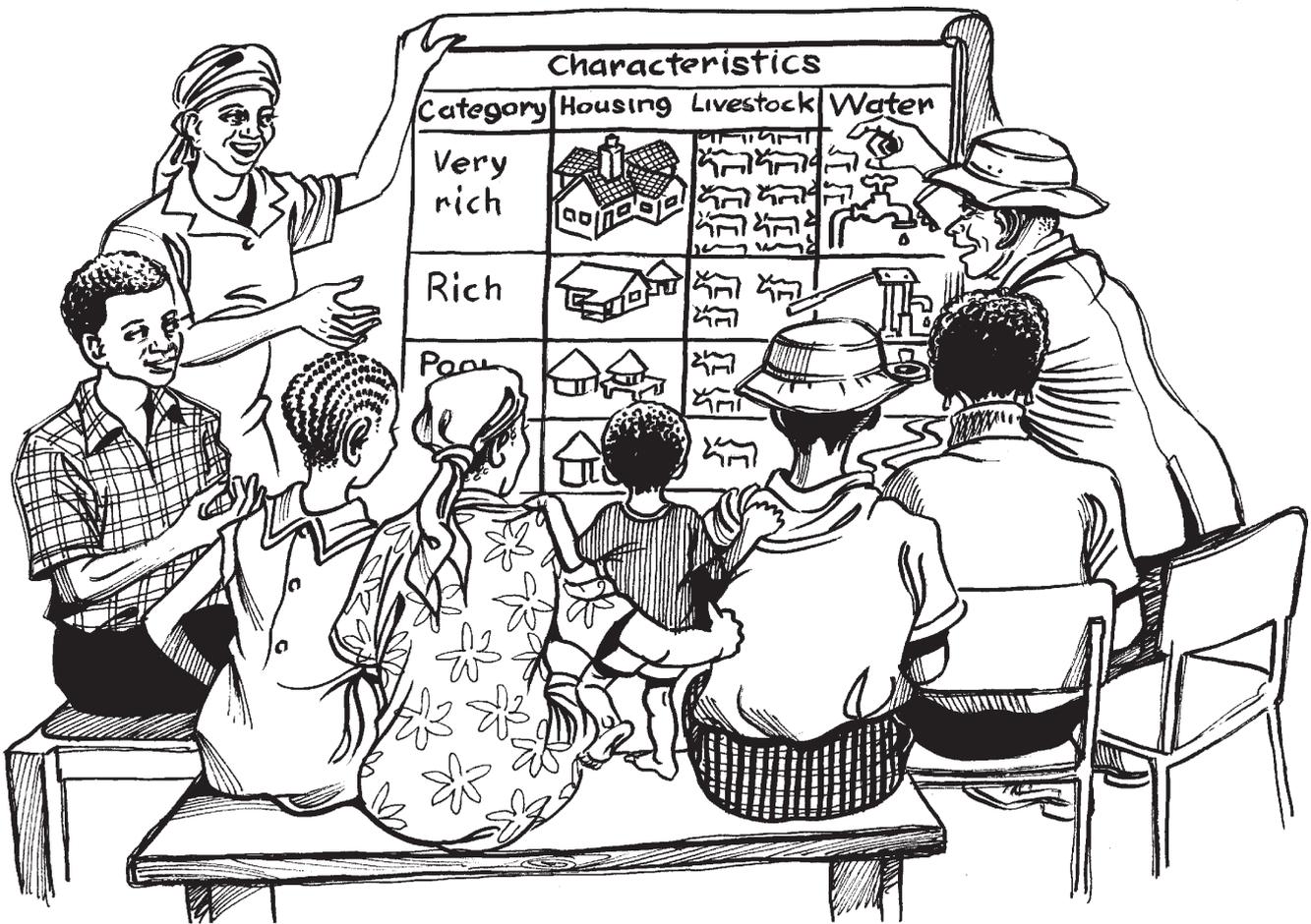
PRA uses a diversity of methods that is only limited by our own imaginations. The methods are flexible and can be adapted to different circumstances. Participatory methods are strong tools for generating qualitative data. These methods can also provide quantitative data or be compared and discussed with the quantitative data collected by routine health information systems and surveys. These methods make more immediate links between data collection, reflection and action. With guidance from facilitators, participants collect, analyse and discuss results, often in the same process. This empowers people to use the information themselves to develop community action plans, to bring findings into formal planning processes, and to support communication between health workers, authorities and communities on health actions. In the process of generating, discussing and reflecting on the evidence, communication can be strengthened between communities and health services – a central feature of people-centred health systems.

People-centred health systems are locally driven, for example, through primary health care approaches. PRA approaches mainly use local resources and may not be financially demanding. They do, however, demand time and effective listening and facilitation skills. Some issues may call for several rounds of reflection and action, and then more reflection leading to further action. In the process, they lead communities and local health services to realise those solutions that lie within their own control and to take initiative. Communities develop the confidence to claim the support they need from other levels – nationally and globally – to build such solutions. Some of the approaches to this and the challenges involved are shared in this toolkit.

Because these approaches empower people and the people-centred health systems they aim to build, they can be considered threatening to some groups or interests in communities and may be resisted. Like any other methods, PRA is open to abuse and can be used in the wrong way or for the wrong reasons. People can claim to use participatory approaches to 'discuss' plans that have already been developed elsewhere, rather than to genuinely base planning on the experiences and views of people. Rather than simply accepting that all methods that call themselves 'participatory' lead to people-centred health systems, we need to question, listen and reflect on what is being said and done.

Can we think of more features of participatory methods that we have applied in the fields of our work?





So we have reached the end of the toolkit: what have we achieved?

By the end of the training, we hope that:

- Participants have learned new skills and methods for participatory approaches to research and training and can apply them to develop different aspects of people-centred health systems. We hope you are excited enough by PRA to want to learn more and apply the approaches in your own work. The list of some further reading later in this module offers a good starting point. You will also need to develop your own skills through interaction with others and, most of all, through practice.
- Participants have a better understanding of the many ways we can make our health systems more people-centred. We hope you are able to understand and work with communities – as dynamic groups of individuals, families, men, women, social groups, health workers and others – to promote health.
- Participants have developed an awareness of the power dynamics in communities and how the methods we use can give voice to those who often have least power and most need to improve health and access to health care.
- Participants have used – and will continue to use – the toolkit and the other PRA resources referred to, to develop the skills to draw on community experience, organise it and reflect on what it means. We hope the toolkit has helped to strengthen your commitment to making our health systems reflect, respond to and actively involve communities.

Section 7.2: Where do we go from here?

Every journey has an end – but we are just beginning ours! The next step is to test our knowledge and skills in working with communities and to reflect on this experience. EQUINET has a mailing list to support you in this journey. You will be able to share your experiences, ask questions and connect with others working with PRA approaches for health equity. Contact us at pra4equity@equinetafrica.org. If you would like to join the network list, please send an email to admin@equinetafrica.org.

Activity 33:

IDENTIFYING NEXT STEPS

METHOD: PREPARING INDIVIDUAL OR ORGANISATIONAL WORK PLANS

Procedure:

- 1 Participants divide up into groups – preferably by organisation or some other common factor (for example, working in the same region or area of work). You can also work on your own if it makes more sense. They then work through one of the following tasks (A or B) over the next 45–60 minutes:
 - A If you have a health problem, issue or research question that you are working on in your community, use the following questions to guide the discussion:
 - What are the features of the community that you will need to know or take into account?
 - What issue or change are you addressing? What research question are you trying to answer?
 - How would you do this? Break it down into steps and for each step indicate what you would aim to achieve.
 - What PRA approaches can you use at each step?
 - What skills or resources will you need in order to implement these changes? Are these available within your workplace or community? Which of these will you have to get from outside?
 - B If you don't have an issue or research question you want to address, discuss the following questions:
 - What are the most important lessons you've learnt from this toolkit which you want to take back to your workplace or community?
 - How can you use the skills and approaches you have learnt during this programme in your community? What changes would you seek to initiate at community level?
 - What are the features of the community that you will need to know or take into account?
 - What skills or resources will you need in order to implement these changes? Are these available within your workplace or community? Which of these will you have to get from outside?
- 2 After discussing these questions, prepare a workplan that takes into account what you've just discussed. Decide on the timeframe for doing the work.
- 3 At the end of the hour, come back to plenary and to report on your workplan. (If there are too many workplans, ask for volunteers and discuss only three or four). Allow time for feedback and discussion.

We used a number of resources in preparing this manual which you can also draw on in your work. These are listed on the next page. Working with PRA and building people-centred health systems calls for solidarity in sharing knowledge, experience and ideas, and in developing skills. EQUINET is one network that aims to build up this solidarity and support around shared values of equity and social justice in health. There are others, where you can link up with other people or organisations with experience in using PRA and those working towards people-centred health systems, to share ideas, experience, reflect – and act!

Activity 34:

EVALUATION

METHOD: BALLOTS IN THE HAT

Procedure:

- 1 Ask participants to take a piece of paper and divide it into three parts. Find three hats, boxes or similar containers.
 - 2 Participants take the first piece of paper and on it write the answer to the question:
 - *What was the most relevant and useful thing that you learned from this toolkit?*Gather all the papers into the first hat.
 - 3 Participants take the second piece of paper and on it write the answer to the question:
 - *What would you most want to change about this course?*Gather all the papers into the second hat.
 - 4 Participants take the third piece of paper and on it write:
 - *A question that you still have about PRA methods or community voice in health systems.*Gather all the papers into the third hat.
 - 5 Take the first hat and ask people to each take a paper (not their own) and read out the answers. Discuss them:
 - Which were the areas most useful to people? Why ?Do the same for the second and third hats.
- Ask if there are other comments that people may want to make about the toolkit and the course and discuss these.

Information used in the development of this toolkit was drawn from experience and from many sources. These are listed on the next page with useful resources for follow-up reading or reference on people-centred health systems or on PRA approaches.

Information on EQUINET, TARSC, Ifakara and CHESSORE

www.equinet africa.org

www.tarsc.org

www.ihrdc.org

Other useful websites and resources

www.who.int/en/

www.cwgh.co.zw

www.phmovement.org

www.eldis.org/healthsystems/poverty/#participatory

www.eldis.org/healthsystems/poverty/#equity

www.eldis.org/healthsystems/poverty

www.sdhct.nhs.uk/info/patientinfo.htm

www.iied.org/NR/agbioliv/pla_notes/pla_basicissues/21

www.careinternational.org.uk/resource_centre/health.htm

www.irc.nl/page/3403

www.aidsalliance.org

www.healthlink.org.uk

On stakeholder mapping:

<http://p2001.health.org/exptopic/topic6/f3dxt.htm>

www.phrproject.com/publicat/inbriefs/ib26fin.htm

www.prgaprogram.org/prga/tool_prga.htm

Institute of Development Studies (IDS), Sussex University Participation Resource Centre, database and information service on participation and development at:
www.ids.ac.uk/ids/particip/ or contact them directly at participation@ids.ac.uk

Participatory Learning and Action, available three times a year at: www.planotes.org or from PLA Notes Subscriptions, Earthprint Ltd, Orders Department, PO Box 119, Stevenage SG1 4TP, UK; email: iied@earthprint.com

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