EMBRACING PARTICIPATION IN DEVELOPMENT

Wisdom from the field

Worldwide Experience from
CARE's Reproductive Health Programs
with a step-by-step field guide to participatory tools and techniques.

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Health and Population Unit

EMBRACING PARTICIPATION IN DEVELOPMENT:

Worldwide experience from CARE's Reproductive Health Programs with a step-by-step field guide to participatory tools and techniques

October 1999

Edited by:

Meera Kaul Shah
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Barbara Monahan

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Acronym List

AA	Applied Anthropology
ANR	Agriculture and Natural Resources
CARE	Cooperative for Assistance and Relief Everywhere
CBD	Community-Based Distributors
CBO	Community-Based Organization
CHAP	Community Health Action Plan
CIAT	International Center for Tropical Agriculture
CI	CARE International
CO	Country Office
CS	Child Survival
DAP	Detailed Assistance Proposal (USAID Title II)
DFID	Department for International Development, Government of the United Kingdom
FFW	Food for Work
FGC/FGM	Female Genital Cutting/Female Genital Mutilation
FP	Family Planning
FSR	Farming Systems Research
KAP	Knowledge, Attitudes and Practices
HIV/AIDS	Human Immuno-deficiency Virus/Acquired Immuno-deficiency Syndrome
HLS	Household Livelihood Security
HLSA	Household Livelihood Security Assessment
IEC	Information, Education and Communication
IUD	Inter-uterine Device
IGA	Income Generating Activity
ILO	International Labor Organization
IMF	International Monetary Fund
LFSP	Livingstone Food Security Project, CARE Zambia
LRSP	Long Range Strategic Plan
M&E	Monitoring and Evaluation
MCH	Maternal and Child Health
MH	Maternal Health
MOH	Ministry of Health
NGO	Non-governmental Organization
NHC	Neighborhood Health Committee
OR	Operations Research
PANA	Participatory Appraisal and Needs Assessment
PFPE	Population and Family Planning Extension Project
PLA	Participatory Learning and Action
PRA	Participatory Rural Appraisal
PROSPECT	Programme of Support for Poverty Elimination and Community Transformation, CARE Zambia
RDC	Resident Development Committees
RFA	Request for Application
RFP	Request for Proposal
RH	Reproductive Health
RHAAPY	Reproductive Health Awareness and Action Project in Yirowe, CARE Somalia
RRA	Rapid Rural Appraisal
SCS	Sentinel Community Surveillance
SRM	Second Republic Mentality
STD/STI	Sexually Transmitted Disease/Sexually Transmitted Infection
SWARMU	Southern and West African Regional Management Unit, CARE
TBA	Traditional Birth Attendant
TEAM	Training in Environmental and Agricultural Management Project, CARE Lesotho
USAID	United States Agency for International Development
VMC	Village Management Committee

Dedication

First and foremost, the editors wish to thank the contributing authors who found time in their busy schedules to share their experiences in the use of participatory approaches in reproductive health programming. These contributions reflect not only their brilliant successes, but also their lessons learned "the hard way", that is learning by doing. The editors especially appreciate the candor with which these articles were written, and encourage novices and experts alike to follow the example of regularly evaluating their field experiences. Each and every field experience provides us with new and deeper understanding of the approach and the tools; we merely need to seek that understanding for ourselves to become more proficient and effective in using the tools and in adapting them to our programmatic needs.

Readers will find within these pages a diversity of opinion and experience relating to the use of participatory tools and techniques in development programs at CARE. While the articles have been edited for length and composition, the Editors have consciously avoided editing the content. Thus, the contributions speak for themselves, reflecting the authors' development philosophies and their perceptions of their field experience, learning and application of these methodologies.

As a compilation of contemplative material, these *Guidelines* portray the current state of participatory development in reproductive health programming at CARE and, now that they are available, will hopefully inspire further experimentation and learning within and outside of the institution.

The editors also wish to acknowledge the many CARE field staff who provided visual outputs, photos and narrative contributions for inclusion in the *Guidelines*. You are the source of CARE's field wisdom. Learning is highly valued at CARE; much of our learning occurs in the field as staff collaborate with partners and clients on project implementation. We, therefore, encourage you to continue sharing tools, experiences and applications so that CARE, as an institution, can establish core capacity in the use of participatory approaches.

The *Guidelines* "project" has received unwavering support from Maurice Middleberg and Catharine McKaig of the Health and Population Unit. What was literally a dream a year ago is now a reality thanks to their commitment and encouragement. In addition, several people at CARE have shared their time, their expertise and their resources to make the *Guidelines* as rich and as comprehensive as possible. The editors wish to pay special tribute to M.J. Conway and the CARE Rwanda field staff, Sandy Erickson, Tim Frankenberger, Tony Ikwap, Anthony Klouda, Mary McInerny, Kanyi Mensah, Michele Munro, Aben Ngay, Irma Ramos, Jim Rugh, Eleonore Seumo and the CARE Madagascar field staff, Tamara Fetters, Marcy Vigoda, and Karen Westley.

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Finally, the editors wish to extend their profound gratitude to the hundreds of men, women and adolescents who participated in the numerous participatory reproductive health assessments and processes across the CARE world during the last few years. Thank you for sharing your experiences, insights and concerns with us; we hope that we have faithfully represented what you have taught us.

Meera K. Shah

Sarah Degnan Kambou

Barbara Monahan

In Memoriam

CARE's Health and Population Unit

joins the editors

in dedicating the

Guidelines *to*

Jennifer Mukolwe

a senior field representative

tragically struck down

in the prime of life.

Throughout her professional life,

Jennifer sought to improve

the reproductive health status of African women;

she will be greatly missed.

Meet the Contributing Authors

MEERA KAUL SHAH

Ms. Shah has degrees in Economics, Rural Management, and Gender and Development. She has been working in the development field for the last 18 years. Meera has worked for NGOs in India for ten years, including five with Aga Khan Rural Support Programme (AKRSP), India. While at AKRSP she helped pioneer PRA as a distinct shift from the more top-down RRA methodology. For the last eight years Meera has been freelancing as a development consultant, specializing as a trainer in participatory techniques and processes, participatory gender analysis, and providing support for strengthening and developing sustainable local institutions. Her main focus of experience has been in the area of participatory natural resources management. She has also been involved in developing field methodologies for participatory research for policy influencing, especially those related to participatory poverty assessment, urban violence, women's concerns and problems, and sexual and reproductive health. Additionally, Meera has worked with projects related to the rehabilitation of people affected by natural disasters and conflict resolution. During this period she has provided support to various NGOs and government agencies in India, Zambia, Morocco, Ghana, Malawi, Tanzania, Ethiopia, Vietnam, Papua New Guinea and Jamaica. Meera recently co-edited the book The Myth of Community: Gender Issues in Participatory Development (Intermediate Technology, London).

SARAH DEGNAN KAMBOU

Dr. Kambou joined CARE in 1991. From 1991 to 1996, Sarah managed reproductive health programs in Togo and Zambia. In Togo, she served as Project Manager of a family planning project that focused on increasing demand, particularly among rural men, and in improving both clinic-based and community-based family planning service delivery. As Health Sector Coordinator in Zambia, Sarah managed an urban health portfolio that included the USAID-funded Community Family Planning Project, which focused on improving health services in townships, and the Partnerships for Adolescent Sexual and Reproductive Health Project, which introduced participatory methodologies into CARE's reproductive health program through its work with urban adolescents. From 1996 to 1998, she was based in Ethiopia and served as a Reproductive Health Technical Advisor in the sub-Sahara Africa Region, leading reproductive health participatory needs assessments and project design exercises in Madagascar, Rwanda, Somalia and Sudan. This position was partially funded by the Andrew W. Mellon Foundation; her mandate included the development of reproductive health programs for refugees in the Greater Horn of Africa and in the Great Lakes Region. Sarah currently serves as Assistant Country Director (Program) for CARE Mali where she continues to promote the use of participatory approaches. Prior to joining CARE, Sarah was a senior staff member of Boston University's Center for International Health and served as an adjunct faculty member at the School of Public Health.

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Ms. Monahan joined CARE in 1996, serving as Program Officer for CARE's Refugee Reproductive Health Initiative. Barbara has conducted participatory reproductive health needs assessment and project design exercises in Rwanda, Somalia Kenya and Macedonia. She works to promote participatory approaches in all aspects of refugee health. Prior to working with CARE, Barbara completed her MPH with a focus in Maternal/Child Health and Nutrition. She served as a health educator in the Peace Corps in Togo and coordinated HIV/AIDS prevention projects in California. In addition, Barbara has conducted research for the New York City Department of Health in Tuberculosis Control to determine types of interventions effective in improving patient adherence to treatment.

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Dr. Drinkwater is a Regional Program Coordinator working for CARE's Southern and West African Regional Management Unit (SWARMU) in their newly established office in Johannesburg, South Africa. He was previously the Assistant Country Director for Programs at CARE Zambia, where he helped to introduce participatory methodologies across the country program, in conjunction with household livelihood security and partnership initiatives. Altogether Michael spent eight years in Zambia, including four and a half years working with DFID as a rural sociologist in the field of farming systems research. It was in this work that he carried out a great deal of experimentation in introducing PRA methods and farmer participatory research as part of a new food security perspective. Today he works across CARE's programs in many SWARMU countries, particularly those with an urban or rural livelihoods framework, with the aim of improving the quality of CARE's programs and encouraging team and capacity building approaches, both within CARE and with the various partners with whom CARE works.

TAMARA FETTERS

Ms. Fetters is a University of Michigan Population Fellow who was seconded to CARE Zambia in order to establish their Operations Research (OR) Unit. While at CARE Zambia, Tamara has worked with her Unit staff to conduct research contributing to both the organizational and the national policy agenda in Zambia. The OR Unit has been most active in research related to the introduction of new contraceptive methods and adolescent sexual and reproductive health in Zambia; it has also been involved in promoting the multi-sectoral use of participatory approaches for research and development throughout Southern Africa.

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Dr. Pérez has over 15 years of experience in international agricultural and rural development. Currently, Carlos is the Director of Agriculture and Natural Resources Unit (ANR) at CARE, where he develops and provides assistance in policy formulation and advocacy, strategy development, technical analysis and training in order to promote ANR program quality and impact in 96 projects throughout the world. He planned and managed agricultural, forestry, livestock and natural resource management projects in Bolivia and Mexico. Carlos has monitored the socioeconomic and agroecological performance of agricultural, forestry, livestock and natural resource management programs throughout the Central and South America, and in Egypt, Bangladesh, Philippines and Thailand. He holds a Ph.D. in Anthropology and an MA in Sociology. Carlos was a Senior Research Fellow in the Cassava Program of the International Center for Tropical Agriculture (CIAT), in Cali, Colombia from 1986 to 1989.

JIM RUGH

Mr. Rugh is the Coordinator of Program Design, Monitoring and Evaluation (DME) for CARE USA. Jim also chairs the CARE International DME Advisory Committee. As such, he provides over all guidance to the standards and Guidelines for DME for CARE programs around the world. Prior to joining CARE in 1995, he had his own independent consulting service for 11 years, called Community-Based Evaluations. During that time he conducted evaluations of many different international development agencies. His publications include "Self-Evaluation: Ideas for Participatory Evaluation of Community Development Programs" published by World Neighbors (Oklahoma City) in 1984 (latest re-print 1996), "Can Participatory Evaluation Meet the Needs of All Stakeholders?", and "Evaluating the World Neighbors West Africa Program," in Practicing Anthropology Vol. 19, No. 3, Summer 1997, Society for Applied Anthropology. Jim earned a M.Sc. in Agricultural Engineering from the University of Tennessee. In addition, he holds an M.P.S. in International Agriculture and Rural Development from Cornell University. In the context of this program, Jim specialized in adult education and rural sociology with a focus on participatory evaluation.

FOREWORD

JIM RUGH
Coordinator of Program Design, Monitoring and Evaluation, CARE

We want to encourage more CARE projects to use participatory methods in their processes of assessing needs and in designing, implementing, monitoring and evaluating projects. We need more guidance for how to do this, and more sharing of experiences with participatory approaches around CARE. This publication makes valuable contributions to these objectives.

As Sarah Degnan Kambou says, "these G*uidelines* are a part of the process of rejuvenating CARE's definition of 'participation' (see Part One, Chapter One). Though it is addressed specifically to those involved in reproductive health programming, these principles and approaches are equally applicable to all sectors."

It includes encouraging examples of how a number of CARE projects are already successfully using participatory methods in their work, including their lessons learned. It also includes historic overviews of the development of participatory methods, concepts and examples for their use throughout the project life cycle, as well as some useful guidelines for using participatory methods not only for assessments, but also for implementing projects.

The contents of this publication are recommended for your reading and application, but a few notes of caution are in order.

We need to be clear on our use of terms. There has been a trend over the past two decades to move from Rapid Rural Appraisal (RRA) to Participatory Rural/Rapid Appraisal (PRA). Unfortunately PRA became such a fad that the term was used by many who were stretching its definition, or at least were using it more for extractive than empowerment purposes. The purists, who consider participatory methodology to be a philosophy which should guide development practice, wanted to separate themselves from this cheapening of the use of "PRA," and so began to speak of Participatory Learning and Action (PLA). The idea is that PRA may be used for rapid assessments, but PLA is a long-term commitment to on-going development of a community's capacity to identify its own needs and implement action plans to improve its own conditions. Unfortunately, now "PLA" is also being used in ways which fall short of that ideal, by those who want to appear "politically correct" (or "participatorily correct") to impress donors or peers.

Here are some suggested definitions to distinguish the difference between these different terms:

Acronym	RRA	PRA		PLA
Name	Rapid Rural Appraisal	Participatory Rural (or Rapid) Appraisal		Participatory Learning and Action
		Shorter version	Fuller version	
Primary purpose	Extractive, mostly quantitative data from surveys	Extractive, but using community for qualitative information	More participatory, but mainly to get information for assessment	Empowerment of community to under-take on-going self-development
Time-frame (involvement of outsiders)	1-2 days in community	1-2 days in community	3-7 days in community	On-going commitment over many months or years
Benefit to outside agency	***	***	**	*
Benefit to community members		*	**	***

* low level of benefit; ** medium level of benefit; *** high level of benefit

Meera Kaul Shah defines PLA (Participatory Learning and Action) as "applicable to rural and urban contexts, and indicates its continued use during the 'action,' or implementation, phases of the project cycle."

If it's used as a one-off event, such as an assessment using participatory tools, call it a PRA. Only call the approach PLA if it's an on-going process. In the latter case, participatory methods will be used in the same communities not only for assessment, but also for project design, implementation (training, learning), monitoring and evaluation.

Ask who the information is primarily for. Also ask what the duration of the CARE or partner project staff team will be in a particular community. If it's only one day as a part of a large survey conducted as a needs assessment, recognize it as a RRA. If the outsiders can be there from two days to as much as a full week it can be called a PRA. Only if the intervening agency (CARE or partner) can commit to maintaining periodic relationships with the community over a long period of time (months to years) can it truly be considered a PLA approach.

Here are a number of other observations or recommendations to keep in mind as you think about participatory methodologies:

- Beware of "faux participation." Some forms of intervention are not participatory in themselves. In such cases it is artificial to attempt to impose participatory techniques on an otherwise top-down process. Examples of this could include "quick-and-dirty" PRA-type exercises in a few villages as a part of a diagnosis leading to the design of a large infrastructure project. The people won't really be involved in implementing the project, but it "looks good" to get their ideas before the project starts.

- *Scale is a challenge.* Usually CARE projects address the needs of many communities in a fairly large geographic area (district, municipality). How does one access the needs of the whole area by doing some PRA assessments in only a few villages? It may be erroneous to assume a homogeneity across the whole area. The project may not have the resources (time and money) to be able to conduct participatory assessments in many (if not all) communities. Ideally, there should be a way for the initial assessment exercise to provide sufficient information to lead to an over-all project design, while allowing for flexibility and building in a process of community-level assessments and customized project adaptations as the project is implemented in each community.

- *Be flexible.* Meera Kaul Shah observes that participatory appraisals can be carried out even after a project has started functioning. However, if a project was pre-designed using a blueprint developed by well-meaning outsiders, but then they decided to use PRA after project start-up, be certain that there really is the flexibility to re-design the project based on participants' perspectives.

  As a matter of fact, it would be a good idea for all projects to have the flexibility to adjust their designs as information is obtained from baseline studies and monitoring during implementation. An iterative approach of initial design › action › learning › revised design would enable a project to continue to improve its plan to respond to real needs and situations, as they are better understood and/or as they evolve over time.

- *To avoid the blueprint approach which depends on a hastily-developed overall plan, donors need to be persuaded to allow for (and support) a prolonged period of action* – research so that sufficient time can be spent getting more stakeholders involved in the evolutionary process of developing project plans. This having been said, there is need to reach a point when a project plan (including a logframe) goes beyond process and aims to achieve outcomes desired by the people.

- *A community development approach is very different than a sector-specific approach.* The former bases itself on the needs of specific communities, taking on the perspective of the members of those communities, helping them to seek out various forms of assistance. The latter brings particular technical interventions to communities.

  As Karen Westley notes, the use of participatory approaches depends upon the objectives of a project. If the objective is to mobilize communities then participatory approaches are obviously called for. However, if the objective is to provide technical training to health workers, such as training mid-wives in IUD insertion, participatory approaches may not be as appropriate (or, at least, they should be adapted to the situation).

- *There is a danger of an outside agency "doing PRA" in a community, using PRA tools designed for long-term community empowerment, when all they really want is information for the agency's use in project design.*

It is useful to consider the levels in Jules Pretty's "Typology of Participation" quoted in Michael Drinkwater's chapter on the project life cycle. In reality "PRA" is called upon (or claimed) at many levels. Though not all are at the ideal of community empowerment, there may be reasons to use participatory methods at different levels. Just recognize what level of the typology applies.

- *There is also a danger in a series of outside agencies "doing PRA" in a community.* In more than one village I have discovered, through some key informant interviews and Venn diagram exercises, that two or three or more other agencies had previously "done PRA" there! Even though these communities may very well have appreciated these opportunities to learn more about themselves, think about what your attitude would be if yet another agency announced that it was coming to do several days of the complete array of PRA exercises?

  At a minimum, find out who's been to the community before, what their purpose was, and what they did. Find out whether or not they left graphical results on paper (or whether these would be available from the agency's office). Most importantly, what would the attitude and expectations of the people be if you came and "did PRA" again.

  There are more than a few places around the CARE world where more than one CARE sectorally-focused project works in the same communities. Have such projects collaborated to the extent of conducting joint PRA assessments? Might CARE be guilty of conducting multiple PRAs for different purposes? One of the advantages of taking a program approach (rather than only discrete, isolated projects) is that a holistic diagnosis can lead to coordinated plans to proactively promote synergy. This includes collaborative PRA (and even on-going PLA).

- *Let's be considerate of community people.* When we ask them to take time from their busy work schedules to participate in PRA activities we're raising their expectations. If we're just doing it to extract information about certain subjects the project has already decided to focus on, why ask them to do a full social map, historic time-line, seasonal calendar, etc? Those tools were designed to be used where the helping agency (visitors) plan to be around for sufficient time to help the community follow up the assessment with action. Even where the intervening agency plans to use more holistic contextual information to design a multi-sectoral program, are we raising expectations in these particular communities beyond our ability to respond? Consider the community's perspective.

  As both Marcy Vigoda and Karen Westley point out, when we conduct a pre-project assessment for the purposes of developing a project proposal, there is no guarantee of funding, or at least, there is likely to be long lag time before the project actually gets underway. We have to be careful not to raise community expectations before we are able to respond. Marcy proposes using only limited PRA exercises for preliminary diagnosis purposes, and wait until project start-up before more extensive community-based needs assessments are conducted, leading directly to action plans for those communities.

Irma Ramos reinforces this concern about raising expectations, suggesting that if an organization has already decided that it will develop a project focused on health, be clear up front, and ask questions that relate to health (and factors which affect health). Also, be sure to provide feedback to the community on the results obtained.

- *Rapid assessments in a few communities cannot usually serve effectively as a baseline for a project working in a wider geographical area.* PRA tools can be used to generate quantitative data. This may be sufficient to serve as measurements for those particular communities. But even where quantitative data is obtained through PRAs, the data will not be statistically adequate to serve as a comparison with an eventual evaluation of a project working in many communities, unless there was an adequate sampling design and size in the selection of those communities.

- As Carlos Pérez points out, *we should be careful not to assume that the communities are homogenous,* and that through PRA techniques we can ascertain one collective vision. Our tools need to look into sub-groups within communities and recognize their different perspectives, power relationships and sources of conflict.

- *Sequencing:* Begin with a wide-open process to identify key issues; probe them by using appropriate PRA tools. Eventually take some measure of the extent of the particular phenomena.

- *Evolution:* Various PRA tools and combinations of tools can be adapted for initial appraisal, for project design, for use to reinforce training during implementation, for monitoring and then for evaluation. If they are used for this whole range of purposes they can, indeed, be called PLA, since they are being used to reinforce participatory learning and action.

- *Be creative.* Adapt PRA tools to the purpose at hand. Invent others. As Meera Kaul Shah points out, there is a danger of "methods fixation" – using tools we were trained to use, rather than considering first what issues the community has identified, and/or subjects the project needs information on. Determine the community's issues first, then choose (or design) tools to probe those issues in more depth.

- *Analysis is a challenge.* Although participants and facilitators enjoy using PRA tools, and much is learned during the process itself, it is not easy to synthesize key findings from PRA exercises. It is even more challenging to synthesize and aggregate the findings from many communities, to use them to inform large-scale project design, monitoring and/or evaluation.

- *Much of what we speak of is the use of PRA methods for assessments.* Continue to look for ways to incorporate them in the rest of the project life cycle, including monitoring and evaluation (M &E). For a project to have a well-developed M&E plan is not antithetical to the incorporation of participatory methods. There can and should be involvement on the part of the project participants in determining indicators which are meaningful to them, including their involvement in the measurement of those indicators in appropriate ways at appropriate stages during the project life cycle.

- We also need to recognize that a project M&E system should meet the needs of a variety of stakeholders. Though there should be consistency and coherence among the different information collection, analysis, and reporting requirements, there may need to be different components to meet the needs of community participants, partner organizations, CARE project staff, the wider CARE organization (Country Offices, Headquarters and CARE International) and, of course, donors.

- As much as we want the fruit of our efforts to be appropriate to and sustainable by local organizations, the reality of the world in which CARE projects operate is that we are accountable to many in addition to the target communities.

IN SUMMARY

It's not a question of either-or, but the right combination of both qualitative and quantitative methods; group discussions by PRA exercises and individual and household interviews; key informants in the community and in institutions which relate to the community. It should not be either a pre-planned blueprint or undefined on-going process-as-an-end-in-itself, but an adequate learning-action phase to develop plans in a fully participatory manner. Sooner or later the project has to take the shape of interventions which lead to substantive, sustainable, desirable change (i.e. impact). "Interventions" do not necessarily need to imply direct service by CARE. Interventions can take the shape of discrete ways of strengthening the capacity of partner staff and/or community members.

By definition of "project," from CARE's perspective, there is some role for CARE to take, over a limited period of time as defined by donors. But what goes on in the community was there before CARE entered the picture, and will continue to go on long after our time and money for interventions run out. If we are successful, the difference will be seen in partners and community members who are better able to carry on the work of improving the quality of their lives (beyond the life of the CARE project).

1

PART ONE

CARE's Experience with Participatory Approaches

Chapter 1 How Do We Define Participation? Are We Ready to Embrace It? 1.1

Chapter 2 Participation and Special Populations 1.11

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CHAPTER 1

HOW DO WE DEFINE PARTICIPATION? ARE WE READY TO EMBRACE IT?

Sarah Degnan Kambou

Participation is not a new concept to CARE; the word has been part of our institutional lexicon for many years. For example, participation is reflected in CARE USA's mission statement and other documents of reference as a core value and as a fundamental programming principle: in other words, our preferred way of "doing" development. In an organization as large and as culturally diverse as CARE International, it is perhaps the very fact that many of us share a belief in participation that we have been able to create and maintain a common, secular identity that spans the globe.

THE NEED FOR A DEFINITION OF TERMS

At regional and international meetings, CARE staff speak with conviction about their experiences incorporating participation into their projects; their enthusiasm and pride in their contributions to community development are heartwarming. Usually for lack of time, terms and methodologies have not always been clearly articulated in project presentations, therefore, the use of a common word such as 'participation' may have led people to believe that we share the same vision of its application in development. At CARE's Best Practices 2001 Conference[1], it was clear from the panel presentation on community participation that, within the CARE world, there is no one definition of 'participation.' In fact, the use of the word 'participation' conceals a vast divergence of definition and application. Whereas the general definition of participation probably does not vary greatly from mission to mission, namely to include CARE's partners and clients in the development process, its specific operational definition may vary considerably, actually spanning a range of modalities whereby one or several forms may be operational in one project.

> "Context is very important and community participation can be a sensitive approach. To operationalize learning, we need to determine what level of participation is realistic considering that governments do repress community participation for political reasons."
>
> Quote from the Community Participation/Mobilization Task Force, Best Practices 2001 Conference, Savannah, GA October 1997

It is possible, therefore, that Country Office (CO) Number One speaks of participation and is referring to its practice of consulting communities on major decisions such as the selection of Community Health Volunteers and arranging with the community for in-kind and financial contributions for project activities such as well construction. These are real forms of participation, though of a lower order in terms of the degree of autonomy and responsibility that they require of community members. Country Office Number Two speaks of participation and is referring to its efforts to encourage communities to achieve the

highest degree of involvement possible. Such a CO also employs multiple forms of participation, perhaps focusing on more active roles for partners and clients in project management, but for whatever reason does not necessarily seek to empower community members. Country Office Number Three speaks of participation and essentially equates it with empowerment. Such a CO will analyze its program through a very different lens, as it may see participation as an end in and of itself, while the first two Country Offices may view participation more as a means to achieving a desired development objective.

FIGURE 1.1 THE PARTICIPATION SPECTRUM

Consultation-----In-kind contribution---------Financial-------Limited role in decision-making----------Role in project management----Empowerment

Less autonomy and responsibility <----------> More autonomy and responsibility

Most passive <---------- Increasingly more active ----------> Most active

So which of these three operational definitions of participation is correct? In fact, all three may be appropriate ***if they have been defined as a function of their operational reality and if they evolve in response to changes in the operating environment.*** For example, in the very earliest phases of an emergency, it is not appropriate to employ a highly participatory style in that the operating environment is ambiguous and programming decisions need to be made efficiently and with authority. As an emergency situation stabilizes, a new operating environment emerges which should allow for increasing levels of 'community' involvement. If a state of emergency settles into a kind of hold pattern as is the case of Somalia, it may be possible, even necessary, to forge ahead and seek to incorporate higher order forms of participation in project implementation. CARE staff need to define precisely their use of the word 'participation' when referring to a programming approach, and should refer to the degree of involvement of and engagement by partners and clients in project implementation. We should recognize that various forms of participation exist, and that the selection of forms for incorporation into a program strategy should be situationally determined – therefore, there is no one way to achieve participation. On the other hand, project staff need to be self-critical in their use of the term and its exact operational definition in a specific project. The most important element is to continue learning what form of 'participation' is appropriate for partners and clients, and then to continue to dialogue with them on how the operational definition may meaningfully evolve over time.

QUESTIONS FOR REFLECTION

- Are we using the term 'participation' because it is politically correct and/or makes us feel good about our work?
- Has our operational definition of 'participation' evolved sufficiently to keep pace with a changing operating environment?
- Are we forging ahead with good intentions but leaving the community behind, all in the name of 'participation'?
- Do we view 'participation' as a 'means' or as an 'end'? What are the implications for our development program?
- If we are genuinely committed to involving partners and clients in the development process, what aspects of our ***own*** behavior do we need to change?

A re-engineered model of development. Participation is not a new concept in development theory; this statement is as equally true to health as it is to other domains. It is not unusual to hear medical officers who served in post-colonial Africa claim that they were doing community participation back when it wasn't even fashionable! They are not very far off the mark, although once again it reverts back to the issue of terms. In the 1960s and 1970s, physicians were preaching participation first under the rubric of community medicine and later under that of primary health care. Except for a few exceptional cases, participation tended to assume a lower order form, more along the lines of community mobilization, as development programming remained essentially paternalistic and authoritarian. Perhaps we can view this early period as the crucible, or formative stage, for today's models of participatory development.

CARE experience with participatory approaches. CARE projects have experimented and are experimenting with various models of participatory development, tailoring approaches to meet their programmatic needs and operating realities, and introducing innovation as they learn from their field experiences. As few of us seem to have the time to document our project experiences to allow for widespread institutional learning, many projects may be re-inventing the wheel in terms of selecting or adapting a particular participatory approach. Others may not have pushed the frontier of participation to the greatest extent possible, that is incorporating it into aspects of project design, implementation, monitoring and evaluation. While these *Guidelines* serve as a resource in terms of providing CARE staff with a theoretical overview and an introduction to various tools and techniques, they also serve as a repository of CARE field-wisdom. As Chapter Two so beautifully illustrates, we are our own greatest resource!

Using counters with community members in Tana, Madagascar to get community-derived projections on fertility and reproductive health behaviors.

"Think globally, act locally." Assuring people's greater participation in the development process emerged primarily as a result of lessons learned from previous development models which did not live up to their anticipated potential, (e.g. integrated rural development.) Furthermore, we learned that global approaches to development had to be adapted to local circumstances that are shaped by socio-cultural, historical, political and economic realities. We can take an example directly from CARE's experience in health and population programming. While CARE's programming approach in Southern Africa falls under the general rubric of household livelihood security and is based on the principles of partnership, institutional capacity building and participation, CARE's reproductive health program in peri-urban Zambia is similar to, yet qualitatively different from, CARE's sister program in peri-urban Madagascar. Both Country Offices actively seek to involve partners and clients in project implementation, but in striving to guide communities and community structures towards ever-greater responsibility and autonomy, each CO is faced with unique challenges which have necessarily shaped the evolution of its project and its strategy.

FIELD WISDOM: POLITICAL REALITIES AS FACED BY CARE ZAMBIA

Zambia and "Second Republic Mentality." CARE Zambia staff frequently cite "Second Republic Mentality" (SRM) as a major obstacle in mobilizing people to take responsibility for the development of their own communities. SRM refers to people's preference for or dependence on handouts which evolved from widespread government welfare programs implemented during the 27-year tenure of President Kenneth Kaunda.

Upon the establishment of multi-party democracy in 1991, the Zambian economy shifted from a centrally planned economy to a market economy; the effect on the price of food staples such as mealie meal was staggering. As the IMF-monitored Structural Adjustment Program steadily shut down welfare programs, the core poor were left without adequate recourse to fulfill basic human needs. The reaction of many to this abrupt and unforeseen change in political culture and economic reality was understandably human: to yearn for the days of the Second Republic when queues, ration cards and government subsidies were the order of the day.

CARE Zambia intensified its commitment to participatory programming in the early 1990s, and as a result faced multiple challenges: (1) developing a strategy whereby its overall program gradually shifted away from pure welfare interventions; (2) assisting its staff to recognize the influence of SRM on their own attitudes towards development, their behavior in dealing with partners and clients, and their readiness to adopt a more participatory approach; (3) training staff in the theory of participatory development and equipping them with tools and techniques; (4) obtaining donor buy-in; and (5) gaining the confidence of operational partners, community structures and project clients to invest in this new approach. CARE has been notably successful in meeting these challenges and re-shaping its program in Zambia.

COMMON CAUSES OF FAILURE

Stan Burkey[2] , who believes strongly that participation is an end in and of itself, conducted an extensive review of the development literature in order to prepare his book on self-reliant, participatory development. He identifies four common causes of failure among programs promoting a participatory approach (Burkey, 1993, pp. 159-161.)

- **Too little preparation.** In our rush to make progress toward project deliverables (i.e., outputs or products that we promised the donor), we do not invest enough time thinking through our own strategy, building rapport with clients, understanding their situation, explaining the project, its objectives, CARE's role and our expectations of the community, listening to their concerns and expectations, refining our strategy accordingly and preparing them to undertake activities that are intended to be sustainable after the project closes.

FIELD WISDOM FROM CARE PERU

As Irma Ramos of CARE Peru stated, "it's much easier to bring food in a can, than to teach community members to cook for themselves." The challenge is taking the short-term time investment to create long-term payoffs for communities.

- **Too little confidence.** Despite our best intentions and conscious efforts to change our attitudes, we continue to believe deep within ourselves that we are the experts and thus know the right way to do things! We lack confidence in the people and in their ability to organize themselves. We "do" for people because it is easier for us and seemingly more efficient. Burkey contends that the Golden Rule of participatory development should be "Don't do anything for the people that they can do for themselves" (op.cit., pg. 160).

FIELD WISDOM FROM CARE RWANDA

When starting field preparation and training for a PLA exercise in Rwanda, an assessment team member from the Ministry of Health had serious doubts about this type of "study." She felt that it could certainly not yield the same type of rigorous results as a quantitative survey. She also doubted that she would learn anything new from community members. While interacting with community members during a participatory reproductive health exercise, she had a revelation. When women responded to a question on RH concerns with great wisdom and insight, she exclaimed, "Wow, these women really are smart!"

- **Not enough immediate benefits.** Because Burkey views participation as an end rather than a means, he feels that the poor should be able to prioritize their needs and that development programming should address immediate needs as a first priority. According to Burkey, the problem is that we guide people into accepting our own priorities, those issues which we feel are paramount to their well-being, e.g., health, sanitation, children's health and so on. People go along with our ideas because they do not want to lose our good favor, but their commitment is half-hearted.

  For those who view participation as a 'means' to an end, a lesson can be drawn here as well. Burkey provides a quote by Martin Scurrah which emphasizes that the poor are fully employed in securing their own livelihood and therefore cannot afford to participate in our activities unless they perceive "immediate and tangible pay-offs" (op.cit., pg. 160). The Editors do not believe that Burkey is necessarily recommending the payment of incentives to community members to participate in activities (although that may be appropriate in some cases); more likely, he is referring to a transparent, logical flow of preparatory activity and the timely execution of a defined intervention.

- **Non-constructive participation.** In the event that one or several people dominate a group or highjack an activity, other people associated with the group or with the activity normally assume a more passive role. In other words, they do not fully and constructively participate. Conflict may arise and remain unresolved, struggles for leadership may occur and people begin to lose sight of their original objective. Given their negative experience, people lose interest and cease to participate.

FIELD-WISDOM FROM CARE SOMALIA

Upon arriving in an internally displaced camp in Somalia, a team of CARE staff was disheartened when some camp residents expressed hostility at the arrival of yet another "assessment team." Having spent two years in the camp, these residents had seen several "visitors" come and go, and little change in camp life had resulted from these visits. When the first day of PLA field work commenced, residents were surprised and delighted to have their opinions solicited and honored. It made a big difference in terms of how the exercise was able to engage the community and make it part of the solution.

EXPLORING OUR OWN ATTITUDES TOWARDS PARTICIPATION

Very recently, CARE celebrated its 50th anniversary. CARE is, therefore, not only one of the largest private relief and development organization in the world, but it is also among the most venerable in that it has a long history of service to poor and displaced populations. There are many reasons why our organization has been able to survive and prosper for over half a century, not the least of which have been the organization's ability to evolve with the times, to examine its operations with a critical eye and to learn from its successes and failures, as well as to play to its strength – working at the community level.

With the production and distribution of these *Guidelines*, we are essentially in the process of rejuvenating CARE's definition of 'participation' as it applies to reproductive health programming. If staff members wish to participate meaningfully in this programming initiative, they are therefore obliged to examine their own attitudes about participation. Why? Robert Chambers offers an explanation.

> "[My critique on how we do development] starts with 'us', with development professionals. It asks about failures, errors and learning, about what we do and do not do, and how we can do better. The argument is that we are much of the problem, that it is through changes in us that much of the solution must be sought. An earlier book [by Chambers] was subtitled 'Putting the Last First.' But to put the last first is the easier half. Putting the first last is harder. For it means that those who are powerful have to step down, sit, listen, and learn from and empower those who are weak and last." (Chambers, Robert. Whose Reality Counts? Putting the First Last. London, Intermediate Technology Publications, 1997, pg. 2.)

Job satisfaction: a potential stumbling block to participation. We derive satisfaction from our work at CARE; we stay here rather than leave to earn a potentially higher salary in the civil service or in the private sector. Something about working in relief and development gets us out of bed in the morning and brings us to the office or (even better) out to the field. We need to better understand the elements that generate our job satisfaction because, although they may contribute to our personal sense of well-being, they may in fact prove counterproductive to the organization's objective of increasing people's participation in their own development.

EXAMPLE: If I am a field agent supervising a Food-for-Work (FFW) gang, I derive a certain degree of satisfaction distributing rations to poor people in my community because I know that they need the food, and it makes me feel good to help them. As the field supervisor, I am in charge of the work site, equipment and supplies, and enjoy my status as a boss. I may also derive satisfaction from the respect that is paid to me by the FFW work gang, by community leaders, and by my family and friends who are impressed by my position at CARE. Then one day, senior staff at my Country Office start talking about increasing people's participation in decision-making and project implementation, and I become worried that I will loose my power and authority over the work gang. I am convinced that the status that I had previously enjoyed in my community will be lessened because I won't be as important as I used to be. And perhaps my greatest fear is I won't be able to do 'this participation thing' the way my supervisors want me to do it! When all of these considerations are added up, it seems like a lot to risk – ***so I resist.*** And I will continue to resist until I understand that I have much to gain by adopting this new approach, that my performance appraisal will be based on my ability to foster participation among partners and clients, and that I will derive satisfaction and status from my new role as a 'facilitator' of community development.

So Take the Plunge! Have the courage to examine critically your own attitudes and behavior and take the appropriate steps to change. Managers should note that people need to be supported through this process and be rewarded with positive feedback. As learning is continuous, people must be encouraged to monitor their attitudes and behavior so that they can adapt when necessary.

WORKING WITH DONORS

Often in development circles people gripe about donor priorities, prerogatives and demands for immediate results. While they understand the donor's responsibility to report back to its government on the performance of its foreign assistance program, they usually feel that donors are far removed from where development really takes place – in the institutions and communities of the nation. In addition to this perception of donors, CARE project staff are slightly in awe of donors, after all they control the purse strings. Consequently, we tend to be overly cautious with our donor contacts and hold them at arm's length. If we hesitate to incorporate more participatory approaches into our projects, it may be because:

1. we lack confidence in ourselves, our partners and our clients;
2. we lack experience with the methodology;
3. we lack familiarity with our donors; and
4. we believe that the donor has neither the interest nor the patience to allow us to experiment with a new approach.

DON'T BE CAUGHT SAYING:

"Well, we wanted to use a more participatory approach, but we didn't think it would meet with the donor's approval."

YOU LOSE! COMMUNITIES LOSE! PARTNERS LOSE! DONORS LOSE!

Our problem is that we view the donor as a monolithic institution, (e.g., the Population, Health and Nutrition Program is the same at USAID Bolivia as it is at USAID Mali as it is at USAID Indonesia). This is ***not*** the case. Just as CARE country programs vary from place to place so too do donor programs. Institutions are made up of people, and each person has her/his own professional domain, range of interests, perspective on development, and position within the greater agency system. If we limit our interaction with our donor, then we are not taking full advantage of the opportunity to know the individual within the institution and to build her/his awareness about CARE's program and its programming approach.

What's the antidote? First, know your donor. Observe your donor contact, note her/his likes and dislikes and her/his preferred style of interaction with people. While it would be nice to say 'be yourself,' it would not be fair advice; learn to manage your relationship with the donor. Then, build rapport as a prelude to effective advocacy. Dialogue with people rather than talk ***at*** them and negotiate an agreement that suits your project's needs and the donor's needs. Now that you've got the donor's attention, maintain meaningful contact – continue the dialogue. Invite the donor for field visits at strategic points in project implementation, participate in donor roundtables and help shape the donor agenda by providing concise, useful information that will assist the donor in reporting back to his authorizing agency.

Over the past decade, CARE's Health and Population Unit and various Country Offices have had the good fortune to work in close collaboration with several donor agencies who have not only financed projects, but have effectively partnered with CARE and contributed substantively to its efforts to build a state-of-the-art reproductive health program. Borrow lessons learned from this success!

Rwandan women actively engage in using counters to determine the magnitude of different reproductive health problems.

Parting advice. Participation is not a magic bullet, ***BUT*** it is our desire that every reader of these *Guidelines* "tries it out" – puts the tools and techniques through their paces, and see what happens! Be realistic in setting your goals, for as we all know, true participation is not easily achieved. As you gain field experience with participatory tools and techniques, your ability to diagnose the community's readiness level will improve, and as you are more able to accurately anticipate people's training needs and reactions to exercises, your confidence in applying

these methods will grow. Don't count on ever getting bored because even the most seasoned PRA/PLA field hand gets surprised from time to time. So that you know what you are up against, read through the ILO's list below of five issues that challenge participation in development – and think proactively on how you can surmount them in your project.

CHALLENGES TO PARTICIPATORY DEVELOPMENT

Stan Burkey summarizes five basic issues identified by the International Labor Organization (ILO) as increasing the challenge associated with participatory development:

- Participation will develop in different ways in specific situations dependent upon the problems faced by specific groups of the poor and the specific factors inhibiting their development.
- The poor need to be approached as a specific group and their economic situation must be improved if participation is to be successful. This will, in most situations, automatically imply conflict with more well-to-do elements in differentiated rural societies.
- There is a complex relationship between self-reliance and the need for external assistance.
- Participation requires organization. Yet organizations easily become centers of formal power controlled by a few. Maintaining 'people's power' requires that the poor retain genuine control over their own organizations.
- Participatory processes seldom begin spontaneously. Such processes are generally initiated by a leader whose vision is external to the perceptions and aspirations of the people concerned. Resolving this contradiction implies going beyond mere mobilization for the support of an 'externally' defined cause.

(Adapted from: Burkey, People First: A Guide to Self-Reliant, Participatory Rural Development. London: Zed Books, 1993, pp. 59-60.)

CHAPTER 2

PARTICIPATION AND SPECIAL POPULATIONS

Barbara Monahan

Our work at CARE serves to affirm the dignity and worth of individuals and families in some of the world's poorest communities. Involving community members from the start not only engages them in problem identification, but also empowers them to seek their own solutions. This philosophy underlies much of our development work, and underpins CARE's approach to reproductive health programming.

In 1991, the United States Agency for International Development (USAID) awarded a grant to CARE which was initially conceived to increase access to and utilization of family planning services in developing countries. This grant is referred to as the Population and Family Planning Extension (PFPE) Project, and in its final phase, the focus has shifted to increasing access to and use of *reproductive health* services. Central to the PFPE strategy is the idea that effective community involvement is essential to the process of expanding access to reproductive health services to those most in need. The following case studies narrate some of the innovative ways in which CARE field staff are experimenting with participatory approaches as a means to achieve this objective.

The case studies present a range of experience, and are taken from the many CARE reproductive health programs that are operational throughout the world. In the text that follows, you will read cases describing how participatory approaches have been used to meet the reproductive health needs of diverse client groups, including hard-to-reach communities, refugee and displaced populations, adolescents, conservative societies and many others. These cases have been selected because they highlight the use of participatory approaches as they span the project life cycle: from needs assessment to evaluation.

While experience with participatory approaches is varied and in most cases, overwhelmingly positive, CARE staff often acknowledged that the use of participatory approaches "complicates things." To understand how and why, read through the case studies submitted by field staff from the following Country Offices:

CARE BANGLADESH
CARE PERU
CARE TOGO
CARE MADAGASCAR
CARE SOMALIA
CARE UGANDA
CARE ZAMBIA

It should be noted that CARE operates many other reproductive health programs – 46 projects in 33 countries to be exact. For a variety of reasons, including time constraints, other country office staff were not able to participate in documenting their experiences with participation for this publication.

Women in Kibungo Prefecture make a map of their community, under the shade of the banana trees. Rwanda

CARE BANGLADESH

PARTICIPATORY RURAL APPRAISAL IN THE WOMEN'S DEVELOPMENT PROJECT

Marcy Vigoda, *Assistant Country Director, CARE Nepal*
(previously: Project Coordinator, Women's Development Project, CARE Bangladesh)

The Women's Development Project, or WDP, was a project that worked in hundreds of Bangladeshi villages. The project aimed to improve the health and economic well-being of women and their families in rural Bangladesh. It did this through two components to assist groups of rural women. While there have certainly been improvements, health conditions remain poor in Bangladesh. The maternal mortality rate per 100,000 live births is still 850 (compared to 12 in the US). Diarrheal disease and pneumonia are major causes of children dying, and few births are attended by trained health personnel.

The first component trained 15 women in each village, organized into three neighborhood-specific committees, to provide health advice and training to their neighbors. Women were proposed on the basis of their good relationships with community members, leadership capabilities, enthusiasm, and availability of time. The volunteer community health workers were called para committee members. They served as local resources, knowledgeable about how to treat things such as diarrheal disease, family planning, the importance of environmental and personal sanitation, the value of nutritious meals, and the importance of appropriate breastfeeding and weaning practices.

Some of the women were also trained in specialized activities, such as poultry vaccination, seed propagation and vending, and as community-based distributors for family planning supplies. Some of these roles afforded the opportunity to earn some additional income. Where these volunteer health workers were also "traditional birth attendants", they received training to upgrade their skills so that they could promote safer deliveries.

Para committee members participated in intensive residential training sessions held away from their villages. In the first year, they attended two three-day sessions where they were introduced to the WDP interventions using participatory techniques. Fortnightly meetings were held with WDP field staff and para committee members to plan their work, strengthen their knowledge, and further develop their training skills, reinforcing this residential training from which they derived respect and status.

Community health education sessions were held in each para on a monthly basis. Initially these were facilitated by CARE staff, who "role modeled" the training, but from the second year onwards the para committee members themselves conducted sessions. Committee members took on responsibility for sharing information with a small group of neighbors (e.g., five to fifteen households).

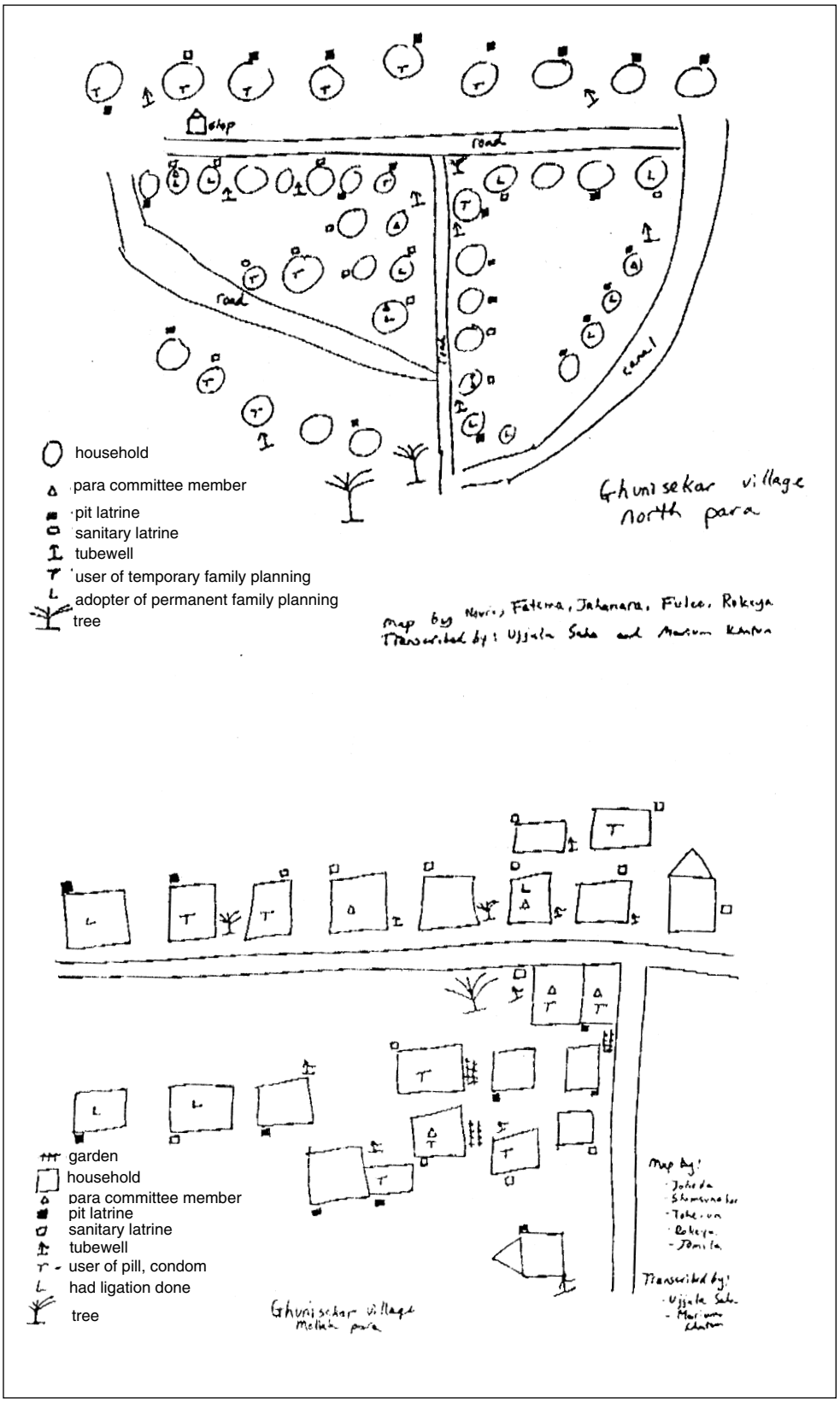
The second component supported the formation of neighborhood-based savings and loan groups enabling participants to start up income generating activities and gain access to small amounts of credit when necessary. The project worked in each village for four years, and it was explicit at the outset that this was the duration of the project. This strategy avoided people becoming dependent on project inputs. By project end, the para committee members were well-known and respected leaders in the community, with a good deal of knowledge about basic health, nutrition and hygiene. The project ran from 1980 to 1996, and during that time evolved considerably, as it learned about what worked well and what could be improved.

Participatory methods were used in many aspects of the project. The design of subsequent phases involved consultations with a range of participants who were asked about what they liked about the project, what they disliked, what worked and what didn't work. As noted above, training utilized participatory approaches. For instance, training on nutrition during pregnancy would begin with a session where participants would describe traditional practices for maternal nutrition, and the reasons for these practices. Staff could then build upon this information, reinforcing positive practices, and promoting appropriate improvements.

The Women's Development Project introduced participatory social mapping in 1992 as a means to further involve the women health volunteers in evaluating their own achievements and planning future work. The women were asked to draw a map of their village, and used sticks and flour to do so. Some asked what they should draw and we suggested they show all the households in the neighborhood, and other important landmarks. That was about all the guidance they needed. Within 30 minutes each group had produced a map showing all houses and landmarks (schools, latrines, tubewells, canals, roads, groves, etc). There was considerable debate among the women as they drew the maps and lots of creativity; they stuck a flower in a small bottle to indicate a flowering bush in someone's courtyard.

After drawing all the households in their neighborhood, they showed the number of men, women and children who live in each household. Their own houses, and those with which they worked, were marked by orange and red powder. They then indicated with beans or other markers who had installed and used latrines, which couples had adopted family planning, houses where they had helped malnourished children become well again, houses where children were treated for nightblindness, etc.

This process was particularly appropriate working with volunteers. It is really important that projects which work with volunteers not impose excessive workloads on these women, who are already very busy looking after their homes and children. Overwork is likely to lead to disinterest and dropout.



The maps depict Ghunisekar village, Tangail district. The exercises were done on December 27, 1992. Participants, all para committee members, had been working with WDP for 2.5 years. Only one of the fifteen participants was literate.

The mapping was an empowering exercise, as women saw at a glance the real impacts of their work. They could also see where they should focus more. For example, looking at the maps, they themselves concluded that no effort was really needed any longer to encourage the use of colostrum – all women now feed it to newborn babies – but that more work is needed to promote family planning. How much more effective it is to have had the women realize this themselves, rather than being told what to do by project staff! Also, the depiction of achievements by household unit enabled them to better target their visits to their neighbors.

There is often a concern that participatory exercises take a long time. In fact, the mapping exercise took an average of two hours in each community. In that time, we generated a full demographic profile of the community, tracked achievement; and planned future activities. This is a terrific use of everyone's time!

The women enjoyed the experience and felt both challenged and proud. The women knew that their work had an impact, but had never in this way depicted what they had accomplished at the household level, and for each intervention. Looking at the beans and leaves they had placed on the map, they saw how much they had achieved, and also saw where further work was needed (e.g., to provide information about family planning). They also felt that they could now easily identify how to work with each household.

When one participant began to say that we (the outsiders) had taught them to do this, another interrupted her, saying, "No, they didn't teach us, we used our brain."

Just as importantly, it demonstrated to staff what the women could accomplish. Many had felt that the women would not be able to make the maps, as they were not literate, so the exercise shattered a myth staff had held about para committee members.

Our worry at the time was that the process, once scaled-up, would become rigid, and people would lose sight of the objective, focusing more on the map than on the discussion about the map. This in fact turned out to be a real issue, one for which there is not any obvious or simple answer. When we have "conduct 'x' number of PRAs" in our annual plan, the completion of the PRAs often becomes more important than the quality of the effort.

Guidelines are helpful, but can encourage the adoption of an inflexible process. The guidelines we developed focused more on "dos" and "don'ts" rather than acting as a step-by-step guide, but still led to a certain amount of rigidity. The information generated can be extremely useful to management, when compiled. There are challenges however in standardizing information without making the process mechanical. To address this issue, we can make sure that our PRA training adequately focuses not only on methods, but also on attitudes required to do effective PRAs. We should also ensure that staff spend adequate time reflecting on the use of PRA and mechanisms for "quality control."

There are many different applications for mapping in health projects. These include:

- selecting villages in which to work, based on a comparison of available resources and local problems/issues (although there is a risk of raising expectations in villages where we do not end up working);
- gathering baseline information at the start of a project;
- determining the proportion of the population covered by service providers;
- setting objectives for health volunteers;
- identifying and then ranking pertinent health problems faced by villagers to prioritize those to be addressed;
- identifying linkages between traditional service providers ("quacks", other local doctors, clinics, government services) and para committee members and villagers; and
- periodic assessments by para committee members of their accomplishments, challenges and future plans (as was done in this exercise), and sharing this with government health workers as well.

Participatory Rural Appraisal (PRA) techniques are also well established in Nepal. CARE Nepal has used the approach largely during annual planning exercises with communities, to some extent for periodic evaluation and in conducting situational analysis for new project designs. We have in fact not used too many visual methods in preparation for new projects, largely to avoid raising expectations. When we go out and design a new project, there is no guarantee of funding. Even if funding appears secure, there is often a lag of two years between designing and starting up the project. Therefore, our preference is to limit the design-stage activities to semi-structured interviews with people, and to wait until project start-up to do more extensive needs assessments.

CARE MADAGASCAR

THE EXPERIENCE OF CARE MADAGASCAR'S URBAN PROGRAM IN THE USE OF PARTICIPATORY ACTION RESEARCH IN REPRODUCTIVE HEALTH

Eléonore Seumo *and the CARE Madagascar Team*

The goal of CARE Madagascar's urban program is to protect and promote food security among 10,000 vulnerable households located in 30 districts of the capital city. The location of these districts is notable in that most border on rice fields which are subject to annual flooding, creating extremely uncomfortable and hazardous living conditions for residents. CARE's program seeks to improve livelihood security in these districts by strengthening local capacity, improving hygiene and sanitation and by improving health status through the provision of better quality health care services and through community mobilization for the promotion of healthy behaviors. The interventions include breastfeeding, weaning, acute respiratory infections, control of diarrheal diseases, vaccination and family planning.

The program's approach is participatory, and collaborating partners include local community members, their local associations and health center staff working in the project area. Together, the partners identify problems, search for solutions, develop action plans, implement them, and monitor and evaluate project activity. This approach has been undertaken in each of the neighborhoods where the program has been conducting its pilot phase.

In order to understand the family planning needs of the adult population, the program conducted a participatory action research exercise. The objectives of the participatory action research were as follows:

- To better understand the community, its demographic make-up, its means of living and surviving, and its social dynamics;
- To obtain various information about knowledge and attitudes of men and women in the neighborhood regarding birth spacing, and more specifically, their perceptions on sexual initiation and reproduction;
- To appreciate decision-making processes and authority within the household (or with the couple) relating to pregnancy, breastfeeding, weaning, birth spacing, and adoption and use of a contraceptive method;
- To identify the obstacles that prevent men and women from adopting and using modern contraceptive methods, and discover the potential areas of intervention and actions to reduce/remove these obstacles; and,
- To involve the community in creating progress indicators for the program.

As the principle output, the process and findings of the participatory action research exercise contributed to the development of an appropriate, community-generated family planning Information-Education-Communication (IEC) strategy.

STRENGTHS OF THE PARTICIPATORY ACTION RESEARCH APPROACH

This approach uses many PRA tools which are adaptive to community needs, varied in their utilization, and complementary to one another. Their simplicity permits their successful use by people of a relatively low educational background.

Collecting relevant information efficiently

The quantity of data collected within only a few days is impressive. More importantly, the breadth of information collected convincingly demonstrates the extent to which communities are knowledgeable about their problems and the causes and effects of unhealthy or high risk behavior, and to which community members can participate in recommending potential solutions. No other approach could have generated such comprehensive understanding of family planning attitudes and practices in such a short period of time. Team members found the findings from the qualitative data absorbing; field exercises constantly produced testimony on the tough reality of life in slum areas. A key finding was that, given life's social and economic pressures, marriages and consensual union are highly unstable and, consequently, people are compelled to adopt high risk sexual behaviors. For the development of an IEC strategy, it was critical that health workers and CARE staff understood this particular consequence of life in an urban slum from the community's perspective.

The participatory approach made it possible to engage all stakeholders (e.g., community members, health center staff and CARE staff) in the development of action plans that corresponded to each neighborhood's perception of its own particular situation and its preferences and priorities in planning solutions. As an example: another interesting, but not unusual, finding was that neighbors play an important role as a reference group when an individual or couple is making a decision regarding birth spacing and total family size. Women invariably pointed out that neighbors can play either a positive or a negative role in influencing their decisions. The advantage of the participatory approach was that it was possible to incorporate the findings immediately into the action plans.

Finally, the use of participatory action research served as a powerful means to bring health care workers closer to the communities that they serve. Throughout the exercise, the health staff were amazed by the communities' knowledge, and grew more familiar with the barriers that exist between the health services and their clients.

Creating a learning role for the development worker

Over the course of a few days, community members participating in the research exercise guided the team, facilitating contact and providing indispensable information on community realities. Moving through the community with residents enabled the development workers to better comprehend their environment and social reality and to perceive the extent and impact of poverty on daily life. Development workers were very impressed by life's daily struggle in the urban slums, and wondered at the permanent courage of communities in facing poverty.

Providing tools that are varied, easy to use and maintain people's interest
Participatory action research utilizes tools that are user-friendly and that are fun; community members on the team felt confident in using the tools, and community members who participated in the exercises were enthralled by the process. According to one member of the team, "the exercises mostly drew participants' curiosity and attention, therefore, they had maximum concentration. They were very passionate." The purpose of many of the tools is to facilitate real discussion among all individuals involved, generating general agreement once a topic has been thoroughly discussed. Many people enjoy contributing to these discussions.

Following is an example of using the fixed scoring method to determine roles played by different people in decision making around reproductive health.

CARE MADAGASCAR'S URBAN PROGRAM
DECISION-MAKING IN REPRODUCTIVE HEALTH

5th Sector: **Women's perceptions on decision-making around major reproductive health**	**Decision-making**				**Implementation of actions related to decision**			
	Husband	**Wife**	**Grand-parents**	**Neighbors**	**Husband**	**Wife**	**Grand-parents**	**Neighbors**
Timing of 1st pregnancy	11	9	0	0	10	10	0	0
Timing of 2nd pregnancy	6	8	3	3	10	10	0	0
Timing of 3rd pregnancy	3	3	8	6	5	5	10	0
Timing of 4th pregnancy	3	3	8	6	5	5	10	0
Timing of 5th pregnancy	3	3	8	6	5	5	10	0
Duration of breastfeeding	6	10	4	0	10	10	0	0
Timing of weaning	5	12	3	0	5	15	0	0
Whether to use a modern contraceptive	15	5	0	0	10	10	0	0
Practice of sexual abstinence	10	10	0	0	10	10	0	0
Type of birth control method to adopt	10	10	0	0	10	10	0	0

This matrix was developed by a group of women in the 5th Sector of CARE Madagascar's Urban Program catchment area. Elements in the right-hand column (Implementation of action related to decision) of the matrix were suggested by the project team although community members were invited to add on other issues that related to reproductive health decision-making. Participants determined who should be included in the analysis: husband, wife, grandparents and so on. Some community groups included other personalities such as health personnel as actors in the decision-making process. A total of twenty counters were used to facilitate the task of showing proportional authority and responsibility among these people when it came time for decision-making around a major reproductive health issue, such as timing of the first pregnancy, and its actual implementation. Once the matrix is completed, the facilitator "interviews" the visual output. For example, in this case, we would want to know more about the role of grandparents and neighbors in the timing of the 3rd through 5th pregnancies. This type of information helps in identifying target groups for IEC messages.

Promotes community empowerment

The majority of community members who participated on the participatory action research team had a relatively low level of education. This did not hinder their participation in the different exercises. For example, at the end of each exercise, a feedback session was held with the community. Community members who were part of the team could no longer be distinguished from the CARE staff during the presentation of results; they presented the tools and results with such pride and ease! It was clear and evident for all those who participated in this activity that the community is the expert as far as knowledge of its problems, quest for solutions as well as implementation, monitoring and evaluation are concerned. The fact that the tools are simple and easy to use empowers people and places them in front of the process.

Causal flow diagram showing the cause and effects of polygamous relationships on reproductive health. Tana, Madagascar

The participatory approach permits effective decision-making by the community. More importantly, at the end of the exercise, they not only understood the role that CARE would play in executing the agreed upon action plan, but fully understood their own role: CARE facilitates and channels their energy, but all the rest (action, monitoring, evaluation) is the communities responsibility. A development worker stated: "When the analysis of a certain situation, particularly the quest for a solution is done in a participatory manner, one can note a stronger and more mature commitment of participants in the realization of the next stages."

As the CARE Madagascar Urban Program is just underway, it is difficult to draw further conclusions from its experience with participatory action research, however, the staff believe that the use of a participatory approach will facilitate the development of partnerships between themselves, the health care workers and the community. The participatory approach improves relations between communities and development actors. Everyone is placed more or less on an equal footing, and tasks and skills are valued as complementary.

CARE Madagascar also anticipates that the participatory approach will contribute to better coordination of stakeholder activity in a given geographical zone. Further, feedback of results and ensuing discussions should contribute to a harmonization of development interventions. During this pilot phase, all reproductive health actors in a given catchment area were involved in the research; issues that were raised by community members, such as free versus modestly priced contraceptives, were the subject of much debate. In this particular case, it was finally agreed that it was necessary that communities pay a token fee for contraceptives as paying for something increases its value in the eyes of the buyer.

WEAKNESSES OF THE APPROACH

Participatory approaches necessarily require the participation of community members. Residents of urban slum areas spend the entire day securing their livelihoods and have little leisure time to devote to such exercises. Therefore, this approach compels the development worker to operate at the community's pace rather than at his/her own pace.

In the case of CARE Madagascar's participatory action research, the tools were not developed with the community at large. Certain tools such as the criteria matrices were not as user-friendly as compared to other tools such as scoring, mapping and calendars.

While it is indispensable that all social strata participate in the exercise, it is not easily achieved and requires special effort on the part of the facilitators to ensure that participation is as representative as possible.

It would be valuable if communities participated in the detailed analysis of the information collected. Given the volume and nature of much of the data collected, i.e., qualitative, CARE Madagascar has not developed any relatively simple tool that allows community members to be intimately involved in the analysis.

In CARE Madagascar's case, the participatory action research has generated a great deal of important information, the application of which remains very limited in terms of incorporating it into the project strategy.

The participatory approach must not appear as an element occurring only once in a project. Rather, it should be part of the very culture of the organization; the staff should be educated in the methodology, its principles and tools and techniques so that they can develop the attitudes, behaviors and reflexes that promote participation. This constitutes an investment in staff development which is made in order to ensure that lasting community empowerment is possible.

LESSONS LEARNED

- The findings of a participatory research study are not an end in and of themselves; they are rather a means which make it possible to address important issues such as livelihood security and reproductive health status.

- Participatory research makes it possible to understand what is important in the eyes of the community. "Listen to the community because they have things to tell!" One must listen carefully when community members discuss: note the proverbs and expressions.

- Participatory methodologies allow communities to resolve their own problems and to take matters into their own hands, as they constitute their own greatest resource.

- Sustainability is ensured only if the community assumes its responsibilities from the outset. The key to success resides in good community preparation before beginning the activity.

- The participatory approach trains not only the community, but also the development worker.

- See to it that all categories of people within a community are reached. Be especially alert that the poorest and most marginalized are not omitted.

- In the case of Madagascar, it is necessary to separate men and women when discussing sensitive issues about the local culture.

The daily report back to other members of the PRA team. Tana, Madagascar

CARE TOGO

PARTICIPATORY APPROACHES TO ASSESS NEEDS

Karen Westley *and* **Kanyi Mensah,** *M&E Specialist*

In the past year CARE Togo has conducted three participatory needs assessment exercises: one in Lomé, one in Dapaong and one in the Borgou Region of northern Benin. The objective of the assessment in Lomé was to simultaneously train CARE Togo staff in participatory assessment methodologies and tools and to help the mission develop strategies for urban programming. In Dapaong, participatory assessments were funded by the Cooperation Francaise in conjunction with a quantitative survey. The objective of these studies is to develop a proposal for urban development in Dapaong to be funded by the Cooperation. The participatory assessments were used to focus the quantitative surveys on pertinent issues and to get an overall idea of constraints to livelihood security in the different neighborhoods of the city. In northern Benin, the objective of the assessments was to gain a broad understanding of livelihood security issues and priority needs in four districts, in order to guide programming in Benin. After three to four days of general needs assessment exercises, the team conducted a series of focus groups and key informant interviews on reproductive health and girls' education (and the links between the two). Examples are given from the assessments in Lomé and in the Borgou Region of Benin.

Lomé

In Lomé, two teams of CARE staff, members of partner organizations and a sociologist from the Universite du Benin, carried out five-day assessments in two neighborhoods in Lomé: one urban and one peri-urban. A three-part analysis included environmental, social and institutional assessments, culminating in the identification of key constraints to and opportunities for improving livelihoods.

In one community a group of adolescents became the most dynamic participants in the week-long exercise. Their participation made it clear to the team that the problems of adolescents are very different from those of their parents. Young people in Lomé are confronted with radical changes in their social and economic realities. They represent a generation in transition from rural to urban, agricultural to industrial, and traditional to modern livelihoods.

As they developed their own list of problems and priorities, unemployment emerged as the crucial issue. Lack of education, lack of entrepreneurial skills and lack of access to credit underlie high unemployment rates. In addition, the group identified a complex listing of social problems that they termed "juvenile delinquency." These problems included drug and alcohol abuse, early pregnancy and unhappy childhoods. According to the group these problems develop due to high school dropout rates and low enrollment rates, combined with the absence of any program or center for reintegration of dropouts into the educational system. These

problems result in a lack of confidence and inferiority complexes, prostitution, theft and mental illness. The group pointed out that they receive no information about reproductive health either from their parents or in school. As a result, high rates of abortion and early pregnancy leads to school drop outs and a loss of employment opportunities.

The results of the participatory assessment and other surveys made it clear that in order to empower young people, particularly young women, CARE Togo must take an innovative and comprehensive approach to girls' education. It is not enough to build schools, or increase girls' enrollment; adolescent girls must be empowered economically, personally and socially to overcome the difficulties they face in a rapidly changing urban context.

Women creating pictorial representations to symbolize health care problems such as lack of water and lack of access to health facilities. Togo

The results of the participatory assessment have been used to design a project proposal for girls who have either dropped out or were never a part of the formal education system. The project will include literacy and life skills training, as well as a small credit program and training for income generating activities. The life skills component of the project will be elaborated with the participation of the girls: (e.g., what type of information and skills do the young women want to acquire). They may range from family planning to nutrition, to opening a bank account, to finding a job or to resolving conflict within the family. We plan to continue to use PRA tools in the implementation and evaluation of the projects proposed. In addition, participation in the assessments gave CARE Togo staff a broad view of the constraints to livelihood security that prevail in the city.

The most useful contribution made by community participants to project design was in the assessment of causes and effects of the problems identified (see page 3.49). In terms of on-going projects, we learned much about the effectiveness of various organizations and institutions from the community perspective. For example, one of the CBOs that is our partner in the AI-Be project did not appear on the Venn diagram institutional assessment. This indicated that the organization was not really representative of the community or responsive to community needs. We found this particular analysis very useful in light of CARE Togo's focus on partnership.

Borgou Region, Benin

In the Borgou Region a team of CARE staff, university students, a medical doctor and a girls' education specialist conducted needs assessments in four communities representing three different ethnic groups and two agro-ecological zones. CARE does not currently have a presence in Benin. The assessments were a first step in the development of a program. The results have been used in the development of a response to a Reproductive Health Request for Proposal (RFP) prepared for submission to USAID by MSH, INTRAH and CARE. The role of participation in the needs assessment stage of program design is significant. First, programming staff in CARE Togo have a better idea of the needs and interests of community

members (as opposed to just government officials, other NGOs, etc.) in the areas where we are planning to work. Second, while the assessments can direct the type of interventions we decide to undertake, they are even more important in directing "how" projects should be implemented: (i.e. with whom, using which strategies and so on). For example, Benin, like most countries in West Africa, is in the throes of decentralizing their health service delivery system, placing emphasis on the role of communities and village health committees. However, in the Venn diagram institutional assessments, we saw that these committees were not active in the majority of communities. We also learned a great deal about attitudes and practices around various RH issues: Female Genital Mutilation (FGM), weaning and child nutrition, Maternal Health (MH), Sexually Transmitted Infections (STIs), preferred traditional and modern methods of contraception, the role of spiritual beliefs in RH decision making, the role of the fetish priest in STD treatment and fertility management, and so on. This type of information is especially important in designing IEC strategies.

Some of the key tendencies/findings in discussions with adults and adolescent girls were as follows:

- **Livelihood security/wealth:** the participants measured wealth in a variety of ways, including having many children (the ideal number began at six) and having many wives (polygamy). Although many households have substantial income from cotton, there was economic insecurity due to poor management of household income.

- **Health care:** people preferred to use traditional medicine and self-care as a first line of treatment; western medical services were sought only when other treatments failed. Preventive health care was not viewed as important.

- **Reproductive health:** knowledge of modern FP was very limited. The most widely known modern FP method was condoms, but only in the context of AIDS prevention. The only known STI was AIDS. Traditional child-spacing methods, such as post-partum abstinence, were widely known but might be practiced less now than in the past. Female circumcision was widely practiced.

- **Adolescent reproductive health and linkages to education:** knowledge of modern FP was very poor and access to health services limited. The concept of limiting the number of children was not widely accepted. Girls' school attendance was low. Reasons for leaving school early were given, such as a pregnancy. The discussions also indicated that few role models existed for girls, that is, the only adult model that girls had was to marry early and have children.

This information was essential to the crafting of CARE's response to the Benin Integrated Family Health Program (BIFHP) RFP. CARE will be responsible for the community mobilization component of the proposed project: building capacity at the community level through provision of technical assistance to local NGOs, CBOs, and COGECs seeking to expand community involvement in Family Health (FH) promotion and service delivery; and the development of

"health insurance" plans. The participatory assessments allowed the CARE Team to develop a strategy that took broader issues of household livelihood security into consideration, rather than just focusing on technical RH problems. For example, by enabling households to save their money – stretch it out over the year – CARE can help communities develop their own "health insurance" schemes. Whereby the cost of services does not prevent households from seeking appropriate care for unplanned medical needs such as an obstetrical emergency. Also, it was clear in the assessments that in order to reduce fertility in the communities, adolescent girls needed to be empowered to seek alternatives to early childbearing. To this end, the RH project will also include a girls' education component, designed to reach girls with FH preventive information and basic education. Alternative youth and adult role models will also be introduced that would influence FH attitudes and behaviors.

STRENGTHS

- If communities are involved from the needs assessment stage, implementation becomes easier. Community participation is seen as part and parcel of the project from the very beginning.

- Communities are encouraged to participate in finding their own solutions instead of waiting for a project to come along (this depends a lot on how the exercise is introduced and how the community perceives CARE's role).

- Project staff are more likely to be committed to participatory approaches to problem solving in all aspect of project implementation – a great "team building" exercise.

- The simple act of guiding a community through a self-assessment exercise empowers people to take a new look at their problems and to find solutions. For example, in Gbeniki, a community in the Borgou Region in Benin, the assessment team started off the mapping exercise with groups of men and women. The women insisted that the men would represent them so there was no point doing a separate map. By the end of the day, the women had done their own map and took on various responsibilities in the assessment, such as organizing focus groups, animating meetings, etc. By the end of the week the women, who claimed to have no solidarity among themselves at the beginning, had decided to form an association to address some of their constraints, such as lack of savings and credit. In Adakpame, a peri-urban neighborhood in Lomé, we had a similar experience. During the institutional assessment exercise it became clear that the Comite de Developpement de Be (CDB) was not involved in community development efforts in the neighborhood, even though it was well within their geographic mandate. When we went back to give feedback to the community on the assessment, the neighborhood chief said he had gone to visit the CDB offices to find out why they weren't working in his area. Simply put, there are certain side effects of participatory assessments that may have little to do with the projects themselves, but have positive implications for the communities.

- Participatory methods are flexible by nature and therefore can be adapted to fit the nature of the exercise. For example, questions pertaining to RH are often personal and may make people uncomfortable. By using different tools – one-on-one interviews, focus groups based on different age groups, gender, etc., facilitators can find ways to make sure that none of the participants feel inhibited or embarrassed to share their views.
- It's fun ☺ .

WEAKNESSES

- It seems difficult for COs to involve communities in the project design phase (as opposed to the needs assessment and implementation phases).
- It is a challenge to generate "statistics" – get quantitative results from participatory exercises for project baselines and to have a good sampling design.
- Need to educate donors – i.e., they may put out an RFP that does not respond to the communities' perceived needs and priorities.
- Needs assessments are often carried out before project funding is secured. It is difficult to explain to communities that there may not be any projects in their community – a problem with community expectations.
- You might not get the results you expect, i.e., if you are going to use participatory methods, you have to live with the results – communities might want interventions that we deem inappropriate or unnecessary (they might want a hospital in their village instead of a community-based distribution agent).
- During the assessment itself you may run into problems or realize that a community really needs some help, but there is nothing you can do about it. You are sitting on the horns of an ethical dilemma. For instance, in several communities we found infants dying of severe dehydration. What is the role of the assessment team in trying to help those children? Also, in Benin, we saw women feeding newborn babies contaminated water mixed with ash. Sometimes assessment team members may not be comfortable taking action. On the other hand, assessments frequently provide a good opportunity for sharing information. For example, in Benin, many adolescents would ask team members questions about contraceptives: where to get them, what their side effects are, etc. The curiosity of community members allows team members to share some of their own knowledge and expertise after conducting the exercises.

When responding to a question about how participatory approaches facilitate work, CARE Togo responded that they think the answer to this question depends on how you define your objectives. If an objective is to mobilize communities, then participatory approaches are certainly going to facilitate your work more than other approaches. If, on the other hand, the objective is to train midwives in Intra-uterine Device (IUD) insertion, then it is perhaps not necessary to use participatory approaches. (Ideally, this training would be conducted because the community identified lack of contraceptive options as a constraint.)

Sometimes participatory approaches can slow down project implementation.

A participatory approach could conceivably cause conflict within a community. For example, In Nyekonakpoe, Lomé, the chief of the neighborhood belongs to the RPT (the political party of the incumbent president). His presence inhibited participation. He also refused to call people together for meetings after the assessment had been completed. People were obviously afraid of expressing their opinions, and we had to find all sorts of ways for diffusing the situation. For example, at one point a team took the chief aside for a "special one-on-one interview" to get him out of the way. We almost felt that in that neighborhood, project implementation would be very difficult if the local authorities felt in any way threatened by CARE's activities. The institutional assessment in this community was very telling. Adolescents also cited lack of information and communication as a constraint for them.

LESSONS LEARNED

- The selection of the community in which to conduct the assessment is very important – not just in terms of how representative they are of the target group, but also, how much time they have to contribute to the exercise, whether community leaders are supportive of the exercise, etc.

- Participatory methods generate a lot of information that may be interesting, but not essential or even relevant to the project. With more experience, a team will be able to facilitate discussions so that information is pertinent. On the other hand, you never know what information might end up being useful. For example, in Benin, we had several discussions about FGM, traditional birth control methods and spiritual beliefs that influence sexual behaviors and attitudes. It is difficult to know what to do with the information, even though as a team we feel the issues are very important.

Orienting the team to the methods is very important. In Benin, it was sometimes difficult for team members to realize that there are no formulas or set ways of doing things. It is clear, though, that flexibility and "thinking well on one's feet" is very important. For example, in Lomé, a group of adolescents spontaneously formed and got involved in the participatory assessments. It was completely unplanned, but at the same time, they were the most dynamic contributors to the whole exercise.

Making sure all team members feel confident and empowered to be spontaneous and make decisions, or to just go with the flow, is important and needs to happen from the very beginning. A good example from the participatory assessment in Lomé is the approach that one of the facilitators suggested – the use of shoes to generate poverty profiles. She used different kinds of shoes to represent people of different wealth status.

CARE Togo intends to use participatory approaches in the future. To date they have used them primarily for needs assessments. They are hoping to develop monitoring and evaluation systems that incorporate participatory approaches as well as using them more in project implementation. CARE Togo mentioned that, in some ways, participatory methodologies are often used in an extractive way to gather information or to get community approval for an intervention that is already underway. CARE Togo would like to experiment with using these techniques as a process as opposed to an event.

CARE UGANDA

UGANDA FAMILY HEALTH PROJECT

Mrs. Tony Ikwap, *Community Development Coordinator and*
Sandy Erickson, *Project Director*

The Uganda Family Health Project (UFHP) is a five-year project, funded by the Department for International Development (DFID), which began implementation in May 1995. The purpose of UFHP is to improve reproductive health (RH) knowledge and practices at the community level, to improve RH service delivery at the community and clinical levels, and to improve management of health services at the district level.

The project area covers three districts in eastern Uganda, with a total population of approximately 1.5 million. The project area includes four distinct ethnic/language/cultural groups, one of which actively practices female circumcision. Utilization of antenatal services at government health facilities is high (more than 90%), but over 50% of women still deliver either at home with no trained assistance, or with Traditional Birth Attendants (TBAs) who may not have received any up-to-date training in safe delivery practices. General knowledge about family planning in the project area is high, but although utilization of family planning has apparently increased from 6% to over 20% during the project period to date, a significant proportion of the population reports that they still lack sufficient information which would enable them to make an informed choice about contraception with their partners.

Project activities cover three broad focus areas, with a variety of specific activities clustered in each.

Community development activities:

- training of community health educators (Peer Educators);
- training of sub-county facilitators for community health education;
- training of District teams for community education and Community Health Action Planning (CHAP);
- community mobilization and community health action planning using PLA methods;
- community participation in health facility construction activities; and
- training of community Health Unit Management Committees.

Reproductive health services activities:

- construction or renovation of 82 sub-county health facilities for provision of basic maternity and RH services;
- renovation and expansion of five county-level health facilities for provision of mid-level maternity and RH referral services;
- provision of basic clinical equipment;
- training of health staff in basic reproductive health & family planning, basic midwifery and life-saving skills, STI treatment and quality of care;
- training of community-level TBAs and supporting TBA supervisory networks and linkages with primary health facilities; and
- training of health unit management staff.

District management activities:

- training of district management staff;
- provision of recurrent cost funding for support supervision, health unit outreach services, and relocation of qualified staff to rural primary health facilities; and
- on-going district management capacity building through direct partnerships with districts.

A major challenge for the project has been to actively involve communities as partners in implementing project activities from the community level upwards. With an overall objective to increase knowledge about, demand for, utilization of and quality of reproductive health services, we specifically set out to elicit direct community participation in construction of primary health facilities, management of primary health services and establishment of community health education networks which would serve as two-way paths for exchange of information between communities and district/project managers.

Our Community Health Action Planning (CHAP) process was initially developed from a variety of PRA and Sentinel Community Surveillance (SCS) methodologies. Given the size, scope and time constraints of the project – our area covers well over 1000 distinct "community" units – we realized from the outset that "pure" PRA approaches involving considerable amounts of time working with individual communities would not be feasible. With our district partners we therefore elected to: a) choose a selection of methodologies from PRA and SCS which would allow us to most effectively involve communities directly in implementing project activities and reaching common project objectives; b) focus the selected methodologies directly on reproductive health issues; and c) train district CHAP Teams, who would be responsible for carrying out initial and on-going CHAP activities in their respective districts during, and hopefully beyond, the life of the project.

Over time, CHAP has developed and evolved into a process which includes the following steps:

- initial introduction to the project and to the CHAP process, to elicit participation of community members and set dates and times for a brief community meeting;
- CHAP "initiation" with community members, involving identification of RH problems, prioritization of these problems, and identification of solutions over a two-day period;
- development of community action plans to address identified problems and solutions; and
- regular follow-up visits to communities to check progress on action plans, and exchange information including introduction of Information, Education, and Communication (IEC) messages.

The CHAP "initiation" uses community mapping, key informant interviewing, seasonal calendars, daily routine timelines, focus group discussions, transect walks, and general group discussions as the primary tools to explore RH-related issues and solutions.

During the first three years of the project, the primary focus of CHAP activities has been to elicit community participation and support for construction or renovation of primary health facilities. While this has inevitably identified CHAP with buildings in the minds of communities, we are beginning to make a successful transition to identifying CHAP as a process for community education about reproductive health, and for identifying other actions besides building clinics to address RH issues.

CARE Uganda realizes that there are many strengths and challenges to participatory approaches. Some of the most common are included below.

STRENGTHS

Community members explore various forms of contraception with a Community Health Educator. Uganda

- Communities clearly enjoy and learn from the CHAP process;
- CHAP has clearly strengthened the sense of community ownership of project activities;
- Communities (and district managers) have found the tools to be useful for addressing a variety of other community-based issues outside the scope of the project;
- The methodologies are free – communities can continue to use the methods and tools to address other community problems and issues beyond the scope and life of the project.

WEAKNESSES

- CHAP is purposefully focused on RH issues and other community problems, and priorities may be overlooked which may, in fact, have an indirect impact on RH.

- Participatory methodologies are inherently time-consuming if quality "results" are to be achieved – this can be frustrating to over-loaded facilitators and to district/project managers who have time deadlines to meet.

- Women may be frequently left out of participatory activities as they carry the burden of work in communities and may not be available to participate fully.

- Participatory approaches can raise community expectations beyond what is possible for the project to address.

CARE Uganda expressed that participatory approaches definitely facilitate their work. Since communities are very aware of project objectives and activities, participatory approaches allow them to feel they are directly a part of the project. CARE Uganda has also observed that CHAP has empowered many communities to ask more questions about RH and other health issues, and to begin demanding quality services from their providers. CHAP has also resulted in the establishment of a strong and accessible network at the community level, which the project uses to disseminate IEC messages, identify TBAs for training, and identify other activities to reach communities. The CHAP process and its community networks also serve as tools for solving problems relating to other project activities, such as resolving land/ownership disputes over health facilities, management of health services, problems with individual health staff, etc.

We have heard that communities themselves have used the tools they have learned from CHAP to solve other community issues. Clearly, many communities have been empowered to address their own problems by introducing them to these methodologies. On the downside, participatory methods are time consuming, and a number of people have noted that they do find it difficult to participate fully.

CARE Uganda feels that participatory approaches complicate things in the sense that they see the CHAP process as central to planning and implementing particular project activities, and it would often be faster to just get on with the activity rather than work through the process with the communities. But despite the time frustrations, we feel the end result is clearly worth the time and effort involved. We feel we have been able to develop and disseminate valuable tools which communities and district managers will continue to use with positive effects well beyond the life of the project. We have received a great deal of positive feedback from communities, health staff, local politicians and district managers not only about the project, but about the CHAP process in particular, for its empowerment of communities.

In one example, we are told that a sub-county official recently used CHAP methods to successfully convince community members to pay their local taxes – then found, perhaps unexpectedly, that the communities demanded to know exactly how the sub-county actually utilized the taxes that had been collected.

LESSONS LEARNED

- Communities find PRA methods both interesting and useful.
- Simple PRA tools can be used by communities on their own to address a variety of issues.
- Implementing activities using participatory approaches does take considerably more time, but can contribute significantly to community ownership of project activities and objectives.

CARE Uganda plans to use PRA methods in on-going implementation of IEC activities, and will also incorporate PRA methods into project monitoring and evaluation exercises.

CARE SOMALIA

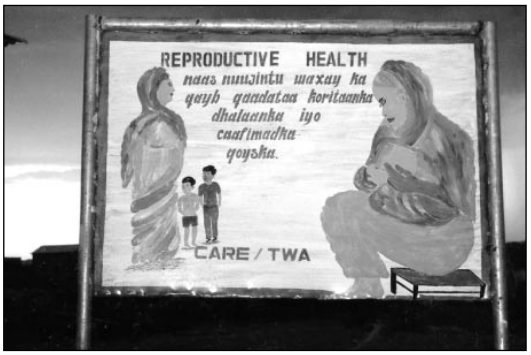
REPRODUCTIVE HEALTH AWARENESS AND ACTION PROJECT IN YIROWE (RHAAPY)

Barbara Monahan *on behalf of CARE Somalia*

Somalia has been ravaged by famine and civil war since 1991. During this time, drought, recurring famine, mass displacement and lack of an organized government have plagued Somalia. Much of the population has been left with limited access to the most basic necessities of life including food, water, housing and health care. In 1991, the Northwest part of the country declared its independence, although Somaliland, as the country is now known, has not been officially recognized by other nations. With the restoration of the government, Somaliland has been enjoying relative stability.

The reproductive health status in Somalia is poor, with women experiencing levels of morbidity and mortality commensurate with early childbearing, high fertility and low social status. Reproductive health status is further compromised by the pervasive practice of female circumcision. Since reliable RH statistics were unavailable, CARE undertook a participatory needs assessment to become apprised of the RH situation in Yirowe, Somaliland. As a result of the findings from this assessment, CARE, in conjunction with a local women's group, Togdheer Women's Association (TWA), is implementing a Reproductive Health project for a displaced population in Yirowe, Somaliland. This project was designed from the findings of the participatory appraisal that took place in March, 1997, and began as a one-year project in October, 1997, with joint funding by CARE Somalia through their USAID Umbrella Grant and the Andrew W. Mellon Foundation.

The initial participatory needs assessment conducted prior to the project design allowed community members to identify those RH problems perceived as most critical to their communities. Tools and techniques as well as triangulation were used to identify and prioritize RH problems. Once the assessment team analyzed findings, a concept paper was developed which led to subsequent funding and implementation of the RHAAPY project. A participatory mid-term evaluation was conducted to measure progress achieved in the first few months of project implementation. The process approach of the evaluation assessed project achievements and progress towards reaching the stated goals and objectives. Throughout the mid-term review, process was valued as much as the outcome. Existing sources of information for the mid-term evaluation were utilized when possible.



One of several billboards the project staff have created with help from a local artist. Notice the message – breastfeeding will help your children to grow and remain healthy.

The overall goal of RHAAPY is to improve the RH status of men and women in Yirowe through a two-pronged strategy. The first approach is to build awareness for critical RH issues by working through respected Community Health Educators (CHEs) to influence behavior change and improve the reproductive health prac-

tices among community members through participatory health education sessions. The second strategy involves strengthening the provision of health services in the displaced camp by providing refresher training to health providers. The project aims to fill a gap that exists due to the lack of a functioning health infrastructure and outreach efforts by the government of Somalia and other non-governmental organizations.

Based on the results of the participatory needs assessment, the project was designed with four major objectives which included: to improve breast-feeding behavior among mothers, to improve antenatal behavior among pregnant women, to increase knowledge about STDs (including HIV) and to reduce the practice of infibulation.

A typical refugee home in the Yirowe displaced camp. Somaliland

The participatory mid-term evaluation was conducted in May, 1998. The process review included six days of fieldwork. The evaluation team consisted of several stakeholders including community members, members of TWA, RHAAPY project staff (CHEs), representatives from public and private health centers, CARE Somalia staff and representatives of the Ministry of Health (MOH). The evaluation stressed a process-oriented approach that focused on introducing the evaluation team to participatory tools and techniques. This aspect was critical, as several members of the team had never been involved with an evaluation before. The evaluation team utilized the following methods for data collection: semi-structured interviews, record review of MCH registries, report and document review, key informant interviews, observation and analysis of health education sessions.

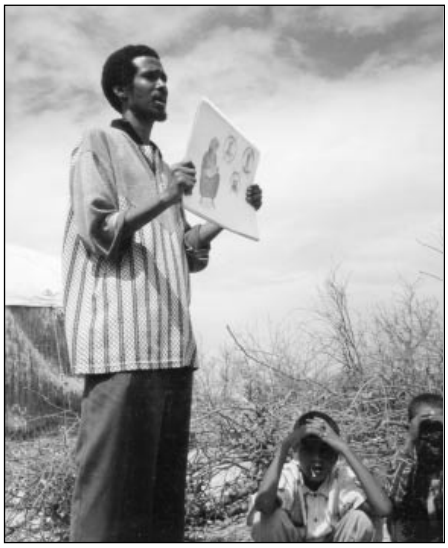
After completing the data collection and analysis of information from the mid-term review, findings were shared with the Yirowe community in a final presentation. Some of the strengths and weaknesses of the project and use of participatory methods are highlighted below.

STRENGTHS

- Community members, health personnel, CARE staff and others were able to actively contribute in collection of data, synthesis and analysis of findings. Literacy was not required due to the interactive nature of the PLA tools and techniques and the use of symbols to represent words.
- The participatory approach allowed TWA to successfully build respect and support for the RHAAPY project while effectively addressing issues considered highly sensitive (such as FGC and STDs) in Yirowe.
- The participatory nature of the project created a strong sense of ownership for TWA, the RHAAPY project staff and community members.
- The skills acquired during the appraisal, program design and monitoring phase can be applied in other work.
- The PLA approach allows technical experts to learn from the communities that they serve. This creates a healthy role reversal between development workers and community members.
- Participatory approaches are by nature very flexible.

WEAKNESSES

- Participatory approaches require a great deal of time and investment, they often take more time than traditional assessment methods. Community members who participate take time away from their livelihoods. These approaches require a skilled facilitator who has a very clear understanding of the principles of the methodology.
- During the course of the participatory work in Somalia, RH was determined to be the programmatic focus. Had community members been asked, they might have had other livelihood priorities given their status as displaced people.
- Participatory exercises can raise expectations of the community. It is very important to be transparent with community members about plans once the assessment phase is over.



A CHE conducts a health education session on exclusive breastfeeding. Somaliland

LESSONS LEARNED

By utilizing a participatory approach and working through key influentials in the community (elderly women and men, respected religious leaders, etc.), RHAAPY staff have managed to gain the respect and trust of the larger Yirowe community. This process has required a substantial time investment, but has broken down mistrust and uncertainty that existed at the beginning of the project. TWA appears to be working within the cultural context of Yirowe and has gained respect and support from important community leaders.

In a difficult operating environment, such as a refugee/displaced setting, like Yirowe where handouts are common, participatory approaches can represent a refreshing change for community members. They are pleased to articulate their own issues and to seek creative solutions to their problems.

Confidence and skills learned through participatory approaches go well beyond the immediate project at hand. For example, TWA has begun tackling additional community problems (such as addressing the lack of schools in their camp and lobbying the MOH to reopen a closed health center) as a result of the RHAAPY experience.

In addition to encouraging health-seeking behavior, RHAAPY efforts have motivated community members to address cultural practices that may have a negative reproductive health outcome. After building awareness about the harmful effects of the most invasive form of FGC, Pharonic circumcision, community members requested an alternative form of the procedure.

Team members were surprised to learn so much from the community, particularly in relation to the impact the project was apparently having on community members' behavior (antenatal care, FGM practices). This became apparent in the focus group discussions and in health education sessions with various segments of community members that the evaluation team observed.

As the project continues second year activities, TWA will continue involving community members in all phases of project implementation. As the participatory nature of the RHAAPY project has been instrumental in its success, efforts should be made to reach out to other community members and groups that may be marginalized. CARE Somalia hopes to continue the use of participatory techniques in the subsequent phases of implementation and evaluation.

CARE PERU

MULTISECTORAL POPULATION AND REPRODUCTIVE HEALTH PROJECT (MSPRH)

Extracted from an interview with Irma Ramos, CARE Peru

The Multisectoral Population and Reproductive Health Project (MSPRH) started as a family planning project working in three regions of Peru – including the coastal areas, the jungle and the valley. In 1993, the project expanded its scope to work in peri-urban and rural areas. MSPRH seeks to improve the quality of health services and increase service coverage, permitting women and their partners to satisfy their reproductive needs. The project coordinates closely with the Ministry of Health (MOH) to enhance the family planning services provided at the local health facilities. CARE Peru sees their partnership with the MOH as critical to the success of the project, as often times CARE and the MOH are the only two groups working in the same rural areas.

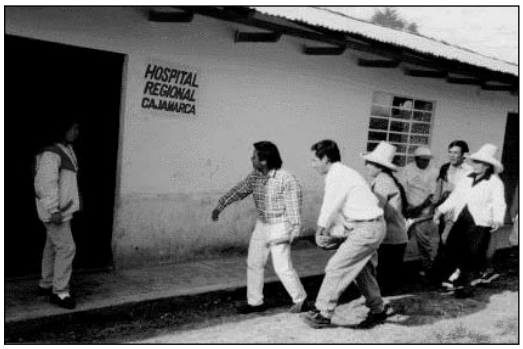
Main project activities include initiating a network of community-based distributors (CBD) to serve as health promoters in rural areas and linking these CBDs to the MOH. Once a CBD is trained, s/he is charged with providing RH information to the community, thereby permitting women and their partners to make free, informed choices about family planning. By setting up referral sites for community-based distributors to increase services, CARE Peru's goal is to increase access to health services for the poorest of the poor.

The technical areas the project addresses include:

- Family planning
- Maternal health
- Adolescent health

While the beginning of the project was not as participatory as CARE Peru might have liked, they felt that it was critical to educate the MOH by training staff to deliver services and supervising the service delivery that followed. After this initial phase, the project became much more participatory as CARE staff and community members began experimenting with mapping exercises including social, risk and history mapping. CARE staff accompanied by MOH staff on visits demonstrated how to work with community leaders. At the time, this was a very innovative approach that had never been utilized before in these areas. Once they met with village leaders, the influentials in the village would bring in community members and explain the project and services that could be offered. The communities would then form a health committee and would engage in mapping exercises to determine the most pressing problems of the community. During these discussions and exercises, transportation was often cited as the greatest problem. Through mapping exercises, communities started to identify various quarters of the village and developed a transportation system for evacuating people in the case of an emergency. In fact, community members designed a very innovative means of addressing this issue. After organizing themselves into groups

responsible for transportation, community members realized that they did not have the financial means to evacuate emergency obstetric cases. They decided to buy a pig with contributions from various community members. It was the community's responsibility to feed and care for the pig as it grew. When the pig became pregnant and gave birth to several piglets, the community members sold the piglets and put the money away for safekeeping to address emergency evacuations. In essence, the community members are developing delivery plans where community members are preparing to deal with emergencies before they occur. One step in this process involves developing geographical maps to determine the most appropriate route to take and health center to utilize. Once a woman has been evacuated, the health committee convenes to evaluate how the emergency was handled and determine how the process could be improved in the future.



Rural community members evacuate a woman experiencing an obstetric emergency.

STRENGTHS

Participatory approaches allow people to develop solutions and think for themselves. They enhance the goal of sustainability, a factor that is critical for long-term development. If a project is not implemented with the goal of sustainability, a project will fall apart once funding ends. When participation is not used, a project is perceived as belonging to the organization rather than belonging to the community.

WEAKNESSES

Often times in the areas where CARE works, community priorities do not match what CARE can offer. While the CARE program may be addressing RH needs, community members often want schools or even seeds for planting. In this case, CARE project staff try to associate themselves with partners who may be able to address and respond to different technical areas that CARE cannot. Participatory approaches require time, money and human resources. As Irma stated, "it's much easier to bring food in a can, than to teach community members to cook for themselves."

A community member helps a hemorrhaging woman reach the health center. Peru

LESSONS LEARNED

Although CARE Peru staff noted that participatory approaches complicate things because of the diverse need of communities, they are the only way to push progress. If CARE and others do not attempt to engage community members in developing their own voice, the rest of our efforts will be in vain.

Another problem encountered was that women were rarely selected as members of the health committees. CARE learned through experience that it was better to require better female representation to balance the teams.

Special efforts are suggested to avoid raising expectations. If an organization's interest is in developing a health project, be clear and upfront with communities that the priority is to learn about their health problems. When soliciting information from the community, it is essential that the results of the information collected gets back to community members. In addition to sharing results, be sure to inform community members about the follow-up steps that will take place.

CARE ZAMBIA

TESTING COMMUNITY-BASED APPROACHES FOR IMPROVING ADOLESCENT REPRODUCTIVE AND SEXUAL HEALTH OPERATIONS RESEARCH STUDY

Tamara Fetters

CARE Zambia, the Planned Parenthood Association of Zambia (PPAZ), and Makeni Ecumenical Center (MEC) are carrying out an Operations Research (OR) study to test community-based strategies that increase knowledge of, demand for, and use of barrier methods of contraception by out-of-school adolescents, 14 to 19 years old, in three compounds of peri-urban Lusaka. Participants in the intervention are either credit recipients of small loans (US$50-70) or commercial sales agents of condoms who will also act as peer counselors addressing issues of reproductive health in their communities. The ultimate objective of the study is to provide examples of successful strategies for motivating adolescents to avoid unprotected intercourse, consequently reducing the incidence of unplanned pregnancies and sexually transmitted infections, including HIV.

In order to better develop projects that address the concerns of adolescents, it is important that the situation is first understood from their perspectives. CARE Zambia has been involved in carrying out participatory appraisals and participatory research training around Zambia as preparation for its Partnership for Adolescent Sexual and Reproductive Health Project (PALS). As CARE has gained experience in participatory learning and action (PLA), the methodology has been refined since the first PLA exercise on these issues took place in Chawama Compound in March, 1997. Giving adolescents a chance to analyze their sexual behavior, reasons for the same, and how they feel their behavior impacts their lives, provides the basis for designing a project that will address their own issues and concerns.

For the OR study, four PLA appraisals were carried out in M'tendere, Ngombe and New Kanyama Compounds, and in a comparison site, Misisi Compound, between December, 1996, and April, 1997. The OR PLAs benefited from CARE's extensive experience by giving CARE facilitators the opportunity to develop a concise set of themes and issues that could be probed in the field. PLA appraisals were selected because it was felt that they could best address the following objectives:

- To learn about male and female adolescent knowledge, attitudes and behavior as they pertain to sexual and reproductive health; their knowledge about sexually transmitted infections and pregnancy; their sources of information; their attitudes about these issues; and their patterns of sexual behavior.
- To establish a community baseline that can be used to evaluate adolescent knowledge, attitudes and behavior over the life of the project.
- To begin to build an informed and supportive community network that can be used to sustain a community-based intervention project on adolescent sexual and reproductive health.

- To learn more about the economics and activities of adolescents' lives and how these relate to their sexual relationships.
- To allow adolescents to self-select leaders and form groups for project intervention activities.
- To "fine tune" the intervention projects based on the needs and action plans of the adolescents.

SAMPLING AND METHODOLOGY

Using a variety and mix of verbal and visual tools, this methodology helps participants appraise their situations. The emphasis is on allowing the community members to identify and analyze their own concerns. There are no predetermined questions and the process is left open-ended and flexible in order to follow the concerns and issues that are brought up during the research. However, leaving the process completely open-ended, especially when there are several facilitators with varying experience using the methodology, could have taken the process in all kinds of directions. As a compromise, a field guide was prepared for the facilitators, which listed the main issues to be probed and analyzed during the appraisal along with a 'menu' of methods that could be used to analyze each of the issues. The field guide was developed at CARE with the assistance of an external consultant and expert in PLA methodologies, Meera Kaul Shah.

The strength of the PLA methodology is in the adaptability and innovation of PLA tools to different circumstances in the field. Some of the PLA tools used include area mapping, social mapping, body mapping, transect walks, ranking and scoring, diagrams, wealth/well-being ranking, sketch stories (drawing picture stories), focus group discussions and sex census by secret ballots.

In order to compile a baseline data set, with details on individual attitudes, knowledge and behavior patterns and to verify findings that some may find controversial, we decided to supplement the participatory appraisal process with a targeted questionnaire survey of adolescents conducted by the PLA facilitators. The results from the survey were analyzed by compound and are included in the baseline report to compare with some of the key findings from the PLA as well as to be enriched by these data.

USING PLA METHODOLOGY

The PLAs were facilitated by teams comprised of approximately twenty members from the clinic staff, Neighborhood Health Committee (NHC) members, the CARE Operations Research team, researchers from PPAZ, community development workers from MEC, trained NHC members from nearby Lusaka compounds, two CARE interns and researchers from other local NGOs. A brief training session was conducted before beginning the PLA and the survey for the new community members. Four groups were then created, each of which included men and women, and experienced and inexperienced researchers. The four groups often split into smaller groups, often along gender lines, in the field to ensure that

boys and girls could freely discuss issues related to sexual relations and reproductive health. Each group took care to meet with boys and girls, both in and out of school, and from different age groups between 10-19 years. On the first day of the PLA adolescents in the crowded compounds came to investigate our activities and soon became engaged in the mapping activities of their compounds. They assisted us by informing their friends and neighbors about the research while we explored with them their daily activities, recreation and leisure spots. On the following days we would often find young people waiting for us with new friends having enjoyed their voices being heard.

After carrying out the fieldwork in the morning and early afternoon, the teams would re-group every afternoon to share the day's experiences with each other and present their findings. Gaps in information were noted, information was shared and key findings were cross-checked at this time to prepare for the next day's research. Daily "process" reports were written by each team member in order to have complete documentation of the day's work. Before setting off in the mornings, the entire group met again to review research questions and findings and to discuss appropriate methods for further exploration of these issues. We found that our research findings were better when there was a rigorous review of the information collected in the evening and a strong facilitator to prepare groups in the morning. We invested time reviewing the research questions, ticking off those that we felt had received enough attention and identifying areas requiring clarification or more data. We also discussed other possible tools or ways to get at these types of information.

The final two days of the five-day fieldwork exercise were spent conducting a survey with adolescents. The questionnaire contained mostly closed-ended questions focusing on reproductive and sexual health behavior, our key variables. The same individuals on the research team were briefly trained in interviewing techniques and sent back to their respective areas in the compound to conduct interviews with a simple one-page questionnaire. Convenience sampling was used in order to maximize resources; interviewers went household to household asking for one adolescent per household who would consent to being interviewed until they had reached their daily quota of twenty questionnaires. At the end of the first day of the survey, questionnaires were collected and tallied to ensure representation from all age groups, both sexes, each of the four quartiles in the compound, and in and out of school youth.

FEEDING BACK TO THE COMMUNITY

After the PLAs were conducted and the data synthesized by a core group of researchers, a number of dissemination workshops were held in each community. The community-based researchers who were involved in the fieldwork (usually health providers and Neighborhood Health Committee members) presented the results to adolescents in a neighborhood meeting to give the communities a sense of ownership and add credibility to some of the more sensitive results. After a dissemination session was held with adults, a series of dissemination meetings was held with adolescents, some who participated in the PLAs and some who did not.

Key findings on sexuality, knowledge and common misperceptions were presented to the young people and they were asked to develop community action plans. Almost all of their suggestions were centered around more recreational and economic opportunities for themselves and their peers. These action plans helped us to tailor our interventions to their own ideas and suggestions and gain support for our programs. The adolescents involved in the dissemination meetings were asked to organize their own peer groups and thus begin the self-selection and recruitment process for the interventions.

IN THE FIELD

The following visuals were selected from a number of participatory appraisals on adolescent sexual and reproductive health conducted by CARE Zambia for the OR study, the PALS project and one conducted as part of a national training for researchers from the Government, local and international NGOs.

In this PLA study of 10-19 year-olds, an adolescent was classified as sexually active if they had intercourse at least once in their lives prior to the study. The definition of a "sexual experience", as understood by the adolescents, was established through body mapping exercises, the evolution of discussions and PLA activities that followed. Many different groups of adolescents were asked to draw the male and female body, label it, and describe the functions of the reproductive system. In this way it became very clear what the adolescents referred to as "sex" and the researcher was certain that the questions on sexual activity were understood correctly. This also enabled the researchers to speak in "the language" of the adolescents and probe into their slang for more information.

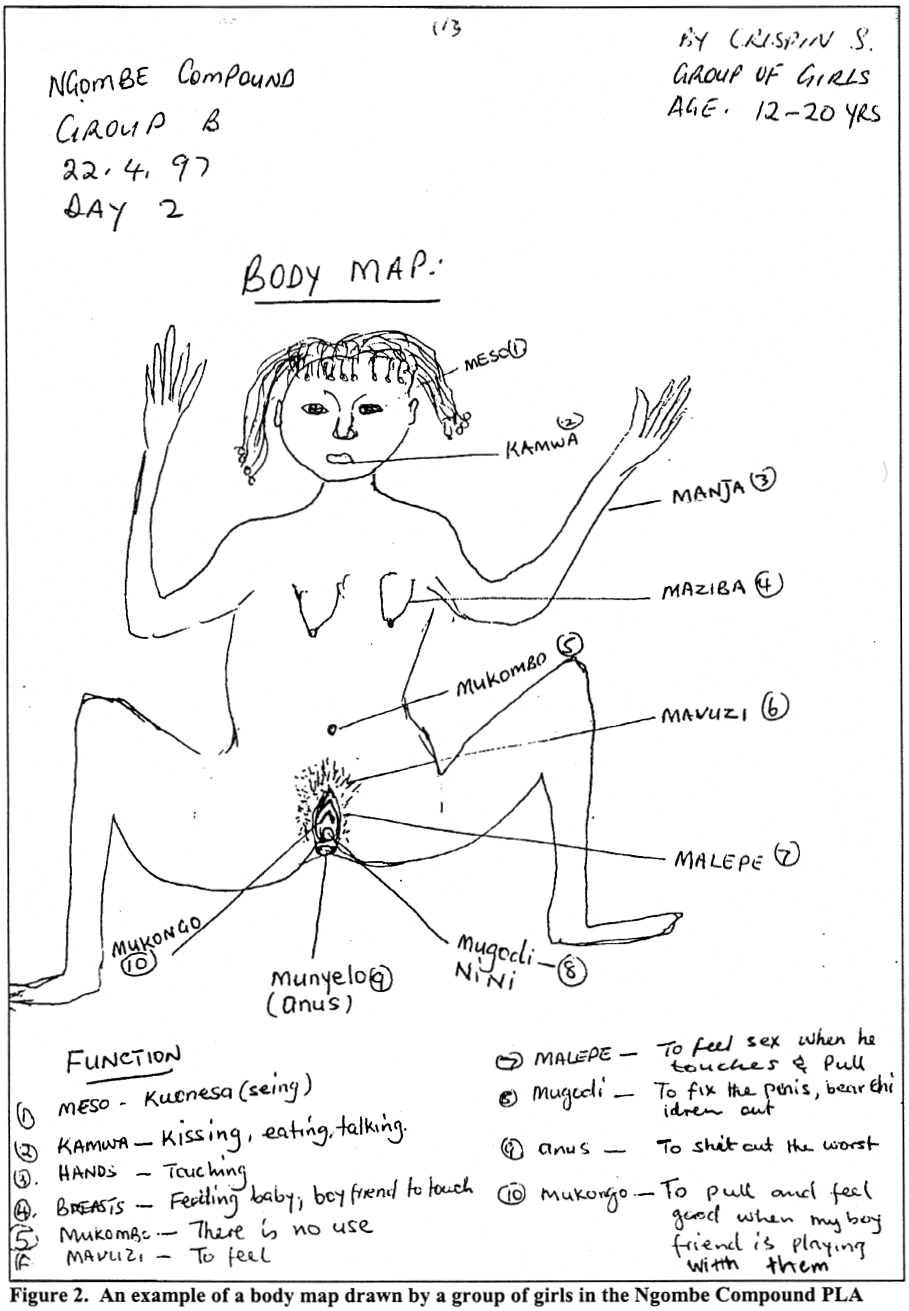


Figure 2. An example of a body map drawn by a group of girls in the Ngombe Compound PLA

The need to address issues of livelihood with other reproductive health concerns has been brought home to us at CARE Zambia again and again. Adolescent perceptions of health risks are generally quite low, so exploring issues that are salient in their lives means including their feelings about the future and their livelihood. The following chart is a pair-wise ranking exercise that allows adolescents to think about the most important aspects of their lives. The boxes form a matrix and the box at the meeting point contains the aspect that they find most important between the two items. The choices are then totaled to see which item(s) were most prevalent and a discussion ensues to rank them. See full description of Ranking and Scoring in Part 3 on page 3.38.

PAIR-WISE RANKING OF ADOLESCENT CONCERNS

	SHELTER	HIGHER EDUCATION	MONEY	FAMILY	EMPLOYMENT
EMPLOYMENT	employment	higher ed	money	employment	X
FAMILY	shelter	higher ed	money	X	
MONEY	money	money	X		
HIGHER ED.	shelter	X			
SHELTER	X				
TOTAL	2	2	4	0	2
RANKING	4	3	1	5	2

11 young people (14 -22 years old)
Dambwa Central, Livingstone (August 22, 1996)

Results from PLAs in Zambia indicate that most of the adolescent sexual activity is associated with some form of gift or payment to the girl. According to the survey findings one-half to two-thirds of the last sex acts reported were remunerated. Many boys even said they preferred sex with younger girls because they do not demand a lot of money or expensive presents in return. A group of 12-17 year-old girls in Misisi created a list of potential sex partners and the expected payments shown below.

BOYFRIEND	EXPECTED PAYMENT
Kawalala (thief)	Kw 10,000
Kantemba (vendors)	Lotion, soap, biscuits, sweets
Unemployed (for love)	Kw 2,000
Hule (prostitute)	Kw 70,000
Teacher	Past papers
Schoolboys	Answers to homework or tests
Footballers	Kw 5,000

List of potential sex partners and expected payments compiled by a group of 12 - 17 year-old girls from Misisi Compound

Exchange (remuneration) for sex and partnership is deeply embedded in the culture of these adolescents and certainly not considered prostitution. Usually boys give voluntarily and girls consent to most sex acts but the exchange, usually benefiting the girl, seems embedded in the culture because of the inherent power and economic disadvantage of girls. The following comment shows the indirect way girls are encouraged to exchange sex for money and shows how field notes and discussions can add depth to the PLA analyses.

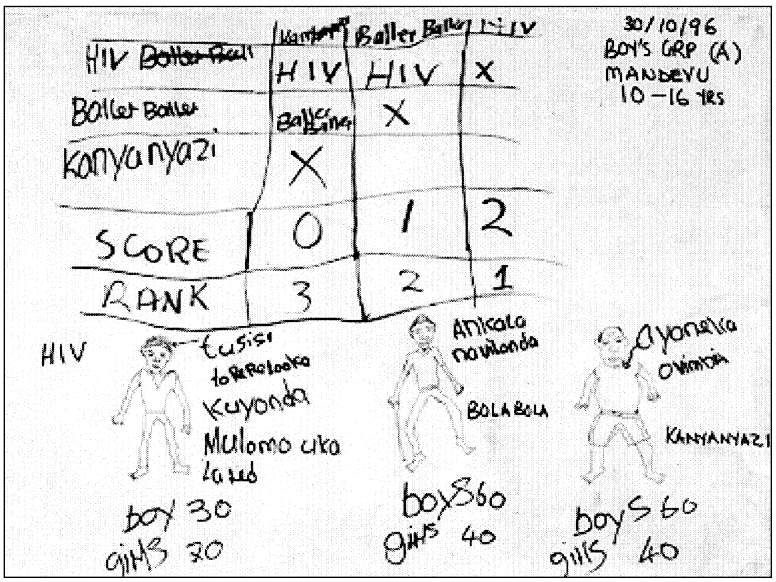
> Several groups of boys and girls narrated instances when a mother or grandmother would ask the girl to seek sex partners so that there is some money at home and they can have enough food to eat. However, it was mentioned that the girl would not be told directly to go and have sex but a mother could pass comments like "sure ti gona nanjala na bakazi balipo pano" (Surely how can we sleep on empty stomachs when there are girls in the house)?

Extracted from the field notes of Thomas Moyo, M'tendere Compound

Whenever possible it is useful to encourage the group members toward quantification exercises. The debates within the groups are useful and odd results can be validated from day to day. A graph was drawn by adolescent girls in peri-urban Livingstone during a national PLA training workshop conducted by CARE. These girls drew a line graph estimating the number of girls they felt would suffer from unintended pregnancy in a class of 25 girls. The peaks and dips were explained as important life cycle events, such as examinations or a girl's desire to marry, in the discussion while the girls were drawing. They followed up their graph with recommendations for "redressing" these issues.

Recommendations to redress the trend:

- *To introduce sex education in the schools.*
- *Out of 100 girls only 10% of them can be disciplined.*
- *Distribution of pills and condoms in schools to the pupils. For girls this must be from 13-14 and boys 14-15. Only 10% of school boys and girls can be disciplined and have self respect.*
- *Children should stop playing at night (1-19 years).*
- *Masaka and Fairmount [local taverns] should have distribution points of condoms.*



Some outputs bring up more questions than answers. This final visual output shows an analysis by a group of boys from Mandevu that was conducted as a baseline for CARE's Partnership for Adolescent Sexual and Reproductive Health (PALS) Project in Lusaka. In this output the facilitators used a pair-wise ranking exercise to get information on the prevalence of sexually transmitted infections in this community. Categorization of STIs can often yield interesting results. For example, diseases like tuberculosis came out. This group of boys knew of three STIs; HIV, baller baller (usually called bola bola), and kanyanyazi. It is clear that the STI called kanyanyazi confused the facilitators so they asked the boys to draw the symptoms and the prevalence associated with each STI. The person with HIV has thinning hair, the person becomes thin and the lips turn very red. A person with baller baller has swelling testicles, penis or lymph nodes or painful lesions that cause them to walk with their legs apart. This person with the STI kanyanyazi has a swollen and deformed neck. This group of boys seems to think that goiter is an STI.

In any PLA situation the visuals created by the participants are merely an entry point for further dialogue. While information generated during the participatory process is being debated, the visual outputs will continue to evolve. Good facilitators with careful attention to detail can capture information in a very short time and always have a question ready. Field notes collected on a daily basis, morning meetings that focus research questions and guided wrap-up sessions at the end of the day can help to ensure quality in the final reports and make sure that information is not redundant.

CONCLUSIONS

PLA research yields relatively quick and low-cost results, useful for program design and implementation. During the research from which these examples were drawn we talked with thousands of adolescents about sexuality and reproductive health and gave them an opportunity to look at their own lives (and the lives of their peers) and identify potential solutions to their own problems. Often we would find adolescents waiting for us at the meeting place wanting to take part and share with us their own thoughts and feelings. At CARE Zambia we have used this research as an entry point into an issue or community and it is the place in a project where it seems to work best. We have used it to form and cement partnerships and begin the "growing process" necessary for strong and sustainable projects. It is useful for exploration of topical areas (like adolescent sexual and reproductive health) but other tools may need to be developed to use this research for evaluation or to measure the incidence of specific behaviors or risk factors. The potential to use this methodology is evident but it requires time, commitment and innovation. At CARE Zambia plans are in process to use the PLA methodology in other ways including:

- Simplifying the list of potential topics and variables to refine and streamline a PLA exercise for use as an evaluation tool that measures coverage of a project and project impact in terms of sexual and reproductive health behavior change.
- In large clinics or hospitals to sensitize clinicians and collect information on quality of care and patient flow.
- To explore community prevalence and information on specific and sensitive issues like unsafe abortion.

It is necessary for innovation and continued success of these types of participatory evaluation and research methodologies so that they become well documented and disseminated through fora like this publication. Widespread dissemination will enable us to exchange ideas and adapt PLA tools to meet special project needs in a wider range of topics and target populations.

2

PART TWO

Some Conceptual Reflections

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CHAPTER 1

PARTICIPATION IN DEVELOPMENT: EVOLUTION OF A PHILOSOPHY

Carlos A. Perez

To say that in the last 15 years participatory research has bloomed is almost an understatement. Participatory forms of research are now accepted and well integrated in development practice, particularly in international development. Although this transformation has not been entirely smooth and devoid of controversies, it represents quite a change from being in the fringes of mainstream social action and research only a decade ago. In this Chapter, I will briefly point out some of the current forms of participatory research, summarize the contributions and opportunities that it brings up for development practice, in general, and discuss the role that participatory research can have to make rigorous ethnographic work. I will also outline some of the challenges that lay ahead to further advance participatory research as a tool for sustainable development, and the role that applied anthropology could play in this endeavor.

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A BIRD'S-EYE OVERVIEW

Participatory research cannot be traced to one source or event. Rather, it reflects a gradual evolution in the paradigm about development. This paradigm shift began in developing countries when national intellectuals and students demanded that they and local peoples have input in development interventions. An additional pressure for increased participation came from the presence of insurgence movements active since the 1960s. At the same time, foundations (such as Ford and Rockefeller) responded to those concerns, and actively promoted participation – and the incorporation of social sciences – in development thinking and action. In short, facing the now obvious limitations of technocratic development models (from "stages of growth" to "green revolution") founded on the prescriptions of "external" experts, development agencies came to accept (often reluctantly) "bottom-up" approaches to development, i.e. increasingly important roles for participants in the orientation and implementation of development projects.

Literature documenting lack of participation in many development projects, and advocating a much needed correction of this flaw began appearing in the 1970s (Cernea, Michael (Ed.), Putting People First: Sociological Variables in Development Projects, the Johns Hopkins University Press, Baltimore, 1985; Cornell University's Rural Development Participation Review in the 1970s and 1980s; Oakley, Peter, David Marsden, Approaches to participation in rural development, ILO, Geneva, 1984). The actual switch from advocating participation to generating methodologies to incorporate the voices, perspectives and resources of the underprivileged took place in several forms. These included Participatory Research, Participatory Action Research, Farming Systems Research, Rapid Rural Appraisal, and Agroecosystems Analysis, which emerged in the 1970s and 1980s, and Participatory Rural Appraisal which spread in the

1990s (for an excellent detailed description see Chambers, Robert, The Origins and Practice of Participatory Rural Appraisal, World Development, Vol. 22, No. 7: 953-969; No. 9:1253-1268; and No. 10:1437-1454).

Participatory research was inspired by the work of Kurt Lewin (Action Research and Minority Problems, Journal of Social Issues, Vol. 2, 34-46, 1946) and Paulo Freire (Pedagogy of the Oppressed, Seabury Press, New York, 1968) who influenced the adult education thought. Lewin's work in social psychology stressed the need for groups to define common problems and work together to overcome them through a spiral of steps composed of planning, acting, observing and evaluating. Freire was more radical. He emphasized that poor people should be empowered to conduct the analysis of their own reality, and thus free themselves from oppression through "conscientization." Both philosophies found an echo in Participatory Research and Participatory Action Research, two movements so similar that they often cannot be differentiated from each other. Participatory Research encouraged poor farmers in Asia and the US to analyze village power structures and urban biases (see "Convergence," the quarterly journal of the International Council for Adult Education, and Gaventa, John and Helen Lewis, Participatory Education and Grassroots Development; The Case of Rural Appalachia, gatekeeper series 25, International Institute for Environment and Development (IIED), London, 1991). Participatory Action Research, for its part, guided social change by defining action plans as a group effort with all participants being involved. The plans emerged from research based on group meetings, sociodrama, folklore, oral and visual representation, where people would set the agenda, participate in data collection and analysis, and exert control over the results and the whole process. (Whyte, William F., ed., Participatory Action Research, Sage Publications, Newbury Park, CA, 1991; McTaggart, Robin, Principles for Participatory Action Research, Adult Education Quarterly, Vol. 41, No. 3, 1991).

In a parallel fashion, in the late 1960s and early 1970s a movement was started that tried to change the way agricultural research was conducted. The challenge was to increase the likelihood that technologies, produced by researchers in experiment stations, would be used by small farmers in developing countries. Until then, agricultural research included investigation on crops and biophysical factors under controllable environments, in ways that bypassed farmers and their highly variable, resource poor and risky agroecological and socio-economic conditions, and so technology adaptation rates were low. Interdisciplinary teams of biological scientists, economists, anthropologists and rural sociologists adopted on-farm research as an alternative to research done exclusively in agricultural experiment stations, and farming systems analysis instead of the study of orderly monocropping arrangements. Over time, FSR progressed from using farmers' fields or labor to conduct research designed by scientists, to incorporating farmers as evaluators of technology, to fostering farmers in the design of their own experiments (Shaner, W.W., P. Philipp and W.R. Schmel, Farming Systems Research and Development: Guidelines for Developing Countries, Westview Press, Boulder, CO, 1982). Soon, decision-making, experimenting and technology adaptation by farmers, as well as indigenous knowledge systems became legitimate research focal points (Richards, Paul, Indigenous Agricultural Revolution, Westview Press,

Boulder, CO, 1985; Brokensha, David, D.M. Warren and O. Werner, Indigenous Knowledge Systems and Development, University Press of America, Lanham, MD, 1980). The techniques that FSR used included secondary data reviews, maps, transects, seasonal calendars, semi-structured interviews, questionnaires, direct observation, on-farm experimentation, economic return analyses, and farmer varietal selection and technology evaluation. For its part, agroecosystems analysis – developed in the late 1970s in Southeast Asia – emphasized ecological and systems analysis thinking expressed in flow and causal diagrams. Its proponents used also transects, informal mapping, seasonal calendars, bar charts with relative sources of income, decision trees and other decision diagrams, scoring and ranking of technological innovations (Conway, Gordon, Agroecosystem analysis, Agricultural Administration, Vol. 20, 31-55, 1985).

Both FSR and Agroecosystem analysis approaches influenced the development of Rapid Rural Appraisal in the late 1970s. At that time, rural development practitioners were trying to overcome the shortcomings of prevailing rural/agricultural research methodologies that emphasized long-term approaches (including ethnography) and/or questionnaire surveys that often were unmanageable, exhaustive but narrow in their scope, and did not necessarily provide reliable data. The alternative was the so-called "development tourism" that was founded on biased, and partial views which tended to include only those areas close to the road and main towns, more men than women, more influential than disenfranchised people, and the most comfortable (dry and cool) seasons. Over a decade, RRA was built into as a systematic research approach based on many of the techniques that FSR and Agroecosystem analysis had used (secondary data review, semi-structured interviewing, key informant interviews, direct observation, informal mapping, transects, seasonal calendars, decision trees and other decision diagrams, scoring and preference ranking), while contributing wealth ranking, analytical games, portraits and stories, and workshops for participatory analysis and interpretation of the information gathered (McCracken, Jennifer A., Jules Pretty and Gordon R. Conway, An Introduction to Rapid Rural Appraisal for Agricultural Development. IIED, London, 1988).

A group of young men concentrate on their visual analysis. Bangladesh

As an aside, from this overview it becomes clear that although Farming Systems Research, Rapid Rural Appraisal, and Agroecosystems Analysis are considered discrete methodological approaches, they did not develop independent of each other, but rather influenced each other, sometimes overlapped each other, evolved into the other forms, borrowed from each other, and often shared techniques, approaches and even researchers. In fact, those approaches owe their distinctive identity more to their affiliation to different sponsoring institutions than to substantive differences in approach.

FSR, Agroecosystems analysis, and RRA developed research techniques that profoundly altered the way in which socio-economic and agroecological research are carried out. These approaches, however, were effective but not necessarily "participatory". The research agendas were still determined and controlled by

external researchers. As late as 1988, Rapid Rural Appraisal practitioners, for instance, differentiated exploratory RRAs (open-ended, hypothesis testing); topical RRAs (to address specific issues); and Monitoring RRAs (for development impact evaluation); from Participatory RRAs ("to help involve farming households in all stages of development work.") (McCracken, Jennifer A., Jules Pretty and Gordon R. Conway, An Introduction to Rapid Rural Appraisal. IIED, London, 1988). Participatory research would come of age with Participatory Rural Appraisal (PRA).

PRA was developed independently in Kenya (Clark University and National Environment Secretariat) and India (Aga Khan Rural Support Programme) in 1988 as participatory rapid rural assessments geared to facilitate "insiders" (poor rural people) in conducting their own analysis for their own purposes. The seeds of PRA were spread out by the Sustainable Agriculture Programme at the IIED through workshops, manuals, and especially its "RRA Notes" (later termed "PLA Notes" for "Participatory Learning and Action") which are the staple references for PRA practitioners along with the "ILEIA Newsletter" of the Centre for Research and Information Exchange in Ecological Sound Agriculture of the Netherlands. Since then, a myriad of other organizations have contributed to making PRA an established research approach.

Although PRA uses practically all the techniques of RRA, it is most commonly associated with RRA's visual, representational and activity-based techniques (social mapping and modeling, seasonal calendars, institutional maps, diagramming, wealth ranking, gender and social group analysis, matrix scoring, transect walks). Typically, PRA-based research involves a series of meetings with local people, in which several group techniques are used in tandem to elicit information that is discussed collectively and graphically displayed with local materials (stones, beans, sticks, models). This visual information display lends itself well to conducting research among illiterate or semi-literate groups of people. PRA values and celebrates the local communities' knowledge and ingenuity. It continues to be applied predominantly in rural contexts in developing countries, but it is gaining acceptance among researchers who work in literate and developed societies.

PRA is used in the analysis of communities' institutions, livelihood patterns, health, gender differentiation, and wealth distribution. It has been used to analyze the impact of AIDS among low-income urban groups in developing countries, the structure of agrarian societies in Northern countries, as well as working environments in urban industrial settings. It is also used in defining community-identified priorities, planning development activities accordingly, and tailoring services to customer needs. PRA has been instrumental in designing or re-orienting agricultural extension, credit systems, family planning services, and homeless children support groups. It is used to improve technical, adult literacy, and environmental education curricula and practice. It has facilitated the management of areas with high biodiversity value by local populations. It is beginning to be used to inform decision-makers and shape policies in ways that represent the views and realities of the poor and disenfranchised.

Anthropology has had an important influence in the development of Participatory Research. Clearly, a great deal of the methodologies used by the participatory research approaches described above were originally developed and used in ethnological field work. This applies particularly to direct participant observation, interviews with key informants, semi-structured interviewing, group discussions, oral histories and biographies, primary data reviews, communal analysis of secondary data, cross-checking (now termed "triangulation"), interpretation of maps, informal mapping, seasonal calendars, time allocation, livelihood analysis, decision trees, ranking of technological innovations, wealth ranking, risk analysis and economic return analysis (Barlett, Peggy (Ed.) Agricultural Decision Making, Academic Press, Orlando, FL, 1980; Ellen, R., Ethnographic Research, Academic Press, Orlando, FL, 1984; Gross, Daniel, Time Allocation: A tool for the study of cultural behavior, Annual Review of Anthropology, Vol. 13:519-558, 1984; Smith, Carol (Ed.) Regional Analysis. Vol.1 Economic Systems; Vol. 2 Social Systems, Academic Press, Orlando, FL, 1976; Sylvermann, S, An Ethnographic approach to social stratification: Prestige in a central Italian community, American Anthropologist Vol. 68: 899-906, 1966). At the same time, applied anthropologists participated in interdisciplinary research teams, and contributed with key concepts to participatory research such as the distinction between emic and etic representations, the value of indigenous knowledge and culture, and the importance of establishing good rapport with informants.

FSR, RRA and PRA, in turn, have contributed to anthropology by systematizing, standardizing, and making more efficient many ethnological field techniques. As a result, anthropologists do not have to invent those techniques every time that they undertake field research. FSR, RRA and PRA have also provided anthropologists with solid research tools that resulted from interdisciplinary work. Today, for instance, an agricultural anthropologist could not find a better research manual than CIMMYT's (From Farmer Fields to Agronomic Recommendation, Mexico, 1984). Participatory research has challenged anthropologists to share knowledge and data ownership with the local populations that they work with. Last but not least, as Chambers suggests, participatory research has contributed to make fieldwork a lot of fun.

PARTICIPATORY RESEARCH IN PRACTICE

Efforts to incorporate the PAR, PR, FSR, RRA, AA approaches, particularly into mainstream existing, public and privately funded development institutions, have largely been unsuccessful. If the current trends continue, this will not be the case for PRA. Excitement over PRA has spread among non-governmental development organizations (such as Action-Aid, Aga Khan Foundation, CARE, DFID, OXFAM, Save the Children, UNICEF, Winrock, World Neighbors, and World Resources Institute), donors (Danida, Ford Foundation, GTZ, IDRC, IFAD, ODA, SAREC, SIDA, among others), and some government institutions.

All of this does not mean, however, that participatory research has reached Nirvana. The goal of participatory research has been to enable local people to define research agendas by incorporating their own criteria and priorities, and

using informal, time/cost effective, and rigorous techniques. The data gathered should be rich in detail and more reliable than those gathered through formal surveys. Information is supposed to be communally gathered, owned and tested for reliability. For some, incorporating data obtained through participatory research should ensure that development projects and services are relevant to local populations. For others, the hallmark of participatory research is that it empowers local communities for action planned and implemented by themselves. On all of these fronts, participatory research needs further work.

In the last 7 years PRA has come to assume a core place in participatory research. The unfortunate part is that this takes place when PRA is often being reduced to techniques for "extractive" research, more for the benefit of development agencies than for the empowerment of the local communities (which, paradoxically, is the antithesis of what participatory research in all its forms was intended to be). A great deal of PRA is currently done as one-shot, cursory, mechanistic application of tools and techniques to describe communities and their needs to outsiders. However participatory this data gathering process may be – and even if the facilitators are local people--the primary emphasis is on collecting data for development agencies to plan development projects, and not necessarily for local-level planning and empowerment. In some cases, PRA is being used simply to develop and test methodologies. In some other cases, PRA is used to identify the acceptable ways of "marketing" services to local populations. In the worst possible scenario, PRA has been used to legitimize development strategies conceived, implemented and monitored from outside. Clearly, this type of PRA does not necessarily translate into increased awareness and confidence among people, their improved ability to negotiate, or their greater control of the development agenda.

Group discussions in progress. Bangladesh

PRA is undoubtedly very important as an opportunity for outsiders (academicians, bureaucrats, middle-class urban dwellers) to be exposed to the realities of the poor, and hopefully challenged in their assumptions about development and poverty. In this context, being part of a wealth ranking exercise, for instance, is far more educational than conducting surveys or reading reports. Training administrators, technicians, policy-makers with PRA is a worthy task, but it is a far cry from using it – paraphrasing Freire – as a practice for local peoples' freedom. The challenge is to ensure that outsiders continue listening and learning from poor people, after the glow of their field experience has faded, lest we risk replacing "development tourism" with "development voyeurism."

Depth in the analysis of social dynamics and complexities is not PRA's forte. This is because of the philosophical populist and empiricist stance that it adopts, and its strong reliance on rapid, public, visual, one-time, descriptive techniques. All current forms of participatory research are grounded in a populist philosophy that is so eager to exult the inventiveness, resourcefulness, and good will of villagers

that cannot bear to accept that those villagers are not a homogenous and socially undifferentiated mass. This is not to say that PRA is gender-blind or unconcerned with social differentiation (virtually all PRA exercises include gender differentiated information, or wealth ranking, nowadays). Rather, PRA practitioners assume that they are able to define through participatory techniques one collective vision for the diverse groups of people that constitute the community, and do not examine critically that the consensus that they have distilled and documented may simply be apparent, masking conflicts among interest groups and local political agendas. Yet, it is not surprising that villagers would be unwilling to publicly clarify to outsiders that whatever has been expressed in the PRA exercises only reflects the view of one segment of the community. Sometimes privacy gets in the way, while some other times it is distrust of development agencies, fear of retaliation from internal and external interest groups (who can be very violent), self-interest, or simply a desire to let laying dogs sleep (Mosse, David, Authority, Gender and Knowledge: Theoretical reflection on the practice of Participatory Rural Appraisal, Development and Change Vol. 25:497-526, 1996). Sometimes, villagers have learned to tailor their responses according to what the development agencies want to hear, and what many agencies want is a very orderly rendition of a much more complicated social reality. This information will only be corrected once trust is gained through relatively long social interaction between researchers and villagers.

History shows that underdevelopment is largely an issue of power and powerlessness among social groups. Currently, however, PRA it is not methodologically prepared to deal with conflict and interest groups. PRA meetings are not enough to ensure that the perspectives and interests of poor people will be heeded by local authorities and elites, project administrators, donors, and any other people who have the capacity to influence societies and economies.

Empiricism is both PRA's strength and weakness. As discussed above, its practical orientation has been extremely valuable in gathering information on agroecological systems, organizational profiles, health delivery mechanisms, to name a few. At the same time, however, many PRA researchers seem to be more concerned with gathering "facts" than interpreting them in social contexts that give these "facts" a meaning. They are more willing to accept extreme variability in crop patterns and yields among farmer fields in a given area, than diversity in goals, intentions and strategies among those farmers. Few PRA exercises start by allowing participants to define their own vision of development, using their own criteria, values, priorities and acceptable trade-offs. Instead, they start gathering "data" on subjects that outsiders have defined as critical, or have defined into discrete categories that seem to reflect Northern, capitalist ideological constructions. This is the case, for instance, when research on environmental issues is targeted to address principally utilitarian concerns on the use of natural resources.

THE FUTURE CHALLENGES

As we have said, the active involvement of anthropologists in participatory research has been beneficial for both participatory research and anthropology. The potential for a much more fruitful mutual influence is enormous. Much of the accomplishments of anthropological theory (and social sciences, in general) are yet virtually untapped in the participatory research practice. Participatory research could become much stronger in its capacity to empower poor people if it drew, for instance, on the political economy literature to understand the local, regional and global roots of underdevelopment. Reflective, cognitive anthropology, could facilitate a deeper understanding of the role of insiders and outsiders in the social construction of something that we wrongly consider to be an "objective" reality. Deconstructivism and feminist discourse could strongly contribute to make stronger an understanding of the structures of power, and how dominant groups define what is then ideologically sanctioned as normal and acceptable for society. All of this would allow villagers to be in better position to re-negotiate power arrangements inside their households and communities, and with authorities and other influential people. It would also be very valuable for development professionals to have a much more critical view of both the role that they and their institutions play in the lives of poor people, and the self-appointed "mandate" to help those people that development practitioners seem to accept as a given.

This, of course, requires a much stronger effort on the part of applied anthropologists to present political economy, cognitive anthropology, feminism and deconstructivist concepts in ways that are more readily relevant and accessible for a wider community of researchers. The onus will be on applied anthropologists to be both practitioners and theoreticians. The likelihood of this happening will increase if anthropologists engage in a deep dialogue with other disciplines and practices. The methodologies that participatory research has been able to muster to date owe their richness to interdisciplinary work in which professional assumptions, concepts and jargon have been challenged in light of different paradigms, experiences and goals. At the same time, increasing the pertinence of social theory to applied participatory research will require a more active engagement of social scientists in the task of contributing to sustainable, equitable, democratic, development, i.e. accepting that, as the young Marx said, the issue is not to understand reality, but rather to change it.

Participatory research – anthropology included – must be action-oriented and problem-oriented research, again. It must be subversive instead of supporting a status quo, practical instead of being oriented toward earning academic prestige, liberating and creative instead of being reduced to techniques and tools, theoretically sound and not merely "fact-finding." For long researchers strongly resisted putting together the art of participatory research into manuals because it was believed that these would freeze inventiveness and limit flexible adaptation to ever-changing conditions. Systematizing methods is not a problem, and in fact it is an important contribution to more rigorous research. There is a problem, however, in reducing methods to tool kits, and blue-printing research (for which a large and profitable market has developed), and getting infatuated with rather mechanistic approaches that sometime become an end in themselves.

Participatory research cannot cease to be inventive. It has to move beyond up-front community assessments and a relatively narrow set of methodologies to include collaborative management of resources, development of technology with farmers, conflict resolution, project design and monitoring, building the capacities of local institutions, and allowing participants to learn and act continuously to gain their own freedom. We all need more of the critical assessments of the accomplishments and shortcomings of participatory research found in the "PLA Notes" (see previous section), and the Overseas Development Institute's "Agriculture and Extension Network" and "Rural Development Forestry Network."

CHAPTER 2

PARTICIPATION AND THE PROJECT CYCLE: AN ITERATIVE PROCESS

Michael Drinkwater

1. Introduction

Although the concept of participation has become a popular one in development activities in recent years, and despite the fact that 'participation' as a word suggests that taking part in an activity over time, in most instances those activities described as participatory are curiously limited in duration. Most frequently it is assessment exercises of various types that acquire the label. Beyond this, if there is any emphasis on community involvement in a development process, the result is usually a very localized development project with relatively little scope or depth.

There are three major reasons for the lack of an actively participatory process, on any significant scale, throughout a project cycle.

- Participation as an active process throughout the project cycle frightens development practitioners because of their lack of understanding of what this entails, and the apparent loss of control over activities that this seems to imply.

- The lack of understanding of what a 'participatory' process is over time stems a great deal from the fact that this is in fact an inappropriate term. It is more accurate and helpful to talk of an 'interactive' process, since the term 'interaction' requires us to look at the roles and responsibilities of all parties in the process. The trouble with the term 'participation' is that on the one hand it can be used to describe activities where the role of community members is in fact either manipulated or extremely passive, or if this is not the case, where that of the project staff instead becomes rather passive and accepting of anything that community members say. In an interactive process, however, all participants are necessarily active with clear roles, and therefore the process is one of ongoing dialogue, negotiation and agreement.

- The third reason for the lack of ongoing participatory projects on any reasonable scale is simply that, even if willing, development practitioners do not know how to achieve this. It is in part because the process is more complicated than people envisage, but more fully because most participatory training people receive stresses methods or tools. This type of training is helpful only if the recipients are then going to carry out the same rather stereotyped and repeated process – some form of participatory appraisal exercise. If practitioners are to go beyond this what they require is a grasp of the principles required, so that they may be both ongoing facilitators of an interactive process, and able to contribute appropriate technical inputs in appropriate ways when required.

In a typology of participation, shown in the table below, Jules Pretty describes seven types of participation. This typology is valuable since it helps illustrate the points made above, as well as providing a guide to the nature of participation and the way it needs to evolve over time as an iterative participatory process throughout the project cycle. It is very easy for participation during the project cycle to fall into the types 3-5 in the table below – 'participation by consultation' (consultation occurs during assessment and then we decide what the project should be); 'participation for material incentives' (food for work projects, in which the infrastructure priorities are decided upon by participants); or 'functional participation' (we encourage the formation of community groups, which assist in the implementation of activities largely decided and managed by the project). The reasons that even well-intended 'participatory' projects often fall into these three categories is very understandable, and is by no means necessarily the 'fault' of the project in this era of increasing donor demands to show results and meet the output performance indicators required by logframe planning.

Nevertheless, if we really do wish to improve the performance of projects by tapping into people's energies and aspirations as fully as possible, it is important that as project and program managers and field staff that we improve our self-awareness of what we are doing, and hence the interactive and iterative nature of project processes. The purpose of this Chapter is to discuss ideas of how to achieve this.

TABLE 1: A TYPOLOGY OF PARTICIPATION

TYPOLOGY	CHARACTERISTICS OF EACH TYPE
1. Manipulative participation	Participation is simply a pretense.
2. Passive participation	People participate by being told what has been decided or has already happened. Information being shared belongs only to external professionals.
3. Participation by consultation professionals	People participate by being consulted or by answering questions. Process does not concede any share in decision-making, and are under no obligation to take on board people's views.
4. Participation for material incentives	People participate in return for food, cash or other material incentives. Local people have no stake in prolonging technologies or practices when the incentives end.
5. Functional	Participation seen by external agencies as a means to achieve participation project goals, especially reduced costs. People may participate by forming groups to meet predetermined objectives related to the project.
6. Interactive participation	People participate in joint analysis, development of action plans and formation or strengthening of local groups or institutions. Learning methodologies used to seek multiple perspectives, and groups determine how available resources are used.
7. Self-mobilization [Local organizational empowerment]*	People participate by taking initiatives independently of external institutions to change systems. They develop contacts with external institutions for resources and technical advice they need, but retain control over how resources are used.

Source: Pretty 1995b (in Pretty 1998).

* Community or local organizational empowerment is probably a more relevant term for this last component of the typology.

2. Participatory Needs Assessment and Project Design

The areas in which development practitioners usually have most experience of working in a participatory way are at the stages of needs assessment, and to a lesser extent, project design. It is comparatively easy to use participatory methods for the purpose of needs assessment since the exercise is usually of a short and fixed duration, yields obvious benefits in being able to persuade donors that the needs the project is addressing are indeed the priorities of the intended beneficiary populations concerned, and does not necessarily commit the emergent project to continuing to work in a participatory manner. In short, the benefits are clear, whilst overall control over project activities – and the needs assessment process itself – need not be diminished.

Nevertheless, if there is a genuine commitment to increasing the role and responsibility of stakeholders over the entire project process, how the interactive tone is set at the outset is extremely important. Interactive processes, or 'interactive participation', as Pretty terms it, are about the mutual empowerment of both project staff and the direct project participants. A hedged process, in which we provide an initial pretense of wanting to be participatory, but then resort back to at best a functional participation, will always be less empowering, since ongoing decision making is retained, not just by the project, but usually merely by a small management elite within it.

For there to be full commitment from the outset to an ongoing interactive enterprise, there has to be an understanding of, and confidence in, the principles that will be adhered to during the whole project – even, and perhaps especially, if it is envisaged that the entire process will take some years to unfold. A starting point for understanding these principles is provided by Chambers' distinction between paradigms of things and people.

TABLE 2: TWO PARADIGMS - OF THINGS AND PEOPLE

POINT OF DEPARTURE AND REFERENCE	THINGS	PEOPLE
Mode	Blueprint	Process
Keyword	Planning	Participation
Goals	Pre-set, closed	Evolving, open
Decision-making	Centralized	Decentralized
Analytical assumptions	Reductionist	Systems, holistic
Methods, rules	Standardized, universal	Diverse, local
Technology	Fixed package (table d'hote)	Varied basket (a la carte)
Professionals' interaction with local people	Instructing, 'motivating'	Enabling, empowering
Local people seen as	Beneficiaries	Partners, actors
Force flow	Supply-push	Demand-pull
Outputs	Uniform infrastructure	Diverse capabilities
Planning and action	Top-down	Bottom-up

Source: Chambers 1997: 37 (adapted from David Korten)

If a project methodology is to proceed along interactive lines, then the principles of the right hand side need to be embraced from the outset – recognizing that negotiation with donors of some of these principles will be inevitable. Nevertheless, as will be shown subsequently, an interactive process project does not mean that a logframe cannot be produced, nor quantitative, as well as capacity oriented targets, be achieved during the project. The form of these measures will however usually differ from a more conventional and relatively numerical logframe.

A worrying ethical problem often faced during assessment work is the dilemma in taking up maybe several days of people's time to participate in the participatory appraisal and design process, when there is not necessarily any guarantee that a follow-up project will actually be funded and initiated. As in many aspects of working with others, the issue is one of the integrity of the approach – in this instance, essentially, being honest about the purpose and intentions of the exercise.

By way of illustrating how participatory appraisal and design exercises can be undertaken in ways that do establish from the outset with communities an understanding of the key principles on which any follow-up project will be built, two case examples from Zambia and Malawi will be referred to in the following discussion.

CASE 1:
LIVINGSTONE FOOD SECURITY PROJECT, CARE ZAMBIA

The Livingstone Food Security Project began as an emergency drought relief initiative in the Livingstone and Kalomo areas of south-eastern Zambia in 1995. Alongside the food relief scheme, a pilot seed loan scheme was established with 330 farmers, so that their relationship with CARE was not solely one based on relief. During this season, a series of PRA exercises were then carried out in three areas as a basis for designing a longer term food security project. These exercises ended with appropriate drought tolerant seed varieties being seen as an overall priority, and agreement being reached on the key components of a future project strategy across the three PRA areas. During meetings held with a far wider range of communities to discuss, validate and refine the project's strategy, particularly for the initial seed scheme, those communities wishing to participate in this scheme the following season were asked to organize village management committees and to register members wishing to participate in the scheme. They were also asked to have one woman committee member in the three-person committee, to ensure women's involvement. In the first season of the scheme, 180 VMCs were formed and seed distributed to 6,800 farmers; the following year this had increased to 230 VMCs and 9,600 farmers. Since then the VMCs have gone on to undertake a range of activities, and in the last two seasons, have begun to federate into area management committees with the capacity to develop their own external linkages. One of the major reasons for the project's success is that communities have known from the outset that to participate they have to have their own organizational structure. Several VMCs have in fact formed and trained VMCs in outlying villages independent of the project.

(continued)

CASE 2
PARTICIPATORY LIVELIHOOD ASSESSMENTS IN CENTRAL REGION MALAWI

In June 1997, three participatory livelihood assessment exercises were carried out in the Lilongwe and Dedza districts of Malawi's Central Region, as part of the process of planning a start-up program for CARE in Malawi. Since CARE had not yet established a presence in the country, it was felt important that detailed community level information could be included in the design, even though CARE was in no position yet to guarantee to those communities that it would be able to implement a follow-up program. In the first exercise, this was explained to the group of around 700 people who turned up and took part in the first day's community analysis activities. Nevertheless, participation stayed high throughout the exercise, and the final day's synthesis meeting was also attended by about 700 people. Again, it was stressed that their work would assist CARE in being able to convince donors of their needs and the types of food security improvement strategies required, but that this was no guarantee funding would be forthcoming. When people were asked if they had questions, one of the two asked was the simple statement, 'As you can see, we are hungry, and hope you will be back soon.'

2.1 The assessment process

Methodologically, the Malawi exercise also illustrates well, the iterative nature of the participatory assessment and design process, in this case using a household livelihood security framework. Assessment field exercises were carried out in three different locations, and for each exercise the generic methodology described in Table 3 and the box following was utilized. A team of 10 people were used for the first exercise which functioned also as a training event, and then of these 10, eight were split into two teams of four for the following two exercises, carried out simultaneously. Six of the latter eight people were Malawians, who had limited participatory methods experience, but had not previously worked with CARE. The pre-training and preparation was limited to just two days because of time constraints; as will be discussed, this need not be a constraint.

Each exercise began with an area level meeting, arranged in advance through the senior village headman. During this meeting, a general understanding of economic activities, environmental resource use and change, and historical trends and issues, was built up through a series of activities carried out with the different groups. On the second day, the survey team moved down to work in two villages to conduct more specific analyses of livelihoods and social differentiation. These meetings were followed up with a series of case studies on the third day, which then allowed a good understanding of livelihood issues and trends to be developed amongst the different livelihood categories, and helped confirm overall levels of poverty and vulnerability. These three days of initial analytical activities completed the first iteration of the assessment process. The final day was given over to another area[3] level meeting, during which the results of the analysis were pulled together by the participants into a synthesis of prioritized issues, the cause-effect and linkage relationships between problems, and potential opportunities for their amelioration.

TABLE 3 : METHODS USED AND KEY INFORMATION COLLECTED

LEVEL OF ANALYSIS	METHODS	KEY INFORMATION COLLECTED
Community level economic and environmental analysis	Resource mapping and focus group discussions around resource map	Infrastructure, key services, land use, farming systems, land tenure, natural resource base, availability, access, quality, historical changes.
	Historical time line	Historical analysis, changes over time, trends, past efforts.
	Seasonality calendars	Seasonal farming activities, income, expenditure, stress periods, coping and adaptive strategies.
	Venn diagramming	Institutional identification, operation, interaction, level of service, performance.
	Matrix ranking	Economic activities, priorities, performance, trends, gender differences.
Household level social analysis	Identification of livelihood indicators	Economic, social, and environmental criteria used for classifying households by well being.
	Identification of livelihood categories	Difference by gender.
	Livelihood category profiles	Location and names of households.
	Social mapping	Proportional livelihood status.
	Case study and household interviews	Vulnerability, shocks, stress, coping and adaptive behavior.
		Potential opportunities.
		Validation.
Problem prioritization, analysis and opportunity identification (synthesis)	Problem identification analysis	Prioritized problems by gender.
		Problem linkages, causes and effects.
	Cause – effect analysis	Previous efforts, successes, failures.
	Opportunity analysis	Roles and responsibilities.
		Potential opportunities and strategies.

BOX 3

DAY 1[4]

The first day's exercise was conducted at a general community level (attended by people from several villages in the area). The day began by introducing the PLA team to the community and explaining the objectives of the exercise and the following days activities. The community group was then split into smaller sub groups, which in some cases were further divided into men's and women's groups. The different groups then carried out either a resource mapping exercise, historical and trends analysis, seasonality analysis or an institutional trends analysis. At the end of the day, when all the groups had finished, a representative from each group was asked to report back to the whole group explaining the outputs from their group activity. Before departing at the end of the day, local leaders helped the PLA team to select villages for the next two days activities.

DAY 2

The teams returned to the selected villages to begin the household social analysis. Once again the village group was split into a men's and women's group. The groups were first asked to identify a list of indicators that could be used for telling the difference between households. They were then asked to identify the different livelihood categories in their village. The groups then identified profiles for each livelihood category in terms of the list of indicators that they had previously developed. Social maps were then drawn as a means of classifying households in terms of the different livelihood categories. Discussion of any issues affecting the different livelihood categories in terms of shocks; stresses and vulnerability were then held. Finally before leaving the village a given number of households were selected from each livelihood category to be interviewed on the following day.

DAY 3

Households from each livelihood category were visited and interviewed in order to validate and deepen understanding of the nature of the different livelihood categories. An effort was made to consolidate understanding of specific issues and trends, and obtain specific examples of shocks, stresses and coping and adaptive strategies specific to each livelihood category.

DAY 4

The final days exercise was once again conducted at a general community level. The PLA team began the day by presenting back to the community group the previous days findings. The community group then broke up into smaller groups of men and women. The individual groups were asked to identify problems and issues. These were then ranked using the pairwise matrix ranking method. The groups were then asked to identify specific linkages between their list of problems and then further develop their analysis by identifying the cause - effect relationship between problems. Finally the groups were asked to identify potential opportunities and strategies that could address and resolve their previously identified problems. When all the groups were completed a representative from each group was asked to report back to the whole group explaining the outputs from their group activity. The differences in the cause-effect analyses and problem prioritizations did not require resolution at this time. Perhaps the main difference was that women stressed much more than men an interest in small businesses (off-farm IGAs), whereas the men focused more on agriculture (dryland or dimba). These different interests were incorporated in the synthesis cause-effect analysis developed by the survey team (in the chapter) and into our strategy (which focuses on both agriculture and IGAs). Before finally leaving, the community was thanked for their participation and enthusiasm. The next stages of the process for CARE were explained to the community and they were finally invited to ask questions before departing.

Source: Nick Osborne (ed) 'Malawi Participatory Livelihood Assessment Exercise (Synthesis Report), July 1998, CARE Malawi.

The information in the box on page 2.17 depicts clearly the process flow over the four days, and the two iterations of the exercise. For this type of process to be feasible, it is imperative that all members of the field team stay on top of what is happening. It is not necessary for people to have a great deal of training to be able to do this; what is essential is adherence to the principle of following a definite daily rhythm throughout the exercise. In this rhythm, the team plans and prepares for the day's fieldwork, then goes out into the field to conduct the work, before returning to document the day's outputs and process notes. Once notes are completed, all work is presented in a plenary session, in which what has been learned during the day is then discussed, before the next day's objectives and agenda are set. Establishing daily, as well as overall, objectives for the fieldwork, helps to remind team members of the type of understanding they are trying to develop, and hence the need to be flexible in the tools they use during the day.

Once the PLA documentation is complete, the third broad iteration, that of project or program design, can be commenced. This in itself is a complex event, likely to consist of several cycles or iterations. To conclude this part of the paper I will continue to refer to the Livingstone and Malawi examples.

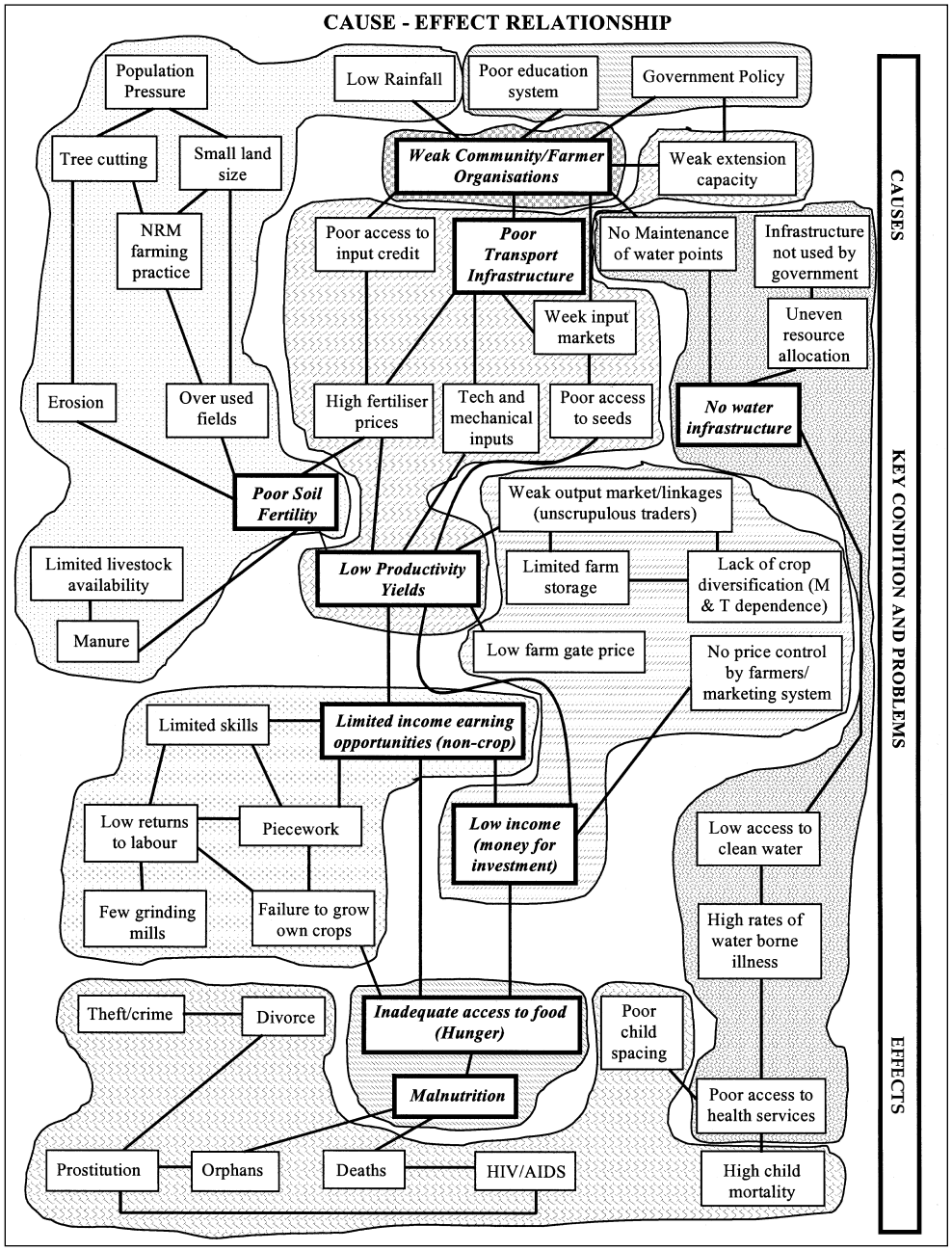
2.2 Project design

One of the common dilemmas faced by program managers is the extent to which potential participants in a project should participate in its actual design. Often it is felt that once the participatory assessment has been carried out, we should simply get on with designing the project, since we know best what potential donors are interested in and will accept. Yet, if it is intended that the project remain participatory in nature during its implementation, it will help greatly if participants understand not only how the eventual project activities arose, but participate in the decision-making on these. This should not only improve the appropriateness of the activities, but also ensure there is greater enthusiasm and feeling of ownership for them by participants. Design is, of course, more than just setting on paper the key priorities generated in an assessment exercise, since there are other factors that need to be taken into account – certainly the interests of donors, other available information, what the implementing organisation's capacities and strengths are, and the cost-effectiveness of the proposed strategy. The priority principle though must be to design a program that is likely to succeed. To maximize the likelihood of this occurring once the project is operational, ongoing participation must continue to take place. There are a number of factors involved here.

First, on completion of the assessment, the design team themselves need to pull together an overall synthesis of issues, priorities and opportunities. This may also take into account additional available information to that collected in the field. In Malawi, the PLA team constructed a linkage diagram showing the cause-effect relationships between the different problems and issues identified during the fieldwork. This diagram became known as the 'IMAP' diagram, following reference by one team member to the 'interactive myriad of accentuating problems' that people faced (Figure 1). Clustering of the problems allowed the team to identify a discrete number of key issue areas, with the central problems of each highlighted and located within a central spine. In turning these issue areas into an initial

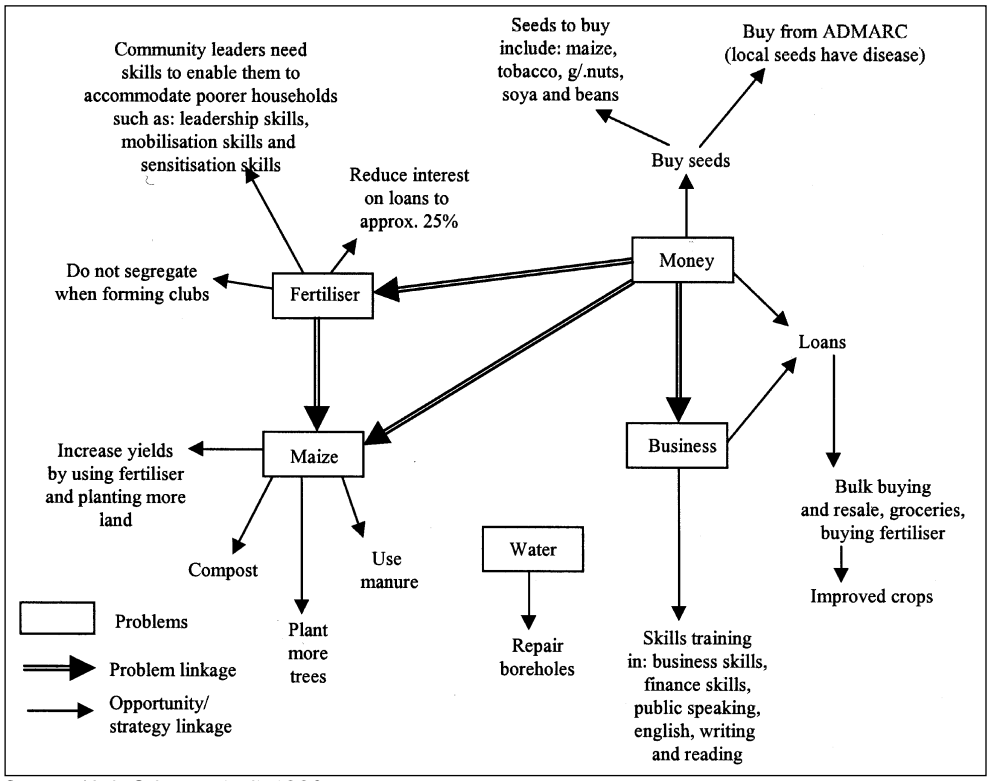
strategy – selecting which ones the project should deal with, and potentially how – both the cause-effect and opportunity analyses developed at community level and validated by the assessment team across communities, were extremely important. In general terms, the project should be addressing the most vital causes of circumstances, and not merely symptoms; it should look to generate synergies; and start with activities where there is relative confidence successes can be generated. The opportunity analysis is particularly important with respect to the latter. This can be illustrated with reference to Figure 2, one of the opportunity analyses undertaken during the Malawi exercise.

FIGURE 1: MALAWI IMAP DIAGRAM.



Source - 'Central Regional Livelihood Security Program,' CARE, October 1998.

FIGURE 2: OPPORTUNITY/STRATEGY ANALYSIS, CHITUKULA WOMEN



Source: Nick Osborne (ed) 1998

Second, once an outline strategy has been produced, delineating broadly what 'lines of action' the project will have the capacity to pursue, this can be discussed in detail with potential participants, in order to refine the framework and begin the delineation of an operational strategy. Usually this is a lengthy process, which may begin before project funding is secured, and certainly will continue during the start-up phase when a more detailed design is developed.

Third, the design stage, both before and after funding, provides project staff with the opportunity to introduce criteria concerning participation in the project. These may include the type of target groups the project will wish primarily to work with; the types of organizations with which the project will work (whether these should be existing or newly formed structures); whether there might be conditions regarding these organizations, such as on the participation of women; or whether the project will simply be relying on the self-organization or mobilization of participants.

Such criteria can be flexible in nature, and form part of the negotiation process at the community level, but are important in ensuring that the project is as cost-effective as possible in its activities, and best able to tap into and nurture local organizational energies and capabilities. Organization, and a clear strategy for the various ways in which people may participate in a project, are vital to ensuring that the project will be able to scale-up once the overall project approach has been successfully evolved. More will be said concerning participation in implementation, monitoring and evaluation throughout these *Guidelines*.

Illustration of the above points can be provided from Zambia and Madagascar. The outline of the assessment, design and start-up process for the Livingstone Food Security Project is described in Case 1 (on page 2.14). This illustrates how communities were involved throughout this process, in a way which ensured that not only were people's overriding priorities addressed in the early stages of the project (drought tolerant seeds and water supply for domestic and agricultural purposes), but that an organizational structure was negotiated with communities which allowed a huge expansion of the project within just two years. Extremely important too was the encouragement of women to participate fully in the scheme by requesting their membership on the village management committee, despite their secondary status in local traditional culture. This has resulted subsequently in the opening of a substantial debate in some communities on the role and status of women, in recognition that keeping them subservient undermines their ability to contribute to household food security.

A second project from Zambia, formerly the PUSH (Peri-Urban Self Help), and now the PROSPECT project (Program of Support for Poverty Elimination and Community Transformation) working in the urban compounds of Lusaka and Livingstone, is now in its third phase. During the first two-year phase, the project was purely a food for work activity. The design for phase two envisaged movement towards a more participatory process, with infrastructural development activities to be managed through resident's development committees – at this stage, existent in theory rather than practice. As a result, the first year of phase two was given over to establishing these resident development committees more definitively, and to conducting a participatory appraisal and needs assessment (PANA) process that would provide the basis for a detailed project implementation plan. When it was agreed the project would submit an application to DFID for a third phase, at this stage the application had to be vastly more detailed and was subjected to rigorous technical appraisal, compared to the skeletal nature of the second phase proposal and lack of appraisal. Nevertheless, the process nature of the project has been maintained – a process of electing representative residents' structures and conducting a PANA exercise, remains the start-up phase in each new urban compound the project extends into. The far more detailed nature of the third phase proposal reflects the lessons learned by CARE and the donor during the previous phase, the vastly increased size of the target population (250,000 to 600,000) and budget ($3 to $16 million) to be spent over five years, and the role the project is expected to play in the future development of urban development policy in Zambia.

A final example is provided by the new urban livelihoods project in Madagascar, which has the Malagache name, Mahavita. As a Title II project, funded by USAID's Food for Peace, a detailed and tightly structured project proposal had to be submitted, the preparation of which is usually a lengthy preparation process. Yet the Madagascar DAP was prepared, submitted and approved within a three-month period. The support of the local USAID mission was certainly vital, but what also helped a great deal was that from a short, one week participatory livelihoods assessment exercise it was possible to provide an understanding of the livelihoods of the urban poor that was not previously available. Bits of information, such as in the World Bank's poverty assessment document, did exist, which

in turn were both validated by and helped to validate the study, but nothing that provided a complete or coherent account of livelihoods. For the project design, this brief participatory analysis helped in two ways. First it provided a rational justification for the key elements of the proposal. Second, it also provided a logical framework – in the full rather than just technical sense of the word – for establishing key outcome and impact indicators in a way which not only satisfies the generic list USAID have for Title II projects, but which can be participatively agreed subsequently. This is illustrated through the extract from a livelihood profile, generated during the exercise, listed below. Reference to indicators such as those in the table, and the framework whereby they will be finalised once the project starts up, is then made in the project logframe, and monitoring and evaluation plan.

TABLE 4: INDICATORS OF LIVELIHOOD STATUS

	VERY POOR	POOR	BETTER-OFF	RICH
HOUSING	Shelter made of cardboard boxes, or lives outside	Walls made of dried mud or unbaked bricks roof of dried reeds	Small house with 2-3 rooms Outside shower and latrine no electricity	Larger house with 2 or more floors water and electricity
FOOD SECURITY	Only eats when food available and has cash to purchase it Sometimes does not eat all day	2 meals a day, one with rice and one with manioc or rice soup	3 meals a day, 2 with rice and breakfast with bread and tea	Eats all types of food Indefinite number of meals
HEALTH	Consistently poor health No access to health care	Uses public health centers or religious dispensary	Uses affordable private health centers or work-sponsored health centers	Usually fetches a doctor to the home able to buy medicines
FINANCIAL STATUS	Begs or steals for money	Daily earnings spent same day	Earns a salary at end of month, but insufficient to meet monthly expenses Often in debt No savings	No financial problems Has bank account

Source: CARE Madagascar, 'Antananarivo Urban Household Food and Livelihood Security Program,' September 1997.

3. Participation in Implementation, Monitoring and Evaluation

If an interactive participatory process is continued through from the appraisal into the design stage of a project, then it should be feasible for this process to be continued relatively seamlessly thereafter, even if there is a delay between design and approval. It obviously makes a difference if some form of activity is able to take place in the intervening period, as in Livingstone where a food relief scheme and pilot seed scheme were operated through the season proceeding the start-up of the larger food security project. The issues involved in maintaining an interactive process through project start-up and implementation, whether or not there is any preceding activity, are discussed in this section.

3.1 Project start-up

The period between design and start-up, and the nature of the process in between will vary considerably. In the Mahavita case in Antananarivo, because of delays in monetizing the food providing the project funding, there was eventually an 18 month gap between the appraisal exercise and project start-up in specific communities. Nevertheless CARE has managed to have an ongoing presence in the appraisal communities through an urban health project, TOUCH 2000. In other types of circumstances, it may be feasible simply to provide those most involved in the appraisal and design stage with periodic updates of the progress being made in securing funding.

The complication in instances where some form of activity is already ongoing, is if the methodology of the early interventions clashes with the new intentions. For example, the Mahavita project will attempt to work more creatively at community level, and will have different objectives and activities. But in setting this up, it is the experience of the TOUCH field staff which will be drawn upon to inform the new strategy. Indeed, what has been decided is to amalgamate the old and the new into a single urban program, which with the ending of TOUCH in another year, will allow a seamless continuation of an evolving strategy. Nevertheless, since Mahavita will introduce different ways of working, the start-up process in communities – fokontany – for Mahavita, will be to return to the original assessment and regenerate it with the fokontany communities, in order to validate and update it, and begin developing a detailed implementation plan.

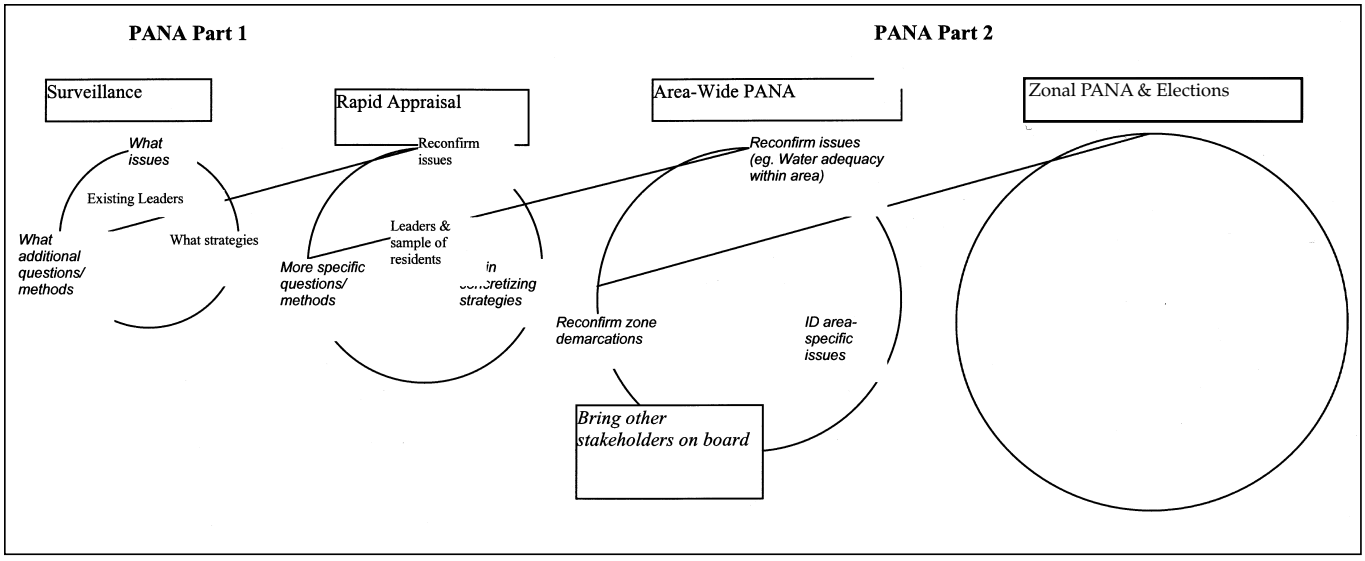
The process Mahavita will use will draw from the lessons learned from the participatory analysis and needs assessment (PANA) activity carried out by the PUSH/PROSPECT project in Zambia, as a community level start-up event. This type of participatory start-up activity, illustrated by the PROSPECT project manager in the following diagram, has several aims.

It is firstly, and perhaps most critically, a strategy to establish the institutional mechanism(s) at community level through which the project will work. There are two sets of issues here: whether there are existing institutional structures with whom the project could work, and their adequacy in terms of how specific interest groups of the project – women, poorer households, youth – are represented. If

existing organizations are not representative of the interest groups with whom it is intended the project should work, then a strategic choice process of deciding an appropriate structure has to be worked through. By default this means seeking the establishment of new or amended structures, and hence to the dilemma involved when a project creates its 'own' structures which become dependent on the project and do not survive beyond its particular life span.

Nevertheless, if we are committed to a mission statement of reaching those who are poorer and in greatest need, this does require seeking to stimulate appropriately representative forms. The key here is adherence to two principles. First, such a process has to become part of an internal social debate, and probably too, a wider debate with government. And second, from the outset ownership has to be vested in the appropriate sectors of the community. Some quick examples can be provided. In the Livingstone Food Security Project, participation by farmers in the initial seed multiplication focus of the project was predicated upon them electing village management committees, and having these registering interested participants as seed groups. The project also had a requirement that one woman be represented on the committee, to ensure women's seed interests were met. Since 1995, some 250 such groups have been formed, with a host of implications. For one, with the federation of VMCs into area management committees, communities are beginning to develop representative structures which can much more successfully deal with external institutions on their behalf. And two, women and younger men are in many cases becoming more involved in community decision making, following processes of internal debate in which it has been agreed the value of such has been demonstrated, and therefore the accommodation of the new structures, along with the more traditional lineage authority of elders, has been sought. In short, the VMCs have become integral to a process of social debate and innovation in conservative rural communities, where, as is emerging, women's rights were badly underrepresented, heightening their and their children's vulnerability.

FIG 3: PROSPECT'S PARTICIPATORY APPRAISAL AND NEEDS ASSESSMENT PROCESS



The same has happened with the urban PUSH/PROSPECT project in Lusaka and Livingstone. A rather vague commitment by national and municipal government that compound (urban low-income) communities should be represented by Resident Development Committees, has been turned into a viable and embedded institutional form. RDC's now have a constitutional backing, hammered out and agreed at City Council level, and are formally recognized as the lowest tier of local government, with their relationship to city councilors, previously an arena of sometimes acute conflict, also negotiated.

In both the LFSP and PROSPECT cases, the initial organizational structures encouraged by the project – VMCs and RDCs – have become part of broader, more federated structures, and because it is clear that there is complete ownership of the institutional form by their members, their acceptance by a widening range of external institutions as a viable and representative community structure, has also taken place.

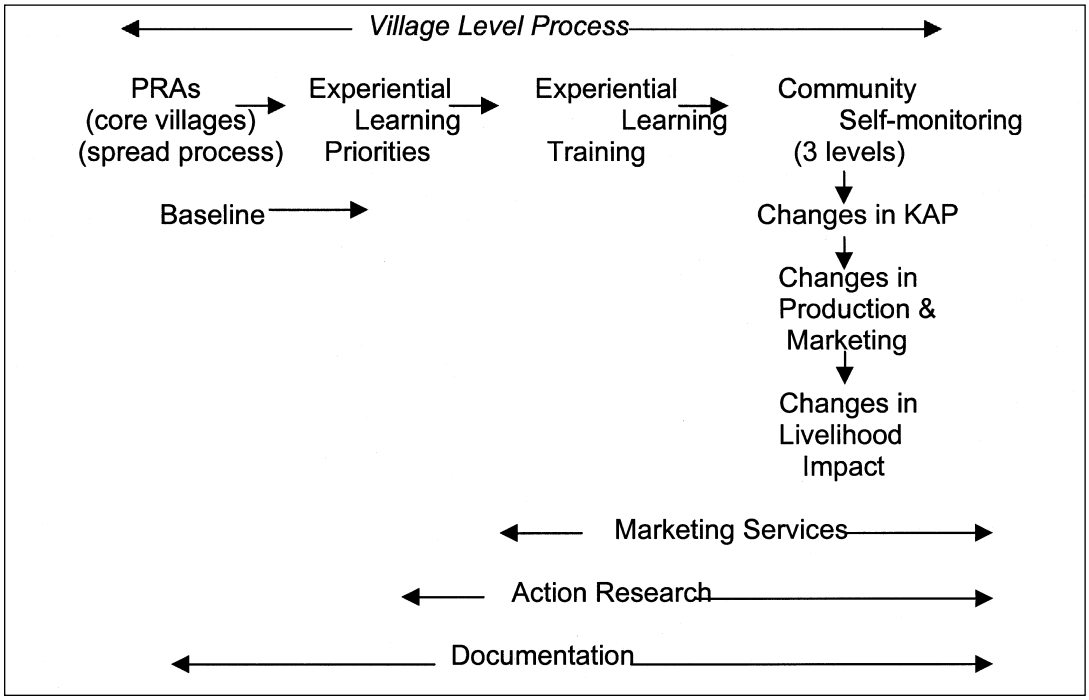
The second role of the start up process is to validate the original needs and strategy identification process more widely, and then to lead this into the development of an initial implementation strategy for the project, with activities, estimated timelines, and roles and responsibilities. As this process often forms the activity around which the institutional form of the project emerges, it may take place over a period of some months. Training of staff, community facilitators and leaders in the participatory analysis and strategizing methodologies is another essential prerequisite of the process. Necessarily, therefore, this period of the project is an acute learning phase. Growing numbers of people, as staff, and members of participating communities and collaborating organizations are coming into contact with the project for the first time, and are grappling with understanding how it will affect their lives. Of course, this is also a decision on just how interested they are in engaging with this new intrusion and what they see as potential benefits. This initial phase establishes very crucially, therefore, an identity in the minds of those coming into contact, and if an inappropriate image is set, it may take substantial effort and time subsequently to amend this satisfactorily.

What is absolutely critical at this stage is to set the interactive tone of the project; not to get things absolutely right. The latter will be impossible anyway. There will be a tremendous amount of learning, conflicts will occur, and strategies will be emergent over longer or shorter periods of time. But attitudes towards, levels of commitment to and belief in the potential value of the project are influenced greatly by the nature of the first contacts. Of course, if the original assessment and design process has taken place interactively, at least some of the critical participants should be expecting this process to happen, but for most this will be their first contact. In projects, such as the Lesotho TEAM project, this start-up process, whilst handled with the right intentions, was not conducted at all efficiently over the first season. A short two day participatory appraisal and planning process in core villages was optimistically intended to result in community action priorities, and some form of household baseline. At this time the project was working with many new and very inexperienced staff, who neither had an adequate understanding of the intended follow up process in villages, nor were used to being expected to think critically and creatively about their work. As a result some 30 or so participatory exercises were completed relatively

quickly, before it was acknowledged that they did not provide a sufficiently detailed understanding of key land use activities and the priority needs associated with these required to develop the experiential learning extension strategy, which was to form the next stage of the project.

This realization led to significant changes being made in the project's internal structure. In particular, vastly more effective team work was encouraged by establishing a series of cross-cutting teams dealing with different themes of the project's work, which required staff, regardless of their formal positions, to take more active leadership roles and to be active learners. A more conscious and explicit effort was taken to outline and then develop a sequenced village level process, and it is on developing this that the two-year pilot phase has focused. The process model is illustrated below.

FIG 4: TEAM (TRAINING IN ENVIRONMENTAL AND AGRICULTURAL MANAGEMENT) PROJECT PROCESS, LESOTHO



A third need of the start-up process is to establish institutional relationships with major stakeholder organizations. There are two essential points to note here. One is that the way in which we view, and seek to involve (potential) stakeholders, says a lot about our own political savvy, and about our level of ambition as an institution. Playing by ourselves is playing small. Involving a wide range of potential stakeholders from the outset does not mean that all will become immediately involved, but it does mean that we are announcing the project intentions, and are informing organizations and inviting their involvement as and when appropriate. For relevant government and/or NGO partners, this means involving them as

fully as they wish in the start-up design process, so that like the participating communities or groups, their own sense of involvement and the potential value of participation is heightened.

Involving other institutions early in this manner, may well involve difficulties. There will be issues around the degree of involvement and the time required; the level of partner resource contributions and their decision-making roles; and of the pace and nature of the overall project process. All of these issues have to be discussed and negotiated, and decisions reached which are appropriate in the circumstances. This subject will be discussed in more detail in the final section of the chapter.

3.2 Project information

The final requirement of the start-up process is to establish the basis of the project's information system. A framework should already have been established during the participatory appraisal and design process and recorded in the preparation of a logframe or other schematic tool. One of the mistaken assumptions often made about process approaches is that they are necessarily open-ended and preclude effective measurement, or that where measurement is effected, this will be primarily qualitative. This need not be so. Measurement can be highly quantitative. However, there are two characteristics about this measurement that are not part of conventional assessment mechanisms. First, information collecting should move progressively towards self-assessment methodologies, and second, all information should be contextuated.

I will try and describe these points in a little more detail, with some illustration. The most important need during the project design and start-up process is to develop a sense of coherency for the information system as a whole – how the different pieces relate together, and for these to be as minimal as possible. Ideally, just as logframes require a nestling of types of information, this will also occur in the way information systems are established. For example, with the TEAM project in Lesotho, a three-level participatory monitoring process is being established at village level.

At the first level, activity level change resulting from the experiential learning training will be monitored through KAP (knowledge, attitude, and practice) indicators, established in conjunction with the community. Thus, agreeing at the planning stage that soil and water management practices need to be improved (or equivalent practices in other contexts), also results in some listing of existing practices and the types of changes participants hope might be achievable. Developing the KAP indicators expands and facilitates this concept.

The second level of monitoring progress in TEAM will occur through assessing how the KAP changes influence changes in production and marketing systems as a whole (output level), whilst the third level will then monitor the overall effect on household livelihood security (purpose level). All of this will be developed as a single community monitoring methodology. There are more issues to be explored here than can be dealt with immediately. Suffice to note a few comments. One is the obvious feeling that once again we are simply imposing our requirements onto communities. To some extent this has to be true, but since donors are justified in asking us to show the benefits of their investment, it is also

necessarily an acceptable part of our own negotiation with communities. The second step in this is to encourage the use of the information for management purposes within the community itself – by organizations and individuals. For instance, when valid questions (considering the brief time in which it was being developed) were being asked about the development of a participatory livelihood monitoring system with the VIDA project in Nampula Province, Mozambique, a simple then and now exercise was carried out with the two pilot groups. This allowed them to see the changes that had occurred in the proportions of male- and female-headed households in different livelihood categories since the end of the civil war a few years earlier. There were some immediate insights. The situation of many male-headed households, often resourceless at the end of the war, had been gradually improving, but for female-headed households there was a different trend. Their numbers had increased, and there was a larger proportion in the very poor category, suggesting a later return migration of women in this category and a high level of current vulnerability.

Illustrating how the community could monitor its own progress in this way was a fascinating concept to those present and gained immediate support for the methodology, even if its 'interactive' nature was still some way from being assured. In the Livingstone Food Security Project, a similar methodology has been much more extensively developed through two-to three-day community level monitoring workshops. Community facilitators and leaders are introduced to the subject of monitoring in these events and then discuss openly the potential value of information about community (and project) activities to themselves. Following this they define what particular information would be of value (subject), how it might be collected (indicators), by what means (method) and by whom. As with the TEAM project, this information can be of value both to participating households and community organizations.

There is no doubt that such self-assessment methodologies take time to develop. For a start, significant amounts of staff and community facilitator training and interaction are required in order to generate a (relatively) common understanding of why we are working in this way and the potential value to all concerned. This means that more formal approaches may be used at the project baseline stage, to ensure that this task is completed. Nevertheless, the more project staff feel comfortable in setting up the baseline in a participatory way, the more easily it is likely to be linked to future forms of information collecting, and to have value in the longer term.

In a one-day workshop facilitated in Zambia in 1997 on the subject of Household Livelihood Security(HLS), the subject of the coherency of information systems was raised for discussion. Three groups of CARE Zambia program staff were asked to select a key intervention theme of their particular program and show how the themes had been carried through each stage of the program process. A first point to note, is that although the task given to the groups was a relatively abstract one, two of the three groups were able to interpret it extremely well and produce highly meaningful outputs. This is partly attributable to the intrinsic value of a

holistic framework such as HLS, but more to its use within the context of a participatory programming philosophy, in which highly interactive approaches are used in relationships with communities and program partners, and within projects/programs themselves. In short, staff understand the larger whole within which their particular roles lie.

One of the three groups was a combined group from two health sector projects. What they chose to illustrate was a theme that had been identified during ongoing project work, and which had then been used to design a completely new project intervention. In the process, an existing whole child health project was phased out and evolved into a reproductive health project focusing on adolescents (PALS-Participatory Adolescent Sexual and Reproductive Health). The theme title itself, 'adolescent empowerment', is indicative of a broader perspective being taken than that involved in many health – or other – sectoral interventions. This perspective had emerged from PLA assessment work undertaken in Chawama and other compounds in Lusaka and Livingstone. Even earlier assessment work by the health sector on orphans, using a household framework, had shown up adolescent girls to be an extremely vulnerable target group in the urban townships because of their level of exclusion from health and educational services and their comparative social and cultural 'neglect'. This household focus, which had helped identify the adolescent girls as a target group in the first place, was then carried through in the analytical work undertaken in Chawama and elsewhere. It helped contextualize the girls' situations, and showed clearly how girls from poor families were the most likely and vulnerable victims of unprotected sex, as a combination of their poverty and lack of access to education and health services. The consequences for them - STIs, abortions, becoming unmarried mothers – worked to ruin their present lives and chances of having any form of improved future. The respective roles of both families and the broader social and institutional fabric of which they were part reinforced this situation, were clearly shown and influenced the ensuing PALS[5] project design.

This explains the three sub-themes indicated in the following box in addition to that of reproductive health – empowerment, skills building and income. The point being made is that all three are essential to the successful improvement of these adolescents' reproductive health status. It is not that the PALS project has been particularly directly engaged in income improvement activities. Where possible, though, what it has done is partner with CARE SEAD activities in the same geographic locations, with for instance, direct business management training being provided to health outreach service providers, and some basic financial and business management skills being included in girls' education curricula. An appropriate monitoring system would therefore need to illustrate trends in all the sub-theme areas, since even though the project could not be held accountable for trends in adolescent income, these would have a bearing on the interpretation of reproductive health trends.

BOX 4: HEALTH SECTOR INTERVENTION THEME: ADOLESCENT EMPOWERMENT

(1) *LRSP* - Lessons learned and targeting

(2) Literature Review and Community Feedback

(3) PLA (Chawama) for proposal drafting
- Develop indicators and choose subtheme (Reproductive Health)
  1. Change behavior
  2. Increase knowledge of consequences
  3. Increase attendance at clinics
  4. Change service provider attitudes
- Proposal submitted and accepted

(4) Baseline using PLA approach plus household survey (in Lusaka, Copperbelt, Livingstone), plus in Lusaka using traditional quantitative (to validate)

(5) *Monitoring:* In PALS and Operational Research, we are developing a system with indicators for subthemes (Reproductive Health, Empowerment, Skills Building, and Income)

(6) *Evaluation:* Will use both PLA and participatory evaluation

Linkages to HLS:

At main theme and sub-theme levels, at each of above stages
- Building capability at adolescent, household and service provider levels
- Increase and maintain attendance at consumption level

This illustration of how the interpretation of reproductive health trends in PALS will depend on trends in the other indicator areas, leads back to the comment at the start of this sub-section on the need for all information to be contextuated. A challenge of all iterative, participatory processes is for them to cease being narrowly defined 'interventions' and to embrace participating individuals and organizations holistically. This does not mean, as may be supposed, embracing all problems and needs, but it means treating people as whole people, and understanding (and helping them to understand) the linkages in their own lives. Revealing such linkage is an essential pre-condition of any so-called empowerment strategy, and one result will be that it will be possible to interpret (most) information collected in terms of what it says about trends and their affect on these linkages.

One final, related issue in this section is that of attribution. It is commonly held that however well we develop a systematic information system, it will still be extremely hard to attribute output level change to change at project goal level. Put another way, how do we show what has really affected changes in people's lives (or changes within the institutions they are part of)? A participatory process attempts to do this in a simple way; as part of self-assessment methodologies, people are asked to indicate not only what change has occurred in their lives, but to attribute the reasons for this. Methodological means of doing this might be enhanced, but the results, since they are hard to deny, however simply achieved, are extremely powerful.

TABLE 5 : CASE STUDY OF IMPROVED HOUSEHOLD, PUSH PROJECT MRS. AKUFUNA FROM LUSAKA

Upward movement from category 4 (very poor) to category 3 (poor).

INDICATOR	BEFORE Personal Empowerment Training (PET)/ Livelihood Improvement Training (LIT)	NOW
Livelihood category	4	3
Family size	6 – grandmother, mother, 2 sisters, herself and her son	2 – herself and her son
Number of children in school	0	1
Food consumption	2 meals/day beef 1 x week fish 1 x week beans 2 x week vegetable daily nshima with every meal	3 meals/day + tea beef 3 x week fish 2 x week vegetables daily nshima with each meal breakfast = tea, buns/rice porridge with milk
Tenure	House belongs to grandmother 3 rooms mud brick/iron roofing sheets	Has moved – now rents own house K6,000 ($5)/ month 1 room mud/brick/iron roofing sheets
Livelihood activity self	None	Sells groundnuts, vegetables and pre-packed mealie meal from home. Her younger brother helps her.
Livelihood activity husband	Widow	Widow
Assets	None (relatives grabbed all her property when her spouse died)	Bed, mattress, table 2 chairs and a radio
Savings	None	*Opened a bank account in Sept. 1995 – has saved K45,000
		* Belongs to a chilimba group, has saved K50,000 with group, contributing K500 each week since Nov. 1995

NOTE: When her spouse died and she suffered property grabbing, Mrs. Akafuna became dependent on her mother. However, after joining PUSH and attending the PET/LIT course she worked hard and moved out of her grandmother's house. She now rents a room where she lives with her son. She also started her own IGA and opened a bank account where she deposits savings every two months. She says her life has changed for the better.

3.3. Decentering: institutional learning, negotiating roles, partnerships and disengagement through institutional capacity building

The final subject of this chapter involves several different aspects, but all comes down to a single ability: that of being able to develop management and implementation structures which cease to become dependent on us either as managers or as an organization. It is extremely difficult for us to do this, both as individuals, and as the organization CARE. The two are related. We trust our own abilities as managers and as an organization to implement projects and programs in ways we believe result in high quality activities. This is extremely important to us, since it is particularly our skill as an implementing agency that we take pride in as an organization. Nevertheless, such an attitude in the end can limit our individual and organizational legacies. What we do alone will necessarily be limited in time and space since it can have no continuity. Thus our larger mark is dependent on our developing the individual skill and organizational ability to decenter.

The two aspects are linked because within a centralized management structure it is extremely hard to develop viable and durable partnerships, since those who need to be active in their development tend not to be sufficiently skilled, confident nor empowered to do so. Some distinction needs to be drawn here, since this is not entirely true. In several instances I have witnessed projects with field staff that have done a wonderful job in working with community structures in participatory, adaptive and empowering ways. Yet, frequently, the lessons learned from this experience remain undocumented, and since they are not drawn upon in the wider project management structure, are rarely used in helping to guide the project's overall direction.

This is a complex issue. At one level, the lacuna may be the project's failure to internalize the participatory methodology espoused at community level: more specifically the senior managers lack the confidence and ability to relinquish management control. This is not surprising. As an organization we have yet to understand the need for and to embrace this type of more team, or learning oriented management training, even if it is a logical corollary of more participatory and partnership oriented project approaches. Yet, even if we did want to move more in this direction, there remains the limiting issue of basic capacities. For example, since most field staff are much better at providing verbal rather than written accounts of their activities, they themselves will not capture on paper the richness of their experiences which is revealed in a discussion.

One of the consequences of the above is that the area in which we remain best in partnerships is that of community institutional capacity building, where the relationship is still largely asymmetrical – at least for most of the project process it is. We are used to asymmetrical relationships, either of a capacity building nature where it is hard to avoid a benevolent paternalism, or of a subservient nature with donors, where we ourselves are the unequal partner and feel obliged not to challenge their wants for fear of forfeiting funding opportunities. An interactive

participatory approach perforce requires a relationship that is not one-sided, even if there is an (inevitable) asymmetry in the power relationships involved. Thus rather, we can try to approach donors with a little more confidence in our own knowledge, skills and experience of the reality of poverty in the environment in which we operate. It is our own dignity at stake too, just as we show respect for the dignity of poorer communities by improving the interactive nature of our relationship with them.

CARE's recent efforts in South Africa to establish an institutional strengthening program have been salutary in this regard, and certainly offer a different experience from that garnered in many other Southern Africa countries. Most South Africa NGOs have their origins as 'struggle' organizations during the latter apartheid years, and as a result, even if they have limited capacity and experience, still demand to be treated with respect and democratic equality – i.e. that their views are listened to and taken into account, in negotiating relationships and designing mutual activities. What this entails is commencing a partnership decision process with an interactive rather than the more-or-less one way relationship to which we traditionally use. For example, we rarely provide prospective partners with as much information about our own organization as we request from them, or allow as open a negotiation on our role as theirs.

Nevertheless, the relationship that is more rewarding and enduring is that in which the partner comes to us and says, based on our previous discussions, and what we believe you have to offer, we would like to work with you in these areas, if we can sit down and reach an arrangement that is mutually acceptable. In past approaches, where our aim has often seemed to be to discover whether an organization is 'good enough' to work with us, the concern at root is of course the justifiable one of capacity – does the partner have sufficient commitment at the outset for our work together not to be in vain and to show real benefits. But even if an organization has capacity, without a substantial commitment being made voluntarily, limited benefit will probably accrue from the relationship. Moreover, with commitment, capacity often develops surprisingly quickly. So as a basis for establishing a partnership, it can be argued that commitment is a more important value than capacity.

Let us extend this argument a little further. Increasingly we understand our overall concern in program processes designed to ameliorate poverty and vulnerability to be that of the empowerment of all that are involved. This is part of the growing realization that the old Marxist view of power as a zero-sum game (the oppressor and the oppressed) is limitingly one-dimensional. The legacy which we do owe to those such as Paolo Freire, however, is that power does not spread without a process of consciousness raising. In our contemporary language, this can be defined as a heightened mutual understanding of people's livelihoods and the organizational and individual means whereby these can be made more secure, resilient and enduring. On this basis we can then design, in collaboration with communities and other potential partners, program strategies which will develop the skills and capacities that will lead towards this endurance. Then finally we need to ensure that our own organizational program management principles are equally supportive.

In participatory appraisal work recently conducted in the barrios of Maputo, Mozambique, the interpretation of the country's new democracy is that the system is now one of 'everyone for himself'. With the decay of the previously far-reaching and thoroughly regulative party structures, an institutional vacuum has arisen since the country still has an extremely limited concept and culture of civil society. In this instance, the process of decentering a centralized state is inhibited by the lack of a broader culture of building teamwork, or voluntarily achieving a commitment to cooperation through a belief that mutual benefit can be realized. Developing teamwork at all levels is the necessary prerequisite to being able to establish a strategy of disengagement through institutional capacity building and federation.

The Livingstone Food Security Project has been engaged in a process of encouraging village management committees to federate at area level for some years now. In the original operational areas, project staff spend more time addressing the planning and management capacity of the area committees, and increasingly less time handling technical issues at the village level, for which local facilitators have responsibility. Then, as the area committees strengthen their linkages with external market, government and other structures, the project in theory gradually phases out, providing only an advisory and information systems monitoring role. For some time though, the project's biggest challenge has been to remain relatively in touch with the rate of and nature of the learning which has been occurring at village level.

Two years ago, for example, one of the experienced women field staff was at a meeting when men accused their wives of 'stealing' crops from the fields. What she discovered was that because once grain crops reached the granaries their sale was controlled by men, women were selling some directly from the field in order to yield direct benefit. Men were mainly reinvesting in cattle, and in the patrilocal society; this rendered wives' status less secure. Thus out of this experience, the fieldworker who assumed a greater responsibility for gender in the project, began to explore with men and women, ways of women's interests being better accommodated to the mutual benefit of all. The project though, still faces the challenge of developing the capacity (and structure) to mainstream vital insights of this nature, since being able to facilitate the broad negotiation of such issues locally is vital to the eventual legacy of the project. Similarly, another debate has arisen in some communities about the need for older, traditional leaders to create leadership space for younger men (and women) represented on the village management structures. By enabling this type of internal negotiation of roles and responsibilities necessary to bring about the broader improvement of the lives of different interest groups, through more representative local structures, the project is able to disengage gradually with pride.

Disengagement at the local level is though, by itself, insufficient. The caveat here therefore, is that we also need to have developed relationships, to a greater or lesser extent, with other organizations who will provide ongoing market linkages and technical support. Those organizations with whom we have had to work hardest to establish mechanisms whereby they can continue to provide necessary services in viable ways – such as savings and credit – will be critical partners of the project, since their continued role will be the second level of the project's legacy. The final level of legacy, will be the level of influence reached within the policy structures of government, donor and other national and broader level institutions.

CHAPTER THREE

OPENING DIFFERENT DOORS: USING QUANTITATIVE SURVEYS TO COMPLEMENT PLA FINDINGS

Tamara Fetters

Editor's Note: *Ms. Fetters is team leader of CARE Zambia's Operations Research (OR) Unit, and over the past three years, has worked extensively on the adoption of participatory tools into OR methodology. With funding and technical support from the Population Council, CARE Zambia has collaborated with two local non-governmental organizations in mounting an OR study*[6] *to test the effectiveness of a set of interventions on reducing high risk sexual and reproductive behavior among peri-urban adolescents. The results of this study have been extensively documented, and are available from the Health Sector Coordinator at CARE Zambia. The editors asked Tamara to comment on her experiences using quantitative tools within a participatory framework and to provide advice for others who may be interested in initiating OR studies in their own Country Offices. For more details on the CARE Zambia experience with the OR study, see Kambou (1999).*

Decision-making criteria: The decision to use a survey as a complement to PLA findings should begin with a critical look at program objectives and indicators, available resources (both human and financial) and the policy environment. As with any monitoring activity, it is always necessary to determine the appropriate balance between cost, quantity and precision. Ask yourself whether the additional information is really necessary to project implementation, and whether the community, local partners or development agency will use it. If the usefulness of the data is uncertain, you do not need to go to the extra expense and effort of a quantitative survey. Even if you can use quantitative data, you need to decide whether it is worth the risk of drawing attention away from rich data collected with participatory tools, and re-focusing it on simple quantitative indicators that are drawn from data generated by problematic samples. From a methodological point of view, there is a fundamental question: will your sampling frame (i.e., the target group that you identify through participatory means) allow enough power to lend credibility to your results? If not, as John Maynard Keynes once said, "It is better to be approximately right than precisely wrong."

Sampling: At CARE Zambia, we have used survey sampling to supplement qualitative data generated by projects concerned with AIDS orphans, adolescent sexual and reproductive health, water and sanitation, food and livelihood security. The reasons for collecting supplemental data have varied, but generally reflect the following:

- The need to provide donors with prevalence rates on a few specific indicators such as condom or contraceptive use or numbers of sexual partners;
- The desire to monitor several population-based livelihood indicators over time such as average cereal production per acre;
- The desire to follow a cohort of individuals or households over time in order to understand the evolution of their needs and the effect of project activity on the individual or household.

Sampling needs and designs have necessarily varied from project to project. At CARE Zambia, the following sampling designs have been used:

- Purposive sampling which stratifies populations on key socio-demographic characteristics that define the general target group and its sub-groups, such as sex and whether an individual is in school or out-of-school;
- Cluster sampling which identifies important population "clusters" through a preliminary mapping exercise; these clusters are then purposefully included in order to create as representative a sample as possible of the target group. For example, a representative sample of adolescents from a peri-urban area should include youth who live in households located next to a bar or market, in new sections of a community, within immigrant enclaves and so on.

It is important to note that CARE Zambia has rarely used random sampling, and when used, only on a limited scale. The costs associated with this type of sampling, as well as the level of skill necessary to replace missing cases effectively while in the field, make it difficult to justify its use.

(Editor's Note: As Tamara notes, the cost of such a survey is often beyond what most project budgets can support. A couple of CARE reproductive health projects in Africa have considered linking their baseline surveys to an on-going Demographic and Health Survey (DHS) in order to obtain baseline data on critical impact indicators such as contraceptive prevalence. In this type of situation, CARE arranges with the DHS to over-sample in its catchment areas so that it has an adequate sample for analysis.)

Details from our field experience: CARE Zambia draws its experience in "Participatory Operations Research" from a study exploring the impact of adolescent sexual and reproductive health interventions in urban communities. In this particular case, CARE Zambia and its research partners opted to introduce short, simple surveys that were implemented for two days following the participatory assessments carried out in the same communities. We based our decision to use a quantitative survey on three elements.

- First, Zambian health authorities were generally aware of the existence of PRA and PLA methodologies, but felt more comfortable with quantitative research results.
- Second, donors as well were seeking quantifiable results that are easily verified and can be justified in a sentence or within a logframe.

- Third, given that our study design was complex and our researchers inexperienced with the participatory tools, we felt that a quantitative survey was warranted in order to further validate study results.

In our case, quantitative surveys provided useful supplemental data that added depth to the team's internal discussions and fueled fires for policy debate. The quantitative data allowed us to notice issues that we had overlooked during the participatory exercises, and compelled us to question contentious findings. At times, the survey results revealed inconsistencies that required clarification with further study. At other times, the survey results validated findings that were not entirely substantiated during the participatory exercise.

Here is an example of how quantitative data further illuminated qualitative data. Throughout the participatory assessments, youth regularly stated that out-of-school girls are more sexually active than girls attending school. (Refer to the table below with representative data gathered from a group of 21 girls attending 7th grade in M'tendere Compound.) During the participatory assessments, the adolescents gave a number of reasons supporting this perception, namely, that girls in school fear having to quit school, they are usually taught the dangers of sex in classes and girls in school are more occupied than those out of school. Out of school girls were thought to start having sex earlier than all other groups because they needed money, wanted stable partnerships, had more free time and often exhibited "bad behavior." Contrary to the belief that being out-of-school increases levels of sexual activity and decreases age of sexual initiation, quantitative data show that most young people are initiating sex before they finish primary school. (Refer to the table below that presents quantitative data gathered in four peri-urban compounds of Lusaka; these data reflect the experience of both boys and girls.)

	GIRLS (14 – 16 YEARS)				**BOYS (14 – 16 YEARS)**	
	Proportion (distribution)	**Sexually active**	**Pregnant**	**Abort Pregnancy**	**Proportion (distribution)**	**Sexually active**
In-School	40	20	7	5	70	50
Out-of-School	60	40	15	10	30	10
Total	100	60	22	15	100	60

From a PLA exercise held in M'tendere Compound, Lusaka, Zambia with 21 7th grade girls

NUMBER OF YOUTH REPORTING THAT THEY HAD SEX FOR THE FIRST TIME WHILE THEY WERE ATTENDING SCHOOL

	N'gombe (n=281)	M'tendere (n=308)	Kanyama (n-293)	Misisi (n=296)
Yes	212 (75%)	247 (80%)	238 (81%)	220 (74%)

The data show that more than 75% of the adolescents were in school when they initiated sex. The proportions are highest in M'tendere and Kanyama compounds where there are more school-going youth who attend school for more years on average. While school may not cause people to engage in sexual activity, these data indicate that school may not act as a deterrent to early sexual activity, and gives rise to important policy and programming considerations for interventions targeting school leavers and in-school youth.

As a result of these quantitative data, our team went back to our PLA analyses, and started paying more attention to dissenting opinions. Generally, these were from girls who didn't believe that there was a difference; these voices were still a minority, however.

> There is no change in behavior between in and out of school. It is even worse for those in school because they want more money for many things. They are even picked in boyfriends' cars.

From discussions with eight girls aged 13-14 years old in N'gombe Compound

Conclusion: PLA research yields relatively quick and low-cost results useful for program design and implementation. At CARE Zambia, we have usually used this type of research methodology as an entry point into an issue or a community to build the partnerships necessary for sustainable project activity. Limited quantitative surveys have the potential to enrich and focus PLA findings. We can improve our use of surveys. How?

- by developing questionnaires with the participation of members of the target population;
- by creating instruments that also provide a forum for people to voice their opinions on related issues;
- by making results manageable and comprehensible to the people with whom you are working; and,
- by involving people in the data collection and analysis.

The process of making your research more inventive and participatory can also extend to instruments that are more "traditional" and extractive, and this process is as important as the outcomes of the research. It has been our experience that these tools (both participatory and quantitative/traditional) can even be adapted for use in evaluation and measurement of incidence of specific behaviors or risk factors[7]. It is necessary that innovation and the continued success of these types of participatory evaluation and research methodologies be well documented and shared through fora such as these *Guidelines*.

3

PART THREE

A Step-by-Step Field Guide to Participatory Tools and Techniques

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CHAPTER 1

PARTICIPATORY LEARNING AND ACTION (PLA): AN OVERVIEW[8]

Meera Kaul Shah

1.1 Definition and background

PLA is defined as a growing family of methods and approaches that enable local people to analyze, share and enhance their knowledge of life and conditions, and to plan, prioritize, act, monitor and evaluate (Absalom et al., 1995; Chambers, 1997). This methodology is also known by several other labels, the most common among them being Participatory Rural Appraisal (PRA).

PRA methodology evolved during the late 1980's as a response to the need for finding ways by which the local people could play a more active role in the development projects being implemented in their communities. This response stemmed from the growing dissatisfaction with the existing practices and ways in which development practitioners and researchers collected information, and used the same for planning, managing, monitoring and evaluating rural development projects.

PRA has evolved from, and draws on, several sources and traditions. Five streams that have influenced this evolution are (Chambers, 1997):

- Activist participatory research
- Agroecosystem analysis
- Applied anthropology
- Field research on farming systems, and
- Rapid Rural Appraisal (RRA).

RRA has been a close relative of PRA. RRA emerged in the late 1970's in search of better ways for outsiders to learn about rural life and conditions. It has three main origins (Chambers, 1997):

- dissatisfaction with the biases of 'rural development tourism'[9];
- disillusionment with the time consuming and costly questionnaire surveys which tend to collect large amounts of irrelevant information and are also difficult to analyze and use; and
- growing acceptance of the fact that rural people themselves have rich and valuable practical knowledge which can be tapped by development professionals.

Everyone wants to have her say! A group of school girls prepare a picture story. Zambia

These led to the search for less costly and more rapid methods of data collection by development professionals. While many methods and techniques used in PRA are the same as used in RRA, there is a fundamental difference between them. While in RRA it was the outsider professional who applied and controlled the use of these methods for data collection, PRA enables the local community to use these methods themselves for analyzing their situation and preparing their own plans. The shift has been from 'extracting' information to enabling the community to take over the process of analyzing their conditions, and planning and implementation of development activities.

The label PRA continues to be more commonly used in the growing literature on the subject. However, in recent years it is increasingly felt that the term is too restrictive with its accent on 'rural' and 'appraisal'. This methodology does have its roots in the field of rural development, but during the past three to four years it has been adapted for use in urban areas as well, where it continues to spread in new fields. It is also felt that the word 'appraisal' indicates a false limit to the use of the methodology in the subsequent stages of the project cycle. Participatory Learning and Action (PLA), in comparison, is a more appropriate label for the methodology in its present form. 'PLA' is applicable to rural and urban contexts, and indicates its continued use during the 'action', or implementation phases of the project cycle.

1.2 Key principles of PLA

Chambers (1997: 156-157)) describes the following key principles of PLA[10].

- ***A reversal of learning:*** Learn directly from the local community, gaining from their local physical, technical and social knowledge.
- ***Learning rapidly and progressively:*** Learn with conscious exploration, flexible use of methods, maximizing opportunities, improvisation, iteration, and cross-checking, not following a blueprint program but being adaptable in a learning process.
- ***Offsetting biases:*** Offset biases, especially those of rural development tourism, by being relaxed and not rushing, listening not lecturing, probing instead of passing on to the next topic, being unimposing, and seeking out marginalized groups within the community (the poorer people, minorities, children and women) and learning their concerns and priorities.
- ***Optimizing trade-offs:*** Relate the costs of learning to the useful truth of information, with trade-offs between quantity, relevance, accuracy and timeliness. This includes the principles of optimal ignorance – not learning more than necessary, and of appropriate imprecision – not measuring what need not be measured, or measuring more accurately than needed.
- ***Triangulating:*** Learn from several (often three) methods, disciplines, individuals or groups, locations and/or types of information, to cross-check, compare and verify. Verification also involves

The facilitator takes a back seat and allows the participants to carryout their analysis without interruption. Zambia

asking different questions during the same conversation to further probe an issue or theme.

- ***Seeking diversity:*** Seek and enable the expression and analysis of complex and diverse information and judgements. This includes looking for and learning from exceptions, dissenters and outliers in any distribution. It goes beyond the cross-checking of triangulation, for defined broadly it deliberately looks for, notices and investigates contradictions, anomalies and differences.
- ***Handing over the stick (or pen or chalk):*** The local people themselves facilitate analysis of their information and make presentations so that they generate and own the outcomes, and also learn. This requires confidence that 'they can do it', that the local people are able to map, model, rank, score, diagram, analyze, prioritize, plan and act. The facilitator may initiate the process of analysis and presentation, but then sits back and observes while the local people take over the process.
- ***Self-critical awareness:*** The facilitators need to continuously examine their behavior and try to do better. This includes embracing error – welcoming it as an opportunity to learn; facing failure positively; correcting dominant behavior; and being critically aware of what is seen and not seen, shown and not shown, and said and not said.
- ***Sharing:*** Ideas and information are shared between the local people, between the local people and the facilitators and of experiences between different communities and organizations.

The three pillars or foundations of PLA are (Chambers, 1997:105-106):

- the behavior and attitudes of outsiders, who facilitate, not dominate;
- the methods[11], which shift the normal balance from closed to open, from individual to group, from verbal to visual[12], and from measuring to comparing; and
- partnership and sharing of information and experience between insiders and outsiders, and between organizations.

1.3 Menu of PLA methods

A variety of visual and verbal methods (explained in Part 3, Chapter 2) are used in PLA[13]. Following is a list of some of the key methods that can be used for reproductive health analysis with a community. It is important, however, to remember that new methods continue to be innovated and designed to meet specific needs in a particular context. Hence, this list is by no means complete.

Social mapping	Census mapping
Body mapping	Dream mapping
Transect walks	Time lines
Trend analysis	Seasonality analysis
Daily time-use analysis	Ranking and scoring
Wealth/well-being ranking	Livelihood analysis
Sex census	Picture stories/cartooning
Venn diagrams (institutional analysis)	Causal-impact analysis (flow diagrams)
Semi structured interviews (SSI)	Focus group discussions (FGD)
Case studies, stories and portraits	Role plays

1.4 The importance of 'sequencing'

Sequencing the use of methods generates a lot of anxiety among many first timers[14]. Many want to know "which method do I use first?" or "which method should follow which?" There are no fixed rules. It is usually better to start with a discussion and analysis of a general nature.

Participatory mapping[15] is usually a good starting point. Different types of maps can be tried out, like social maps or census maps. The participants find maps easy to prepare and the maps help the facilitator get a general idea about the community. This can be followed by a transect walk in the area. A transect helps us observe the living conditions of the people in the area and to understand the layout of the settlement. It also provides an excellent opportunity to meet with a lot of people on the way, discuss and explain the objective of the appraisal to them, invite them to join in the transect and invite more people for discussions. The facilitators can also decide to take a transect walk first and then facilitate the preparation of a social map. Timeline is also a good method to use at the start. It helps as an icebreaker. It is always easier to start the process with more general discussions and analysis (like discussing the area and its features using the social map or transects, the changes that have taken place in the area using the timeline or trend analysis methods, etc.) and only when the discussion warms up and the facilitators are able to build a rapport with the community members, should more specific, and individual, information be discussed (like well-being ranking, ranking and scoring, venn diagramming, sex census, etc.).

The map or a transect walk should lead to some discussions with the participants. Depending on the issues being raised, the facilitators can decide which method would be most suited to analyze the topic. It is important not to be guided by the methods to be used in the community; do not allow the tools to drive the process. It is more important to be clear on the issues being discussed and to select a method that can enable a better analysis of the issue being discussed.

PLA team members conduct a transect walk through a rural community in Rwanda.

DO NOT ALLOW THE TOOLS TO DRIVE THE PROCESS.

PLA is essentially an incremental process. Discussion on one issue should lead on to another, as should analysis with one group provide a lead to start discussions with another group in the community.

1.5 Setting the objectives for a participatory appraisal

The first thing that we need to work out before starting a participatory appraisal process is the broad objective of the exercise. We need to be clear about what we hope to achieve from the process and what we intend to do with the information generated from the initial interaction with the community.

In the case of the PALS project in Zambia, the one thing that was clear at the very beginning[16] was that we wanted to work with the adolescents in the peri-urban areas. Since we were entering a relatively unknown field, we wanted to get a complete understanding of their knowledge, attitudes and behavior in respect of sexual and reproductive health. Keeping this in mind, the following objectives were decided for the PLA:

- To learn about male and female adolescent knowledge, attitude and behavior as they pertain to sexual and reproductive health; their knowledge about sexually transmitted infections and pregnancy; their sources of information; their attitudes to these issues; and their patterns of sexual behavior.
- To learn about adolescent gender and generational relations, e.g. how do age mates interact when it comes to sexual activity and more specifically preventing STIs or pregnancy; and how do cross-generational couples interact; what are the various patterns of social interactions for adolescents; and where do adolescents go for help and support during crisis in their lives.
- To identify the obstacles to high utilization of reproductive health services by adolescents at public sector clinics and determine potential points for intervention.

Source: Shah and Nakhama, 1996, Sarah Degnan Kambou

Given the incremental learning that occurs during a PLA process, it is recommended that the facilitating team reviews the process and reflects on the findings while the appraisal is being carried out so that, if necessary, the objectives can be modified.

1.6 Preparing a check-list of issues to be covered

Once the objectives have been set, it is helpful to prepare a tentative list of issues and themes that need to be explored during the participatory appraisal. The facilitating team can prepare this list before the fieldwork starts. It is useful to have a brainstorming session with all the facilitators to generate this list. If all the facilitators are not present while preparing this checklist, it is important that this be discussed with them before the appraisal starts. However, it must be noted that this is only an indicative and tentative list, which can be modified and changed during the appraisal process. We may start with a list of issues that we (facilitators) think are important and must be covered, but it is very difficult to pre-determine all the issues and concerns that will be raised by the participating community members during the appraisal. Hence the process has to be flexible to incorporate all of the necessary modifications. It must also be noted that this checklist should not be used as a blueprint or the basis of a questionnaire that has to be followed in the field. This checklist should only help the facilitators to keep track of the process and to review their progress. In case the facilitating team is large and works as sub-teams in the field, this checklist also helps to ensure that there is at least some common ground covered by all the teams and that the process does not move in several different directions based on the specific interests of the particular facilitators.

For each of the issues listed in the check-list, a 'menu' of methods can be provided. This helps the facilitators to gain confidence in selecting appropriate methods for analyzing specific issues.

The following matrix gives an example of a detailed checklist of issues that can be covered while facilitating participatory appraisals on sexual and reproductive health with adolescents, along with a 'menu' of PLA methods that can be used to explore and analyze each of these issues (this list has been developed from the PALS experience in CARE Zambia).

ILLUSTRATIVE CHECKLIST OF ISSUES AND METHODS FOR USE IN PARTICIPATORY ASSESSMENTS ON SEXUAL AND REPRODUCTIVE HEALTH WITH ADOLESCENTS

	TOOLS AND ACTIVITIES FOR SHARED LEARNING																
	Social Maps	Census Mapping	Transect Walks	Wealth & Well-being Ranking	Body Maps	Venn Diagrams	Listing, Ranking & Scoring	Causal Impact Analysis (Flow Diagrams)	Daily Time Use Analysis	Seasonality Analysis	Trend Analysis	Participatory Sex Census	Picture Stories/Cartooning	Semi-structured Interviews	Focus Group Discussions	Case studies, sto-ries and portraits	Role-plays
ILLUSTRATIVE ISSUES																	
Information/Knowledge																	
From what sources do adolescents get information on sex, reproductive health and contraceptives?						X	X					X	X	X	X	X	X
Type of knoweldge they possess and depth of information about: reproductive health system, pregnancy, contraceptives, STIs, treatment of STIs					X		X	X		X			X	X	X	X	X
Needs expressed for other information					X	X	X									X	
With whom do they feel free to discuss their health problems and fears?						X	X					X	X	X	X	X	X
Attitudes																	
What is the ideal age to get married?					X		X	X			X		X	X	X		
What is the ideal age to have children?					X		X	X			X		X	X	X		
Views on use of contraceptives					X		X	X			X		X	X	X		
Conditions under which contraceptives are used							X	X					X		X		
Conditions under which contracpetives are not used							X	X							X		
Do girls or boys carry more STIs?							X	X			X	X			X		
In case of pregnancy, who takes responsibility?							X	X			X	X	X	X	X		
Is it acceptable to have sex with a close relative (which relatives and why)?						X	X					X	X	X	X		
Why sex?							X	X			X	X	X	X	X	X	X
Why no sex?							X	X			X	X	X	X	X	X	X
Proportion of girls and boys abstaining from sex							X					X					
Behavior																	
Age at first sex					X		X				X	X	X	X	X	X	X
Gap between first and second sex							X					X	X	X	X		
Number of partners and reasons				X			X	X	X			X	X	X	X	X	X
Payment for sex - what and how much?							X	X	X			X	X	X	X	X	X
Preferences for sex partners: type, age, wealth/well-being, relationship		X		X			X	X				X		X	X		X
In which places do adolescents have sex?	X		X				X						X		X		
What do they do when they have STIs?								X					X	X	X	X	
What do they do when they become pregnant or make a girl pregnant?								X					X	X	X	X	X
Proportion of girls becoming pregnant							X	X			X	X	X		X		
Proportion of pregnancies ending in abortion (with reasons for the same)							X	X			X	X	X		X		
Who decides whether/type of contraception to be used?							X	X					X	X	X	X	X
Who obtains contraceptives?							X	X					X	X	X	X	X
Preferences for different types of contraceptives							X	X							X		
Use of condoms, proportion of couples using condoms							X								X		
Where do they get the condoms?	X		X				X						X	X	X		
Are the condoms easily available?															X		
What are the constraints to increasing the adoption of condom use?							X	X					X		X		
Impact of adolescent sexual activity							X	X					X		X	X	X
Living Conditions and Sexual Relations																	
Distribution according to living arrangements (who do they live with)?	X	X	X				X		X								
Most preferred living arragnement							X										
Relation between level of sexual activity and living arrangement				X			X	X	X			X	X		X	X	X
Frequency of sexual relations with close relatives				X		X	X		X			X		X	X		
Circumstances under which this sexual activity takes place (forced or voluntary)				X		X	X	X			X	X	X	X	X	X	X
Trends																	
Cross-generational changes with respect to: age of sexual initiation, levels of sexual activity, sources of information, traditions/beliefs, methods of family planning, number of sexual parterns, practice of safe sex, types and treatment of STIs							X			X	X				X		
The Use of the Clinic																	
Proportion of adolescents using the clinic	X	X				X	X	X		X	X				X		X
Reasons for which the adolescents use the clinic							X	X							X		
Can the utilization of the clinic facilities be increased - how?							X	X							X		
Information on whether any services are provided free of charge at the clinic															X		
Adolescents' Suggestions																	
Regarding improving the clinic services							X	X							X		
Regarding improving their reproductive and sexual health					X		X	X							X		

Source: Shah, 1999

1.7 Composition of the facilitating team

Participatory appraisals are best facilitated by teams of three to four members. In case the team size is more than five, it is best to sub-divide the team in smaller groups. In any case, care must be taken that the *facilitators do not outnumber the participating community members*.

It is important that the team of facilitators includes some members from the community (i.e. local residents), partner organizations (e.g., clinics, MOH, etc.) and other local NGOs. Having local residents on the team increases the acceptance of the process by the community, and provides a practical approach to generating durable and meaningful partnerships with communities and partner agencies. This way the ownership of the process, and subsequently the Project, is well shared with the community. During participatory appraisals with adolescents in Zambia the facilitating teams included clinicians, members of the Neighborhood Health Committees (NHCs) comprising of local residents, and representatives from other NGOs.

A good gender balance within the facilitating team is recommended. In general, mixed teams of facilitators function well in the field. However, for facilitating analysis on sensitive subjects, it may be necessary to have a separate group of female facilitators interacting with female, and male facilitators with the male community members. During the PALS appraisals we used both, gender – segregated as well as mixed teams of facilitators. While the female facilitators did not have any problems in interacting with girls or boys, some of the male facilitators found it difficult to facilitate discussions on sensitive and personal subjects with the girls.

> The facilitators were having separate semi-structured interviews with some adolescents in Kanyama Compound when a girl approached the older looking female facilitator. The girl mentioned that she had already had a discussion with another (much younger) female facilitator but had not told her everything. Making her feel comfortable, the facilitator started a discussion with the girl. The girl informed that she had not been able to tell the other facilitator that she had been gang raped some time ago.
>
> After a long one-to-one discussion, the girl told the facilitator that she had felt much more comfortable because she had shared her story with her.

From the field notes of Betty Muleya, Old Kanyama Compound, Lusaka, Zambia

There are other characteristics that should be considered when composing a facilitation team. Age can be a sensitive factor, especially when facilitating discussions on reproductive health with older men and women. In other settings, ethnicity and language groups might be important characteristics.

1.8 Assigning roles for all the facilitators

An important aspect of preparing for the fieldwork is to discuss with the facilitators, and to prepare them for the different roles they have to play during the appraisal. The three main roles are that of:

- the facilitator (who leads the discussion);
- the documentor and observer; and
- the logistics coordinator

A facilitating team should have at least two members, one to facilitate the discussions and analysis and the other to document the process. The facilitators can take turns at these different roles.

The person who leads the facilitation should have the confidence to handle discussions, to facilitate the use of visual methods, and to ask probing questions. S/he should also be prepared to handle the introductions with the community, including explaining the purpose of the appraisal. This has to be repeated several times during the course of the appraisal as we keep meeting new groups and individuals.

The documentor has to record all of the discussion and the visual analysis carried out by the participants in the field. The process of documentation is discussed in detail in Part 3, Chapter 3. If the facilitating team is comprised of more than two members, all of them other than the facilitator should take notes and document the process. The observer has to observe the process and can also support the facilitator and the documentor in their roles. The observer should be able to give feedback on the process to his/her teammates.

One person also needs to be made responsible for logistics (i.e., carrying material required for the visuals such as chalk, marker pens, paper, counters [seeds, beans, stones, etc.] and is responsible for tracking time).

1.9 Site selection; informing the community and collecting secondary data

As a part of the preparation before the fieldwork, it is important to have selected the site or the community with whom the appraisal is to be carried out. While selecting the site it should be borne in mind that the appraisal needs to be followed up by supporting activities in the community. Select sites where it will be possible to support and implement some activities or a project. Participatory appraisals should not be carried out if there is no intention to follow them up.

Once the site/community has been selected, collect whatever secondary information is available for this community. This could include census data, a map of the area, DHS service statistics, clinic records, any relevant reports, studies or situational analysis, etc.

Having selected the site, it is important that at least some of the residents are informed about the intended appraisal. They need to be informed about the purpose and duration of the appraisal and that this will not be possible without the active participation of the local people. It is best if the timing of the appraisal is finalized with the residents, so that they can take part in deciding the best time for them. In the case of PALS project in Zambia, this information was passed to the clinic in the compound and to members of the Neighborhood Health Committees (NHC). They in turn were requested to pass on the information to other residents in the area.

1.10 Material required

While carrying out any visual analysis with the participants, it is best to use any locally available material. Leaves, sticks, seeds, empty cigarette cartons, matchboxes, pebbles, etc. are very effective and easy to use on the ground. However, most facilitators do like to carry some material with them as well. It is useful to have the following at hand:

- ❑ Large sheets of paper
- ❑ Marker pens (in different colors)
- ❑ Masking tape
- ❑ Rubber bands or string (to use on rolled paper bundles)
- ❑ Colored chalk
- ❑ Seeds and/or beans (to be used as counters)
- ❑ A-4 size plain paper
- ❑ Scissors
- ❑ Pencil
- ❑ Eraser
- ❑ Glue
- ❑ Small notebooks (for the facilitators to record notes)
- ❑ Plastic bags (they are very handy for carrying the above listed materials)

Even though the facilitators may be carrying all these items, it is important to allow the participants to first start preparing their visual analysis using any locally available materials on the ground. Only if it is not possible to use the ground for some reason, should paper be used. Paper can be used later to record the visual analysis carried out on the ground.

1.11 Duration

It is not possible to recommend a standard duration for a participatory appraisal. The time required can vary from a couple of days to several weeks. This will depend on the topic being analyzed, the size of the community, its internal dynamics, the diversity within the community and the size of the facilitating team. Urban communities tend to be very large, and therefore, take more time as compared to rural communities.

During the participatory appraisals with adolescents in Zambia we had fairly large teams of facilitators, ranging from 12 to over 20 members in a compound. It was, therefore, possible to divide the team into sub-teams of 3-4 members each. This made it possible for us to cover a lot of ground within a relatively short span of time. Usually we spent about five to seven days in a community.

The first few participatory appraisals may require more time. As the facilitators gain experience in handling the methodology and the process, it is possible to facilitate the same process in less time in subsequent appraisals.

While planning for participatory appraisals it is important to budget for some days at the end for writing the reports. During the participatory appraisals carried out with adolescents in Zambia we allocated two days at every compound to complete the report. The synthesis report for the seven compounds in Lusaka took about a week to prepare.

1.12 The daily routine[17]

A participatory assessment must necessarily take place when people are available to participate. Therefore, the team must assemble early in the morning so that the day's agenda can be reviewed and material gathered before setting out. An example of a fairly typical schedule is working in the community for five to six hours without taking a break, e.g., from 8:00 AM until 1:00 or 1:30 PM. It is possible that the team of facilitators spends this time with one group of people in the community, however, there is some fatigue and often it is difficult for the people to spare 4-5 hours at a time. It is common, therefore, for facilitators to meet, and have discussions with, several groups of people in the community in one morning. The teams disengage slowly from the community activity, discussing if appropriate with community members whether they should all meet to continue discussions the next day (sometimes it may be necessary to follow up the discussions in the afternoon on the same day), and then thanking the people for their time and effort. The teams then return to the central meeting point for a short break and lunch.

After lunch, each team gathers its members together and begins sifting through and recording data generated during the morning sessions; as a team, they then pull out the main findings and results. In the late afternoon, by about 4:00 PM, each of the teams then briefly presents the day's outputs to the larger group, including the display of important visuals prepared by the community. Once all the teams have presented, data are then systematically compared and contrasted

to identify similar findings and variations and to determine: 1) whether the findings have been adequately substantiated with several groups in the community, and 2) whether additional discussion and analysis is required with a specific group or different groups in order to triangulate the findings. Team members must take notes on the discussions to include in the team's daily field journal (Part 3, Chapter 3), which is written later that evening.

The process of comparing and contrasting data assists the teams to draw up the following day's agenda and plan, (i.e., issues or questions to be pursued with the community). The other daily activity is for the team leaders to review progress against the original research objectives to ensure that all topics are being or will be addressed. Depending upon the complexity and richness of the day's process in the field, it is possible that the day's work may not end until late in the evening. The final activity for the day for the team members is to write up the daily field journal.

A SAMPLE DAILY SCHEDULE USED DURING A PARTICIPATORY REPRODUCTIVE HEALTH NEEDS ASSESSMENT IN GITARAMA, RWANDA

7:15 AM	Meet at rendezvous point and drive to the field
8:30 AM	Gather materials at CARE Gitarama office and leave for the field
9:00 AM	Begin participatory exercises
1:30 PM	Wind down participatory exercises and return to CARE Gitarama
2:00 PM	Lunch at the field office; team data review and prepare presentation
3:30 PM	Team presentation (15 minutes per team)
5:00 PM	Return to Kigali
6:00 PM	Team Leaders plan following day's agenda

Source: Kambou (1999)

1.13 Monitoring quality and encouraging innovation

It is important to remember that there is no 'fixed' way of facilitating a participatory appraisal process. Since the process is flexible and iterative, each context presents a unique situation. This poses challenges for the facilitator, for they have to continuously adapt and innovate in the field. Facilitators should be encouraged to 'use their own best judgement at all times', and try out any new ideas or adaptation of existing methods. PLA methodology is young and still evolving, and all its major innovations have taken place in the field.

Flexibility and open-endedness of this methodology poses another challenge – that of ensuring quality. Since there are no standard procedures, or recording or reporting formats, it is very important that the facilitators, and especially the supervisors, make a conscious effort to monitor quality. This can be done in several ways. First, ensure that the facilitators are trained and briefed well about

the process. Since there are several facilitators functioning at the same time, they need to have a shared understanding of the process. Second, daily review of the process is crucial to gauge the progress. Review and reflection enables the facilitators and the supervisors to assess whether the analysis carried out is in-depth and clear. It also enables facilitators to learn from each other. Third, poor or inadequate documentation is another factor that can affect the quality of the assessments. Last, and perhaps the most important, is being rigorous about triangulation.

1.14 Points worth remembering in the field

1.14.1 Don't lose sight of the objectives

The most important point to remember as a facilitator of a participatory appraisal is not to lose sight of the objectives of the appraisal. It is very easy to get carried away by the quantum of information generated during such a process. The facilitators have to be careful about ensuring the quality and depth of the analysis rather than discussing too many issues with no real depth of understanding on them. Reflection is an important aspect of this process.

1.14.2 Establish a 'Group Contract' for facilitators

Coordination and a good understanding among the facilitators are also very important. It helps to discuss individual behavior and attitudes (of the facilitators) before going out in the field. Many facilitators find it useful to prepare a commonly agreed 'group contract' before starting out in the field. This contract comprises a set of behavioral norms collectively decided by the team of facilitators in relation to how they will relate to each other during fieldwork and also with members of the community. Such a contract acts as a reminder to us when we are in the field. It also helps in giving feedback to fellow facilitators and team members and in reflecting on our experience. Following is an example of a group contract used by the team while facilitating participatory appraisals with the adolescents in Lusaka Compounds.

TEAM GROUP CONTRACT

We agree to:

- practice active listening[18];
- be punctual;
- be respectful towards the community members;
- not to be biased against any individual or group;
- try to put in my best efforts and work hard; and
- not to argue amongst ourselves in front of the community members.

Source: Field notes of Meera Kaul Shah, Chawama Compound, Lusaka, Zambia

Giving feedback to each other is a good way of reminding ourselves of the group contract.

1.14.3 How to ask questions

Sensitive facilitation is the key to a successful participatory appraisal. Facilitators have to be good listeners. Other qualities that are necessary for good facilitation are patience, ability to work in a team, good communication skills and cultural sensitivity. Facilitators should also know how to ask open-ended questions and to refrain from asking closed questions. Using the following seven helpers can enable the facilitators to ask open-ended probing questions:

What?
Why?
When?
Who?
Where?
How?
How much?[19]

1.14.4 Verify and triangulate results

Facilitators also need to remind themselves constantly about triangulating the information generated from any analysis. It is important to ensure that the views and the concerns of all the different groups within the community have been heard and analyzed. Diversity within any community can be on account of social hierarchies, economic or well-being categories, gender, age, location (especially in urban settlements), etc. During appraisals with the adolescents in Zambia we also included differences according to those who attend school and those who don't.

1.14.5 Seek local terminology and definitions

It is important to be clear about the terminology, and the definitions, used by the local people. Very often what we assume to be a standard meaning of a term may not be the case in that area. This can cause confusion and misinterpretation of data. Attempts should be made from the start to understand the local terminology and how these are defined before we start using the same in the appraisal.

GANGSTERS, WENGES AND YOOS:

Wenge, refers to boys/men who wear very high waisted trousers. This term is coined after a Zairian Band of the same name, who are known for wearing these high waisted, almost at chest height, trousers.

Yoos are boys who dress in baggy trousers which are worn very low down the waist, almost halfway down the hips.

Both these styles of trousers are considered stylish and fashionable, which makes the boys who wear them look very attractive to the girls. Usually these 'well-dressed' boys also have more money.

Gangster is yet another fashion terminology, which refers to the very well dressed boys and men (and could include Wenges and Yoos), who can be identified by their good looks, their particular style of walking, they usually carry a lot of money, and can be found wearing check shirts and jeans. They also wear 'head socks' (woolen cap). Gangster has nothing to do with the boy being involved in a gang, or involved in violence, as we had first misunderstood the term to mean.

Source: Field notes of Meera Kaul Shah, Chipulukusu Compound, Ndola, Zambia

1.14.6 Transparent and clear introductions

One question that most of the first-time facilitators of participatory appraisals worry about is 'how do I start?' There are no fixed rules. However, it is best to start any discussion with an individual or a group with introductions and explaining the purpose of the appraisal. Transparency is very important in building rapport. It helps in not generating any false expectations. It is always best to clearly state the intention and the possible outcomes.

During participatory appraisals with adolescents in Zambia, the introductions with any group or individual included:

- introductions by name (facilitators as well as the adolescents)
- explaining the purpose of the appraisal, which would go something like the following:

"We are from CARE, and are here to understand the problems and concerns faced by adolescents in this compound, especially those related to sexual and reproductive health. We are having discussions with different groups of adolescents and some elders in this compound this week. We want to first discuss with you and find out what kind of problems and concerns you are facing so that we can know from you whether and how CARE can provide some support in the future. We are not sure about the outcome of this process or what kind of project it will be at this stage; but, if a project is needed here, we would like to finalize it only after discussing these problems and concerns with the adolescents, their parents and guardians, the NHC members and the clinicians. We will be having discussions in groups and talking with some of you individually. We request that you feel free to discuss any issues and invite more friends and neighbors for these discussions. If you do not wish to speak in a group, you can decline freely."

1.15 Reporting back to the community

An important part of the participatory appraisal process is reporting back to the community. This includes sharing and presenting the findings of the appraisal with the community. Since the facilitating teams include some local representatives as well, it is best to let them handle the presentations to their fellow community members. This sharing of information not only helps in triangulating and verifying the results once again, but also takes the process to its next step – i.e. ,that of preparing the community action plan.

While it is relatively easier to handle this reporting back process in a rural community, it may require several meetings to do the same in a large urban community.

1.16 Questions often asked about a PLA

1.16.1 Where, and how many, PLAs?

One question that is often asked is whether it is necessary to facilitate participatory appraisals with the target group (e.g., adolescents, women and men of reproductive age, or sexually active women and men) in all the communities that a projects plans to work in or is it sufficient to cover one or two zones of a larger catchment area.

The first step in a participatory development process is the involvement of the community in identifying their needs. This process builds rapport with the community. It also involves the community, as an important stakeholder, in their own development process. The results of participatory appraisals may be similar or common to several communities/groups, though this was not the case in Zambia (see box on the following page), but by not carrying out a participatory appraisal with the community we lose out on an important first step in the process. Also, the process then tends to become top-down and imposed from outside, rather than be initiated by the community. The important aspect is to establish rapport and to create partnership or ownership of the activity that will follow as a result of the participatory appraisal.

There were some differences that we observed in the KAP of the adolescents, regarding their sexual and reproductive health across some of the compounds in peri-urban Zambia. Whereas in most cases we found a fairly high level of sexual activity among the adolescents aged 8-14 years, in a couple of compounds this did not seem to be the case. The same was also found in the case of age of sexual initiation. This was found to be higher in a couple of compounds as compared to the rest. These variations could be on account of one or all of the following factors:

- differences in economic and general well-being of the communities;
- differences in the size and the layout of the residential plots (the closer the houses are to each other and the more densely the area is populated, the higher the probability of adolescents starting sex early);
- differences in the proportion of boys and girls attending school;
- differences in the location of the compound - how close is it to the town center; and
- facilitator's biases and inadequate triangulation.

These differences are important to understand as they do have a bearing on the project design and the activities that can be supported in the compounds.

As an important part of the participatory process, therefore, it is essential that appraisals are carried out with the local people in every community that the project wants to work in. Since urban settlements tend to be large and spread out, it may be easier to facilitate separate appraisals in different sections/areas of the same community.

Participatory appraisals can be carried out even after a project has started functioning. However, such a step should be taken only if the project has the flexibility and willingness to make any changes in their approach or plans, in case the results from the participatory appraisals show the need for such a change.

1.16.2 How much does a participatory assessment cost?

Most first timers want to know how much a participatory assessment costs so that budgetary provisions can be made and the necessary resources are made available to carry out the same. It is not possible to give an estimate because contexts and conditions vary so much. What may be a necessary expense in one place may not be the case in the next. Other variations can be due to the duration of the appraisal, the size of the community, the size of the facilitating team, etc. In many cases the cost of conducting a participatory appraisal is small, such as when the agency may have their own vehicles and sufficient staff. The usual expenses include the following:

Material and stationery (details in Section 1.10);
Vehicles and fuel;
Staff time;
Camera and film/cassettes (if photographs, slides and/or video are used); and
Refreshments and snacks (if provided).

Per diem for local participants can also be included, if that is a part of the local CARE Country Office policy. The costs of a consultant/trainer should also be included in this list in case one is being invited to support the process. The following box gives the estimated cost of carrying out a participatory appraisal with adolescents in one compound in Zambia.

ESTIMATED COST OF CARRYING OUT A PARTICIPATORY APPRAISAL IN ONE COMPOUND:

Participatory appraisals were carried out over seven days in one compound. Each day refreshments (soft drinks) were served at the clinic before the team left for field work. Lunch was also provided for all the members of the facilitating team, including local representatives, clinicians and members of the NHC who took part in the process, to maintain group dynamics. A transport allowance was also given to non-CARE facilitators who had to find their way to the compound. The break up was as follows:

	US$
Transport allowance for partners	500
Refreshments/Lunch	440
Stationery	177
Motor vehicle fuel	140
Total	**1257**

The above costs do not include the staff time spent on this activity. Also not included here is the cost of hiring a consultant who trained the facilitators, supported the appraisal process in some compounds, provided support for synthesizing information and writing the reports, and also helped with initiating some of the early activities with the adolescents during the project implementation phase.

Source: PALS, CARE – Zambia, cited in Shah (1999)

The cost of participatory appraisals should be considered, however, within the larger context of project implementation. While participatory processes by nature require intensive interaction with the community, the time and resources required in the early stages of the project tend to taper-off as the activities gain momentum and the community takes over a large part of the responsibility of implementing them. External support costs are relatively much lower in the later stages of the project. Costs should also be evaluated with long term sustainability of the initiative in mind. While it may cost less to implement an activity in a top-down manner, it is more likely that it will not be sustained, and more importantly not owned, by the community.

1.16.3 The qualitative vs. quantitative debate

Another issue that often comes up for discussion is whether we need to top-up a participatory appraisal with quantitative data collection (e.g., that collected by a questionnaire survey). We feel this is not necessary. While many may believe that it is not possible to collect quantitative information during a qualitative analysis, we feel otherwise. It is possible to collect quantitative data in a qualitative mode, as was made possible by developing and using methods like the 'Participatory Sex Census' (see Section 2.12 on page 3.56) during the participatory appraisals carried out with the adolescents in Zambia. The challenge is in innovating and finding ways by which the participants themselves collect and analyze quantifiable data in a systematic and participatory manner. It is important, however, to be aware of this challenge from the start and to be prepared to facilitate quantitative analysis during the participatory appraisals. Most community members have no difficulty in quantifying their analysis. In most cases it can actually be carried out in a much easier and quicker way with the involvement of the community as compared to tedious questionnaire surveys. However, while dealing with sensitive subjects, like sexual behavior, which are also of a very personal nature, care is required in facilitating these discussions in a large group. Such subjects are easier discussed in smaller groups or with individuals, and only when the participants are ready to discuss the topics.

If it is necessary to collect quantitative data through surveys, it is best to base their design on results of the participatory and qualitative assessments. This helps to ensure that appropriate questions are asked and that there is complimentarity of the information generated.

1.17 Some problems and challenges

1.17.1 Behavior and attitudinal

It is easy to learn and understand the use of PLA methods. It is more difficult to develop the appropriate personal attitudes and behavior required to facilitate the use of these methods. For facilitators who lack the ability and patience to listen to the community, and the willingness to learn from them, these methods are of little use.

Many facilitators find it difficult to 'hand over the stick' (or pens or chalk or whatever material is being used) and to allow the community to carry out their own analysis. It is important to move away from being in a dominant and extractive mode to one which enables the community to take an active role in the decision-making process. This attitudinal change is usually the most difficult part. Attitudes cannot be changed in a day. It is, however, important that the facilitators are aware of how they behave and present themselves (e.g., our body language, the way we ask questions, the kind of responses we give, how well we listen, etc.) so that some of the negative attitudes can be identified and reversed over time.

We need to constantly remind ourselves that PLA is about reversals – in our attitudes, in the way we perceive the community's role in their own development process and how we enable them to take over what we have for long understood to be our role (Chambers, 1997).

1.17.2 Methodological

One of the biggest problems faced by the facilitators of a participatory appraisal process is their hesitation to use visual methods of analysis. Those who have not used visual methods before find it difficult to introduce them in discussions with the community. They feel more comfortable remaining in the verbal mode of analysis. This is partly because of a lack of confidence in being able to facilitate a visual analysis and in the ability of the participants to use them. This confidence comes only from practice. The only advice that can be given to a beginner is to move to visuals at the very start.

Related to the lack of confidence in using visuals is the doubt that facilitators have in selecting methods to be used for analyzing a specific topic. Very often facilitators are driven by their 'methods fixation', i.e., the urge to try out the different methods in the field. This approach can lead to a lot of frustration when methods may be used without any purpose. Facilitators must learn how to use the different methods as a means and not to see them as an end in themselves. Identifying themes and topics for analysis before and during discussions with the local people, and sequencing the analysis, should be of primary concern. Only when the topic for discussion is clearly understood should the facilitator introduce a suitable method to enable the analysis. Again, practice is the only way facilitators can acquire this skill.

It is also very easy to get carried away during a participatory appraisal. Those who have never facilitated the use of visual methods in a participatory mode can be amazed at the quality of the visuals and the depth of analysis generated by the local people. It is important to remember that getting a large and detailed map made by the community is not an end. The important thing is what the map means to the community members who developed it, what is done with that map and how it gets used during the subsequent stages of the appraisal process.

Many facilitators do find it difficult to innovate and to adapt the methods to suit different topics and situations. Very often facilitators only follow the examples that they may have seen during their training. We had to face this problem repeatedly during the PALS appraisals when facilitators continued using only a few methods the same way day after day. Innovative application of the methods is a skill that also develops with practice.

1.17.3 Analytical

Proper analysis of information generated is crucial for the success of a participatory appraisal (as also in monitoring the implementation of activities during the implementation phase). Analysis should be understood as a continuous process of reviewing information, classifying, and verifying it before any conclusions are drawn. The first level of analysis is with the community itself. Very often visual outputs prepared by the community are not probed enough. Outputs have to be 'interviewed'. A discussion must follow a visual presentation.

Information given by only one group or individual should never be taken as applicable for the community as a whole. Triangulation is very important before any results can be finalized.

It is important to remember that a participatory appraisal is an incremental process. Results from one set of analyses have to be linked to the analyses carried out earlier and that will be facilitated in the later stages. The role of the facilitators is important during this second level of analysis. While most facilitators are, with practice, able to master the use of methods in the field and in facilitating participatory appraisals, many find it very difficult to analyze the huge quantity of information that such a process can generate.

1.17.4 Process related

A group of girls working on a visual analysis. Zambia

Very often PLA is understood to be synonymous with 'rapid'. This is a myth. A participatory process takes time to develop and evolve. A map or a matrix ranking exercise may take less than an hour for the community to prepare, but this is only a small step towards developing a participatory process.

Another common misconception is that of achieving a participatory process by merely facilitating a participatory appraisal with a community. It has been mentioned several times here that a participatory appraisal is only the beginning of a participatory process. Without following up the appraisal by the preparation of a community plan and its implementation in a participatory manner, the process is only half-baked. Methods, it must be repeated yet again, are only a means to facilitate a participatory process.

1.17.5 Institutional

The greatest danger to the successful facilitation of a participatory process is the lack of understanding of the support that such a process requires in the long run. In order to support a participatory development process it is necessary to have the institutional willingness and capacity to:

- be flexible enough to allow the community to prioritize its own needs and plan its own action;
- have a flexible time-frame (participatory processes usually take more time to get started);
- have access to flexible funding (usually the funding plan is decided way before the first dialogues are held with the community and this may not match the community's plans and priorities);
- be able to support the process initiated with the community (especially as the appraisal translates into preparation of plans and their implementation); and
- be able to negotiate with donors to gain support for the process.

Participatory appraisals should not be initiated unless the above are ensured.

A lot of interest has been generated in the use of PLA within the development community in recent years. While this creates the potential for greatly improving the way development projects are designed and implemented, there is an underlying danger. It is increasingly becoming fashionable to be able to say that, 'we are using PLA'. Donors are placing the use of PLA as a condition for funding. In the quest for being able to join the bandwagon, a lot of poor quality work gets passed off as PLA. Many participatory appraisals never get followed-up or translated into action, or are followed by the conventional top-down planning and implementation of projects and development activities. The challenge lies in ensuring a proper understanding of the process and its implementation.

CARE has always upheld excellence in programming so it benefits CARE field staff to practice participatory methodologies with integrity.

CHAPTER 2

A STEP-BY-STEP GUIDE TO POPULAR PLA TOOLS AND TECHNIQUES[20]

Meera Kaul Shah

This chapter lists and describes some of the main tools/methods that can be used during participatory appraisals on reproductive health[21]. Each of these methods is described here along with some tips on how to facilitate its use in the field, and the material required for the same. The examples given here are only illustrative of the ways in which the tool can be adapted and used in different contexts[22]. It is worth remembering that the tools are a means of analysis and not an end in themselves. It is important to be clear about the issue that is being analyzed and select the tool accordingly, rather than the other way around.

2.1 Social maps

Map of Rusumo Commune, Kibungo Prefecture as made by a group of community men. Rwanda

A social map is a visual presentation of the residential area. It gives the boundary of the settlement, the social infrastructure (roads, water supply, schools, playgrounds, places of worship, clinics, and other public spaces) and the housing pattern – with all the houses in the area being depicted on the map.

This is one of the easiest methods to use and can be introduced in the early stages of interaction with the community. Mapping generates a lot of enthusiasm among the local people and acts as a good icebreaker.

Maps are best prepared on the ground using any locally available material (sticks, leaves, seeds, beans, stones, etc., or by simply drawing in the sand with a stick)[23]. It is best to copy the map carefully on paper as soon as it is ready on the ground. Having a copy on paper ensures that it is preserved and can be used for further analysis and reference at later stages.

Kibungo Prefecture Rwanda. A young woman draws her community map as others look on.

As with any visual method of analysis, there should be some warm-up discussion about the settlement, the area, infrastructure and facilities available before the participants are asked to present the information in the form of a map. Mapping, as most other participatory methods, is best carried out in a group rather than with individuals.

STEPS

1. Select an open space where the map can be prepared on the ground.
2. Ask the local people to prepare a visual presentation of their settlement that can help us understand their community.
3. Ask the group to show all the features of the settlement that they can think of.
4. Leave the group to prepare the map and observe the process.
5. Labels or symbols can be used to identify different facilities, features or infrastructure (allow the participants to select the symbols).
6. Any additional information that the facilitators want to discuss should be introduced only at the end, after the group has finished preparing their map.
7. Once the map is ready 'interview the output' by asking questions.

Social maps can lead to discussions about diversity within the area and the differences between different parts of the settlement. Sometimes discussions may even bring out social, economic or political conflicts within the community, for which possible solutions can also be discussed.

During participatory appraisals with adolescents in urban compounds in Zambia, we had to use social mapping in stages and sequences. On the first day, when we had a de-briefing session at the clinic, the NHC members and the clinicians that took part in the appraisals were asked to prepare a map of the compound. Since the compounds are very large, it was important to zone and divide the compound, so that we could capture the diversity and natural divisions within it. This also helped to crosscheck that we did not leave out any area during the appraisal. The NHC members, who are local residents, decided the basis on which to make these divisions. Usually the criteria included – population density, type of housing, plot sizes, access to services, perceptions of relative well-being, etc.

Since the first social maps covered a large area, it was not feasible to have all the houses plotted on them at this stage. Once the different zones were identified, the facilitators were divided in smaller teams and were allotted separate work zones. Once the smaller team started working in a zone, a detailed map of the zone was prepared with the residents. Most of these also included a visual representation of all the households living in the area. Usually these were prepared by groups of adolescents, but there were instances when we started the mapping exercise with a group of adults. In both cases it proved to be an excellent way to introduce ourselves to the community and to build rapport with them.

The local residents, using their own criteria, also divided the zonal social maps into different neighborhoods. When we worked with adolescents in several of these neighborhoods, detailed social information was either plotted on the zonal map or they prepared a separate neighborhood map. It was on these maps that demographic details were also presented (see Census Mapping in next section for details).

These detailed maps were very useful reference materials as they helped in understanding the diversity that exists in a compound. We found them of great use throughout the subsequent stages of the appraisals.

It is important to mention here that mapping is probably the easiest visual technique that can be used with the local people. Those who use it for the first time never fail to be amazed by the depth of analysis and the ease with which the local community can carry it out. It is, therefore, important to not get carried away by the first maps – this is only the beginning. Participatory mapping has to be used as a means for further analysis and is not an end in itself.

2.2 Census Mapping

As the name suggests, this is a quantitative tool used in the qualitative appraisal (or monitoring) process. Census mapping is used to put together easily quantifiable information about the settlement. Household information, like number of adults (men and women), number of children (boys and girls), education and literacy, employment, resource ownership, health problems (e.g., incidence of malaria or tuberculosis), use of contraceptives, etc. can be analyzed using this method.

Census mapping can be carried out in two different ways

1. using cards; and
2. using the social map.

Using Cards

In this case, household cards, one per household, are prepared. Each card carries a number or a name that identifies the household it represents. All the information pertaining to that household is completed on the card. This can be done using symbols or colors for different variables (e.g., red dots for girls, green for boys, etc.) or by writing on the card[24].

Using the Social Map

Since the social map shows all the households living in the area, it is very easy to fill in census information for each of the households on the map. This is a fairly simple method and within very little time it is possible to prepare a basic demographic database for the settlement with the local people.

STEPS

1. Start with a discussion on the need to put together some quantitative information for the area.
2. Decide whether the census will be carried out using the card method or the social map.
3. Ask the group to first prepare the household list. The numbers or the names of one representative for each of the households can be written on their respective cards or on the households depicted on the map. This makes it easy to identify the households for reference.
4. The group decides which variables to select. The facilitator can give an example of human population to start with, but allow the participants to select the other variables. In case the facilitators have any specific issue in mind, which has not been included by the group, it can be introduced at the end, after the group has finished its analysis.
5. For each indicator, quantified information is written or placed on the card or in the house on the map.
6. At the end, ask the group to aggregate the information for all the variables. Some simple analysis can also be carried out with the same group.

During the appraisals carried out with the adolescents in Zambia it was easier to use the social maps to carry out the census. Since social maps were one of the first visual outputs to be prepared in a compound, it was easy to continue using them for further analysis. The following information was usually collected:

- demographic details, including number of adolescents by gender; and
- school attendance of adolescents.

Since the compounds in Lusaka (and urban settlements in general) are very large, it is not possible to carry out the census for the entire compound in one attempt. Census mapping was possible only at the neighborhood level, considering 50-100 households at one time.

The social map containing census information was very useful for carrying out wealth/well-being ranking of households later during the appraisals (discussed later). This also provided a good base for selecting samples for the questionnaire survey, which was carried out in some of the Compounds at the end of the participatory appraisals.

> We were having a discussion with a group of girls who had just completed the census analysis for their neighborhood. Amidst some laughter and joking we casually asked whether they would have been able to identify all the sexually active boys and girls on the social map that they had just used for the census exercise. Promptly the map (which had been prepared on paper) was pulled back into the middle of the group and all the adolescents marked on the map were given spots of color to show which ones were sexually active!
>
> While this group had no problem in carrying out this analysis, we felt that such information is of sensitive nature and those who are not present there for the discussions may not approve of their sexual behavior being discussed and analyzed in public. We, therefore, did not use that output for any further discussions nor did we try the same analysis elsewhere.

Source: Field notes of Meera Kaul Shah, Dambwa Compound, Livingstone, Zambia

2.3 Transect walks

A transect is a structured walk through an area. This walk is best carried out with a group of local people who live there and know the area well. These local people should act as guides for the walk, showing and discussing all the diversity that exists within the area.

If a map of the area has already been prepared it can be used to decide the route of the walk.

The transect walk should be used as an opportunity to meet with different people on the way, and to stop to have discussions with them. It is important to be observant on this walk and to ask probing questions. Also ask the guides what they would like to show you.

It is also helpful to revisit the social map (if it has been prepared earlier) after a transect to see if any additional details can be added. If the map was not prepared before the transect, it can be prepared after the walk by the local guides who participated in the transect.

During transects with the adolescents in Zambia, we focused on the following:

- learning areas frequented by the adolescents and their meeting places;
- using this as an opportunity to meet more adolescents and to invite them for discussions;
- using it as an opportunity to introduce ourselves in different sections of the compound (meeting parents, guardians, opinion leaders and other elders to explain the purpose of the appraisal);
- visiting video shops, bars, taverns, market places and other locations where we found many adolescents to have discussions with; and
- observing the activities of the adolescents.

2.4 Wealth and well-being ranking

Wealth and well-being ranking is a method used to analyze ways in which a community identifies differences and divisions among its members. Usually this analysis identifies different categories of households within a community. The same can also be used to categorize individuals in a group.

Wealth and well-being ranking can be a relatively difficult analysis to facilitate in the community. People can become suspicious about the purpose of the analysis. They may also hesitate to discuss individual or household level information in public. Sensitive facilitation skills are required since this analysis is about individual and personal information. It is best to introduce this subject at the later stages of the appraisal after establishing rapport with the community. Go ahead with this analysis only if the community members feel free to carry it out. Do not impose. It is also important to be observant of the process and follow the discussion while the analysis is going on. Care needs to be taken that there are no individual biases influencing the ranking. This analysis is best carried out in a group, so that the facilitator can follow the discussion and debate among the participants.

Upon arrival in Lubuto for the third day during the appraisal with the adolescents, we were told to present ourselves at the police station immediately. Taken aback, and wondering why we had been summoned, the entire team of facilitators reached the police station in the compound.

Posing for a photograph outside the police station. Lubuto, Ndola, Zambia

We found a visibly upset woman and her daughter and some very angry men from the compound waiting for us. Soon we learned that these men had found out the day before that this girl, along with some other adolescents, had participated in the wealth ranking analysis. Not quite understanding the purpose of such an analysis the men were understandably infuriated. The matter had been reported to the police and the girl was being held at the police station for questioning.

It took some time to explain the purpose of what we were doing and showing the visual outputs to all the people present at the police station. When satisfied, the policeman on duty said, "Well, you are doing good work for our children. We appreciate it. But you should enter the compound through proper channels. If you had met me the first day, I could have explained everything to the residents myself". We had found an ally!

Before starting work in any compound, we informed and sought permission from the local clinic as well as the neighborhood health committee (which included resident representatives). The same practice had also been followed in this case. It never occurred to us that it might be necessary to seek permission from the police!

The residents explained that the area had recently witnessed a spate of armed robberies and that they had assumed us to be a part of the gang of robbers, getting innocent children to give us information so that we could strike again!

One hour after our arrival at the police station, we were getting invitations from the men to visit their area again. They, along with our new found policeman friend, even posed for photographs with us outside the police station!

Source: Field notes of Meera Kaul Shah and Roy Mwilu, Lubuto Compound, Ndola, Zambia

There are two different ways in which this analysis can be approached. We can first start by asking the group to discuss the criteria on the basis of which they differentiate among households. These can be listed. Then the group can be asked to use the criteria to decide how many categories they would like to divide the households into. Ask them to describe each of the categories. They can then proceed with the ranking of all the households.

Alternatively, it is possible to first start with the ranking itself and, once they have completed the analysis, the group can be asked to describe the criteria on the basis of which they differentiate the categories.

This ranking of households can either be based on the relative economic well-being of the household (called wealth ranking) or can have broader criteria for analyzing the relative well-being of the household (which includes less tangible aspects like problems, access to services, etc). Well-being analysis can also include wealth as one of the criteria, while focussing on other (e.g., social) criteria that contribute to the general well-being of the household. In some cases the classification is done using categories like 'happy' and 'unhappy' households.

This ranking of households provides an insight to ways in which the community understands and sees differences within it. It also provides an idea of all the different groups of households that must be considered in order to involve them in the appraisal process. This categorization is also useful as a purposive sampling technique, since it helps in identifying the different categories of households in a community with whom separate discussions can be held on their sexual and reproductive health needs.

The ranking of households can be carried out using one of the following two methods:

Card sorting method

In this case one card is used for each household. A name or a number on the card identifies every household. If the census mapping has already been carried out using the card method, the same cards can be used for the well-being ranking. The group is asked to sort the cards into different categories.

Using the social map

If a social map of the community is available, the same can also be used to mark the categories on each of the households depicted on the map. Symbols or numbers can be used to identify the categories. Following is an example of well-being ranking carried out by a group of boys in Chipulukusu Compound, Ndola, Zambia (Shah, 1997):

> A group of boys first prepared a social map of the neighborhood. A total of 101 households were shown on the map. Having prepared the social map, they carried out the human census and added this information on each of the households. Later they were asked whether it is possible to categorize the households in this neighborhood into separate groups. They came out with four categories
>
> Category 1 – the poorest
>
> Category 2 - poor
>
> Category 3 – Efilyako (better–off)
>
> Category 4 – Abaikala Bwino ('some of us' – the few best-off)

The same group of boys was asked to list the criteria on the basis of which they had decided on these categories. They listed the following:

Category 1 – the poorest

- Roofs are made of cardboard or plastic waste material
- People wear rags and use sacks for blankets
- They eat once a day or beg for food
- Their children attend the literacy school run by the Catholics, where education is free
- They have poor hygiene
- The poorest are so hungry that they do not have the strength to sweep or maintain their surroundings
- These people are often neglected and live in isolation from the rest of the community
- This category is comprised of the handicapped, the aged, or orphans who have lost either both or one parent (and are being looked after by a step-parent who neglects or mistreats them)
- Some households are even headed by children

"The poorest usually depend on funerals", commented one man. He explained that the area has a high death rate and nearly every day there is a funeral. The poorest people attend each and every funeral, and move from one funeral house to another, so that they get some food to eat.

Source: Field notes of Mary Simasiku, Chipulukusu Compound, Ndola

Category 2 – the poor

- They have fields from where they get some seasonal food
- Sometimes they work for 'food for work programs' like PUSH
- They beg food from neighbors
- Husbands do not work
- Houses are partly roofed with Korrie[25] sheets and partly with cardboard
- Women engage in prostitution while men resort to stealing in order to raise money
- They depend on a vegetable diet without oil or tomato
- This category is mainly comprised of widows, or households where the husband does not work and the wife runs some small business. However, the little money she makes will be grabbed by the husband, who will use it to buy beer

Category 3 – the better-off

- They can afford to eat meat or chicken once a month
- Houses are well roofed with iron or korrie sheets but sometimes they leak
- They dress well
- They have blankets and beds
- They have furniture and mats
- They own black and white TVs and radio cassette players operated by batteries
- Their children go to government primary schools

Category 4 – some of us

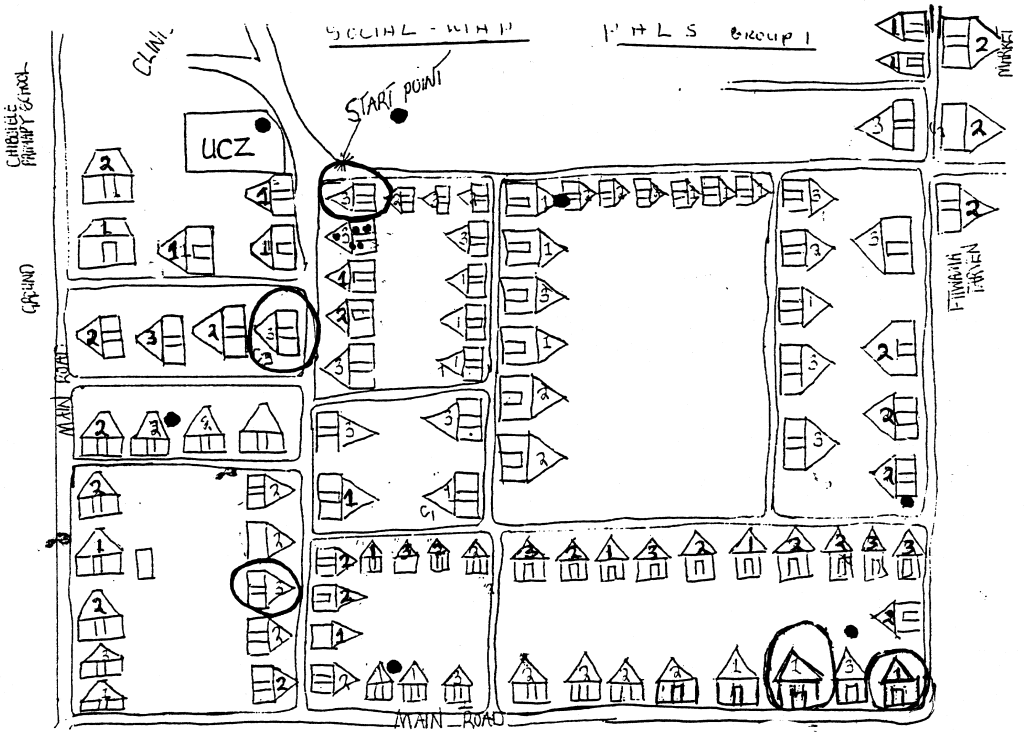
- Own a tavern
- Houses are wall-fenced
- Own color TV and fans, which are operated by generators
- Work for big companies like ZESCO
- Their children go to schools where the fees are high (private schools like Modern School)
- They dress in the acceptable standards
- They own two houses, some are rented out
- They engage people to work in their fields
- They own hammermills, salons, barber shops, or mini buses
- They can afford to book taxis
- They are able to sponsor funeral costs

After having listed the criteria for the classification of households, the group categorized the households they had shown on the social map for their cluster. The aggregated information from this analysis is as follows:

CATEGORY	NO. OF HOUSEHOLDS
Poorest	17
Poor	53
Better-off	17
Rich-some of us	14
Total no. of households on the social map	**101**

Following is a copy of the social map that was used to carry out the well-being analysis in Mandevu Compound, Lusaka by a group of girls.

WELL-BEING RANKING USING SOCIAL MAP
MANDEVU COMPOUND
PREPARED BY A GROUP OF GIRLS



KEY

- Water Tap
- Female Headed Household
- Traditional Healer
- Number Indicates Well-Being Category (1 to 3)

2.5 Body maps

The body mapping technique was used a lot during the participatory appraisals carried out with adolescents in Zambia. This tool is very useful for understanding the level of knowledge and the type of information individuals and groups have about the human reproductive system. This diagramming method requires the participants to draw maps of the female and male bodies, with emphasis on detailing the respective reproductive system and how it functions. The same can also be used by the participants to mark what they consider to be the male and female erogenous zones.

School girls used the blackboard to draw body maps in Chawama, Zambia.

With a visual like the body map, it is very easy to focus the discussion on the group's understanding of the reproductive system and to find out whether there are any gaps in their knowledge and whether the information they have is distorted in any way.

Young women in Kibango, Rwanda draw body maps.

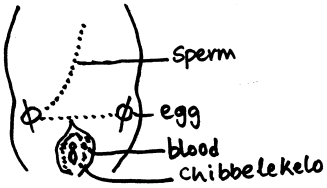
These body maps are best carried out in gender-segregated groups, with 4-7 participants. Body maps can be prepared on large sheets of paper or on the ground using chalk. Following are two examples of body mapping.

A PREGNANT WOMAN
drawn by a group of
13-year old girls (not attending school).
Old Kanyama Compound

Note: The fetus is shown as a baby in a dress and also has a hair-do! When we asked what this woman is carrying in her hands we were told - "Her handbag and a basket of fruits. A pregnant woman must eat a lots of fruits."

Body mapping by a group of school girls. Chawama Compound

FEMALE REPRODUCTIVE SYSTEM



Note: The girls explained that the sperm flows from the top of the body ("from somewhere") to one egg and then to the other egg.

MALE REPRODUCTIVE SYSTEM

Part 3

2.6 Venn diagrams

These are also known as Chapati Diagrams because of the circular paper cutouts used in this analysis. This method is mainly used for institutional analysis. Venn diagrams help in understanding the role different institutions (formal or informal groups or key individuals) play in a community. It is possible to analyze the relationship among these institutions, how important they are in peoples' lives and how the people perceive their relationship with them.

This method is best used with a group rather than individuals, as the discussion and debate that accompanies the analysis is as important as the final visual output.

A large circle represents the community and other circles, each representing an institution, can be placed in or around the main circle. The size of these circles represents their importance to the community (the bigger the circle, the more important the institution). Different colors can be used to show negative and positive relationships the community has with these institutions. The placement of the circles represents how close the community feels to these institutions. Institutions placed inside the main circle are institutions the people feel close with. Distance between the circles represents the links they may have between them. Circles touching or overlapping each other show a close link between them.

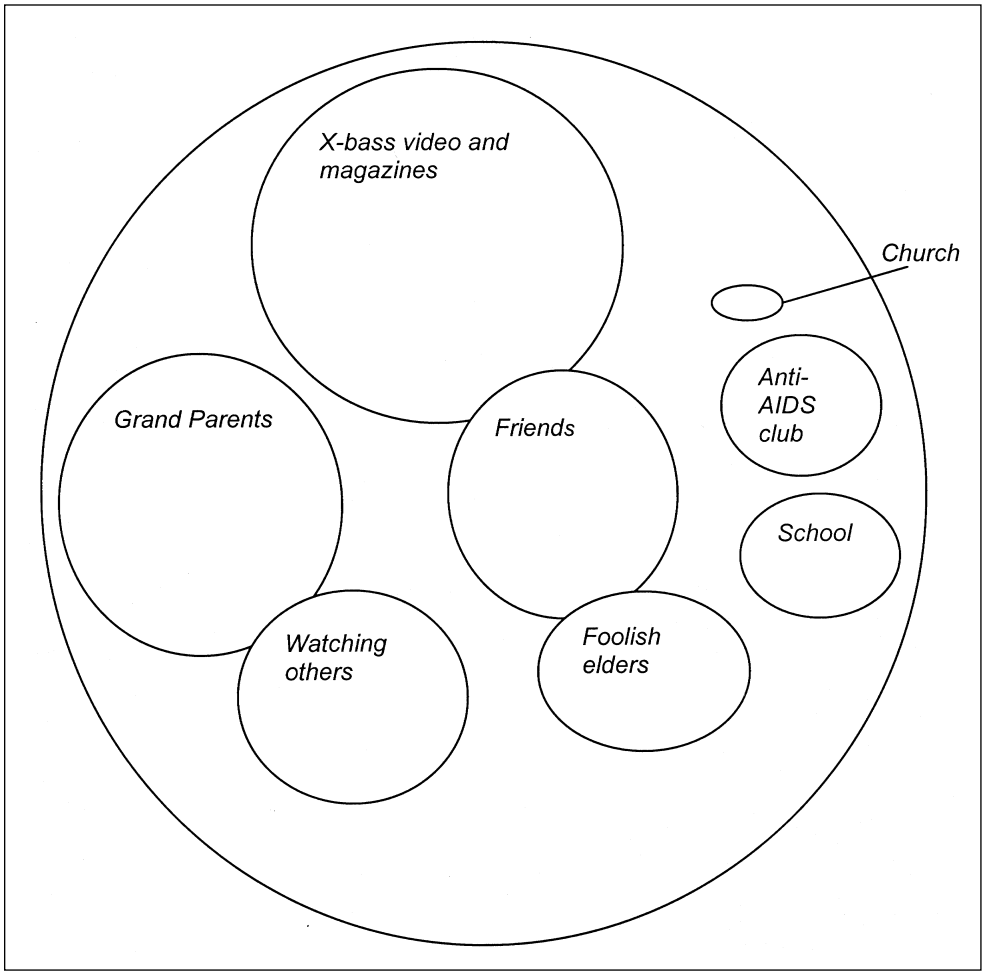
It is important to remind the group that this is not a physical map of the institutions showing their location. This is a perception map of the role these institutions play in their lives and does **not** show whether these institutions are physically within or outside the area, nor does this show the physical size of the institution. This analysis should include all the institutions the community has links with and can include those which may be physically located outside the area (e.g., the village headman who resides outside the village, or a clinic, located three kilometers away).

This visual can also be used to discuss possible conflict among the institutions and the degree of their contact. We can also include institutions that are new and old, as well as those that are functional and those that are dysfunctional.

This visual is usually prepared on a large sheet of paper using paper cutouts for the different institutions. It is useful to carry large sheets of paper or cards (at least two colors), scissors, marker pens, and glue or tape. This visual can also be prepared on the ground using colored chalk.

One of the main applications of this method during the participatory appraisals with the adolescents in Zambia was to analyze the main sources of their information on sex and reproductive health. The following example illustrates this application.

ADOLESCENTS' SOURCES OF INFORMATION ON SEX AND REPRODUCTION
ANALYZED BY A GROUP OF BOYS, OLD KANYAMA COMPOUND, LUSAKA



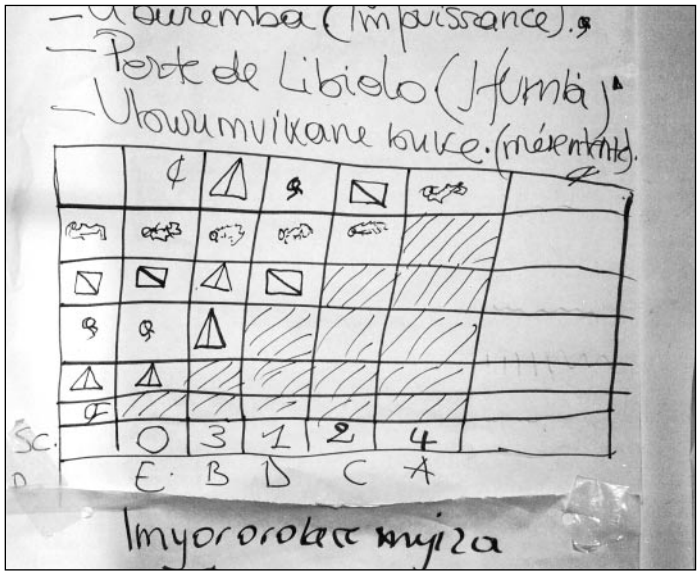
From the above analysis we get the following ranking of the different sources of information, according to their importance, for this group of adolescents:

1. X-bass video and magazines (pornographic material)
2. Grandparents
3. Friends
4. Watching others
5. Foolish elders
6. Anti-AIDS club
7. School
8. Church

It was explained that foolish elders are those who get drunk and then insist on talking about sex with young children. They mentioned that the adolescents do get some information at the church but most of it is about abstaining from sex before marriage, rather than any information on sex and reproduction.

2.7 Ranking and scoring

This technique is most useful in analyzing preferences, prevalence and decision-making processes. We can use ranking and scoring in any situation where different options are to be weighed against different criteria. This technique helps in analyzing the different options available or considered under one subject, the criteria on the basis of which these are evaluated by the individual or group, how each of these options fares against the selected criteria, and the final choice of the participants.



A pair-wise ranking exercise where the men opted to use symbols instead of labeling problems in Ki-Rwanda. Rwanda

The ranking and scoring technique not only helps in understanding the different options available to the individual or group on a particular subject/topic, but also assists in eliciting criteria on the basis of which choices are made. Together these help in determining the important elements for future action and decisions.

This technique is particularly helpful for analyzing sexual behavior and people's attitudes, including topics like:

- sex partner preference;
- contraceptive preference, and the prevalence of their use;
- prevalence of different STIs;
- gender differences in sexual behavior;
- differences in sexual behavior according to age groups;
- levels of sexual activity among different groups of males and females;
- analysis of problems faced by the different groups; and
- sources of information.

This analysis is best carried out in a group. It is the discussion among the participants that clarifies why they evaluate options the way they do.

This technique can be used in a variety of different ways, ranging from a simple ranking or scoring of various options available, to the more complex matrix ranking or scoring analysis which evaluates all the available options against each of the selected criteria. The choice of using ranking or scoring is best left to the participants. This may seem difficult at first, more because of our (facilitators') own hesitation, but is very easy to introduce as we learn with practice. The best way to handle this is to ask the participants themselves to decide the way in which they would like to analyze the differences between the options. The facilitator can help by suggesting the use of counters (stones, seeds, beans, etc.) for enumerating the difference.

We can also use the pair-wise ranking technique, which evaluates options, by considering them two at a time.

Each of these applications is described as follows.

Ranking

Ranking is a fairly straightforward method, whereby the options are evaluated and ranked in a sequence.

STEPS

1. Start with a discussion on the selected topic (e.g., use of different types of contraceptives).
2. Once the participants have mentioned some of the options available, ask them to prepare a list of all the possible options. This list can be prepared on the ground using chalk, by using symbols or by writing on slips of paper which are placed on the ground. It is also possible to use large sheets of paper for preparing this visual with literate groups.
3. Once the list is ready, ask the participants to select the most preferred option. This can be ranked one. The next most preferred option could be ranked two, and so on till the list is exhausted.
4. The facilitator's role is important in initiating the discussion and to explain the technique. Once the participants start doing the analysis, it is best for the facilitator to be an observer and not to interfere with the analysis.
5. Once the ranking is complete, ask the participants to explain the reasons for their preferences.

Following is an example of a ranking analysis carried out by a group of boys. We first started with a focus group discussion (FGD) on whether they perceived any differences in the risk of contracting STIs among the boys. When they started mentioning different categories of boys and how they differed in their sexual behavior and attitudes, they were asked to prepare a list on a large sheet of paper. Once the list was ready, they were asked to rank the different categories according to the risk they carried.

RANKING DIFFERENT CATEGORIES OF BOYS ACCORDING TO THEIR RISK OF CONTRACTING STIS

(Prepared by a group of boys in Lubuto Compound, Ndola)

RANK ACCORDING TO RISK OF CARRYING AN STI (1=HIGHEST RISK)	DIFFERENT CATEGORIES OF BOYS IN THE COMPOUND **
1	***Yoos*** – those who wear fashionable big clothes and like music. They move in groups and move with knives. They also wear earrings.
5	***Niggers*** – They don't fear anyone, they only fear God and only God can judge them. They dress smartly. They don't go for girls because they are homosexual.
3	***Gangsters*** – These are 'young' brothers of niggers. They move in groups and they have a leader of the gang known as 'Stalin'. The members of this group move with dangerous weapons like knives. Usually they share their girlfriend amongst them – even nine of them could be having sex with one girl, by turns. It will be up to the girl to keep a timetable for each one of them, so as to not annoy the others.
4	***PLO (Posse Lazy)*** – these put on nice clothes but they have no money. They come from poor families and like to have friends from rich families. For them to have clothes, they do piece work and spend all the money on clothes and beer.
2	***Rasta*** – These smoke dagga, listen to reggae music and they are vegetarians. Rastas propose girls but girls don't like them because they are dirty, are slaves, and walk to town.
6	***Home Guys*** – these are ordinary boys, they go to church sometimes and some may have girlfriends.

** NOTE: The terminology and the language presented above is the same as used by the adolescents who carried out this analysis. Please note that some of the terms used by the adolescents do not carry the same meaning as is understood in general.

The above analysis shows how the boys categorize themselves in different groups. They do not perceive 'home guys' and 'niggers' to be at risk of STIs. They feel that homosexuals and those who have few girlfriends are relatively safe from STIs.

Scoring

Scoring is another way by which different options can be evaluated. In this case the analysts give a score for each of the options instead of a direct rank. Scoring provides a much more in-depth analysis as compared to simple ranking. While scoring does give the overall ranking, it also gives a weight to the differences. Counters can be used to evaluate, by quantifying, the differences between the different options.

Following is an example of using the fixed scoring technique. In this case the group decided to give scores out of a fixed maximum of 100 in order to analyze the prevalence of sexual relations among relatives. As in ranking, scoring also starts with preparing a list of options (in the following example it is a list of different sets of relatives who could be involved in sexual relations), followed by giving scores to each option to analyze their preference, prevalence, etc.

SCORING DIFFERENT RELATIONSHIPS ACCORDING TO PREVALENCE OF SEXUAL RELATIONS AMONG THEM

Prepared by a mixed group of girls and boys in Chipulukusu Compound, Ndola (Shah, 1997)

RELATIONSHIP	FIXED SCORE OUT OF 100 SHOWING HOW COMMON IT IS FOR THESE TO HAVE A SEXUAL RELATIONSHIP**
Brother and sister	5
Cousin and cousin	50
Grandfather and granddaughter	0
Grandmother and grandson	0
Uncle and niece	25
Aunt and nephew	0
Father and daughter	15
Brother-in-law and wife's sister	60
Sister-in-law and husband's brother	30
Neighbor and neighbor	100

**The higher the score, the higher the probability of sexual relations among these relatives

++Although not a relative, neighbor was later added as a category because it was felt that they are as close, and as important, as the relatives.

NOTE: The most common sexual relationship, according to the above analysis, is that among neighbors, ("it happens all the time"). The next is sex among brother-in-law and sister-in-law (wife's sister). It is also common to have sex among cousins. The group felt that only fathers who have no sense will have sex with their daughters. The group analyzed that out of 100 boys about 45 would have had at least one sexual relationship with a close relative and out of 100 girls about 50 percent would have done the same. Usually these relationships are willing and voluntary. While analyzing the relationship between a grandfather and granddaughter, some girls in the group felt that some grandfathers do have sex with their granddaughters, but most boys felt that it was not possible. These boys aggressively asked the girls in the group to confirm, "does the grandfather pouncha (puncture) you?", which made the girls very uncomfortable and they were shy to speak anymore on the subject.

A scoring analysis can also be carried out without fixing a maximum score at the beginning. This is called the ***free scoring*** method. In this case too the list of options is prepared first, and then the analysts use counters to give weights to all the options. Usually the counters are counted and then placed against the option. Since the number of counters placed against an option is relative to the score given to the other options, the analysts may add or remove some of the counters against the different options as the analysis progresses. It is important for the facilitator not to interfere when the analysis is going on.

Following is an example of using the free scoring method for analyzing the comparative preference of different contraceptive methods for single and married males.

CONTRACEPTIVE PREFERENCES OF SINGLE AND MARRIED MALES (USING FREE SCORING METHOD)

(Analyzed by a group of boys, Old Kanyama Compound)

METHOD	SINGLE MALES	MARRIED MALES
Pills	5	151
Herbs	0	0
Condom	183	41
Safe period (natural)	2	0

NOTE: According to this analysis, boys prefer condoms while they are single. After marriage, condoms are used only with sex partners other than the wife. After marriage it is up to the wife to use a contraceptive. Hence, the high score for the pill for married males. No score was given to herbs, as these are used by females and these did not have an impact on the decision making of the males. It was also mentioned that most males are not aware whether their female partners use any herbs.

Some may point out that if we were to add the scores vertically, for single males and married males, the totals do not match. They are not meant to. In free scoring there is no fixed maximum out of which a score is given. The analysts can start with placing a score in one cell and the remaining cells are filled with numbers relative to the first one as also the scores in all the other cells. Therefore, there is no reason why they should give equal totals either along the vertical axis or along the horizontal axis.

Matrix ranking and scoring

When the options have to be analyzed on the basis of multiple criteria, it is most effective to use the Matrix Scoring or Ranking method.

STEPS

1. Starting with an FGD, the participants prepare a list of options and the criteria on the basis of which they are differentiated, compared, contrasted and evaluated.
2. All the criteria in the list should be positive, or else it is difficult to make comparisons. In case some criteria are negative (e.g.,'expensive'), these should be changed to their positive meaning (e.g., 'cheap' or 'affordable').
3. A matrix can be prepared on the ground or on a sheet of paper.
4. In the cells along the top, on the x-axis, place the different criteria (one in each cell). Along the y-axis, on the left-hand side place the options, again one in each cell. (We could also have the options on the x-axis and the criteria along the y-axis!).
5. Each option on the list is evaluated against all the criteria in the matrix. This can be done by using scoring or ranking methods. Counters can be used to fill up each of the cells in the matrix.
6. It is important to remember that the scores for the options should not be added in order to arrive at the overall preference. Such totals can be misleading as it assumes that all the criteria have equal weight.
7. Overall preference can be arrived at by asking the group to add another column/row to the matrix at the end and to rank or score the different options to show preference.
8. It is also possible to rank (using ranking or scoring) the different criteria in order to understand which ones are more important.

Following is an example of using the matrix scoring method:

MATRIX RANKING OF PREFERENCE FOR SEX PARTNERS FOR GIRLS

Prepared by a group of 14-16 year old girls in South Chilenje, Lusaka
(From the field notes of Meera Kaul Shah and Mary Simasiku)

Type of male sex partner	Criteria for deciding preference (fixed score out of 10; 10=best)						Overall preference (ranking, 1=best)
	Not married	Not moving with many girls	Can take responsibility	Has money	Dresses smartly	Is educated	
School boys	10	5	2	5	8	5	**2**
Yoos	10	0	0	5	7	5	**6**
Home boys	10	8	8	2	2	5	**3**
Taxi drivers	8	0	5	10	5	5	**7**
Teachers	5	0	5	3	5	10	**5**
Doctors	5	0	10	10	10	10	**1**
Cousins	5	5	4	5	5	5	**8**
Stepfathers	0	2	5	10	5	5	**9**
Church mates	8	5	8	8	8	5	**4**
Monku*	10	10	0	10	0	8	

Monkus* are homosexuals (males). The girls first included them in their list, but when they started evaluating each of the categories as sex partners, they decided that they could not include the ***Monkus*. Therefore, they did not give them any preference ranking at the end.

The group of girls carrying out the above analysis decided to give scores out of ten for evaluating each of the types of sex partners against the selected criteria. Doctors, who were ranked the most preferred sex partners, can take responsibility, have money, dress smartly and are educated, but are usually married and move with many girls.

Note that the last column in the above example gives ranks (while the rest of the matrix has used the fixed scoring method). This column was added to the matrix at the end, after the girls had completed their analysis. The group was simply asked to rank the different types of sex partners in their list according to their overall preference. One common mistake made while using the matrix scoring method is adding up the scores to arrive at the overall preference. The scores should never be totaled. Totaling the scores in the cells would indicate that all the criteria have equal weight. This is very rare. Check this with the above example. If the group had simply added up the scores in each row, they would have come up with a rather different overall preference from the one given above. Although doctors would have retained the first rank, it would have been church mates, rather than school boys, in the second place, and monkus (who were not given any rank at all), rather than home boys, in the third place, and so on.

The following example illustrates how the adolescents are capable of carrying out a very complex analysis using an equally complex methodology. Before the group of school girls carried out this analysis, we had a long discussion about the various dimensions of selecting a sex partner. Once the discussion had warmed up, we asked the group whether they would like to list these different dimensions as well as the typology of sex partners they had been talking about. It can be seen that the issues listed on the top of this matrix relate very closely to the questions that we had asked to facilitate the discussion. This, therefore, definitely has the influence of the facilitators. Once these issues were listed on paper, the girls were asked how they would like to evaluate each of the types of sex partners against these different dimensions. This is an interesting example as we can see that the group decided to use a mix of ranking and scoring methods. Such an analysis may seem very complex, and perhaps difficult to understand for the reader, but it must be mentioned that it took the girls only about 40 minutes to carry out this analysis and to discuss the reasons for their analysis.

TYPOLOGY OF SEX PARTNERS AND PREFERENCES OF GIRLS

Analyzed by a group of grade seven school girls in M'tendere Compound, Lusaka (Shah et. al., 1996)

Type of partner	How common is the relationship (score out of 10)	Preference ranking) (1=best)	Highest payers (ranking, 1=best)	Use of force (scoring, 10=use most force)	Social acceptability (scoring 10=least acceptable)**
Pastors	4	15	15	3	6
Friends	10	2	5	0	0
Servant	5	7	6	5	10
Drivers	5	3	2	5	0
Gonena++	10	6	4	7	3
Gangsters++	15#	1	3	8	0
Sene Sene++	6	10	1	10	0
Grandfather	4	14	16	10	10
Neighbor	5	5	7	0	5
Cousin	5	9	11	6	7
Brother-in-law	4	11	8	7	7
Teacher	10	4	10	9	5
Uncle	4	13	12	10	8
Doctors	5	8	9	1	0
Father	2	16	13	10	10
Brother	6	12	14	4	9

** This criteria emerged from the question we asked, "If your mother comes to know that you've had sex, which category of sex partner will she be most upset by?" Since the girls decided to use fixed scoring out of ten for this column, the higher the score, the more upset the mother will be.

++Gonena are bus conductors. Gangsters are well-dressed boys who hang out in small groups. Sene Sene are Senegalese traders (male).

A score of 15 was given, even though the maximum had been decided at 10, in order to highlight that it is very common to have a sexual relationship with gangsters

NOTE: This complex and detailed analysis shows the variety of sex partners a girl can have in the compound. According to this analysis, it is the most common for a girl to have sex with gangsters. They do use force, mainly by being persuasive (rather than using physical force), with the help of money they pay. The next most common sex partners are bus conductors, friends and teachers. The bus conductors pay relatively well and also give free rides to town. With friends they feel free and since they are familiar with each other, they find it nice to have sex with them. Teachers give 'leakage' (of exam papers) in return for sex.

The most preferred sex partners for the girls are gangsters, friends, drivers and teachers, in that order. Gangsters are liked because they can pay a lot of money, just like the drivers. Sene Sene (Senegalese, usually traders), pay the most, followed by drivers, gangsters and bus conductors. "A grandfather, pastor, brother and father don't pay anything". With the exception of Sene Sene, there is a strong positive correlation between levels of payment and preference. In general, Sene Sene are viewed as physically well built and tall, with large penis and huge appetites for sex, and can be aggressive during sex. As a result, the girls mentioned that even though they pay the most, younger girls like to keep away from Sene Sene as sex with them is painful.

The least preferred relationships for the girls were also the most forced. Sexual relationships with Sene Sene, grandfathers, uncles and fathers are more likely to be forced. Usually the girl is not willing to have sex with these categories of boys/men. Doctors have to use very little force to have sex with a girl. A relationship with a doctor takes place when a girl has no money to pay for the medicines and the doctor accepts sexual favors instead. The issue of forced sex was also discussed with other groups of boys and girls, and it was explained that the type and level of force varies from threats to beating the girls, and in some rare cases boys even use knives to threaten and hurt the girls if they refuse to have sex with them. While most girls enter sexual relationships voluntarily, it was estimated that about 20% of the girls are forced to have sex. However, 'force' here was explained more as persuasion rather than 'rape', except that in the case of Sene Sene, and some close relatives.

Looking again at the previous table on typology of sex partners, it can be seen that a girl's mother is likely to be most upset by her daughter having sex with close relatives, like her father, grandfather, brother and uncle, and also if she has sex with a house servant. All these are people she knows well. It hurts less, it was explained, if she does not know the boy/man. Also, if there is money coming in, she will mind less.

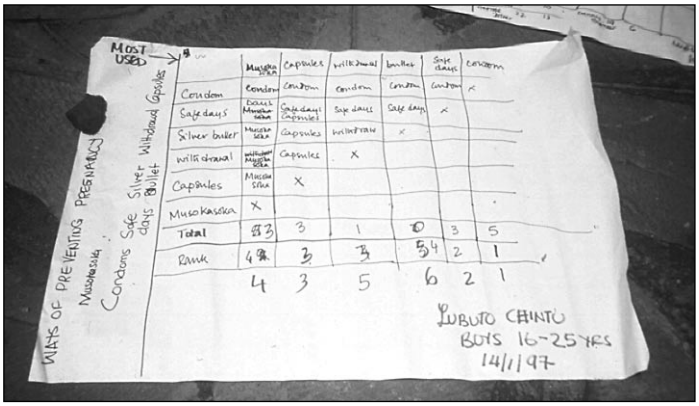
This analysis brought out the complexity of relationships the girls have and how they evaluate them. The bottom line seems to be the 'payments' or 'favors' in return for sex (like the free rides to town offered by the bus drivers and conductors). The same group of girls called payments they receive from boys in return for sexual favors as 'sleeping allowance'.

PAIR-WISE RANKING

This method helps in analyzing different options and choices available under one topic, by evaluating them two at a time. These options could be related to contraceptive preference, preference of sex partner, sources of information, etc.

STEPS

1. The participants prepare a list of the different options they have under the selected topic. If the group is analyzing contraceptive preference, the options could include: condoms, pills, herbs, natural method, withdrawal, magic, etc.
2. These are written on slips of paper and placed on the ground. Alternately, a grid can be prepared on the ground using chalk or on a large sheet of paper.
3. The analysts are asked to consider the options two at a time and select the one that is more prevalent, more common, more difficult, more preferred, or on whatever basis the analysis is being carried out. Each option is directly compared with all the other options, one by one, e.g., - they could be asked between condoms and pills which one do they prefer, between condoms and herbs, between condoms and natural method, and so on till all the combinations are exhausted.
4. The number of times an option is selected is the score that it gets. The higher the score the more preferred the option is for the analysts.



Pair-wise ranking of different ways of preventing pregnancy. Zambia

Part 3

The following example shows how a group of boys analyzed the reasons for early initiation of sex among girls using the pair-wise method.

PAIR-WISE RANKING OF REASONS FOR EARLY SEXUAL INITIATION OF GIRLS

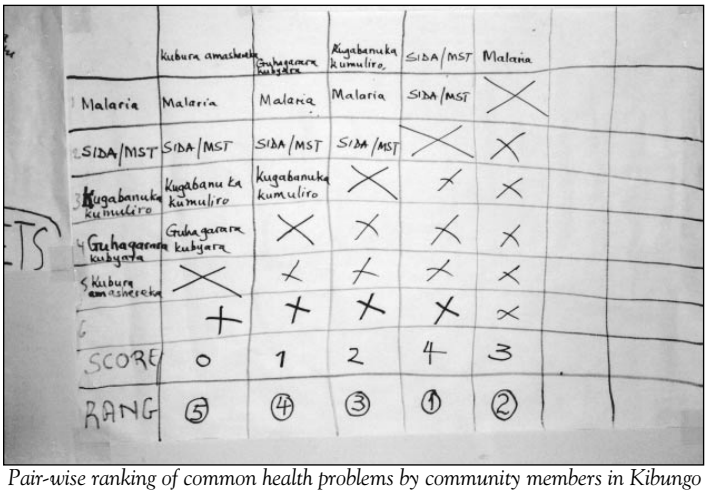
(Analyzed by a group of boys, Chawama Compound)

(Shah and Nakhama, 1996)

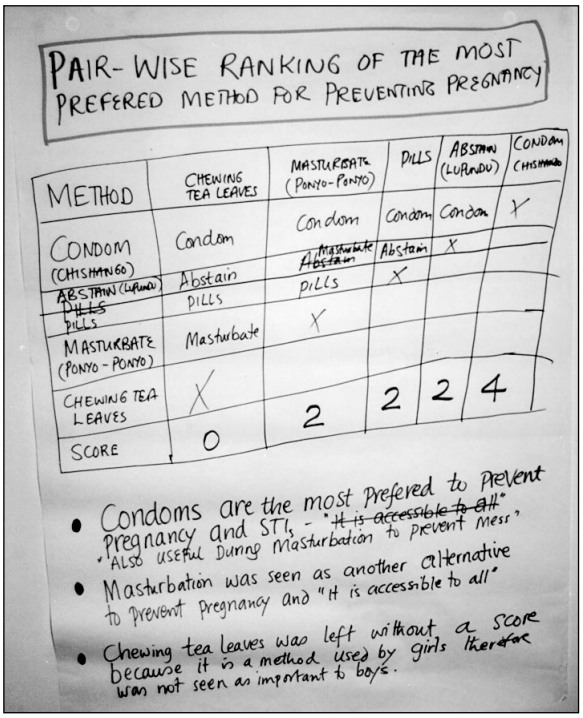
Reasons	Anzabo (peer pressure)	Bana (children)	Ndalama (money)	Kumvela Bwino (pleasure)
Kumvela Bwino (pleasure)	Pleasure	Pleasure	Money	X
Ndalama (money)	Money	Money	x	X
Bana (children)	Children	X	X	X
Anzabo (peer pressure)	X	X	X	X
Total Score	**0**	**1**	**3**	**2**
Rank	**D**	**C**	**A**	**B**

NOTE: The above analysis shows that this group of boys feels that money is the main reason why girls initiate sex early. The next most important reason being pleasure, followed by the need for having children. The boys felt that there is little peer pressure among the girls (as compared to that among the boys).

It must be noted that while the pair-wise ranking method is very easy to use, it lacks the depth of analysis that is possible by using the matrix scoring method.

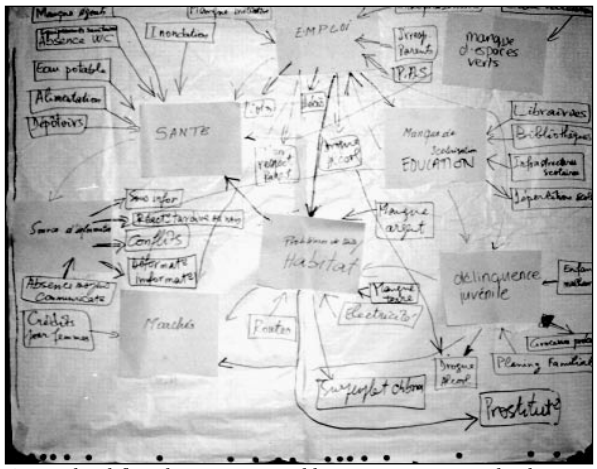


Pair-wise ranking of common health problems by community members in Kibungo Prefecture, Rwanda



2.8 Causal-impact analysis (flow diagrams)

Flow diagrams are very useful for understanding the causes and impact of an event, problem or activity on people's lives. They also help in identifying links between different causes and impact. This analysis helps in initiating a discussion with the participants on how the problem can be approached and the types of inputs required to improve the situation.



A completed flow diagram prepared by young men in Nyeknakpoe, Lomé.

It helps to use this method during later stages of the appraisal, after the group has brought up several issues during the discussions. Prior discussions help in selecting a topic that has been surfacing repeatedly during the analysis. Results from preference ranking analysis can also be used to initiate a causal-impact analysis. This method helps in analyzing a problem in totality rather than discussing it in abstract.

STEPS

1. Select a topic for analysis.
2. The analysis can start with discussing the causes leading to that problem or activity.
3. These can be drawn as a flow diagram on the ground or on paper.
4. The impact or effect can similarly be drawn on the diagram.
5. Different colors can be used for the causes and the impact.
6. Links can be discussed between different causes and impact.
7. Keep asking if there are any other causes or results of the problem or activity. We can also probe into further impact of the results.
8. Both, the causes and the impact, can be given ranks or scores to analyze their intensity.

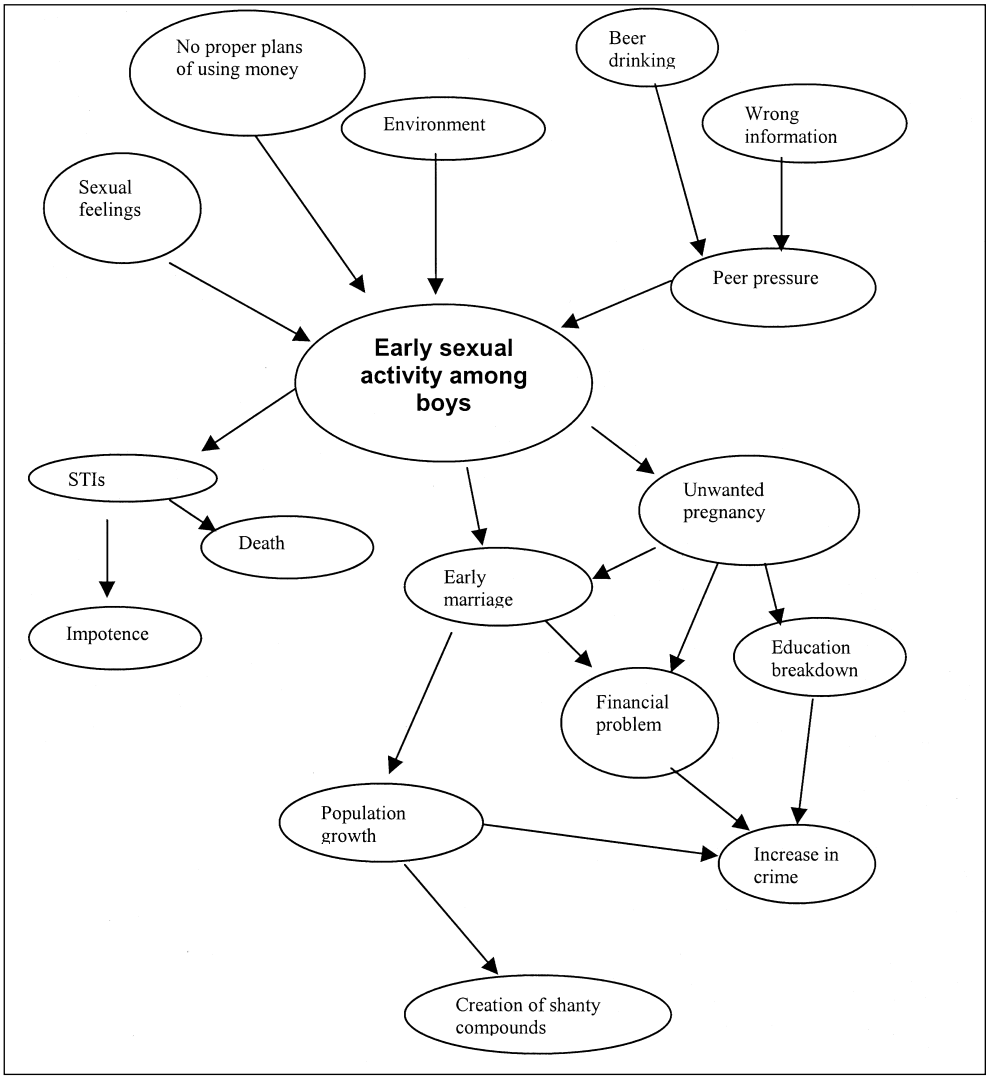
Flow diagrams can also be prepared showing only the causes or only the impact of an event, problem or activity.

Also, it is possible that once a problem or issue has been identified by the community as the cause of a problem under discussion, it is then possible to place that 'cause' in the center of a new causal-impact analysis to probe its importance further. This is how the facilitators were able to discuss the issue of Female Genital Mutilation with groups in Somalia and Sudan where the people did not identify it as a primary RH problem but brought it up as a cause of the primary problem (Sarah Degnan Kambou, personal communication).

Following are two examples of causal-impact analysis. The first one has been prepared by a group of boys analyzing the causes and impact of early sexual activity among boys. The second one has been prepared by a group of girls analyzing the same issue for girls. In both the examples the causes are shown on the top and the impact on the bottom (as also indicated by the direction of the arrows).

CAUSAL-IMPACT ANALYSIS OF EARLY SEXUAL ACTIVITY AMONG BOYS

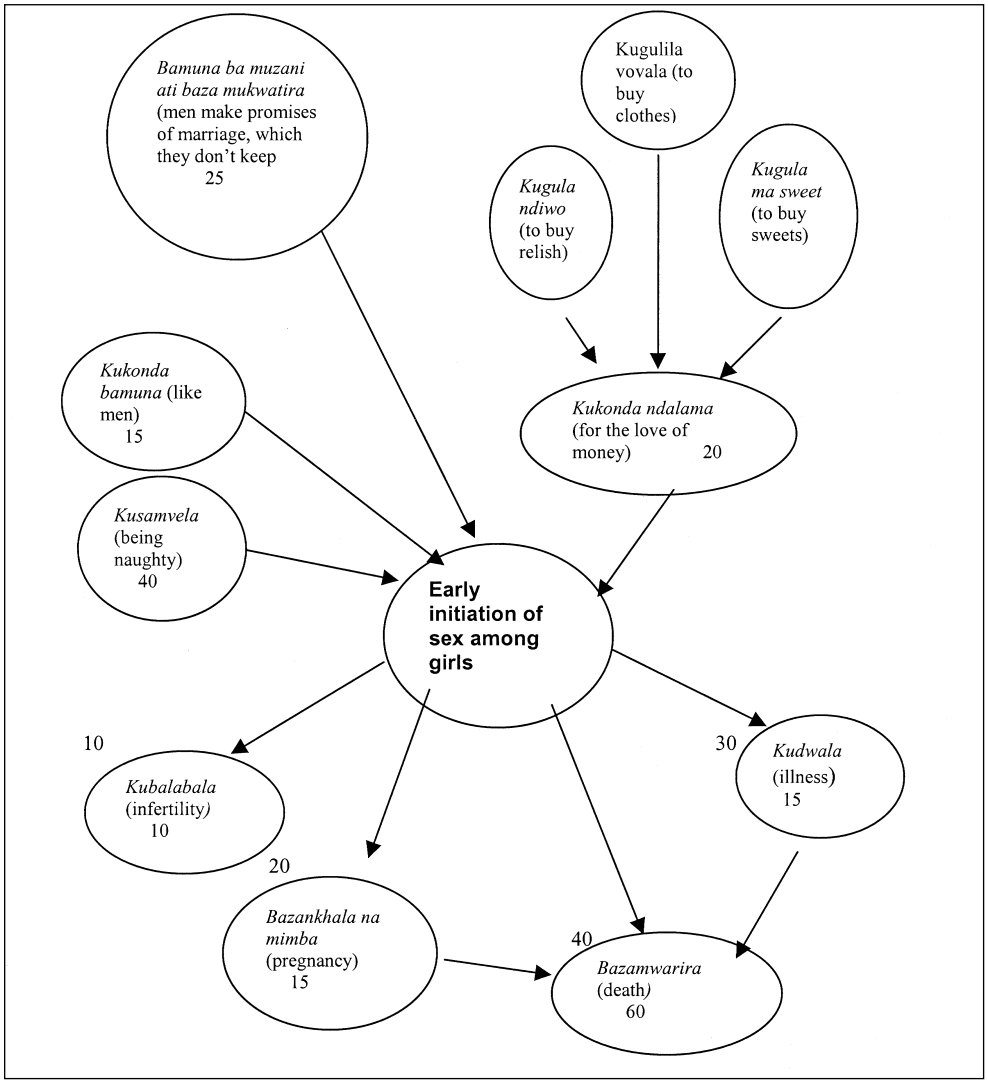
Analyzed by a group of boys from South Chilenje Compound, Lusaka



Part 3

CAUSES AND IMPACT OF EARLY INITIATION OF SEX AMONG GIRLS

Analyzed by a group of girls, Chawama Compound, Lusaka
(Shah and Nkhama, 1996)



The numbers inside the circles for the causes are the scores (out of a total fixed score of 100) given to show the importance of the cause. The higher the number, the more important the cause. On the impact side, the numbers inside the circles show the score (out of a total fixed score of 100) for the influence that particular result has on their lives. The numbers outside the impact circles give the proportion of girls (out of a total of 100) who are affected by this.

2.9 Daily time use analysis

This is a fairly straightforward method. This analysis of a typical day for a participant is easy to understand and analyze. This method can be used in groups, though it is more effective when used by an individual as there can be specific information to focus the discussion on.

This method is a good ice-breaker and helps in starting a discussion. Questions can be asked on the basis of the analysis carried out by the individual/group.

Since the analysis is about how the person(s) spends a typical day, the first thing to be done is to ask the participant how they would like to divide the day. Some may divide it by the hour and some may simply divide it by morning, afternoon, evening and night. The participant(s) is asked to analyze how his/her time is spent during a typical day.

Following is an example of daily time use analysis, carried out by a group of boys in Chilenje Compound:

DAILY ACTIVITY CHART OF BOYS
BY A GROUP OF SCHOOL BOYS IN CHILENJE SOUTH, ZAMBIA

TIME	WHAT THE BOYS DO
0600 hrs	-wake up -tisamba ku maso (wash) -tisukusa mukamwa (brush teeth) -eat breakfast -prepare to go to school
0645 hrs	-report to school
1230 hrs	-lunch break
1400 hrs	-afternoon group reports to class -morning group reports back for football practice
1700 hrs	-practice over -classes over for p.m. group
1745 hrs	-water vegetables and lawns -bath, change into clean clothes -watch TV, video shows -reading
1900 hrs	-supper -some play with girls at school -some play "pool-table", others drink beer – mosi (at bottle-stores), drink kachchasu (local brew) in the Mapoloto area,
2100-2200 hrs	-some sleep with girls along paths -bed time

As can be seen from the above example, this daily activity analysis does not give us complete information, but provides an opportunity to ask a number of questions. Once the group has prepared an analysis like the one above, they can be asked several questions like:

- Do you think this analysis will apply for all the boys in this Compound or would it be different for some?
- Will a girls' daily activity analysis look the same?
- Out of 100 boys living in an area, how many will go to drink beer or kachchasu, how many will play at pool tables, how many will be sleeping with girls and how many will go to bed at home?

Used this way, the daily calendar can open up several new topics for discussion and analysis. It is also important to differentiate between the weekday calendar and weekend calendar, as there can be significant differences in the way time is spent during different times of the week. The other dimension of daily calendars is to check whether they change according to seasons (i.e., is their time spent differently during winter as compared to summer, etc).

2.10 Seasonality analysis

Seasonal calendar being created by community members in Tana, Madagascar.

This method is used to analyze the seasonal patterns of some aspects of life. Activities, events, or problems that have a cyclical pattern can be analyzed using this method, including availability of food, prevalence of diseases, indebtedness, relative prosperity, stress in livelihoods, levels of sexual activity, availability of free or leisure time, etc. By analyzing several related variables in one visual it is possible to analyze the relationship between them and their impact on life.

STEPS

1. Decide on a topic.
2. Ask the participants to decide how they would like to divide the year (months, seasons, quarters, etc.). Do not impose your calendar – there can be different forms of local calendars, which the people may be more familiar with.
3. Develop the calendar on the ground using chalk, sticks, stones, or any other locally available material. This can also be prepared on large sheets of paper.
4. The seasonal variations of the different variables are compared and depicted visually on this calendar.
5. Once the visual is ready, the facilitators can ask probing questions regarding the relationships between different variables and whether there are any other aspects of life that are affected by this seasonality.
6. This visual can also be used to discuss problems and opportunities.

Following seasonality analysis of common health-related problems was carried out by a group of girls.

SEASONALITY OF HEALTH PROBLEMS

Analyzed by a group of girls in South Chilenje Compound, Lusaka
(Source: Field notes of Meera Kaul Shah and Mary Simasiku)

HEALTH PROBLEMS	MONTH											
	J	F	M	A	M	J	J	A	S	O	N	D
Malaria	4	2	1							8	7	6
Cough					6	3	4	9				
STD						9	9					
TB	1	1	1	1	1	1	1	1	1	1	1	1
High blood pressure										5	3	
Wounds	5											5
Burns						8	6					
AIDS	1	1	1	1	1	1	1	1	1	1	1	1
Headache	1	1	1	1	1	1	1	1	1	1	1	1
Madness	8	3	4	4	3	3	1	1	1	1	1	8
Pregnancy	3	2	1	7	2	2	1	7	1	2	2	7

This group used the 12 month calendar to analyze variations over a year.

Numbers in the cells indicate the relative score (using free scoring method) for prevalence of a health problem during different months in a year. The higher the score the higher the intensity of prevalence during that month. This group analyzed that AIDS, headache and TB have no seasonal pattern and are prevalent throughout the year. That's why they gave a score of 1 for all the months. There is high incidence of STDs, and burns during June and July – the cold season.

Pregnancy was added to the list, even though it was mentioned that it is not exactly a health problem, but it is related to health and has a seasonal pattern.

NOTE- By itself, the above analysis does not provide a lot of insight into the community's and/or adolescents' health problems. However, it provides a list of health problems that the adolescents perceive to be important, as well as their perception of when these problems can occur during the year. This can be the starting point for asking probing questions about whose problems these are, why they have a seasonal pattern, what do adolescents do when they are unwell or discover that they are pregnant or have an STD, etc.

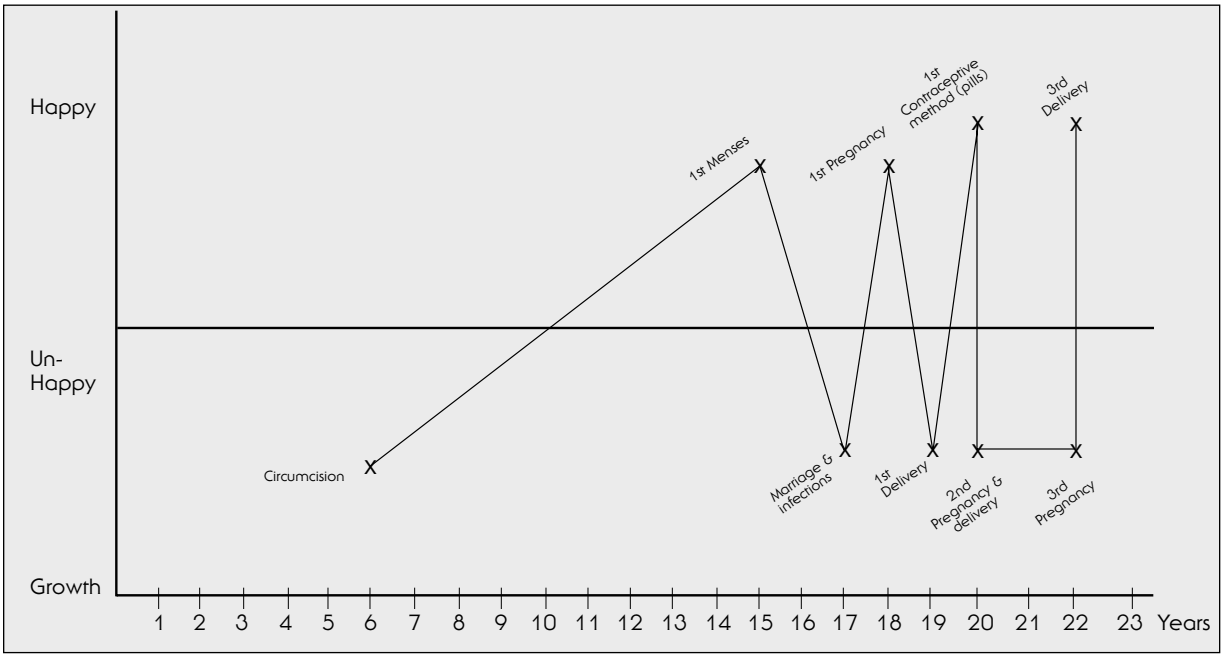
2.11 Trend analysis

Trend analysis is used to understand people's perceptions and patterns of change regarding selected indicators and topics that are of concern to them. Usually a 40- to 50-year period is considered for analyzing these changes. This is a useful tool to initiate a discussion with older people to analyze their perceptions of changes taking place in their community and in their own lives.

STEPS

1. Start with a discussion on major changes that have taken place on a selected topic.
2. Ask the group to decide on how far back in time would they like to go for this analysis. They should identify the years or period when significant changes were witnessed. These can be plotted on the visual.
3. Ask the group to show diagrammatically how the changes for each of the indicators have taken place over the years. This can be shown by line drawings (like graphs) or by scoring.
4. Discuss what prompted these changes. Which ones are considered positive and which are negative. Why? Ask whether any of the negative changes can be reversed.

REPRODUCTIVE LIFE-LINE – UN KENEDIEN - BARA PROVINCE – EXERCISE WITH WOMEN



Source: CARE Sudan. Un Kenedien - BaRa Province – Exercise with Women. The Reproductive Life Line above depicts the "high's (first menses, first pregnancy) and low's (circumcision, marriage and infections and first delivery)" of a women's reproductive life cycle.

2.12 Participatory sex census

This is a methodological innovation. During group discussions with boys and girls in Zambia it became increasingly evident that while boys may talk about their sexual behavior and experiences in an exaggerated manner, mainly to impress their peers, the girls tended to be secretive about their experiences. The girls would usually express themselves in third person or talk about a subject saying: *"I have a friend, who …", "I know a girl, …", "There are many girls, who …", or "Girls don't mind…."*

Given the sensitive nature of the subject being discussed we did not want to impose upon the participants to disclose what they did not want discussed in front of their peers. Hence the participatory sex census was designed, in order to understand, empirically, the sexual behavior of the adolescents. This was also necessitated because of several doubts being expressed by some 'experts' and critics about PLAs providing only an understanding of adolescent's perceptions of their sexual behavior, which, it was felt, could deviate significantly from their actual practice. It was, therefore, important to generate quantitative data during a qualitative process in order to dispel the myth that quantitative analysis is not possible during a participatory appraisal and to test how close the adolescent's perceptions are to their actual behavior patterns.

There are two ways in which this method was used:

- the paper slips method, and
- the 'open' method

Participatory sex census - the paper slips method:

This variation of the method was mainly used with groups of girls and boys at their schools. It was used, with similar results, in both gender-segregated and mixed groups.

STEPS

1. Sit with a group of adolescents in a place where the group will not be disturbed. There should be adequate seating space available.
2. At least two or three facilitators are required to handle this process.
3. All the participants should have a pen or a pencil (facilitators can carry some extra pencils with them).
4. Keep a bundle of small pieces of paper ready. The number of paper slips required will depend on the number of participants and the number of questions to be asked (you can always cut out more slips of paper from large sheets if you run out).
5. Explain to the group that you will be asking them a series of personal questions. You will ask one question and they should write their answer on one slip of paper. They should not write their names, as the answers will be kept anonymous. Therefore, they should feel free to write their answers. Also mention at the very beginning that anyone not willing to take part in the analysis can decline freely. You can start with a general discussion with the group as a warm-up exercise and as an ice-breaker, before actually starting with the census.
6. When you sense that the group is feeling at ease with undertaking this exercise, start by asking the first question. The first question could come straight to the point, e.g., by asking - 'have you ever had sex?', or a more general one like 'do you have friends of the opposite sex?'
7. Give out slips of paper, one to each member of the group. Ask them to write their answer. They should not show their answers to the others.
8. Ask them to fold the slips.
9. Collect the folded pieces of paper.
10. Count the responses according to the replies.
11. Destroy the slips of paper in front of the group.
12. Move to the next question, repeating steps 6-11, and then the same with the next question, and so on.
13. After all the questions are exhausted, aggregate the information. This can be shared with the group for further discussions or to seek clarifications on non-personal topics.

The set of questions to be asked has to be prepared beforehand. Additional questions can be asked, or questions can be changed, depending on the responses obtained from the group. Some questions that we asked during such an analysis included:

- Have you ever had a sexual relationship?
- What was your age at first sex?
- With whom did you have your first sexual relationship?
- Did you give/receive any gifts or payment for this sex?
- With how many partners have you had sex so far?
- Have you ever used a condom?
- How many times have you had sex in the last month?

From our experience, we learned that we need to ask the same question in two or three different ways in the beginning to triangulate the information. While answering the first question, usually fewer participants admitted having had sex. When they saw the slips being destroyed after each question, their confidence increased, and subsequently more of them would admit having had a sexual relationship. Such responses increased till about the third question and stabilized thereafter.

Participatory sex census is somewhat different from the other methods described in this field guide. It is one method where the focus is on the individual. Individuals share and analyze their own personal experiences. Most of the other methods described here are based on analysis by groups of adolescents and their perceptions of reality. Sex census provides an effective means to triangulate information on a very personal and sensitive subject. It also generates quantitative information that can be compared with the adolescent's perceptions, as analyzed by them using other methods.

Following are the results from a sex census exercise using the paper slips methods.

RESULTS FROM THE SEX CENSUS (USING THE PAPER-SLIPS METHOD)
(Schoolgirls and boys participated in this analysis in two separate groups.
The results from both these are presented together here)
Twapia Compound, Ndola, Zambia

Q. NO.	QUESTION	RESPONSES			
		Boys		Girls	
	Total number of boys and girls in the group	Total number of boys = 17		Total number of girls = 16	
1.	Have you ever had sex?	No 3	Yes 14	No 5	Yes 11
2.	Age at first sex (in years)	Age / Number of boys 6 / 2 7 / 1 8 / 3 9 / 1 10 / 5 11 / 1 12 / 1		Age / Number of girls 7 / 4 8 / 1 9 / 2 10 / 2 11 / 1 14 / 1	
3.	With whom did you have first sex	Neighbor = 8 Friend = 5 Cousin = 1		Friend = 7 Neighbor = 4	
4.	Payment given or received for this	Two of the boys paid: K 500 K 200		Seven girls received payments: K 500 K 600 K1000 (three of them) K1500 K10,000	
5.	Number of partners with whom you have had sex so far	No. of partners 2 4 5 8 14 15 17 20 27	No. of responses 4 2 2 1 1 1 1 1 1	No. of partners 1 2 3 4 6 10 15	No. of responses 3 3 1 1 1 1 1
6.	Have you ever had sex with your grandmother or grandfather?	No 17	Yes 0	No 14	Yes 2 (with grandfather)
7.	Have you ever had sex with a cousin?	No 16	Yes 1	No 16	Yes 0
8.	Have you ever had sex with a close relative other than a cousin, grandfather or grandmother	No 17	Yes 0	No 15	Yes 1 (with uncle)

RESULTS FROM THE SEX CENSUS (USING THE PAPER-SLIPS METHOD) (cont.)

(Schoolgirls and boys participated in this analysis in two separate groups.
The results from both these are presented together here)
Twapia Compound, Ndola, Zambia

Q. NO.	QUESTION	RESPONSES			
		Boys		Girls	
	Total number of boys and girls in the group	Total number of boys = 17		Total number of girls = 16	
9.	How many times have you had sex in the last three months	No. of times 1 2 3 5 6 18	No. of responses 2 2 2 2 3 1	No. of times 2 4 5 6 7	No. of responses 1 1 2 1 1
10.	Number of partners with whom you have had sex in the last three months	No. of partners 1 2 3 4 6	No. of responses 5 1 2 3 1	No. of partners 1 2 6	No. of responses 4 2 1

Participatory sex census - the open method

Another variation of the above mentioned method is the 'open' sex census method. In this case, there is discussion and the information is put together and analyzed in an open way as compared to the 'secret ballots' used in the paper slips method.

STEPS

1. Inform the participants that we will be discussing personal information. Proceed only if they are willing to discuss their personal experiences in the group.
2. On a large sheet of paper prepare a matrix with the selected questions/indicators on the top along the x-axis. Along the y-axis, on the left hand side ,will be the names of the participants (if they wish to write them) who take part in this analysis.
3. The indicators on top can include: age, age of sexual initiation, number of sex partners to date, whether uses condoms (always, sometimes, never), number of sex partners in the last month (or three months), number of times had sex in the last month, whether had a pregnancy/made a girl pregnant, etc.
4. These indicators can be selected and kept ready beforehand. Additional questions or indicators can be added as the discussion progresses. Some may even be dropped. The participants can also be asked to suggest the indicators.
5. Ask the participants to fill up the row against their name with their own particulars in each of the cells.
6. Once everyone in the group has filled up the information on the sheet, aggregate the information and discuss the same with the participants. Ask questions like – Is this representative behavior? Is this behavior different for different categories of people? Does it vary by age? By gender?

It is possible that some of the participants feel shy in front of the others and hide some information. It is also possible that some may exaggerate in order to show off in front of their peers. Sensitive facilitation is very important for getting meaningful results from this exercise.

Following is an example of the open sex census method. Given the personal and sensitive nature of this information, the names of the participants have been withheld.

PARTICIPATORY SEX CENSUS

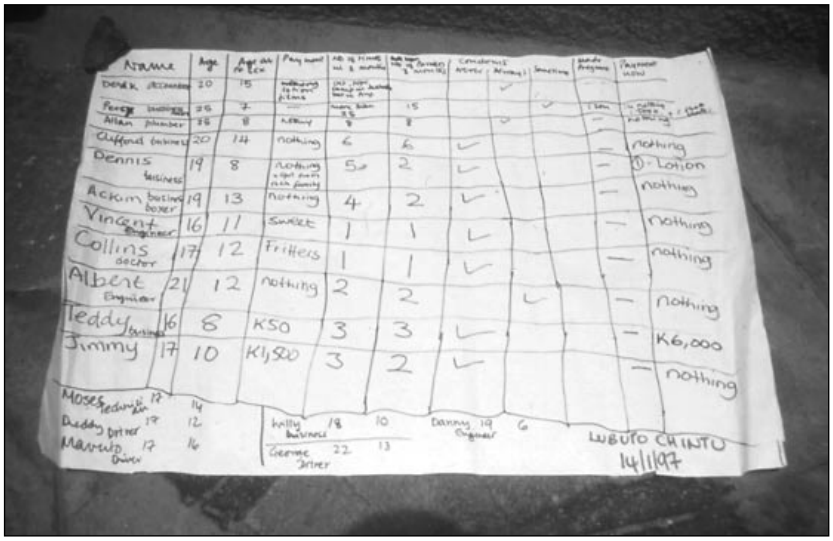
(Analyzed by a group of boys in New Twapia Compound, Ndola, Zambia)

Name (not mentioned here)	Age	Age at first sex	Age at second sex	No. of times sex in the last 3 months	No. of sex partners in the last 3 months	Ever had an STI	Condom use: Never	Condom use: Always	Condom use: Sometimes
1	15	10	11	4	2	No	X		
2	15	11	14	1	1	No	X		
3	15	10	13	24	1	No	X		
4	18	10	12	2	1	No			X
5	14	11	12	15	3	No	X		
6	17	7	12	10	7	No	X		
7	18	15	17	30	1	No	X		
8	15	13	14	3	3	No		X	
9	18	12	13	5	3	No	X		
10	14	7	12	Nil**	1	No	X		
11	17	13	16	2	2	No			X

** He has a girlfriend, but he has not proposed to her so far.

One of the important results from the above analysis was that though some boys may be initiating sex as early as 7 or 10 years of age, there tends to be a fairly big gap before they have sex for the second time.

Among other results, it can be seen that all the boys in this group had initiated sex. Only one of them had not been sexually active during the last three months. Eight out of the eleven boys had never used a condom. Only one of the boys uses a condom regularly while two others do so sometimes. None of these boys had ever had a STI. Five of the boys in this group had sex with only one partner during the last three months, while two had two partners each, three had three partners each and one had sex with seven partners.



Participatory sex census. Lubuto Chintu, Zambia

2.13 Picture stories/cartooning

This tool can be used to get a more in-depth understanding of sexual behavior and to triangulate the results obtained on the subject from other discussions. This is a simple technique, where the participants are asked to prepare, individually or in a group, a pictorial presentation of sequence of events that are likely to take place in a person's life. We can also ask them to prepare a picture story on what happens when a boy and a girl start a relationship, or how a couple negotiates the selection, or use, of contraceptives.

Most of the stories that the adolescents prepared, across different compounds in Zambia in gender-segregated and mixed groups, had nearly the same theme and sequence. This was quite an experience for us (the facilitators). Nearly all the stories had boys approaching the girl for friendship which very soon turns to be a sexual relationship. After having sex the girl asks the boy for money, or the boy gives it before he can be asked. The girl becomes pregnant and faces the negative consequences. The repetitive pattern of the story did imply that this sequence must be common. More disturbing was the learning that, in general, the boys and the girls do seem to be aware of the negative consequences of early sexual activity, and yet the practice persists.

A group of girls engrossed in preparing a picture story. Zambia

Once the stories were prepared, we asked several questions in order to triangulate the information as well as to understand whether these stories were based on hearsay or were based on personal experiences. Our questions included:

- After how much time of knowing each other do they have sex?[26]
- Where are they having sex? At what time?
- How much time does it take to have sex?
- How long will this relationship last?
- How old is the boy? How old is the girl?
- Will she tell anyone about this experience? Will he tell anyone about this experience?
- With how many boys will she have such a relationship? With how many girls will he have such a relationship?
- Is money always paid by the boy after sex? Is there any other form of payment?

It is not possible to prepare these questions beforehand, as they should relate to the responses from the participants.

On the last day in Chawama, after we had wound-up the field work, the facilitators met at the clinic to discuss the results. While we were busy with our discussions a large group of 10-13 year old schoolgirls turned up at the clinic and said that they wanted to continue the discussions with us. Not wanting to hurt them by asking them to go away, we gave them a sheet of A-4 size paper each and asked them to sketch a day in their lives. They were all asked sit separately and to draw their own routines.

In disbelief we looked at the filled-up sheets. Only one of the 36 girls who took part in the exercise had drawn her daily routine, like sweeping, helping her mother prepare breakfast, going to school, playing with friends, etc. All the rest, 35 of them, had written a story, which ran something like this:

"When I was washing dishes outside my home a girl approached me and said that there is a boy interested to be friends with you."

The girl and boy are introduced. The boy says he wants to be her friend. The girl agrees. They decide to meet again. The boy gives small gifts or money. After two or three meetings the boy suggests having sex. The girl refuses. The boy tries again. The girl refuses. He persists. The girl refuses. End of story.

We asked two or three of them, separately, to tell us what happened afterwards. The girls did not say anything. We asked if they would like to draw what happened next. They refused. We did not persist.

It is possible that all these girls drew a girl-boy relationship sequence, instead of a simple daily routine, because of the influence of the discussions that we had on the subject with them earlier. However, we had not asked them to prepare a picture story earlier. Even then, getting nearly the same story and sequence of events from 35 out of 36 girls was a mind-blowing experience for us. We were stunned for quite some time.

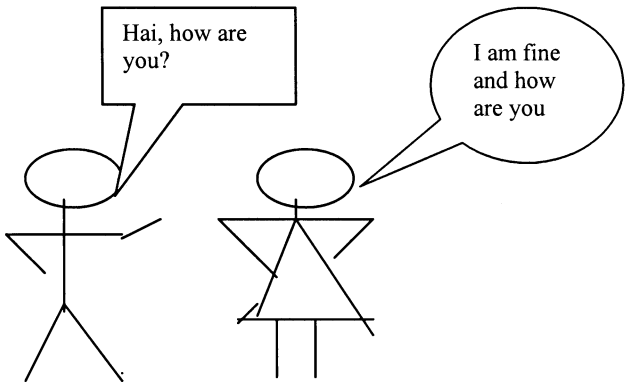
From the field notes of Meera Kaul Shah, Chawama Compound, Lusaka, Zambia.

Following is a copy of one of the picture stories prepared by a group of boys from the M'tendere Compound.

MARY AND JOHN: A PICTURE STORY

Prepared by a group of grade seven schoolboys, M'tendere Compound, Lusaka
(Copied from the original. The original was drawn on large sheets of paper)

1. A boy coming from school ....



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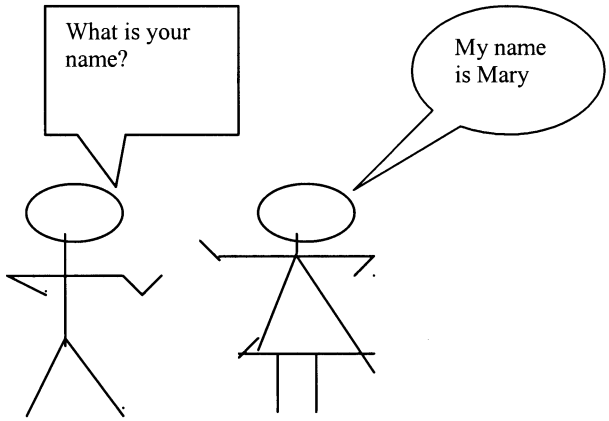

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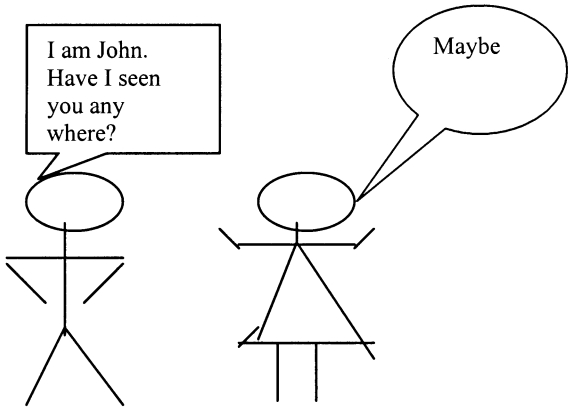
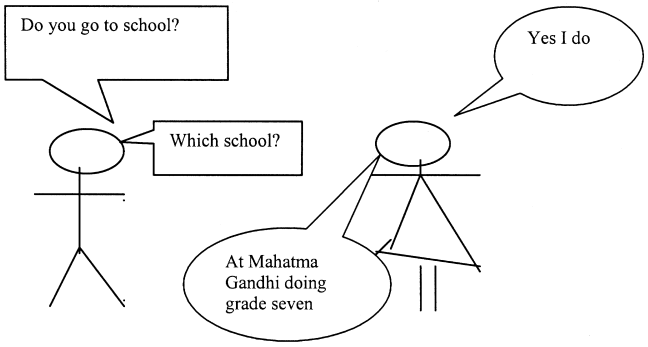


Part 3

MARY AND JOHN: A PICTURE STORY (cont.)

4.



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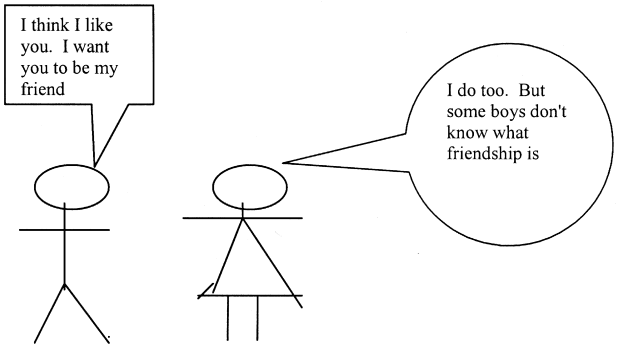

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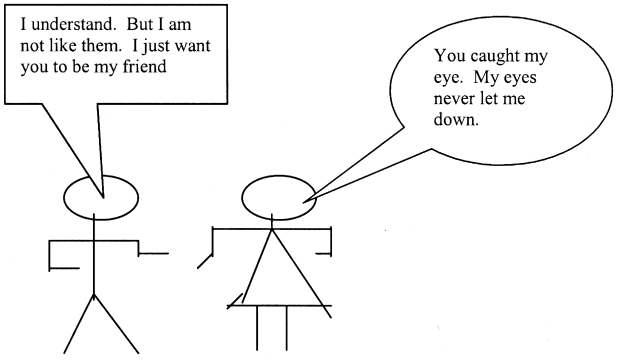
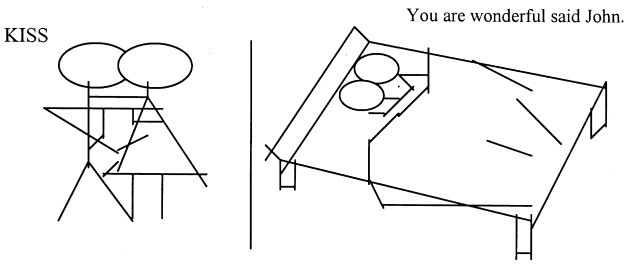


7.

After two months John and Mary had sex



2100 hrs

John's bedroom

Part 3

MARY AND JOHN: A PICTURE STORY (cont.)

8.

1. After that night Mary asked for some money so that she can go and use it for breakfast at school.

2. John gave her 1000 Kwacha. After that John never saw Mary again and she never heard from him again.

3. She had a new boyfriend. After two weeks of sex she discovered that she was pregnant.

4. She was expelled from school. She did not know who the father of the child was.

5. She had an abortion. As the result she died.

6. John finished school. He had a good job and a good wife.

The above story enabled the facilitators to initiate a long discussion on relationships between boys and girls and why they get into these situations, when they know that it could lead to a negative outcome.

2.14 Semi-structured interviews (SSI)

This section draws from Pretty et. al. (1995:73-76).

Semi-structured interviewing (SSI) can be defined as :

> "Guided conversation in which only the topics are predetermined and new questions or insights arise as a result of the discussion and visualized analysis."

Central to all good participatory research and development is sensitive interviewing. Without it, no matter what other methods are used and applied, the discussion will yield poor information and limited understanding. Developing effective interviewing skills is difficult as it largely depends on self-critical awareness, perceptive listening and careful observation. These qualities take time and effort to acquire.

There are seven core components to SSI:

1. *Preparation:* preparing an interview guide or check list of issues to be discussed.
2. *Interview context:* the interviewer has to be aware of the importance of timing, duration, setting, body language, biases, etc., that can influence the interview.
3. *Sensitive interviewing:* involves sensitive listening and an open attitude.
4. *Sensitive questioning:* asking open ended and non-directive questions, and carefully probing the responses.
5. *Judging and cross-checking responses:* by cross-checking and verifying responses.
6. *Recording the interview* (see Part 3, Chapter 3 on documentation).
7. *Self-critical review:* to assess the effectiveness of questions asked and whether the interview was influenced by the facilitator in any way.

SSIs are useful for discussing topics like individual sexual behavior and attitudes. This analysis compliments the general analysis carried out in groups using visual methods. Some of the issues that can be discussed during SSIs include:

~ *Sexual behavior:* age at which she/he first had sex; with whom; reasons for the same; frequency of sex and number of partners; why were partners changed, whether she/he receives or gives any gifts or payments in exchange for sex; use of contraceptives; who decides the use of contraceptives; etc.

~ *Their source of information on sex:* where they get information on reproduction and STIs, including from where and whom do they seek help regarding reproductive health.

~ *Attitudes towards sex:* number of sex partners; use of contraceptives; how they make decisions; etc.

2.15 Focus group discussions (FGD)

FGDs are small group meetings for discussing a specific topic. These are conducted in an informal setting where all the participants are encouraged to present their views and opinions.

During a PLA exercise, a focus group discussion takes place with women on their priority reproductive health needs. Rwanda

FGDs play an important role in a participatory appraisal process. It is difficult to use any of the visual PLA methods without first starting with a FGD. Even after the visual is ready, it needs to be discussed. The main issues arising from the analysis need to be clarified, and there can be several questions arising from the visual analysis that need to be discussed. FGDs can also be used to discuss visual outputs prepared by another group in the community. Sometimes this works out to be an excellent method for triangulation.

Sensitive facilitation skills, with the ability to listen and ask probing questions, are important for facilitating a FGD.

The ideal group size for facilitating a FGD is between 7-12 participants. However, group sizes can be very large during participatory appraisals. The visual analysis can be prepared and discussed in a large group, followed by more in-depth discussions on selected topics in smaller groups. The smaller groups could be self-selective, or the facilitators could ask them to divide according to gender, age or any other criteria appropriate for the context.

Facilitators play a key role in introducing a topic for discussion and in asking probing questions. It is best to allow the group to discuss the issue among themselves, without interrupting them too often. The facilitator should be able to listen attentively, take notes and observe the participants.

This method is central to any participatory appraisal process. Some FGDs can be planned well in advance and people can be invited for discussion at a fixed time and venue. However, very often we may have to start a FGD when we see an opportunity, e.g., if we find a group of 14 year old boys outside a video shop, we can invite them for a discussion right then and there.

2.16 Case studies, stories and portraits

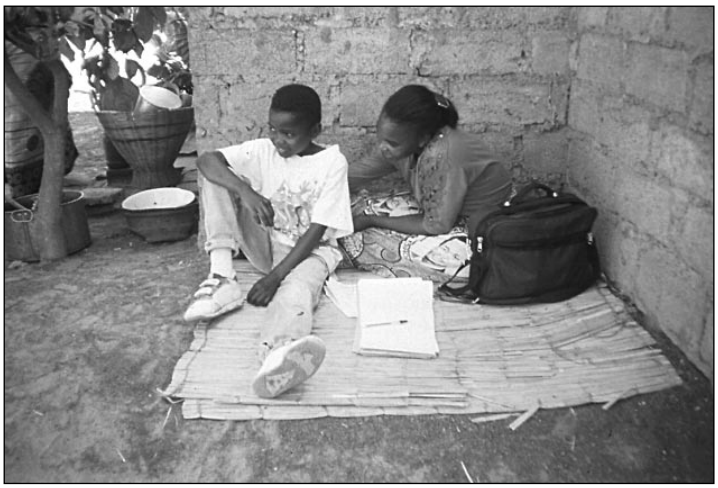
Anecdotes, individual life histories or the description of a significant event in a person's life that may come up during discussions provide a valuable insight on the issues being discussed. Most visual methods of analysis provide a group's or an individual's perception on an issue. Individual experiences and testimonies can be used to support the results from group analysis. Usually these experiences are heard but not recorded by the facilitators.

> The boys in the school frequently ask the girls in the same grade for sexual favors. "Sometimes they only want to touch some parts of our body and sometimes they also pinch us. They also ask us to have sex", explained a group of 9-15 year old schoolgirls, and added, "When they ask us to have sex, we have to agree."
>
> "Why do you have to agree?" we wanted to know.
>
> "Because if the girl refuses, the boy will not help her with homework, and may refuse to lend her a pencil when she wants one."

Source: Field notes of Meera Kaul Shah, Chawama Compound, Lusaka

> We were discussing the use of condoms with a group of boys. Since some of them had mentioned that they do use condoms, we wanted to know where they obtained the condoms from and whether they purchased them. There was some laughter as the boys replied, "No, we don't buy them. We make them ourselves!" Naturally we were curious to know how they did that.
>
> "It is simple. We take the empty plastic covers of ice-blocks [ice-candy] and use them like a condom. They have to be tied with a string on the penis".

Source: Field notes of Mary Simasiku, George Compound, Lusaka



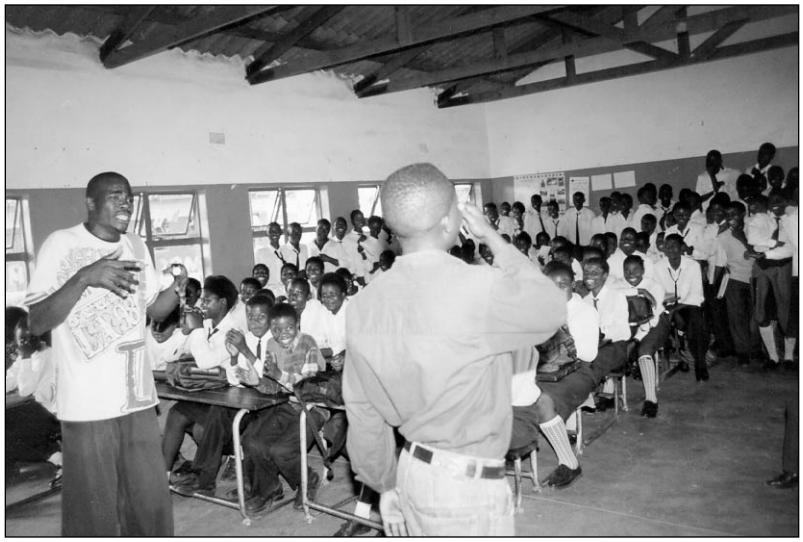
Christine, a member of the Neighborhood Health Committee, has a one-to-one discussion with a boy from the compound. Zambia

2.17 Role-plays

Role-play is an enacted presentation of a real life situation. Participants can present their own experiences or those of which they have heard or seen. Role-plays can vary from very short sketches, which present an event or a character, to longer ones which may cover several aspects of a theme.

Role-play helps in building rapport with the group as well as in boosting their self-confidence. Usually role-plays are fun and provide an opportunity to understand other people's view points.

Sometimes role-play takes up too much time, especially when the participants feel hesitant to take part. Some may find it embarrassing and threatening to expose themselves in front of others. It is best not to impose, but the facilitator should try to explain the objectives of such an exercise and its use.



Volunteers enact a sequence at school, in order to start a dialogue with younger school children on the negative impact of casual sex. Zambia

Role-play should be followed by a discussion on the presentation by which the problem or issue is analyzed and their solutions are discussed.

During the participatory appraisals with the adolescents in Zambia, we had several impromptu role-playing sessions presented by the adolescents. Usually they depicted how boys approach the girls, and the consequences they face after they are involved in a sexual relationship. Another common theme of the role-playing was how the sugar daddies approach the young girls and persuade them to have sex with them. Adolescents enjoyed role-playing and it helped in building rapport with them. It was possible to initiate discussion on many sensitive subjects after these issues were presented in role-play.

Role-play continues to be used as an effective communication medium by the adolescent peer counselors during the implementation phase of the PALS project.

CHAPTER 3

TACKLING DOCUMENTATION, ANALYSIS, SYNTHESIS AND REPORT WRITING[27]

Meera Kaul Shah

3.1 The challenge of documenting a participatory process

Documentation and synthesis of information generated during a participatory appraisal is a very important part of the process. Often this is where the facilitators have most problems (Shah and Shah, 1995). Problems in documentation and reporting arise because:

- Fieldworkers are often more comfortable with, and are more used to, the verbal mode of communication.
- Facilitators are not used to taking notes in the field, and have to be continuously reminded about it, at least in the beginning.
- Usually a participatory appraisal process provides an opportunity for enormous learning. Given the way we learn so many new things, at an unbelievably fast pace, it is very easy to get carried away while following the discussions with the community and to forget recording the same.
- Very often the documentors find it difficult to separate the participants' analysis and views, from their own judgement. This can create a lot of confusion later, while synthesizing the information.
- Fieldworkers often lack the necessary analytical and writing skills, especially if they have not been trained in this field. Usually their work does not require them to have such skills.
- Analyzing and documenting information generated through a participatory process is far more difficult as compared to that using a more conventional method (like questionnaire surveys).

3.2 Three stages of documentation

There are three levels at which documentation takes place during a participatory appraisal:

1. taking field notes;
2. preparing daily reports; and
3. writing the synthesis report (for every community/site where the appraisal was carried out, and if several communities are covered, an overall synthesis report as well).

3.2.1 Recording field notes

Proper recording of all the discussions and the visual outputs is of crucial importance in the documentation process. This is the basic data that can be used for analysis and synthesis. Given the huge quantum of information and analysis that is generated during an appraisal it is very easy to lose and forget a lot of it, if it is not recorded immediately in the field. It is for this reason that the role of the documentor is very important in the team. The following should be kept in mind while recording field notes:

- It is good to start by requesting permission from the participants to take notes.
- Use a small notebook for taking notes in the field.
- If for any reason it is not possible to take notes during a discussion, this should be done at the first opportunity available. It is impossible to recall any discussion in full, and important points may be lost if the recording is left for long.
- Record all discussion, debates and disagreements during an analysis.
- Record key phrases and terminology in the local language.
- Ensure definitions of key terms used are elicited from the participants (see box on the following page).

DEFINING 'RAPE'

While discussing preferences for sex partners with adolescents in Zambia, a group of 9-15 year old schoolgirls mentioned that they don't like having sex with grown up men, even though they do give better gifts and more money in return. The reason being that older men rape the girls when they have sex. Not quite understanding how they called it rape, since it was mentioned that the girl would be willing to have sex with the man, we asked what they meant by 'rape'. "Rape is when an older man has sex with a much smaller girl and in the process tears her vagina … the vagina tears because it is small and the man's penis is large", it was explained.

'Rape' had nothing to do with 'forced sex' the way we understood it to be.

Source: Field notes of Meera Kaul Shah, Chawama Compound, Lusaka

~ Carefully copy all visual analysis on A-4 size paper.

~ Don't try to 'beautify' the visual. Try and retain as much of the original features as is possible (e.g., if the lines drawn on a map are not straight, don't try to straighten them while copying).

~ Record names of all the participants on the visual outputs. In some situations, especially while analyzing sensitive topics, the participants may not like their names to be recorded. Also, the facilitators may decide in some situations that it is too sensitive to record the names. If it is too sensitive to ask for or to record the names of the participants, record the number and composition of the group.

~ Record who participated in the analysis – older men, younger women, children, boys not in school, better-off women, etc.

~ Record the date, time and place.

~ Don't make visuals of your own. If you are presenting data that was only discussed verbally – it is best to write in a narrative style. If you do make visuals in your notes (presenting discussions for which the participants did not prepare a visual), state clearly that this is your presentation and not that of the participants.

~ Don't forget that the analysis is not complete until the visual is interviewed. Probe and ask questions after the participants have finished preparing the visual. Record the questions asked and the responses given. If there are any arguments or disagreements among the participants, these should be recorded as well.

~ Be careful to be factual while recording. Record what was said or explained, rather than what you think was implied.

~ It is important that the responses are judged according to the type of information that is being shared. Information can be divided in three categories:

FACT - a commonly agreed time and place a specific truth

OPINION - a person's or a group's view on a particular topic

RUMOR - unsubstantiated information from an unknown source

(Source: Sam Joseph, cited in Pretty et. al., 1995: 193)

Hence, it is useful to mention which information was triangulated, and how, and that which was only stated by a group or an individual.

~ While recording the visual outputs, make sure to have notes on the symbols or methods they have used (e.g., if using ranking, explain whether 1=best or 1=worst, etc.).

~ Any stories, anecdotes or case studies should also be recorded as these provide supporting information to the analysis carried out in groups.

~ Any observation should be recorded separately.

3.2.2 Preparing daily reports

It is important to review the appraisal process on a daily basis. After completing the fieldwork for the day, the facilitators must meet to reflect on the day's process and to share their experiences with each other. Daily reviews are important, especially when the facilitators are divided into several teams and work in different locations with separate groups from the community. This review makes it easy to triangulate and analyze the results. This can also be used as an opportunity to give feedback to each other.

Once the outputs are shared, the team should divide and share the responsibility for writing up the process notes for the day. All the analysis carried out in the community should be written and the visual outputs copied with proper explanatory notes. Having lots of visual outputs with no explanation renders them of little use. *(Note how examples in these* Guidelines *have explanatory notes without which many of them would have conveyed little meaning to the reader.)*

Wherever there is any quantification, aggregate the data (e.g., total number of households, or female-headed households shown on a map, or the distribution of households according to the wealth/well-being categories, etc.).

These daily reports should be ready before the start of fieldwork the next day. All reports should be collected by one person and kept together in a safe place.

The daily review also helps in reflecting on the progress made and in planning for the next day's fieldwork. Information that needs to be triangulated can be identified, and issues not explored so far can be included in the next day's plan.

3.2.3 Synthesis reports

Synthesis reports are written at the end of a participatory appraisal with a community. Synthesis reports are more difficult to write as they have to take into account a variety of information generated in a variety of different ways. Often it is this analysis which proves to be the most difficult part of the participatory appraisal process. The necessary analytical skills have to be acquired in order to be able to use the results effectively. Unless the documentation is carried out properly, and in a disciplined manner, there is always the danger of missing out on learning from the process which would allow one to begin planning and designing activities with the community in the future.

Before the report can be written it is necessary for all the facilitators to review the process together. All daily reports should be analyzed before conclusions are reached. The best way to start is to revisit the checklist of issues used for the fieldwork. All the information available on each of the topics should be analyzed. Any new themes or topics that may have emerged during the appraisal, and not listed in the checklist, must be added.

It is important to bear in mind that the final report need not give single statements as results on a particular topic. It is quite common to get multiple responses on a topic that do not match. These will depend on the diversity within the community. The synthesis report should reflect this diversity. It should also clearly indicate results which cut across the different groups within the community.

The synthesis report should present all these major findings and only at the end should the facilitators give their views and deductions separately.

In case there are any gaps in the information, or some questions have remained unanswered, state this clearly in the report. Do not give your own views on a subject that was not analyzed with the community.

3.3 Sharing the results

It is best to share by reporting back the findings from the appraisal process to the community before the synthesis report can be considered final. This can be done in a large gathering in the community, or if the community is too big (as is often the case in urban settlements) several such presentations can be made with different groups within the same community.

Writing the daily report for a Reproductive Health PRA conducted in Tana, Madagascar.

Such a process provides an opportunity to verify and triangulate the results; as well as to keep the community involved in the synthesis process.

The same meeting can also be used to discuss the next steps to be taken with the community for planning different activities that could be supported there.

ENDNOTES

(1) In October 1997, the Health and Population Unit held an international conference for project staff from CARE's global health and population program to review best practices in reproductive health programming. Prior to the conference, each of six task forces reviewed the literature and CARE experience in a specific programmatic domain, and then presented findings and recommendations for programming directions at the conference; community participation was one subject area.

(2) Stan Burkey is an experienced NGO field-worker who recently wrote People First: A Guide to Self-Reliant, Participatory Rural Development. detailing his reflections on self-reliant, participatory rural development. See the reference list for the book's citation.

(3) 'Area' here refers to between 12-15 villages that may fall under one group village headman.

(4) Preparatory dialogues were held earlier with both the group village headman (to inform him of the purpose of the exercise, gain his cooperation, and to arrange the meeting), and CPAR, a NGO that undertakes health-related activities in the area, with whom CARE is cooperating.

(5) See Meera Kaul Shah and Gladys Nkhama (1996) 'Listening to Young Voices: Participatory appraisal on adolescent sexual and reproductive health in peri-urban Lusaka', CARE Zambia.

(6) Operations Research or action research involves testing various interventions with the client population through a quasi-experimental research design, and is quite often considered to be the pilot phase of a project before it is scaled up.

(7) Editors' Note: For an example of a PRA tool that has been specifically adapted for measuring reported prevalence of sexual behavior, refer to the description of the "sex census" in the Step-by-step guide to participatory tools and techniques in Part Three of these *Guidelines*.

(8) This Chapter has been adapted from Shah (1999).

(9) Chambers (1983) describes rural development tourism as the phenomenon of brief rural visits by urban-based development professionals leading to five kinds of biases: spatial (visits to villages closer to the cities and on the roadside to the neglect of interior regions); project (visiting areas where projects are being implemented); person (meeting the elite rather than the poor, men rather than women, the articulate, etc.); seasonal (visiting during the cool and dry rather than the hot and wet season); and diplomatic.

(10) Chambers (1997) continues to use the label PRA.

(11) These methods are explained in detail in Chapter 2.

(12) This is an important shift. Most of the PLA methods require diagramming and preparation of visual presentations by the community. Visualisation enables the shift from the 'closed' to the more 'open' means of communication. Preparing maps, models, diagrams and using counters (like seeds, beans, stones, etc.) for quantification and ranking enables more people to see and participate in the analysis. Preparing these visuals on the ground also means that there is no direct eye-contact between the facilitators and the local people. Their eye-contact is at the ground-level, on the visual. This helps in building confidence among the community to carry out their own analysis as well as in building rapport with them. Since several people participate in preparing and analyzing a visual, it is easy to triangulate the information.

(13) In this part of the field guide, we focus mainly on the use of these methods during a participatory appraisal process. The same methods are also applicable and adaptable for monitoring and evaluation purposes.

(14) Facilitating participatory development processes in a community requires appropriate skills. While most experienced fieldworkers find it easy to initiate dialogues with individuals and groups, they find it more difficult to introduce the use of visual methods of analysis. It helps to start with providing some training to the facilitators. If possible invite someone with experience of using PLA methodology to conduct training and to provide support during the first fieldwork. This makes learning easier. However, if it is not possible to get any external help, you can always start on your own with the help of reference material like this guide. A good understanding of the PLA methods and process comes only with practice in the field.

(15) Participatory mapping and other PLA methods are explained in Chapter 2.

(16) At this stage the PALS project did not exist. In fact, in the beginning we did not even know whether any new project would emerge from this interaction at all, or indeed what it would look like. This flexibility, of allowing the project framework to emerge from the participatory appraisal is an important element of the process. Having available flexible funding in the initial stages significantly strengthens the participatory process.

(17) Section 1.12 has been adapted from Kambou (1999).

(18) Active listening includes: paying attention when someone is speaking, allowing others to complete whatever they want to say and not interrupting, and not having conversations on the side during a group discussion.

(19) Usually six helpers are listed (see Pretty et al., 1995). I have added 'how much'. I feel that very often we place a fictitious constraint in qualitative fieldwork of not being able to quantify. In my experience local people, including the non-literate, have no problems in carrying out most types of basic quantitative analysis.

(20) This chapter has been adapted from Shah (1999).

(21) This list is by no means exhaustive. There are several other PLA methods, which are used in other contexts, but were considered inappropriate for our topic and hence are not discussed here.

(22) Examples given in this chapter have been taken from the PALS project for adolescent sexual and reproductive health, being implemented in peri-urban Zambia by CARE.

(23) A map, or any other visual analysis, prepared on the ground enables more people to participate in the process and to observe it. Using local material also makes the participants feel free. It is also easier to make corrections on the ground as compared to that on paper.

(24) This version of census mapping can also be prepared on the ground by making a grid, which has one cell for each of the households. Then using locally available materials these cells can be filled with the information for each of the households.

(25) Korrie is the brand name of a popular vegetable oil, sold in 20 liter tins. The empty tins are cut and used for roofs.

(26) We also asked questions to clarify whether it is 'playing at sex' or 'penetrative sex' that they were discussing

(27) This chapter draws from Shah (1999), Listening to Young Voices: A Field Guide for Facilitating Participatory Appraisals on Sexual and Reproductive Health with Adolescents (CARE International in Zambia and FOCUS on Young Adults)

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