A Rough Guide for CBOs: Participatory approaches to working on sexual and reproductive health and human rights to promote safety in the context of gender-based violence in communities

1. Introduction

There is a deeply ingrained assumption amongst many development workers that groups of rural communities are fairly homogeneous, with similar outlooks, problems and needs. It is also assumed that female-headed households and people with disabilities are even poorer and more vulnerable than others and are in need of special help. Neither of these statements is necessarily true. Rural communities are rarely homogeneous and the poorest do not always have the same characteristics. Participatory Learning Approaches (first known in the early 1990s as Rapid Rural Appraisal (RRA)) can help us to recognise these fallacies.

Many development agencies are concerned about the extent to which assistance really reaches most vulnerable groups. Two tasks facing them are to identify which people are falling through the safety nets and then to work out if and how they can develop programmes which can effectively and sustainably ensure improvement in their wellbeing. Until the complexities of intra-communal life are recognised, there will be scant chance of success with either of these two tasks. RRA techniques, allow us to study intra-communal difference effectively.

This document is a compilation of extracts from various materials that have been published over the past 25 years regarding sexual and reproductive health and human rights to promote safety in communities that are struggling with issues around gender based violence. It describes various approaches, concepts and tools which have been of use to understand the following:

- **Community Diversity:** different diverse groupings in any community (including those based on gender, age, socio-economic well-being and more)
- **Community Priorities:** different priorities of diverse groupings and how these differ from one another, as well as how they differ from those of the CBO working with people in communities
- **Diverse Community Knowledge:** the knowledge that local communities have is rich and complex and is based on a vast range of different issues.

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2. **Techniques described in the Annex include:**

In this document, in the left hand margin there is an icon for bookmarks. Each bookmark is labelled with a number and the title, which corresponds to this chart below, for easy reference. You can also view the bookmarks by going to "View" then "Navigation Panels" then click on "Bookmarks" to move up and down to different pages.

DIAGRAM TYPE	THEY CAN HELP US & COMMUNITY MEMBERS TO UNDERSTAND:	EXAMPLES IN THIS DOCUMENT
Mapping exercises	how different groups in the community see and prioritise their surroundings and relevant issues	1a, 1b, 6a, 13c
Seasonal calendars	how events such as GBV can be related to seasonal variations in e.g. rain, food security, access to income, etc.	1c , 2a, 2c, 3Bb, 10
Cause and consequence flow charts	how diverse issues are inter-connected and can have both positive & negative - & unforeseen/unintended consequences	3Ba, 4d, 6c
Labour charts	how many different tasks women do, how much time this takes – and how little men often realise this	4c
Time lines	how our lives are full of highs & lows & which particular incidents can have huge consequences for us; future events planning	6f, 12c
Transect walks	how many diverse issues in the landscape can affect our lives. E.g. in Malawi only by walking around with women did we realise that all the trees around the village were for men for tobacco curing – the women had to walk much further for fuelwood – and they faced increasing tension with neighbouring communities for this scarce essential resource. This was in turn causing stress at home when meals were not cooked on time… [No images available for this activity]	
Well-being ranking exercises	community members' perceptions of well-being & status vs poverty & exclusion	1d, 1e
Chapatti diagrams (to determine decision-making structures and information flows)	women's and men's respective perceptions of their (lack of) decision-making capacities	2d, 3Ad, 5Ba
Organograms to analyse male/female ratios in organisational hierarchies	how the number and seniority of women in an organisation can have a significant effect on its ability to create a gendered environment	4g
Vision trees & strategic planning charts using drawings	strategic planning exercises using an easily accessible & widely recognised metaphor	5Bf, 8, 12b
Priority ranking	how different issues have greater or lesser importance	2b, 3Ac
Diagrams of organisational planning structures	how different planning structures are more top-down or more participatory	3Aa

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Force field analysis	negative and positive factors to move forward to where we want to be	3Ab
Barriers and solutions analysis	how barriers can be turned into solutions – challenges can be seen as an invitation to think creatively	3Bc
Community gendered institution analysis	how males and females have different labour spheres	4a
Pros and cons of being female	women's own perceptions of their sex and gender roles	4b, 5Bd
Triangulation charts	to compare assumptions or findings between organisations and NGOs, or between genders	4e, 5Be, 6d, 6e
Methods analysis chart	who was involved in which method, by gender & numbers.	4f
Necklaces for monitoring	sexual health issues by encounter	5Bc
Textual analysis	the complexities of any issue	5Bg
Drawing of events	what issues are of concern in a community	6b, 7a
Participation and language	how meaningful participation of those most affected by an issue is key in finding the solutions; and the importance of positive language & solutions-focused thoughts and actions	9,11,12a,
SMART & SPICED Indicators	how to involve diverse community members in setting their own indicators	12e
Ability spotting	the immense skills and resource diverse community members already have	13a
Human rights	human rights – what they are and how important they are in upholding our safety, SRH&HR and well-being	13b
Other techniques, including role-play, statues of power, tableaux, games….	how people feel, think, act in relation to many diverse situations in their lives – and the connection of all these to their SRHR, GBV, HIV and well-being.	Further references to training manuals and films with examples of these on request

These techniques are a small taster of the vast amount of information and tools that are available to work with communities to understand perspectives and challenges of people in communities: to help others put themselves in our shoes – and to place ourselves in someone else's shoes.

The beauty of these tools and drawings is that they enable anyone to take part, without the need for reading or writing. Intelligence and education are ***not*** the same thing and many people with limited or no literacy have often been excluded from development projects, yet, once engaged in this way, can produce highly creative solutions to issues they face. This technique allows people to express their knowledge and ideas clearly and also begins the process of change through enabling them to feel socially included.

A note of caution: from problems to solutions-oriented thinking Many of these exercises in this volume focus on *problems.* This is how people often think it's best to address an issue – by first identifying the problem which is important. You will see that later articles in this document try to focus instead (wherever possible) on ***solutions*** and how these have been reached. This is based on recent research, which recognises the power of positive thinking (which we often find much

harder!) to produce better ways forward. For example: Instead of saying "their needs and concerns are xxx, we could say their visions and dreams are YYY".

Nonetheless many of the techniques described throughout this document can still be used to look at possibilities rather than problems. This just requires a shift in thinking and framing the question from our side. For instance instead of asking people to draw a problem map, community members can be asked to draw a map of what their *safe* community could look like in 5 years' time – and where there are particular differences from the current situation. Thus the creative ideas start to flow and the journey of change begins.

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3. PLA Notes semi-special issue on HIV and AIDS (special edition starts on p76)	ed. Alice Welbourn	PLA Notes Issue 23, pp.3–5, IIED London	1995	29 &77
4. Extracts from "The Myth of Community"	eds. Irene Guijt and Meera Kaul Shah	The Myth of Community, Practical Action Publishing	1998	103
5. PLA Notes From Reproduction to rights: participatory approaches to SRH (special edition starts on p122)	eds. Andrea Cornwall and Alice Welbourn	PLA Notes Issue 37, IIED London	2000	111 & 123
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2

RRA and the analysis of difference

Alice Welbourn

· Introduction

There is a deeply ingrained implicit assumption amongst many development workers that rural communities are fairly homogeneous groups of people, who have similar outlooks, problems and needs. It is also assumed that female-headed households and people with disabilities are even poorer and more vulnerable than others and are in need of special help.

Neither of these statements is necessarily true[1]. Rural communities are rarely homogeneous and the poorest do not always have the same characteristics. RRA methods can help us to recognise these fallacies.

Over the last year I have used RRA techniques in health-related research and have conducted RRA training courses in Western and Southern Africa and in Bangladesh. Whilst the technical exercises involved in this work were similar to those widely used by RRA practitioners elsewhere, I have aimed to use RRA as a method for identifying, exploring and analysing intra-communal difference; and as a means of training development workers to appreciate the importance of this to their work. I have done this by training around 15 workers together in one village at a time. They have been divided up, so that the women fieldworkers have worked exclusively with village women[2], the older male workers have worked exclusively with old village men and the younger male workers with young village men. All have conducted parallel exercises and enquiries and have produced similar - but contrasting - sets of results. But what is the relevance of this to development?

· The setting

Most rural communities are made up of people connected through kinship, patron-client and other close social, economic and political ties. Within each community there are biological differences of age and sex; and these are combined with and contribute to socially defined, economic and political divisions of status, ethnic background, caste or wealth. Most communities have traditionally attributed higher status to elders and to men: older people are 'naturally' wiser because they have been alive for longer... men are 'naturally' more authoritative than women because they are stronger... wealthier people are 'naturally' superior to poorer people because that is their place in the world and they command more resources... mothers are 'naturally' superior to infertile women, because they have borne children... and so traditional authority structures were defined. 'Natural' differences were - and often still are - inextricably connected with social differences and traditional community authority structures were socially constructed around the axes of age, gender and access to material resources.

[1] Those communities which do indeed have the most socio-economic homogeneity seem to be of displaced people who are in great stress. They have been separated from their lands and traditional access to other resources and are mostly facing the same predicament. For the most part they do not then function as a 'community' per se, but rather as a group of individuals. This article concentrates instead on traditional indigenous settled rural populations.

[2] Ideally, separate groups should have worked with older women and younger women - and children - but there have never been enough fieldworkers or time for this.

Source: RRA Notes (1991), Issue 14, pp.14–23, IIED London

Just as traditional western values have recently seen great changes, so rural communities in the developing world are also in a state of flux. Old men complain that their sons no longer hold their traditional values and run after money; marital breakdown and lack of financial support for child care are becoming commonplace and the gap between rich and poor is on the increase everywhere. There has always been tension between old and young, men and women in societies. But nowadays that tension is often far greater than it ever used to be. There is never a single root cause to all problems, but much the most major one is economic pressure. As economic pressures increase, as rural communities become ever more permanently linked to the outside world and as access to health, education and other services become matters of economic wherewithal, traditional community support structures start to break down with the strain. Increasing numbers of people fall through the community safety nets.

Many development agencies are concerned about the extent to which their assistance really reaches the most vulnerable groups. Two tasks facing them are to identify which people are falling through the safety nets and then to work out if and how they can develop programmes which can effectively and sustainably ensure an improvement in their well-being. Until the complexities of intra-communal life are recognised, there will be scant chance of success with either of these two tasks. RRA techniques, however, allow us to study intra-communal difference effectively, and I draw upon various applications in Sierra Leone, Ghana, Malawi and Bangladesh[3].

· The problem

- Whose problems? When development workers call a village meeting, those who attend are normally the male elders, who are the traditionally respected village leaders and representatives. Their opinions of the village's needs are asked and the community is then considered to have been consulted.

- Who decides? When development workers plan a new school or a new health clinic, the advice of the elders whom they first met is sought and their decision is heeded.

- Who gets left out? RRA course participants in Malawi, after carrying out field work were clearly able to state from their own experience that:

    - on the whole, the richest people do not attend meetings, or show us around, because they have little to gain from us and have their own means of access to resources;

    - the poorest people do not attend meetings or show us around because they think we are not relevant to their lives and they consider themselves inferior; and,

    - people who do speak in meetings and show us around are those who have more respect and self-confidence. They present their own outlooks, problems and needs. They come from above-average socio-economic groups of the community and do not represent the needs of the poorest.

These issues are important because we may assume that we are responding effectively to the needs of all the villagers. Usually we do not.

· Some analysis

The following case-study material from RRA exercises is presented to highlight four particular axes of difference in communities: age, gender, ethnic background and poverty. These are never clear-cut: in some communities one axis is more important than another. Yet it is helpful to identify each axis individually, to acknowledge its existence before returning to the whole picture.

[3] The material from Sierra Leone is reproduced with kind permission of the Liverpool School of Tropical Medicine from whom the research was conducted. The material from Ghana, Malawi and Bangladesh are reproduced with kind permission of ActionAid, for whom the author conducted RRA Training courses.

Source: RRA Notes (1991), Issue 14, pp.14–23, IIED London

The relevance of age

In a preliminary meeting at the beginning of some RRA work in a village in Sierra Leone, village elders, young men and women were all asked to come together to hear about the proposed exercise. They were asked what matters concerned them about their village and some old men began to reply. As they spoke, the young men suddenly got up and walked off, complaining as they went. On being asked what was the matter, they replied: these old men never represent us or our needs - they only talk about themselves and forget about us. What's the point in our staying? We then encouraged the young men to stay, promising them that we planned to spend some time specifically with them, in order to learn about their views. They agreed to stay and the meeting resumed.

The old men in that village were talking about a new bridge to get across the river to the satellite villages where their agricultural land is, and a new mosque; the young men wanted a school and football goal posts: a classic battle between the old times and the modern.

How do the development workers decide who to help? Not by ignoring their differences. The dispute which took place was an important part of our information gathering exercise for that village. Subsequent exchanges during the map drawing exercise and other activities underlined the tension between old ways and young in this and other villages around. In my view it is no coincidence that the greatest tension was apparent in the poorest village. Development workers need to learn to be receptive to these arguments. RRA, which encourages communities to speak out and show us their village, provides us with an excellent opportunity to perceive this accelerated breakdown in community coherence.

The relevance of gender

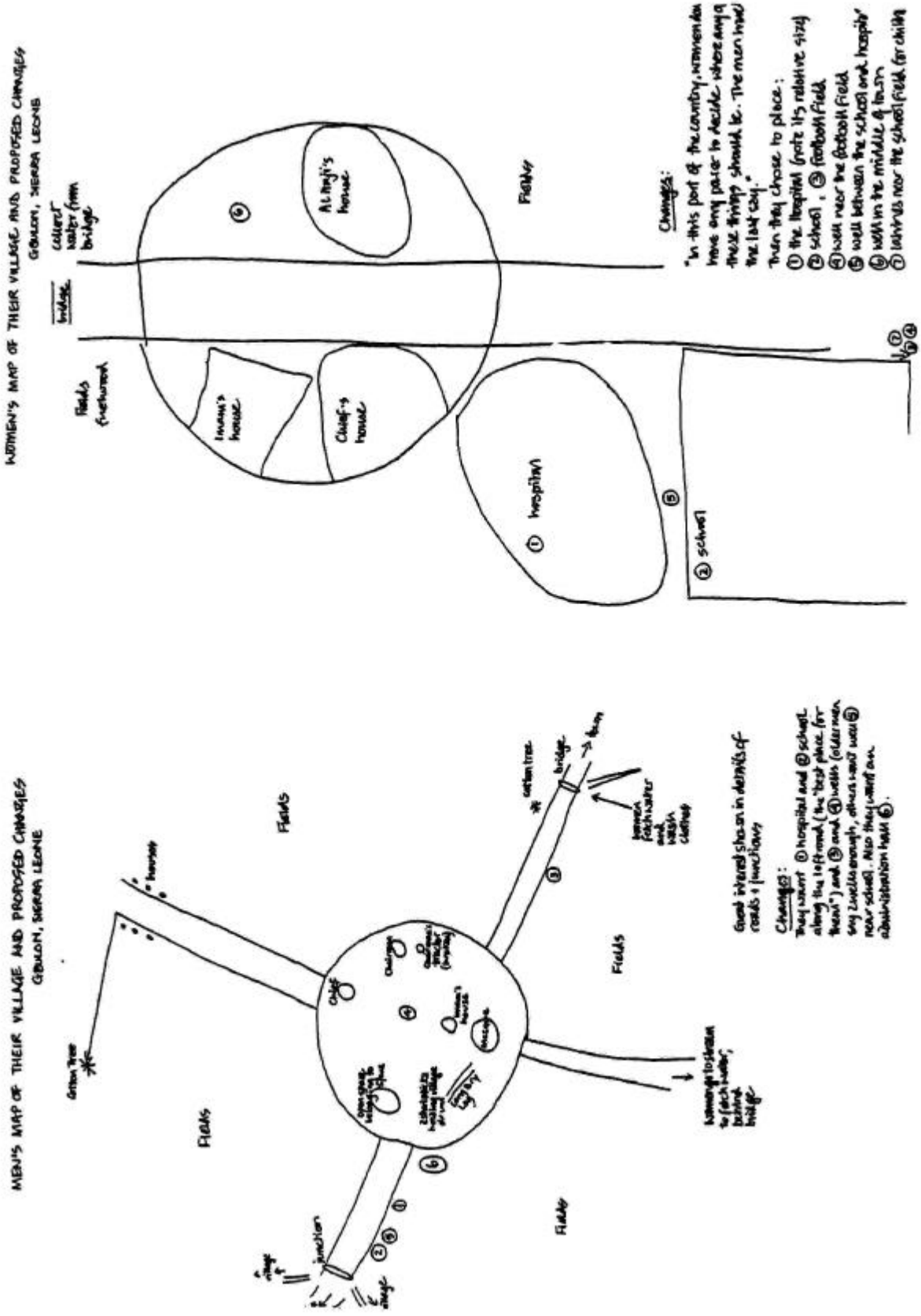
The two mental maps shown in Figure 1 are of one village, again in Sierra Leone. One is drawn by the men, the other by the women. When compared, various differences of perspective can be noticed. Men's maps, like the one below, often tend to reflect their contact with the outside world, their public and political roles in life, whereas women's maps reflect their domestic, more private activity sphere within the community. Men's maps tend to include all the roads which lead elsewhere from their village, while women's maps concentrate more on the village centre. Men tend to identify boundaries and objects of status, such as the cotton trees (reflecting the two separate clans which make up the village - it was from this map that we learnt of this), the (broken) chairman's tractor, the village drum and so on. Women did not show any of these. When asked to mark changes which they would like to see, men marked a series of buildings, lining the route of the main road leading into the village. The buildings would look very smart, prestigious signposts to their settlement. The nearest building to the centre was an administration hall. By contrast, the women, when asked to mark changes, first explained that this was not their role: "Women do not have any power to decide where any of these things should be. The men have the last say"; but when they were encouraged to pretend, they resolutely drew a huge hospital, close to the centre and of comparable size, followed by a school and wells to serve them.

In this part of the world, women take their children to clinics, if there is one nearby; and women would be the ones responsible for their children's school fees, if they were sent at all. Yet rare is the development project which asks the opinions of those who are most likely to use such services where they would like them to be situated. In another village, much poorer than this one, when women were asked to draw changes on their map, they replied: "We can't draw changes on this map, because the kind of changes we need can't be drawn". They had been telling me about overwork, breakdown in co-wife support and beatings from their husbands. How could drawings on a map help them?

The three maps in Figure 2, from Bangladesh, lucidly illustrate both generational and gender differences. The informants live as squatters on a government embankment beside a great river which is constantly eroding its sides. Their traditional lands lie below the water and they are now landless. The young men have to resort to migrant labour for many months of the year.

Source: RRA Notes (1991), Issue 14, pp.14–23, IIED London

Figure 1



Source: RRA Notes (1991), Issue 14, pp.14–23, IIED London

Figure 2

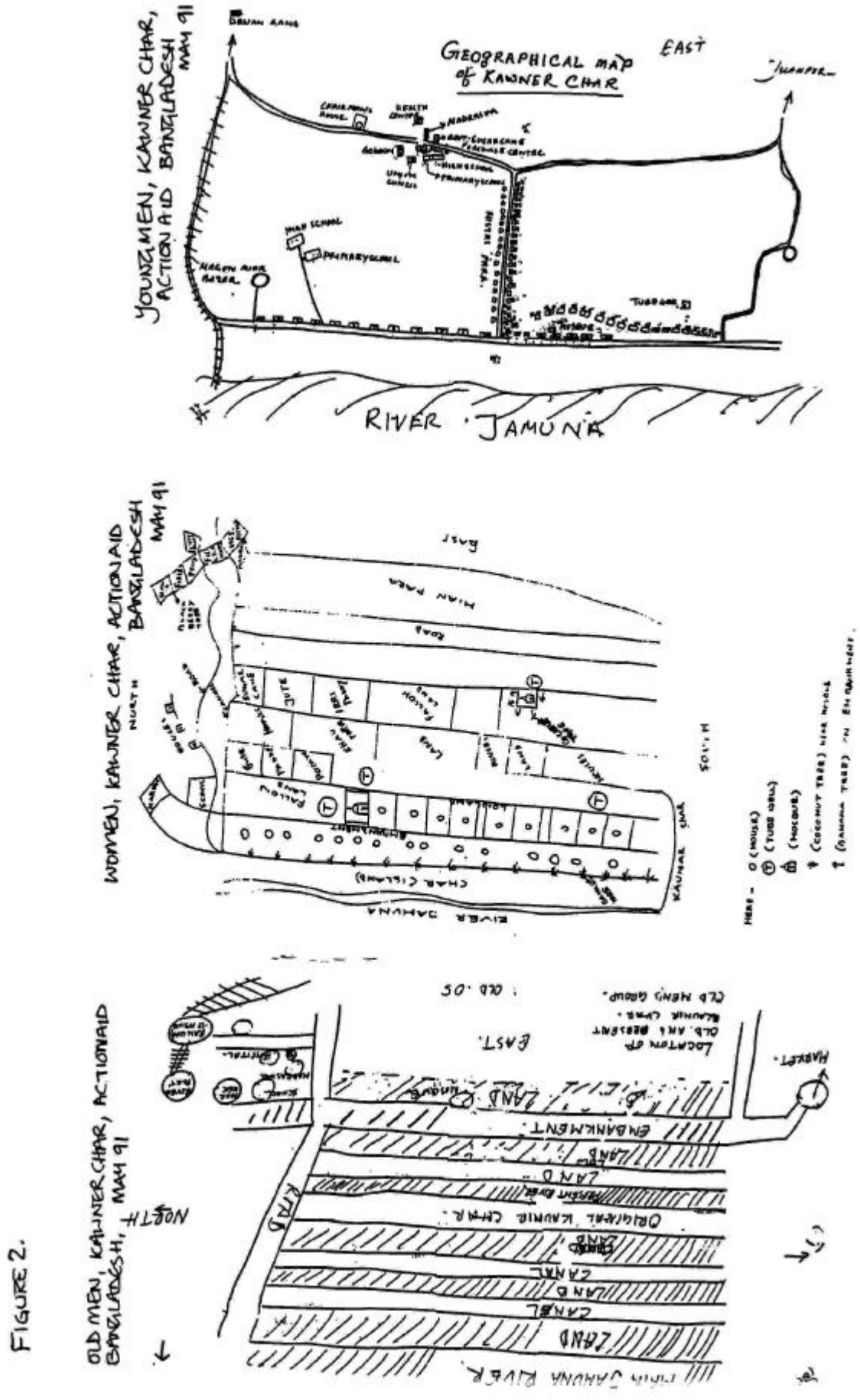


FIGURE 2.

Source: RRA Notes (1991), Issue 14, pp.14–23, IIED London

The old men's map charts precisely the land which they consider still belongs to them beneath the wide flowing river. They live in hope that some day the river will change its course once more and they will be able to reclaim it. (Some sections of the government think otherwise.) The young men have shown carefully the tracks surrounding their settlement and have marked also the road and railway which link them to potential work in the outside world. Finally the women who barely move off the embankment have studiously plotted the individual houses and land use within the settlement.

There are no rights and wrongs about these maps: although development workers initially find it hard to agree, they soon appreciate that there is no 'best map'. Instead they come to realise that different perceptions do exist and that each is important in its own way in helping us to understand how the village functions.

Seasonal calendars are another useful way of developing different perspectives of gender roles in communities (Figure 3). Women, for instance, are often much better at identifying individual disease patterns and normally include childhood illnesses as a matter of course in their health calendars (men, as a rule, don't). Women and men can both be asked to list their specific tasks in different seasons. Women's home maintenance work does not necessarily ease up after harvest, which is when men often have more time for discussions with development workers. (Other times should then be identified to work with women.) Men are sometimes - but not always - more useful informants on sources of, or fluctuations in, off-farm income and credit.

The answer to 'who is the best informant' is rarely straightforward. Again these variations in information help the development workers to understand that they should listen to a variety of opinions: that different members of the community have different information for us, depending on their experience. It is our job to learn from them and make use of the variety of views in our work.

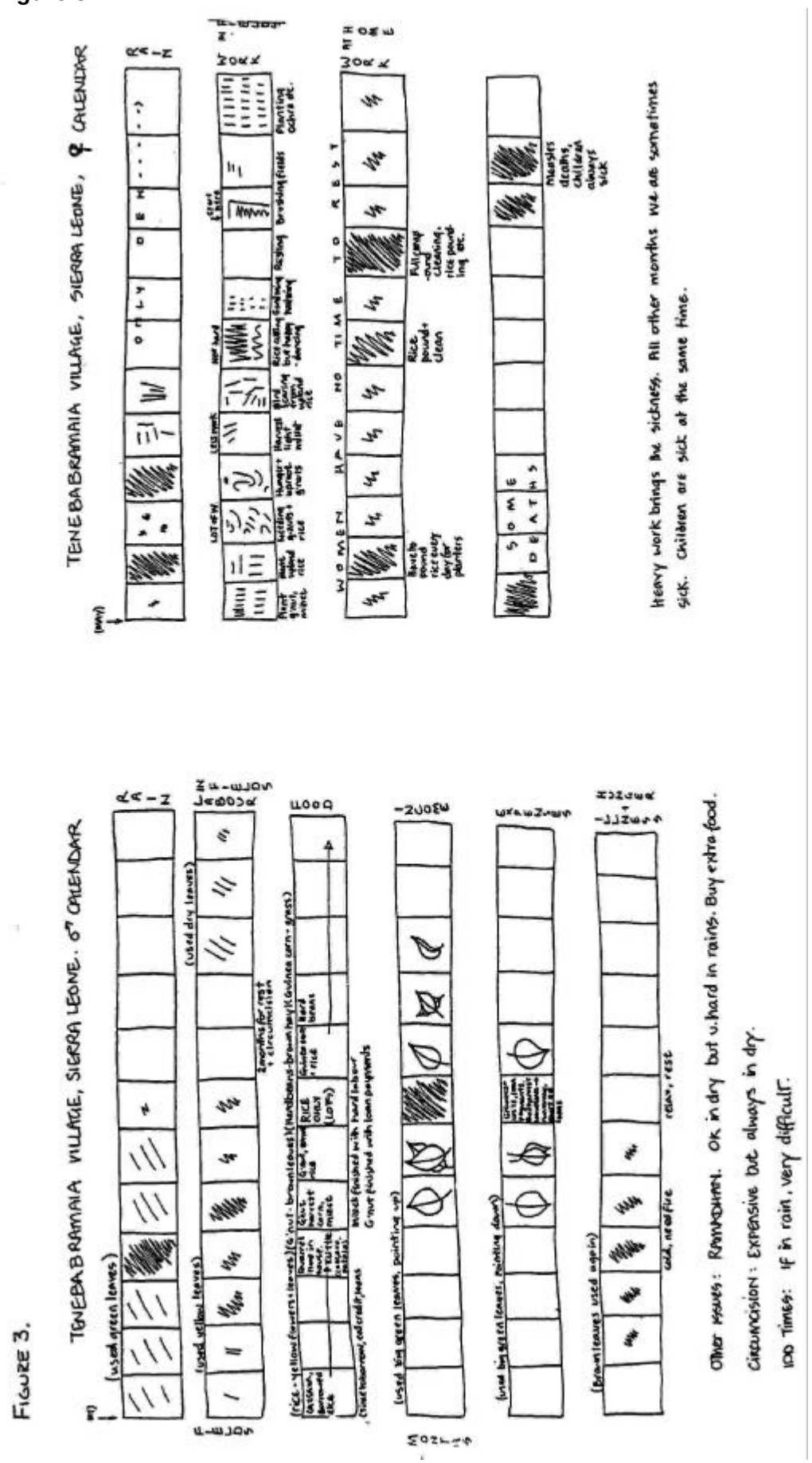
In some case, differences of opinion in the information we collect are particularly marked. Only to listen to one view would guarantee that a project based on it would fail. In Malawi, for example, the women of one village did not express much interest in family planning. Some said that they would like to have a three year break between children; but others said their husband would not like them to use contraceptives and the majority said they did not mind having more children. The young men of the village said that they did not recognise a need for family planning on the basis of population, since the population of the area, as they believe, has decreased since former times and people have moved elsewhere. Nonetheless, they said they were interested in child spacing, but that it was the women who were not interested. The fieldworkers doubted the entire truth of this statement.

The old men, by contrast, perceive a real increase in population and land shortage and consider that family planning is urgently needed to help control the problem. However they say that women want to have more children and refuse to take family planning. They say that women compete with one another for children. Traditionally, if a man had more children than available land, he could ask the traditional chief to give him more land to divide amongst his sons. It would follow that a woman would be glad to have more children, because more land would then be farmed by them. Nowadays new land is no longer available and so this logic no longer applies. But, from what they said in this village, women there still appear to follow the traditional values of favouring more children. (N.B. This is in marked contrast to elsewhere in Malawi or the continent[4]).

[4] For more details on the importance of recognising differences in attitudes of men and women in respect to family planning, see Welbourn 1991 in GADU Newspack 13, from OXFAM.

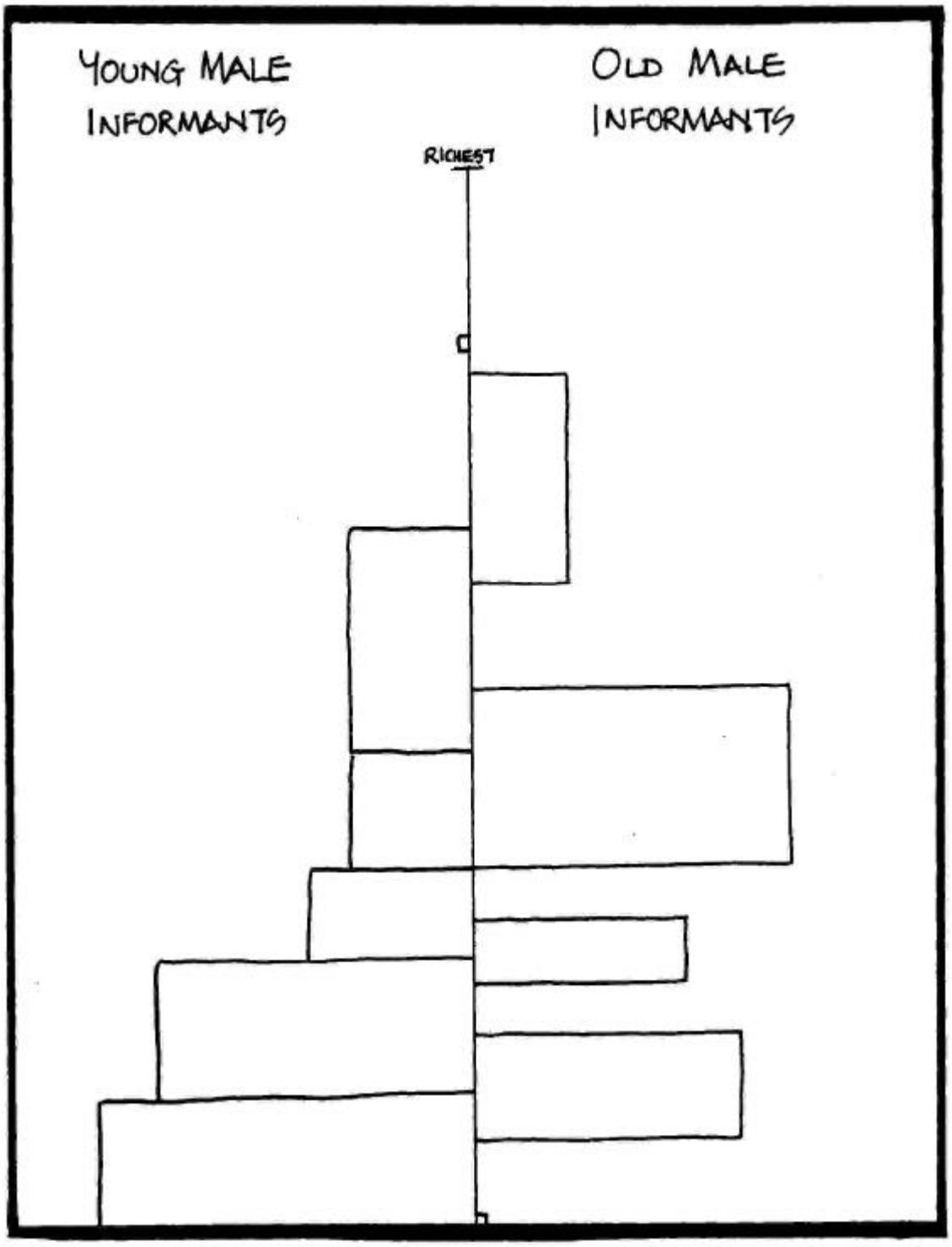
Source: RRA Notes (1991), Issue 14, pp.14–23, IIED London

Figure 3



Source: RRA Notes (1991), Issue 14, pp.14–23, IIED London

Figure 4 Socio-economic dimension ranking, ActionAid, Ghana, Banku. December 1990



Source: RRA Notes (1991), Issue 14, pp.14–23, IIED London

This example explains all too well the necessity of understanding everyone's perspectives on an issue in order to determine how best to tackle it. It also shows how important is the inter-disciplinary approach, which RRA offers us, to designing an effective solution. Provision of family planning services alone is not the answer.

The relevance of ethnic background

In some communities, perspective can be greatly influenced by ethnic background. A common difference of opinion in Africa is between pastoralists and agriculturalists: pastoralists look down on agriculturalists, who in turn value their sedentary lifestyle. Their attitudes to many things are governed by their ethnic background.

An interesting example of different perspectives was seen during an RRA exercise in Ghana, where socio-economic dimension (SED) ranking exercises were performed with old men, young men and women respectively. These ranking exercises are basically wealth ranking, a la Grandin, with a different name. The term 'wealth ranking' can suggest that it is only wealth that can bring status, so we chose to adopt the more cumbersome, but more accurate term (SED ranking, for short) instead.

In the village where the ranking exercise was conducted, there live five different ethnic groups. Preliminary comparison of the old male informants' rankings with those of the young men produced some interesting results. Whilst the young male informants' views of their community produced a reasonably standard Lorentz[5] curve shape (see Figure 4) the old men's views produced an apparently nonsensical shape (unfortunately the women's ranking is yet to be completed). The fieldworkers' conclusions from this comparison were that each old man interviewed had his own ideas about status and well-being based on his own ethnically based perceptions of what constitutes this (e.g. a large herd compared with a lot of land). By contrast, the young men produced much more uniform results. This was thought to reflect the extent to which modern economic interests of all the young men, regardless of ethnic background, are far more geared towards dry season river bank vegetable production and no longer towards the diverse economic practices of their elders. This was merely a hypothesis of the fieldworkers: but it makes sense. Values are changing and once again, fieldworkers need to be aware of that. The unusual profile created by the old men's ranking highlighted the important differences in their value systems[6].

The relevance of poverty

The fourth axis of difference discussed here is poverty. Socio-economic dimension ranking is a powerful tool for the analysis of poverty: of who the poor are, of how their needs differ from those of others, and thirdly of their hidden nature. In Malawi, for instance, fieldworkers demonstrated to themselves:

- that whilst old men ranked female-headed households as the poorest, women and young men ranked the old, handicapped and childless as the poorest (Table 1);
- that the problems and priorities identified by village members were in some cases totally irrelevant to the needs of the poorest members of the community: for instance provision of school building roofs and teachers' housing, whilst a widely expressed need by old men, young men and women alike, would have no impact whatever on the needs of the poorest, who have no resources to send their children to school anyway, or who in many cases are the old and handicapped; and,

[5] See Hope, Timmel and Hodzi 1984: Training for Transformation Mambo Press, Harare, p.9.37.

[6] I am not trying to say that ranking does not work: it does: we just need to be aware of what it may be telling us. See Alsop 1989, RRA Notes 4, for an example of the successful informant-based ranking of a village dominated by the caste system. As she suggested, in cases where cultural or caste-based differences are likely to influence results: "If a cautionary note is to be sounded it is not to use those household attributes identified by informants, in their definitions of wealth, as discrete indicators of wealth. In this instance perceptions of wealth took in to account variables other than those discussed by informants in their definition of wealth" (1989, p12).

Source: RRA Notes (1991), Issue 14, pp.14–23, IIED London

- that the highest sections of the community are more known to other villagers than are the poorest. There was much more common agreement on who the most important people of the village were than there was on the poorest.

It became clear to the fieldworkers from these observations that providing assistance without attending also to the needs of the poorest, could make an agency inadvertently responsible for making the poorest even poorer and more hidden. As those better off have their needs attended to, they would be even less likely to voice the needs of the poorest.

Table 1. Pemba village rankings, Malawi - March 1991

Young men's groupings	Women's groupings	Old men's groupings
1. Grow burly have money in the bank, food available throughout the year, offer ganyu to others for money, clothes and food; have reasonable cattle, goats, poultry and more children. 2. Grow NDDF tobacco plus illegal burley tobacco, get more money in May than only maize grower, maize is fertilized, hence enough to eat. They are club members, but do not profit from the credit they receive. 3. Mostly very old people supported by children for clothes, food and money, keep poultry produce little food, club members but do not receive profit from the credit they receive. 4. Mostly very old people who don't have children to support them, they are not club members and do not use fertilizer, have no food throughout the year, have no source of income, have very poor houses, they don't have any chickens and some are disabled.	1. They grow burley tobacco. Have farm carts. Have cattle. Houses have corrugated iron sheets. Enough maize for the whole year. People do ganyu labour in their fields. 2. Some grow burley tobacco. Food not a problem. 3. Mostly middle aged. Enough land but gardens are eroded so they don't harvest enough to eat for the whole year. 4. Those who are middle aged are just lazy. They fail to work to help their families. They do ganyu most times. 5. They are old. No clothes. Female headed with children and divorced. Do not have enough food for themselves and their families. Don't have fertilizer to put in their gardens. 6. Very old and handicapped. No food, no clothes and unable to do any work.	1. They have tobacco, big gardens. They grow burley tobacco. They employ some people to work in their gardens. They have cattle. 2. They have big gardens. They grow NDDF tobacco. Most of them employ people to work on gardens. 3. They don't employ people but work on gardens themselves. Most of them have enough food for the whole year. 4. Most of them have enough food for the whole year. They do ganyu on rich the people's gardens. They make use of their small resources (land) which they have. 5. Most of them are single but with children. They rely on ganyu for most of their food.
Those attending Group meeting: 2 3 4 Those who spoke: 2 3	2 3 4 5 2 3 4	1 2 3 4 5 2

Source: RRA Notes (1991), Issue 14, pp.14–23, IIED London

· Making choices and changing attitudes

The above case-study material has highlighted a number of examples of the use of RRA to explore, identify and analyse intra-communal difference. However, some may feel that there would appear to be so much difference within a community that the task of unravelling it becomes an end in itself. In the Ghanaian community, for instance, there are 5 different ethnic groups, 2 sexes, old and young, rich, average and poor (at least).... these differences already produce at least 60 different sub-groups within this community. It would clearly be nonsensical to try to delineate the different interests of so many sub-groups.

Instead the important thing is to recognise that different interests exist and, by using RRA techniques, we can quickly identify which axes are of more relevance to issues concerning community development in which communities. In Sierra Leone and Ghana, for instance, gender and age differences seemed to generate quite a lot of tension in the communities; in Malawi, and Bangladesh these differences appeared to generate less tension compared to the commonly felt urgency of food security and landlessness. All communities possess dimensions of difference based on age, gender and poverty. But it is important for us as development workers to understand how these matters affect community cohesion - and their ability to help themselves - if we want to develop sustainable projects.

The recognition of such intra-communal differences as those discussed here has important implications for effective programme development. Some may consider that it is beyond their capacity to work with the most vulnerable, since they are often more in need of welfare than able to work together with agencies to improve their lives. This paper is not trying to suggest that the most vulnerable have to be worked with: that is for each agency to decide. But it is important for agencies to be aware of the choices which they are making by default, through not taking intra-communal difference into account. Agencies should at least be aware of whether projects are in fact increasing the gap between the poor and the better-off.

Finally, I consider this use of RRA to explore and analyse intra-communal difference as a powerful training tool for fieldworkers. At the start of a new training course, fieldworkers often say ‘everybody in this area is poor’; or ‘women in this country can say whatever they want to and are not oppressed’; or ‘the old men don’t really know anything round here: the ones with the good ideas are the young men.’ By the end of the training courses, having worked separately with young men, with women and with old men, the fieldworkers have come themselves to realise that:

- each individual group has its own story to recount;
- often these stories are partly conflicting; and,
- each is of equal importance in helping us to fill in the jigsaw of our understanding.

If we are to take community participation seriously the study of intra-communal difference should be a central part of our investigations. In real life, the sum of the parts is always greater than the whole.

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Source: RRA Notes (1991), Issue 14, pp.14–23, IIED London

RAPID RURAL APPRAISAL, GENDER AND HEALTH — ALTERNATIVE WAYS OF LISTENING TO NEEDS

Alice Welbourn

INTRODUCTION

Rapid Rural Appraisal (RRA) is a concept and methodology which has grown rapidly in its use in recent years. My own use of it began last year when conducting research for the Department of International Community Health of the Liverpool School of Tropical Medicine on the health needs of rural people in sub-Saharan Africa. In this work (Welbourn 1991a), RRA methods were used to identify the specific health issues affecting people in rural areas; and the relative value given to these health problems in comparison with other problems faced by these people. The work was conducted from a gender perspective, i.e. a perspective that recognises that women and men have different roles and experiences, which often result in their having different opinions, needs and options.

I was impressed by what I had learnt through using these techniques, compared with more conventional methods of qualitative data collection. I was also impressed by what I saw in the potential of using RRA methodology to train development workers to think differently.

It is one thing for us to theorize about gender and health: but it is often quite another to address these issues at grassroots level. Yet unless project field staff themselves have an understanding of the gender issues governing appropriate health care, there is little chance of the right kind of development work taking place.

I have decided therefore to use RRA as a tool for training development (including, but not exclusively health-) workers to think differently about their work. The two main objectives of the training courses have been:

i to break down walls between the disciplines of health, education, agriculture, community development, etc. and

ii to build up a recognition that communities are diverse: that they are not homogeneous, passive units, but that they are highly structured, socio-economic systems. They are structured around various axes of difference, including gender, age, poverty, disability, ethnicity, etc. How these axes relate to each other varies in each context.

By using RRA techniques, it has been possible to persuade development workers, in a non-threatening manner, that both of these objectives are valid premises, fundamental to the success of their work.

Development workers are trained to become aware of these issues, firstly by studying material which has been collected from communities elsewhere in the world. They then have the opportunity themselves to collect and analyse similar material from their own area by employing these techniques. This learning by experience allows them to see for themselves what information can be learnt about their own locality, provided they are open to seeing and hearing it. It convinces them that what they have been taught is real fact and not just the machinations of an outsider trainer.

The rest of this article studies some of the information collected by using RRA techniques, and analyses the kind of understanding gained of rural health needs through this methodology. It should be pointed out that all the examples used were produced by non-literate communities.

STEP ONE: ANALYSIS OF DIFFERENCE

The first step taken with the development workers is to encourage them to begin to recognise that communities are made up of a variety of different sub-groups, with different experiences, perspectives, interests and needs. For instance, poorer people, or those with less access to certain critical networks have different needs from those with higher status or more wealth. Women can have different needs from men and so on. The development workers are encouraged to recognise that poverty issues, age differences or gender can never actually be considered in entire isolation from other 'axes of difference'. The needs of a poor woman, for instance, may be quite different from those of a rich woman. Yet they are led through various exercises which enable them to perceive for themselves that these differences are there to be recognised if only we look for them and that their identification and analysis is fundamental to effective development.

An initial assumption made by most development workers, when asked to compare maps or charts produced by men and women, richer or poorer, is that those produced by the men or the richer (more educated) people are better. However, they are

[1] See RRA Notes for examples of developments and applications in recent years.

constantly encouraged to recognise this as a mere assumption and to challenge its validity. They gradually come round to acknowledging that the information is neither 'better' nor 'worse'. Instead they grow to realise that the information is just 'different', based on the perceptions of those whom they are asking. They also learn to recognise that it is always important to bear in mind what information is being sought and who would be the best interest group to ask. The workers finally recognise that current development planning really depends on a very limited perspective of need, often provided by elderly men alone.

Through this realisation development workers then recognise the basic necessity of having both men and women in their teams. There are many parts of the world where men just cannot speak to women at all and in most of the world the information that people give members of the opposite sex is influenced by the gender issue. So the training courses always consist of a mixed team of investigators, who can build up a mutual respect for each others' contribution. Women can then speak with women and men with men in the villages where the exercises are conducted. Whenever possible, groups are formed to talk with older and younger men separately as well. Ideally, older and younger women should be consulted separately too, but the reality of few female staff makes this division rarely possible.

Figures 1 and 2 provide an example of the different kind of information to be learnt about men and women, through using an exercise known as seasonal calendar construction. Women and men in the same village are asked, at separate meetings, to construct a calendar of events that occur in their lives over an annual cycle. The calendars are drawn on the ground, using stones, sticks, different coloured leaves, chalk or whatever is to hand. Piles are made in separate boxes, where each box represents a different month or season of the year, according to local terminology. The size of each pile reflects the amount of rainfall, or work done or so on for each period.

Figures 1 and 2, from Sierra Leone, illustrate the wide scope of information to be collected from such exercises. They reveal to us, the outsiders, the extent to which different resources and activities are linked into poverty and well-being.

The calendars illustrated in Figure 1 were constructed by people in a relatively well-to-do village, where rainfall is quite plentiful throughout the year, harvests are good, labour is hired from surrounding villages, debts are largely paid off and singing and dancing feature highly on the women's food availability and sickness charts. On the two calendars shown here, whilst the men consider themselves to have a break from work after the harvest period, women were at pains to illustrate how much work they continue to do throughout the year. However, overall, these charts give strong indications of the relative well-being in this village. The apparent paucity of reported sickness is clearly linked to the rest of the picture.

In contrast, good rain is absent from the charts of a nearby village, which is located in a rain shadow (see Figure 2). Poverty, ill-health, and worry feature much more strongly in the charts from this second village and with them a fair amount of family upheaval was also reported. Women in this village explained that nowadays they have to return to field labour just a week after child birth for fear of being beaten by their husbands. Men pointed out the months when quarrelling at home develops, and when some have to run away from the village for fear of being brought to court for non-payment of debt. In this village, women still have no time to rest; song and dance have no mention, and they say that some deaths occur during the rains and that their children are always sick.

In comparing Figure 1 with Figure 2, development workers soon begin to recognise the linkages to be made between agriculture, food, income, expenditure, labour, sickness and general well-being. They are also able to begin to appreciate the need for concern over the effects that increased pressures bring upon relationships between men and women. Gender, economic, psychological and physical well-being are linked through these charts and start to be accepted as given.

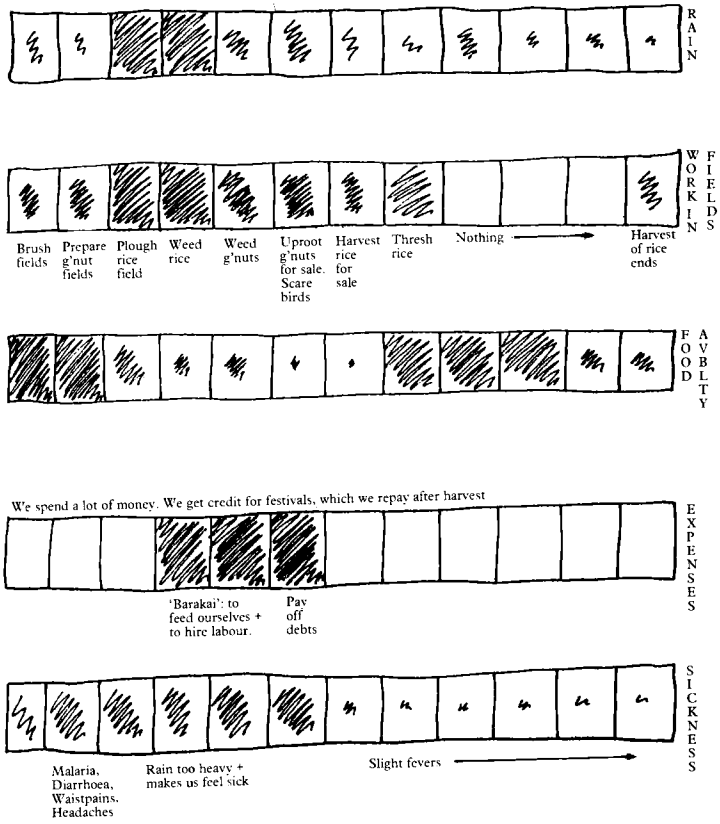
On a more immediate practical level of gender difference, development workers are shown two maps of another village, also in Sierra Leone. One was drawn by men, the other by women. Each map shows where the artists would like new wells to be dug. The men had drawn three separate wells in different corners of the village. The women had drawn one well in the middle of the village. The development workers are asked if they can explain the different choices.

It turned out that there were three separate clans in this village and the men thus automatically drew one well for each clan area. By contrast, the women thought first about the need for water and placed it centrally for all to use. The development workers are then asked what they should do, given that there are only enough people in the village to warrant the agency paying for one well there. Through discussion, they appreciate that the needs of the clan structure, perceived by the men of the village, need to be taken into account because of the decisions which would need to be taken on location, use and maintenance of the well: but that the women's readiness to share a well, for the sake of easy access to a safe source of water, will be a useful support to their planning needs.

A third illustration of the importance of recognising difference connects gender issues with age and

Figure 1: Seasonal Calendar

GBULON VILLAGE, SIERRA LEONE. MALE CALENDAR



GBULON VILLAGE, SIERRA LEONE. FEMALE CALENDAR

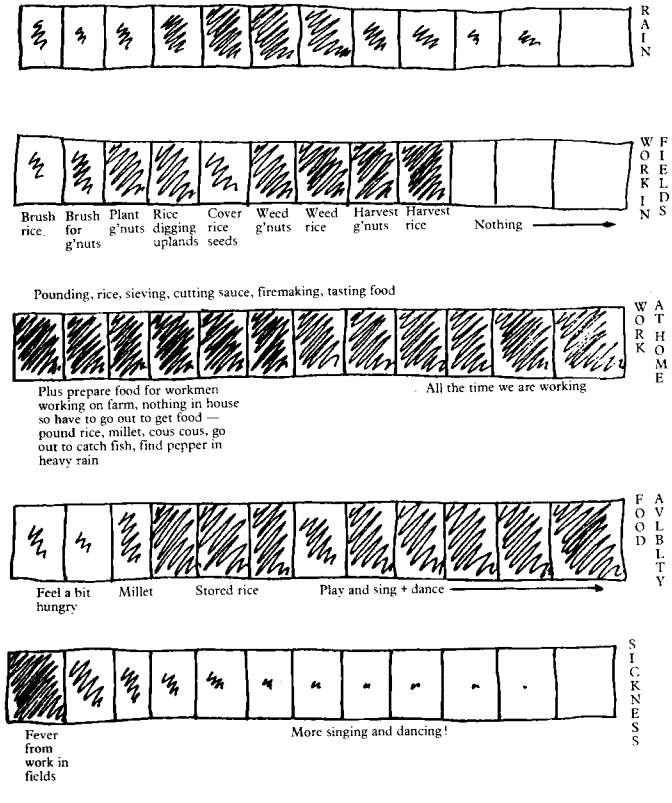
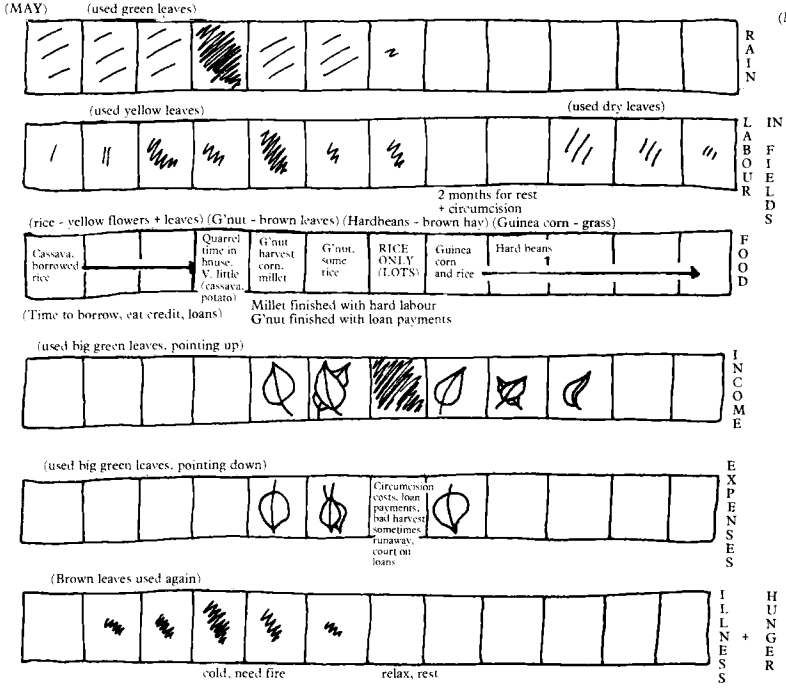


Figure 2: Seasonal Calendar

TENEBABRAMAIA VILLAGE, SIERRA LEONE.

MALE CALENDAR

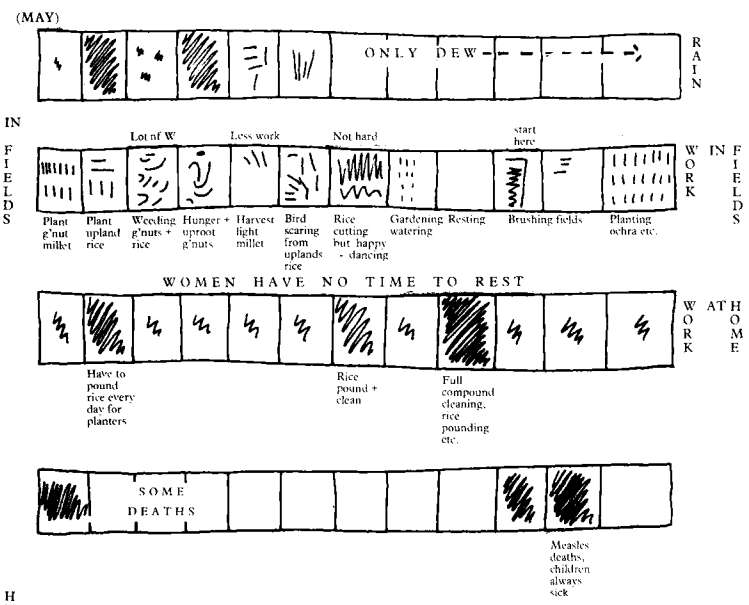


Other issues: RAMADHAN. OK in dry but v. hard in rains. Buy extra food.
CIRCUMCISION: Expensive but always in dry.

IDD Times: If in rain, very difficult.

TENEBABRAMAIA VILLAGE, SIERRA LEONE.

FEMALE CALENDAR



Heavy work brings the sickness. All other months we are sometimes sick.
Children are sick at the same time.

perceptions of poverty. Figure 3 shows a summary of perceptions of well-being and poverty in a village in Malawi. These perceptions were gathered through an exercise in socio-economic ranking. Three old women were asked to rank the households in their village (including female-headed households) in order of overall status or well-being. Three young men were asked to do the same and so were three old men. Each villager conducted the exercise individually. This chart compares the average opinions of the three separate groups. The most significant difference of opinion appears between those whom the old men consider the poorest in the village (female-headed households) and those considered poorest by the rest (old people with no support from their families). The development workers are encouraged to ask why the old men have placed the female-headed households at the bottom; and to consider once more the potential consequences of only listening to the opinions of one group in the village.

In these ways, a recognition of both intra-communal and inter-communal differences, and the clear need to analyse the consequences of those differences, is firmly established in the minds of the development workers. At the same time they start to appreciate the inter-connectedness of different aspects of people's lives. The next section deals specifically with this matter.

STEP TWO: HEALTH VERSUS WEALTH

The most striking aspect of the RRA approach for health workers is the fact that all better-off members of communities, provided that some kind of curative care is locally available, place the need for access to a regular income well above the need for decent health services. Moreover, there is often no community recognition whatever of primary health care (PHC) as a health programme. Community health needs are focused on curative care and not on the preventive care which PHC has to offer. Villagers know perfectly well that when they have reasonable economic wherewithal, their health is, on the whole, reasonably good. They recognise that health care nowadays is essentially an economic commodity and, if they have the cash to pay, health problems are not normally the first priorities in their lives. Their health problems start to get out of hand when they grow poorer. Health and wealth are finely in balance. When people are poorer and cannot so readily afford drugs or treatment, health problems do start to come to the fore and are given much more priority. For people in distress, who have faced some kind of calamity, which necessitates immediate access to efficient curative care, health as well as wealth becomes a matter of urgency.

This realization is an important one, particularly for health workers. If they go into a village, as health workers, talking to villagers about their needs, they will indeed be told about health issues. But if they go in as a part of a multi-disciplinary team, using this type of approach, they will learn instead about people's own perceptions of the way in which well-being is connected to the rest of people's lives.

Such a realization can often be quite a shock to development workers who, having struggled through the system to complete a western education, learn that their expertise is often rather far removed from village experience or village needs. Western donors and NGOs often have a set blueprint agenda of health care, education or water programmes. Yet often what people themselves say they want is very different from what we prescribe. For them, life is clearly a continuum, linking agriculture and environment to general well-being. Our approach makes rather a nonsense of how they experience the world. Communities' health problems may often better be addressed through increased access to cash to pay for curative care than through PHC programmes.

Figure 4 shows the results of an exercise in problem priority matrix ranking with recently landless women in Bangladesh. The women were asked to name their main problems. A symbol for each problem mentioned was drawn on a separate card. Symbols were easily understood by all, such as coins for lack of money. The women were then asked to compare each problem with another, one by one, until an overall sequence of importance was established. The results demonstrate clearly the women's over-riding concern for economic wherewithal, future diminution of resources (the river bank on which they live), and lack of business opportunities. Health and medical issues are of much less importance to them. Even though these women are landless, their priorities still lie with economic concerns. It is envisaged that, unless their economic situation improves, their health will indeed begin to be affected and priority given to health problems will then increase. Yet the standard western agency approach might be to prioritise health care and education needs: and might well overlook the connection between good health and good economic well-being. Similar priorities are normally voiced by communities in Africa also, and it is time that they be listened to.

Not only do development workers tend to assume that issues such as health and education are far more pressing than they usually are for communities, it is regularly assumed that those health and education needs which are identified in village meetings will benefit everyone in the village. Yet normally, those who come to village meetings are not at all representative of everybody's needs. Instead, through this training, development workers recognise that those who do come are men rather than women and better off rather than poorer: also that they are often the village elders,

Figure 3: Socio-Economic Ranking Comparisons

ACTIONAID MALAWI, PEMBA VILLAGE RANKINGS, MARCH 1991

Young Men's Groupings	Women's Groupings	Old Men's Groupings
1 Grow burley tobacco, have money in the bank, food available throughout the year, offer ganyu to others for money, clothes and food; have reasonable cattle, goats, poultry and more children.	**1** They grow burley tobacco. Have farm carts. Have cattle. Houses have corrugated iron sheets. Enough maize for the whole year. People do ganyu labour in their fields.	**1** They have big gardens. They grow burley tobacco. They employ some people to work on their gardens. They have cattle.
2 Grow NDDF tobacco and illegal burley tobacco, get more money in May than only maize growers. Their maize is fertilised, hence enough to eat. They are club members, but do not profit from the credit they receive.	**2** Some grow burley tobacco. Food not a problem.	**2** They have big gardens. They grow NDDF tobacco. Most of them employ people to work on their gardens.
3 Mostly very old people, supported by their children for clothes, food and money, keep poultry, produce little food, club members but do not profit from the credit they receive.	**3** Mostly middle aged. Enough land but gardens are eroded so they don't harvest enough to eat for the whole year. Some have big families so food is not enough. Some have children who send remittances.	**3** They don't employ people but work on the gardens themselves. Most of them have enough food for the whole year.
4 Mostly very old people who don't have children to support them, they are not club members and do not use fertiliser, have no food throughout the year, have no source of income, have very poor houses, they don't have any chickens and some are disabled.	**4** Those who are middle aged are just lazy. They fail to work to help their families. They do ganyu most times.	**4** Most of them have not enough food for the whole year. They do ganyu on rich people's gardens. They make use of their small resources (land) which they have.
Those attending group meeting: **2 3 4** Those who spoke: **2 3**	**5** They are old. No clothes. Female headed with children and divorced. Do not have enough food for themselves and their families. Don't have fertiliser to put in their gardens.	**5** Most of them are single but with children. They have small gardens. They rely on ganyu for most of their food.
	6 Very old and handicapped. No food, no clothes and unable to do any work.	Those attending group meeting: **1 2 3 4 5** Those who spoke: **2**
	Those attending group meeting: **2 3 4 5** Those who spoke: **2 3 4**	

Figure 4: Priority Ranking of their Problems (Women) — Landless
ActionAid May 1991, Bangladesh

Problems	River Erosion	Economic Problem	Health and Medical	Sanitation	Lack of Work for the Women	Lack of Business Opportunity	Dowry System	Infertility of Soil
Infertility of Soil	River Erosion	Economic	Medical	Sanitation	Work for Women	Business	Dowry	X
Dowry System	River Erosion	Economic	Medical	Sanitation	Work for Women	Business	X	X
Lack of Business Opportunity	River Erosion	Economic	Business	Business	Business	X	X	X
Lack of Work for Women	River Erosion	Economic	Work for Women	Work for Women	X	X	X	X
Sanitation	River Erosion	Economic	Sanitation	X	X	X	X	X
Health and Medical	River Erosion	Economic	X	X	X	X	X	X
Economic Problem	Economic	X	X	X	X	X	X	X
River Erosion	X	X	X	X	X	X	X	X

Economic — 7
River Erosion — 6
Business — 5
Lack of Work for the Women — 4
Sanitation — 3
Health and Medical — 2
Dowry — 1

CAUSES:
1. In order to meet everyday necessities economic problem must be solved.
2. River erosion forced them to move again and again.
3. Income will increase if they can do business.
4. Income will increase if women get work.
5. Women need good sanitation.
6. If other problem solved dowry itself will not be a problem.
7. Infertile land doesn't matter here because landless now.

and that the needs of younger people — and children — are overlooked entirely.

In the exercise conducted in Malawi, illustrated in Figure 3, it was recognised that those talking in the meetings came predominantly from socio-economic groups 2 and 3. It was then also recognised, on analysis, that a health clinic and a roof for the school building, which were identified as village needs at these meetings, were mostly of relevance only to the needs of those who talked at the meeting. The school roof would be of no relevance at all to the poorest of the village, who could afford neither the time nor the resources to send a child to school, or who were in any case at quite the wrong stage of their lives to benefit from schooling. The health clinic would be an unlikely intervention, given the relative proximity of a larger health centre. However for the poorest, transport and treatment costs and lack of time and support structures normally form a barrier to adequate health care.

By collection and analysis of such information, development workers learn to see for themselves how easy it is to assume that we have consulted villagers, when in fact we have only scratched the surface of people's needs. The next section shows how further RRA techniques of data collection can help us to understand in much greater detail what people's health needs are and how they might begin to be addressed more effectively.

STEP THREE: A BETTER UNDERSTANDING?

Once development workers have learnt to recognise the importance of identifying and analysing difference; and once they perceive the value of adopting a multi-sectoral approach, the level of awareness of communities' needs can increase dramatically. Various different RRA techniques can be adopted and modified to this end.

Figure 5 shows a seasonal calendar of illness incidence and prevalence in Bangladesh, constructed by the landless women mentioned previously. Collection of information like this provides development workers with a clear opportunity to home in on specific times of the year and to provide appropriate health education, vaccination campaigns and so on at the times when they are of most relevance to people's lives. Such exercises could be taken further, to analyse how people rank different health problems in terms of severity, danger, effects on labour demand, time costs of caring, financial cost of treatment — or in terms of other characteristics, identified by communities themselves.

Figure 6 illustrates an exercise which asked the same Bangladeshi women to list various staple foodstuffs and to rank them in terms of characteristics identified as important by themselves. Such exercises often produce surprising results, such as the high value given by these women to wheat, compared with rice. Similar exercises could be used to compare preferences for different types of health care and they should be conducted of course with different groups within communities, to see if different key issues emerge according to gender, wealth or other factors.

A further technique of great potential use is illustrated in Figure 7. This technique is known as a 'Chapati Diagram' and the one illustrated is based on one which

Figure 5: Seasonal Calendar of Illness
ActionAid Bangladesh, May 1991, Landless Women

Number of Months	B	J	A	S	V	AW	K	AG	P	M	F	C
Gastric	00	00	00	00	00	00	00	00	00	00	00	00
Fever	—	—	0	00 00 00 00	000 000 000	—	—	—	—	—	—	—
Chicken Pox	0000 0000 0000 0	—	—	—	—	—	—	—	—	—	—	0000 0000 0000 0
Diarrhoea	—	—	—	—	—	0000 0000 0000 00	000 000 000 000	—	—	—	—	—
Goitre	00	00	00	00	00	00	00	00	00	00	00	00
Worms and Anaemia	00	00	00	00	00	00	00	00	00	00	00	00

Figure 6: Food Preference Ranking
Food Ranking (Women) Kawner Char, Bangladesh, ActionAid, May 1991

Name of Food / Characteristics	Fish	Vegetables	Rice	Sweet Potato	Wheat	Dry Fish
Low Price	1	4	1	4	5	1
More Filling	0	0	8	2	6	0
Available	0	1	2	5	8	0
Total	1	5	11	11	19	1

Wheat = 19
Sweet Potato = 11
Rice = 11
Vegetables = 5
Dry Fish = 1
Fish = 1

was also constructed by the landless women in Bangladesh. The exercise is carried out once more on the ground, using circles made of old newspaper and lines of sticks or chalk, to link or separate them. Each circle represents a different individual or group and the lines around them illustrate the sphere of influence of each or connections between them. The size of each circle reflects the power of each body. In this way, non-literate people can provide graphic illustration of the political structures within which they perceive themselves to operate. Whilst use of such techniques sometimes seems quite difficult and daunting for literate people, who are used to the powers of the pen, non-literate people have proved themselves most skilled in expressing themselves through this medium. The exercise was accompanied by a long and detailed discussion amongst the women, which revealed greatly detailed information about the political and economic structures and tensions experienced by the community.

Once again, it would be most important and valuable to compare the ways in which women would construct a chapati diagram of their village decision-making structures in comparison to men. We would be likely to find that women's powers of influencing decisions about western health care structures were rather less than those of men. Chapati diagram construction and problem priority ranking would also be useful ways of investigating women's alternative options for health care — western and traditional — both for themselves and for their children. Access to financial resources, for instance, to pay for certain health care, is often severely constrained by their access to their husband's resources. Such barriers may greatly influence their choices over what they do when sickness occurs. Yet there may also be alternative resources controlled solely by women, which could in some way be given support, thereby alleviating pressures on women to cope. Techniques such as those described here, would enable development workers to explore such options in a far more creative and dynamic manner than conventional questioning allows.

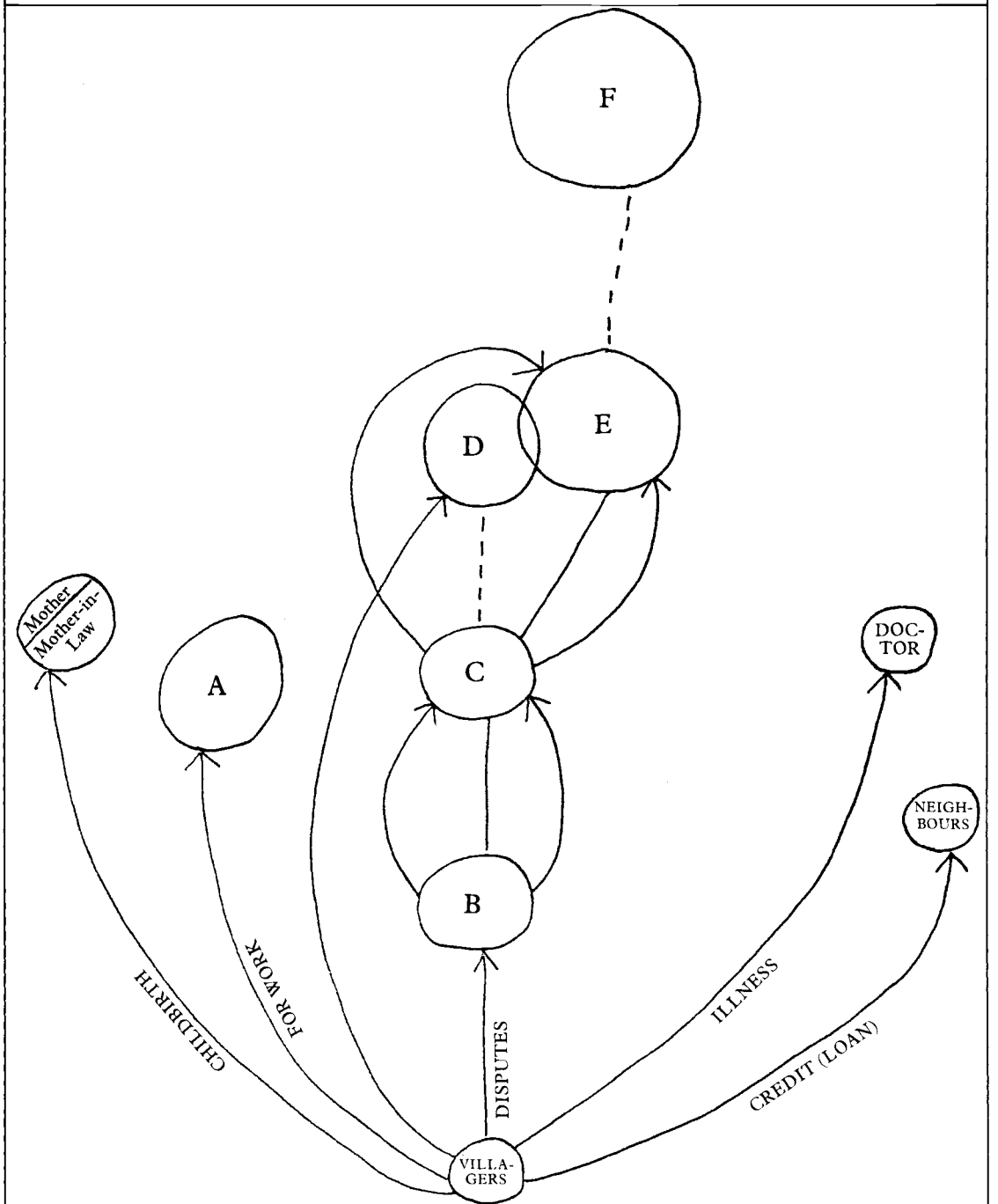
STEP FOUR: A BETTER RESPONSE

Some people worry that this approach advocates a complete dismissal of western knowledge of what can help. It is feared that, unless women express an interest in vaccination, for instance, or clean, safe drinking water, that such obviously beneficial interventions of these can have no place.

This is not the intention of people using such techniques. Instead the aim is rather to try to redress the balance between 'us' and 'them', so that the interaction between both sides is viewed as a dialogue rather than a monologue.

Development workers in the different projects where RRA exercises have been carried out have all commented on the enhanced community trust and cooperation which has resulted from the work. Similarly Eng et al (1990), were surprised by the increased understanding of health workers in Togo

Figure 7: Chapati Diagram, Women, Bangladesh
ActionAid, May 1991



Note: Circles A-F represent various individuals and institutions within and beyond the village

after they had been trained in focus group discussion techniques, as well as the greater uptake of western health services by the women whom they met with.

In particular, the increased empathy which is generated with villagers through using these techniques, has allowed development workers to begin to explore many sensitive issues which are never usually mentioned between villagers and development workers. These include gynaecological problems, STDs, extra-marital relations, the stress of unemployment, wife-beating, greatly increased psychological illness, drug abuse, increased pregnancies and the plethora of other consequences of the severe economic problems affecting both men and women nowadays in most of the world. Development workers have begun to recognise also that these too are some of the health issues that are of real and deep concern to their potential clients.

RRA techniques rely a great deal on Freirian thinking. There are of course other techniques of communicating with people which are closely connected. But the active participation of villagers in graphic exercises of the sort described here provides, I believe, a particularly exciting breakthrough in tapping the knowledge of communities.

CONCLUSION

This article has briefly described a variety of different RRA techniques and the type of information which can be collected. Particular achievements of using RRA techniques in training development workers can be listed as follows:

- We could talk together about the differences between men, women, richer, poorer and so on as something obvious and non-threatening. They appreciated that different people have different perspectives, depending on the context; and that it is essential to their own task as development workers to understand this.
- We could understand that health is not just in a compartment on its own, but that it is affected by all kinds of other factors; and that it is essential to our work to develop a multi-sectoral team approach to health care development.
- We could see that people rarely prioritise health themselves, unless they are in distress. Otherwise, we could see that income, food security, access to and control of resources and benefits are often issues of far more importance than whether there was a health clinic there or not; and that this prioritisation is not ignorance but well founded.
- Finally, we could see that, once people are given the space, in small separate groups, to explain themselves and their needs to others, who are prepared to listen, they open up in a manner rarely seen in normal, conventional encounters. It was then that the real needs of well-being and all that that embraces truly began to be voiced.

The concept and methodology of RRA does appear to have significant potential in exploring issues concerning gender relations and health issues, within the wider context of community needs. Development workers have been deeply impressed by what they have learnt from this approach to their work. The question now facing health staff and others is how this new understanding can be incorporated into western health service delivery. I consider that employment of RRA techniques has notable potential in that area also.

NOTES:

For publication purposes it was necessary to typeset the diagrams in this article. Normally these would be handwritten and drawn freehand by fieldworkers.

Figure 2 appeared first in Welbourn 1991a.
Figure 3 appeared first in Welbourn 1991b, with kind permission of ActionAid Malawi.
Figures 4-7 are reproduced with kind permission of ActionAid Bangladesh from their recent RRA report.

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You cannot have failed to noticed the recent proliferation of special issues of the *Notes*. Although providing valuable material in considerable depth, they have meant a long wait for those of you submitting more general articles. We feel that both types of article are useful, and so are trying to combine them in 'semi-special' issues. In this issue, along with 10 general articles, we are including a small selection of pieces which describe experiences and discuss issues relating to participatory approaches to HIV and AIDS programmes. We hope that these few articles, and the useful editorial overview by Alice Welbourn, will stimulate some discussion and perhaps encourage others to share their experiences of working in this field.

The articles in the more general section of this issue have clustered around three main themes: participatory approaches to planning, reflections on the potentials and limits of PRA, and the development of new methods.

Participatory approaches to planning

Five articles in this issue provide some useful approaches to using or adapting PRA for participatory planning. The first three of these discuss approaches to planning that incorporate factors such as external forces and internal conflict, which can often undermine community planning processes and natural resource strategies. The opening piece by Michael Warner discusses the importance of ensuring that plans made with communities take into account the external forces which will largely determine the success or failure of those plans. He suggests ways in which strategic planning can become an integral part of a broader process of participatory planning and how an internal appraisal can be linked to external appraisals of the wider context of community strategies. Similarly, Richard Montgomery recognises the need for planners to be aware of the wider forces acting on any development process. He outlines a method called force-field analysis which can help to determine the constraints and opportunities which shape the future of any aspect of development. His article provides us with two case studies from widely differing contexts - public transport and primary school education - illustrating the potential of such a method. These two pieces - suggesting ways of linking community appraisal to analyses of broader political and economic forces - point to one area where PRA approaches still need further development.

If external influence is one type of force which can undermine the viability of community resource management, another such force is local conflict among different social groups. Derek Armitage and Suman Garcha outline their experiences in Tanzania of developing community-based land and resource use plans in such a context. They suggest an approach they feel was especially suitable for an area where the 'community' consisted of a number of different ethnic groups, including pastoralists and settled farmers, who all had distinct land and resource use patterns. The planning process aimed to be both a tool for planning and a means to bring smallholder groups together. Nick Osborne then gives a more specific example of how participatory methodologies were used in a roads rehabilitation programme in Zambia to allow local people to prioritise and plan for themselves. The case is interesting for it shows how participatory planning increases the community 'ownership' of an infrastructural project. It is also a case where a successful pilot led to the programme-wide adoption of PRA planning processes.

Finally, the piece by Kamal Kar and colleagues assesses the value of PRA in the development of village resource management plans in Sri Lanka. This article also touches on a problem which is key to encouraging the scaling-up of the participatory approach and its institutionalisation. This is the challenge of how to facilitate the reversal of attitudes of civil servants *"locked into age old hierarchical*

Source: PLA Notes (1995), Issue 23, pp.3–5, IIED London

bureaucracy and accustomed to top-down planning, inflexibility and an 8-5 day"? One of the conclusions is that the preparation of village resource management plans with those civil servants is one step along the way in this process of reversal. However, the broader challenge of institutionalisation of this reversal in a whole bureaucracy remains, and we would welcome any contributions showing how this process has occurred, or is beginning to occur elsewhere.

Reflections

The second section groups three pieces reflecting - on the basis of experience - on the pros and cons, potentials and pitfalls in work with PRA and PRA training, particularly in national, local and institutional contexts. The first piece, by Andrew Inglis and Ann Lussignea, draws lessons from experiences with using participatory approaches in Scotland. They suggest that PRA does indeed have a role, but that effort will have to be made to ensure quality if its role expands. Interestingly, they also argue that despite the many differences between the developed and developing worlds, the same old problems of institutionalising participatory approaches and of giving a voice to local people are once again all too familiar, in Scotland as much as anywhere else.

Carrie Turk's detailed and thought-provoking piece on identifying poverty in Vietnam takes us one step beyond well-being ranking. She emphasises the inherent difficulties of trying to target development assistance at the truly poorest members of a community and comes up with some useful well-being categories which reflect the constantly fluctuating fortunes of rural households. Her article also shows how community resistance can frustrate the use of well-being ranking to target only the poorest in a village. People may participate in planning processes and methods but they may not want to participate in certain uses of the information generated by that 'participatory' planning.

It is always interesting to read the reflections of those who have conducted PRA training courses. The experiences vary so much from situation to situation and there is always something new to learn. Saloni Singh and Birendra Bir Basnyat's lively and thoughtful account of their experiences in Nepal provides some lessons on how to stimulate interest in participatory approaches and how to deal with the unexpected!

Methods

As always, this issue contains some creative innovations and adds some new approaches and methods to the repertoire. De Groot and colleagues provide a lively and highly readable account of how they tested and adapted stories in villages in North Cameroon to stimulate discussion and provoke thought. The technique has much potential for application in a variety of ways and settings. Finally, David Archer's fascinating article describes how PRA can be adapted for reforming adult literacy programmes. He bemoans the common misinterpretation of Paulo Freire's teachings and assesses how PRA can be used to put his innovative approach back on course.

Your letters...

We are always pleased to receive comments about *PLA Notes*. Please keep your letters coming! A recent spate of letters indicate that most of you are pleased with the new title. I hope there is general agreement on this - we certainly feel that the name is much more appropriate to the content of the journal. However, we should emphasise that the term *"PLA"* is not intended to be the name for a new 'methodology' and we do not use it as such. It is a collective term which refers to the whole range of participatory approaches to development and research.

Some of you have mentioned that the *Notes* contain rather too many articles on process and that you would be pleased to see more articles on impact and action. We agree with you. The focus on process has certainly mirrored the development of participatory methodologies. We feel that they have now come of age and it is time we turned our scrutiny on how well they are working in practice and the extent to which livelihoods are being improved as a result. In particular, it will be important to know cases where the impact of participatory approaches has moved from the local to a far larger scale. If any of you would like to write up your experiences of how the use of participatory approaches to development have led directly to

Source: PLA Notes (1995), Issue 23, pp.3–5, IIED London

action, empowerment and/or improved livelihoods, we'd love to hear from you.

Your space...

On turning to the back pages, you will notice that *Endnotes* has a new title and a slightly new format. These changes reflect our hope that these final pages will become much more of a resource for readers. There is so much happening in the field of participation around the world - networks springing up, training being carried out, books being written and so on. We feel that there is a pressing need for a forum to keep us all in touch. Your comments and ideas are vital for making this work.

SUBSCRIBING TO PLA NOTES

This issue is the first issue for which subscriptions will be charged. Although we are only asking readers from OECD countries to pay the subscription charge, it is important that any reader who is currently on the mailing list fills in the green form which arrived with this copy of *PLA Notes*. Completing and returning this form will ensure that your name is kept on the mailing list and that you continue to receive *PLA Notes*.

If you do not return the green form we will assume you no longer wish to receive *PLA Notes* and you will eventually be dropped from the mailing list.

Source: PLA Notes (1995), Issue 23, pp.3–5, IIED London

1

A strategic approach to participatory development planning: the case of a rural community in Belize

Michael Warner

· Introduction

In July 1991, in collaboration with a local agricultural development NGO, the Environmental Research Unit of the University of Keele worked with the community of St. Margaret's village in Cayo District, Belize, Central America. The main objective, as decided by the village council, was to design a medium-term village development strategy which would have community-wide benefit.

This paper describes our experiences in incorporating participatory methods into strategic development planning at the community level.

· Components of strategic development planning

Participatory approaches to planning often tend to concentrate on analysing community problems or opportunities from within a village, cooperative or group. This stance is understandable since it is the basic principle of PRA that the starting point for sustainable local rural development should be the knowledge base, priorities and perceptions of the local community (Chambers et al. 1989). However, when community strategic development planning is the goal, the appraisal also needs to address how a community's development decisions will be affected by outside, macro-economic or political forces.

The benefits of combining an internal appraisal with one external to a community lie at the heart of approaches to strategic planning for organisations and groups, developed largely for businesses (Quinn, 1980; Schmidt-Pauleen, 1990). Principally, this approach provides a framework for establishing achievable development objectives and practicable development strategies and can be summarised as follows (LEK, 1990):

1. set the organisation's development objectives;
2. conduct an external appraisal of, for example, market trends, competitors etc.
3. conduct an internal appraisal of, for example, financial and resource capabilities;
4. analyse the options of the plan; and,
5. prioritise development options to make a strategic plan of action.

Participatory planning often contains parts (1), (3), (4) and in a few cases (5) (Kabutha and Ford, 1988). Figures 1 and 2 below compare the components of organisation strategic planning with those of participatory community planning. To ensure that our planning approach was more strategic in St Margaret's village, we adopted three additional steps (Figure 3):

1. a formal external appraisal of NGO and government policies and services, and macro-economic forces in relation to the development aims of the village;

2. participatory analysis of the village's **s**trengths, **w**eaknesses, **o**pportunities and **t**hreats ('SWOT' analysis); and

3. formulation of a village development strategy designed to achieving a range of development objectives.

Source: PLA Notes (1995), Issue 23, pp.6–10, IIED London

Figure 1 **Process of Organisational Strategic Development Planning**

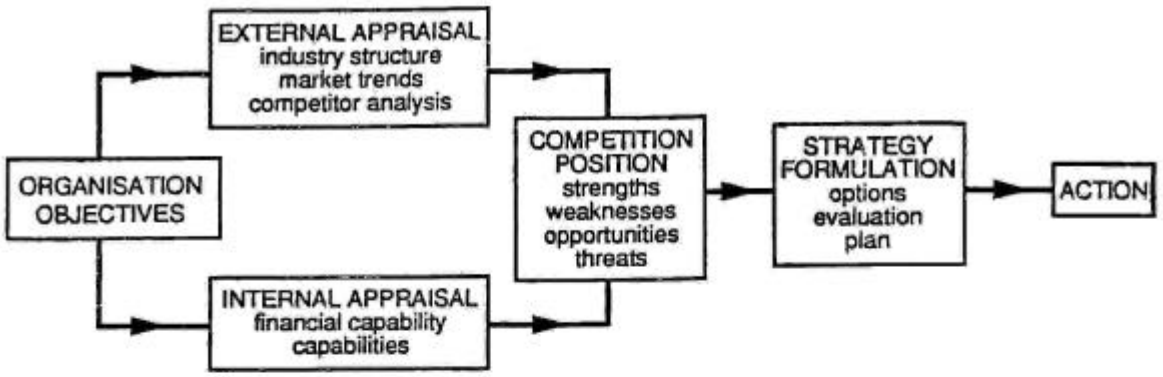


Figure 2 **Process of Participatory Planning**

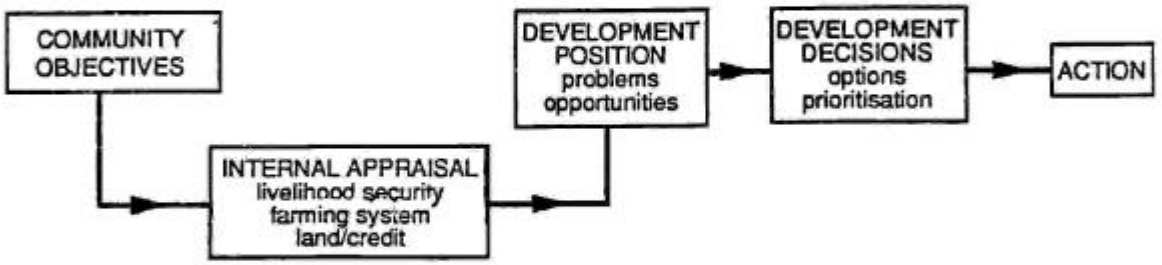
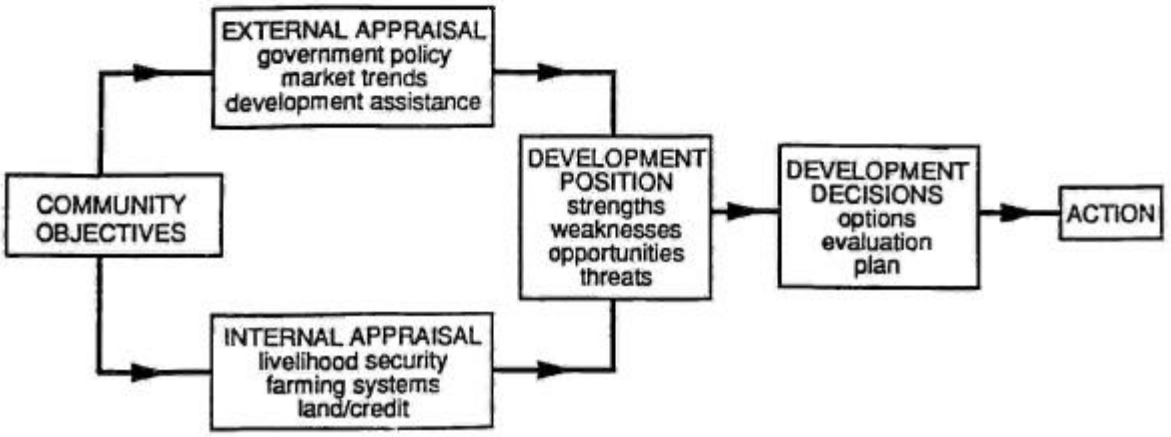


Figure 3 **Processs of Community Strategic Development Planning**



Source: PLA Notes (1995), Issue 23, pp.6–10, IIED London

· The external appraisal

Early on in the planning process we undertook a formal external appraisal to identify the wider political and economic forces likely to affect St. Margaret's village council's development objectives. This involved two weeks of interviewing government departments, local NGOs and representatives of international assistance agencies. The interviews were semi-structured, based on a checklist of key issues derived from a secondary data review and revised by our umbrella NGO. The exercise provided us and the community with an understanding of the wider political, economic and technical arena within which potential community decisions would be implemented.

Some of the benefits of our approach were demonstrated early in the project. For example, one issue was the possibility of smallholder expansion into citrus (orange and grapefruit) production. Frosts in Florida in the late 1980s had caused a shift in citrus cultivation southwards into Central and Southern America. The resulting increase in fruit processing capacity and the relatively high price of citrus attracted many rural smallholders in Belize to expand their citrus production. The external appraisal sought to identify whether there were likely to be political or commercial forces affecting this expansion in the future. In particular, were there any pressures which would undermine the sustainability of village smallholders converting areas of their subsistence crops to citrus?

Surprisingly, the external appraisal revealed that both the Government of Belize and the country's large commercial producers were supportive of smallholders moving into citrus. Not only did the Government view citrus as encouraging settled agriculture, but since Belize is a small producer on the world stage, the Government and commercial producers were keen to develop the country's citrus production capacity wherever possible.

The appraisal concluded that there were no political barriers to the villagers expanding their citrus growing. These findings then fed into the subsequent participatory analysis in the village about the overall plan to diversify smallholder crops.

In another case the external appraisal discovered important information for the fertiliser producing cooperative in the village. The cooperative learnt that its ideas for a fuelwood plantation (required to ensure the long term viability of production) had potential funding support from a local NGO, and resource support from two Government Ministries. Furthermore, potential sites for fuelwood plantations had already been proposed by the Government, one of which would be accessible from the village. These were factors of which the cooperative was previously unaware.

In a third case, the results of interviews with the High Commission for Refugees revealed that the refugee population of St. Margaret's had reached a critical size. This suggested that the village council was eligible to apply for educational funding assistance from the Commission. Such funding would help the council pursue its objective of community-wide primary education.

· Internal strengths and weaknesses

Our overall goal was to facilitate a medium-term village development strategy. To provide a framework for villagers to identify and assess their community's internal strengths and weaknesses, and the external political and economic opportunities and threats affecting them, we introduced a common strategic planning technique known as SWOT analysis (Bryson, 1988), where:

SWOT = Strengths, Weaknesses, Opportunities and Threats

The village council then incorporated the results of this assessment into the community's preferred development strategy.

For example, a substantial portion of the smallholders in the village were unaware of either the Government's policy towards smallholder citrus production, or of the trends in world commodity prices for citrus. If this had been a conventional PRA, it is possible that development decisions concerning citrus

Source: PLA Notes (1995), Issue 23, pp.6–10, IIED London

expansion would have been made in an environment of uncertainty. Decisions may have been taken without knowing about the availability of Government extension services for citrus, venture capital, and preferential land allocations for citrus production and without knowledge of a trend of declining market prices.

We encouraged the village participants to assess these findings by identifying threats and opportunities relevant to an expansion of citrus production. These threats and opportunities then fed through to the village council to be translated into a village development strategy for crop diversification. The strategy finally selected was to promote expansion of citrus cultivation within the village; but, in response to the knowledge that future citrus prices were expected to fall, the community also decided to take up the available Government extension services and venture capital provisions. It was concluded that this would improve yields and maintain competitiveness.

· Limitations

We hope that this approach is a first step towards highlighting the importance of a strategic approach to development planning at the community level. However, we recognise that our approach has some limitations. First, the structure of an organisational strategic planning methodology devised in a North American business environment (Figure 1) clearly cannot be transplanted unchanged to a village in rural Central America. Not only are there obvious wealth and socio-cultural differences between the two environments, but the development goals of a community tend to be heterogeneous whereas those of an organisation are more homogeneous. However, we would argue that the village council of St. Margaret's did demonstrate some similarities with a homogeneous organisation. In particular, the council shared the common goal of community-wide benefits.

Another problem is that the external appraisal was conducted by the PRA team alone. Although we had the development objectives of the village council to guide us, we decided which information was relevant to the community decision-making process without the participation of community members. The external appraisal could therefore be criticised as being biased towards our academic disciplines and value systems. One counter argument might be that the use of outsiders brings the benefit of easier information access (Messerschmidt, 1991). However, in future we would recommend that the external appraisal include representatives of the village. This is likely to improve the benefits arising from the process greatly.

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Source: PLA Notes (1995), Issue 23, pp.6–10, IIED London

2

Force-field analysis: identifying forces for and against change

Richard Montgomery

· Introduction

This note describes the use of force-field analysis which I first came across during an ODA-commissioned institutional appraisal course. Originally, this technique was intended as a workshop tool for analysing a static situation (to identify the forces which keep an institution in its present state). However, during two recent project visits it was used in a modified form to provide a way of drawing staff and stake-holders into the planning process, defining possible objectives and how to attain them. The fact that the two examples described here are very different (a non-formal education project and an urban environmental improvement project) suggests that the method might be valuable in a variety of contexts including village PRAs, and be useful to those interested in participatory planning generally.

In both examples there was a need to reflect on the present situation *("where we are now"*), to identify an ideal future (*"where we want to be"*), and to assess the factors which may determine the feasibility of attaining an objective (*"can we get there, and if so how?"*). In both examples, the exercise was carried out using a diagram drawn by participants (see figures below), and once the exercise was under way the facilitators stood back and were confined to an occasional prompting role.

· Assessing rural non-formal schools in Bangladesh

While undertaking an evaluation of Concern Worldwide's primary school programme in Bangladesh in early 1994 it became evident that there was a pressing need for more non-formal education (NFE) schools in the *haor* (low-lying, flood prone) areas in the north-east. Concern already has five pilot NFE schools, but is thinking about extending their activities. Community PRAs, which included wealth-ranking of households with school-age children, clearly showed that poorer families are not being served by existing government schools. More flexible school timings and curricula are needed for this target group.

Concern's five teacher trainers regularly come into contact with all existing schools, and therefore have both local level and broader knowledge of the programme. This group is based in Dhaka, but individuals circulate between both rural and urban schools to give in-service training. Conducting a force-field analysis with them revealed a range of positive and negative factors which they deemed important for deciding on how to expand the NFE project.

We first discussed the present situation of the five existing NFE schools which had a total of 30 teachers (working in a three-shift system). Most of the teachers are quite well qualified which meant that many are not from the villages in which they are teaching, most are men, and are being paid well by local standards. This latter point means that the schools are relatively costly. The teacher trainers then outlined an ideal future sometime early in the next century where there would be 50 schools and 300 teachers.

The brief definitions of *"where we are now"* and *"where we want to be"* in the future were then scribbled onto opposite ends of a large sheet of paper, with an arrow linking the two (see Figure 1). The trainers then set about discussing and drawing in positive and negative

Source: PLA Notes (1995), Issue 23, pp.11–15, IIED London

forces, using arrows to indicate the direction of the forces. The resulting diagram took about two hours to create.

Out of the exercise came a recognition by all participants that a major task lay ahead. False expectations were not being raised because negative forces were being clearly identified, but the trainers remained optimistic that expansion was possible. They concluded that some positive forces could be accentuated as long as some changes to the programme were made. For example, the training unit could be expanded, new training courses devised, community-school relations could be strengthened by recruiting more local people and more women onto the staff, and school effectiveness could be increased by liasing with local government officials in planning school sites.

Conversely, some of the negative forces could be countered. Financial resources could be used more efficiently by reducing school unit costs, especially if less highly qualified teachers were recruited. Existing staff, potentially unhappy at new staffing policy, could be absorbed slowly by creating new training posts, a head-teachership for the larger schools and finding work in other projects, for example the urban schools.

Overall, the exercise led the trainers to suggest that any expansion be carefully phased. New schools, employing local teachers, needed to be opened on a pilot basis, in areas away from the old NFE schools (partly so that existing staff have more time to be absorbed 'naturally'). Expanding the project in the original areas should be delayed for some years. Liaison with local education officials was also highlighted, to create a 'satellite' system, enabling class III NFE graduates to continue in government schools if they wished.

Throughout the exercise detailed notes of the discussion were taken and the ideas generated by the trainers' analysis were incorporated into the final evaluation report which was then circulated amongst Concern's staff, and is still under consideration by the organisation.

· Cleaning-up Calcutta's transport sector

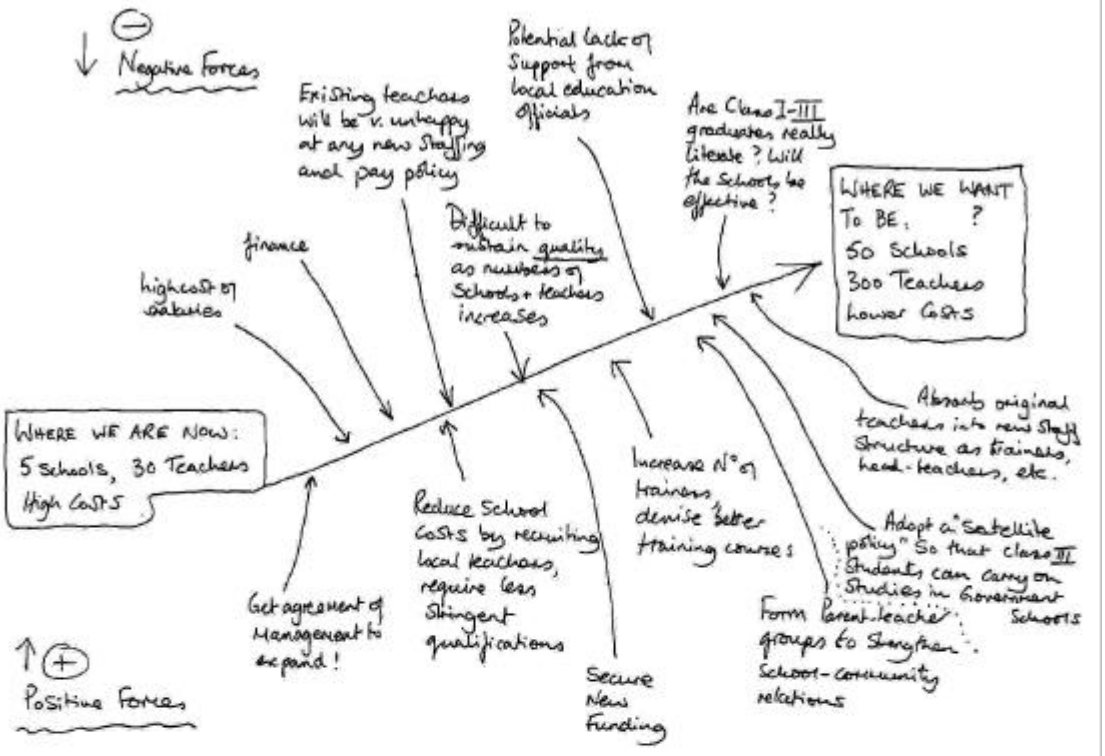
While working on an appraisal mission for an urban environmental programme in Calcutta we wanted to involve NGOs and individuals in the preliminary project planning. Given that urban environmental improvement implies a vast range of potential sectors, we chose just one - the transport sector - as a dry-run for participatory planning.

The exercise was too brief (and the problem too large) for a fully satisfying outcome. However, while concrete plans failed to materialise, the principle of NGO participation in the project gained importance. The exercise therefore played a useful strategic role.

Calcutta suffers, like any large metropolis, from poor transport services. Particular problems are inefficient bus services, a collapsing tram system, and congestion caused by taxis and the growing car-ownership amongst the middle classes. Traffic congestion leads to chronic air pollution which has major health implications, especially for the more vulnerable such as the poor and children. Major problems with enforcing existing legislation (eg. on vehicle emissions) are also evident.

Source: PLA Notes (1995), Issue 23, pp.11–15, IIED London

Figure 1. Teacher trainers' force-field analysis for expanding a rural non-formal school programme in Bangladesh



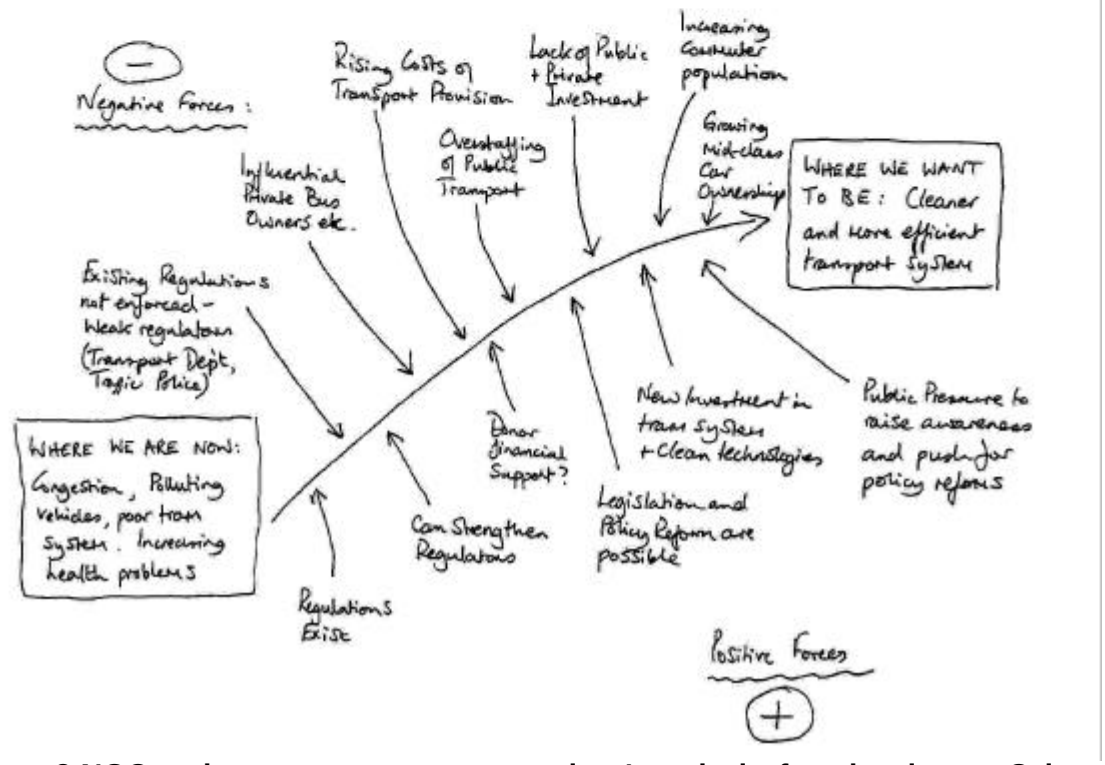


Figure 2.NGO and government representatives' analysis for cleaning-up Calcutta's transport system

Source: PLA Notes (1995), Issue 23, pp.11–15, IIED London

This outline of the present situation was drawn up by a small group of both government and non-government organisation staff in a collective discussion. Both advocacy and development NGOs were represented in the group (people representing 'green' and low income groups' interests). All participants agreed that there was a serious need to develop a cleaner and more efficient metropolitan transport system over the next two decades. Forces acting for and against achieving this objective were then discussed and the outcome is shown in Figure 2.

Having outlined the various forces, the participants then considered how negative ones could be reduced, and the positive ones accentuated. Lack of finance could be off-set by attracting donor funds, devising local policies to attract private investment and create new pricing policies to encourage such investors. The need to increase the efficiency of the transport department was highlighted, so that existing legislation could be applied more effectively.

During the discussion the key role of public awareness (and pressure for change in policies) was highlighted. For this to be effectively stimulated more transparency in the Transport Department's planning process was suggested by NGO representatives. They pointed out that NGOs could contribute to this planning process, as well as to awareness-raising campaigns amongst various public constituencies and activities to gain the support of the press.

Out of this force-field analysis came a strong justification for NGO involvement in the improvement programme (not just transport sector planning), and a realisation that a formal consultative structure for NGO-government cooperation was needed. The exercise, by bringing together diverse interested groups, therefore appeared to further the principle of stakeholder participation in the overall project.

· Variations on a theme

The original force-field exercise outlined in the ODA course also suggested a checklist of questions for following up the initial analysis:

- What are the relative importance of the positive and negative forces (eg. can they be ranked in terms of strength, ease of change or impact)?
- What are the reasons behind such rankings; and what implications do these have for the sort of action that can be taken?
- Which stakeholders have the most influence?
- What will happen if we don't achieve the desired objective(s)?

To these, one might add:

- Have the interests of other stakeholders (especially the less organised and more vulnerable) been taken into account during the analysis?
- Should the exercise be carried out with a different group of interested stakeholders to see what different objectives and perceptions they have?

· Conclusions: wider applications of the exercise?

Force-field analysis should not necessarily be confined to workshop situations. While both case studies above involved literate participants who could draw out the diagram themselves, there is no reason why people should not attempt to use the technique in other PRA situations. One analogy to illustrate this point is the use of time-lines. Force-field analysis is a little like doing a future time-line for forecasting the factors which will have to be considered if a desired objective is to be achieved. Just as time-lines can be constructed using symbols, counters or representative objects rather than text, so might force-field exercises be feasible for non-literate community groups.

In both the case studies, the final outcomes were not perfect by any means. In the Calcutta example the subject was very broad (the transport sector for 12 million people!), and difficult to handle in anything other than a general sense. In the Bangladesh example, the ideal objective also began to look a bit too grand, and it needed expanding from a simple

Source: PLA Notes (1995), Issue 23, pp.11–15, IIED London

quantitative target to a more qualitative idea of what the schools should be trying to achieve. In fact, the discussion did lead to this. When the trainers started talking about school quality and the need to set up a satellite system with local government schools they were recognising that they should be developing their original objective. If we had had more time, perhaps the exercise could have been repeated with revised objectives in mind.

However, force-field analysis is a useful way of involving different people in the analysis of objectives and how they can be achieved (and not just the collection of data). It is therefore a potentially empowering tool. In the Bangladesh case study, the teacher trainers felt enthused by their contribution to the planning process. In the Calcutta case study the NGO participants felt that they had proved their importance to government representatives. Hopefully, the latter also increased their commitment to NGO involvement in the planning process.

If there are any *PLA Notes* readers with participatory planning tools similar to, or improving on, the above please drop me a line.

- **Richard Montgomery,** Centre for Development Studies, Singleton Park, Swansea SA2 8PP, UK.

ACKNOWLEDGEMENTS

Thanks are due to Siddiqur Rahman, Education Programme Manager, Concern Worldwide (Bangladesh) and Ken Robson, independent institutional analyst, who helped facilitate the exercises in Bangladesh and Calcutta respectively.

Source: PLA Notes (1995), Issue 23, pp.11–15, IIED London

3

A participatory methodology for community-based land and resource use planning: a case study from Tanzania

Derek Armitage and Suman Garcha

· Introduction

This paper provides a short account of a participatory methodology used in the development of land and resource use plans. This methodology overcomes constraints imposed when traditional processes focusing on technical issues such as land use capability are employed. Moreover, it allows stakeholders to develop their own land and resource use designations and encourages local-level resource management. The outcome of the process is, we argue, a more sustainable and appropriate land and resource use plan.

· Background

For centuries the Lake Eyasi basin in Tanzania's Rift Valley has been inhabited by a small hunting-gathering community (the Hadza) whose complex understanding of the local ecology enables them to cope with the harsh environment.

However, since the middle part of this century land and population pressure in surrounding areas has meant that agriculturalists (the Iraqw) and pastoralists (the Barabaig) are migrating into the area in search of 'open' lands. The result has been significant land loss for the hunting and gathering group, environmental decline of the fragile dryland ecosystem (eg. habitat loss and wildlife decline, deforestation, and overgrazing), and increasing land and resource use conflict.

To address this situation, a land and resource planning process was initiated by an international NGO in consultation with representatives from the Hadza community.

The process was undertaken for an area of approximately 150,000 hectares in the western zone of Mbulu District. Three core villages formed the primary focus of activities. Each village is inhabited by one of the three groups. The western zone of Mbulu District has largely been ignored by District authorities for several reasons. Physically, the environment is harsh with little potential for agricultural use. Although located in an area of high population density, the zone remains isolated partly due to a steep escarpment that has hindered the construction of roads. One of the greatest barriers to community involvement in this zone is based on the attitude of government workers. Most Tanzanians consider hunter-gatherers and pastoralists as 'backwards' and 'primitive'. The zone has a long history of forced settlement schemes that impose agriculture as the

Hadza and the Barabaig are now reluctant to discuss matters with the District authorities when their viewpoint has been excluded for so long. Activities were thus implemented where possible through the District government in an effort to further collaboration and support.

The need for a participatory approach

There is an emphasis in Tanzania on the demarcation and titling of villages and the development of Village Land Use Plans (VLUP). However, methods for undertaking VLUPs are not well developed, and where they do exist, focus on technical issues and are developed outside the village. The result is a land and resource plan that overlooks critical socio-economic and ecological interactions and that has had little input from those most affected by the process. A participatory approach allows a more sustainable and appropriate planning process to be initiated. If

Source: PLA Notes (1995), Issue 23, pp.16–19, IIED London

stakeholders can develop their own land use maps, workable management systems are more likely to be created. Overall resource management activities can be improved by combining technical analysis of land and resource systems with the participatory development of land and resource plans.

A participatory approach to the land and resource planning process was considered essential. There were several reasons for this:

- only a few members in the Barabaig and Hadza community able to read or write;
- resource use patterns necessitating cooperation and dialogue in the development of a broader resource management plan;
- making land and resource interactions more complex. It was felt that PRA approaches would allow a deeper understanding of these issues. Moreover, a flexible approach was needed since the nomadic lifestyle makes scheduling of activities difficult; and,
- trust between the communities and the District authorities was critical. Listening and creating dialogue were key elements of the methodology.

To meet these challenges, several participatory methods were used, including participatory mapping, focus group meetings, semi-structured and open interviews, community transects, and seasonal diagramming.

· Planning process description

After introducing the project to stakeholder groups, participatory mapping helped to outline physical and spatial aspects of land and resource use (eg. important wildlife areas, grazing areas), and specific sites of importance (eg. dry-season spring sources). Materials used when mapping were chosen by the participants and included seeds, bark, rocks and leaves.

Mapping activities then led to broader group discussions about various land and resource uses and the key problems associated with land, people, and water resources. No limits were placed on the number of people who could participate. However, while the number of men and women were roughly equal, only a few women would speak on a regular basis. Consequently, focus group discussions and mapping with women as the primary participants were also undertaken.

Having gained an insight into land and resource use issues from the initial mapping and group discussion activities, a second series of mapping activities was initiated. The objective was to facilitate a more focused discussion on demarcating certain areas for specific uses, to clarify the areas of land and resource use conflict and to develop ways to overcome them by adapting resource management systems. In this context, the role of land rights was brought up by the participants who also raised the need for having some tool to protect their resources raised. Throughout the mapping process, other methods were used to verify, enhance, and improve the information gathering and discussion process (eg. transects, seasonal diagramming, interviews).

Through these activities the stakeholder groups developed land and resource use plans for their village territory. The groups are able to present the rationale behind the decisions and this helps them to support their plans. The need for resource management and conflict resolution systems can also be addressed. For example, the Hadza and Barabaig communities have already developed an informal management system for using certain springs in the dry season. Such management systems can be formalised with greater precision through plan development. And as each village completes and agrees to the plan, it can be passed through the ward and district government levels for approval, official status, and legal recognition.

· Lessons learned and insights gained

The process proved both challenging and illuminating. Outlined below are several lessons and insights gained during the planning process.

Source: PLA Notes (1995), Issue 23, pp.16–19, IIED London

participants placed relevant landforms on the map, it was a straightforward process to identify the significant land use areas for their traditional economy.

- will help overcome problems that arise from the fact that village boundaries bear no resemblance to actual land use. This is of particular importance in this context given that two of the three groups are nomadic.

Conclusions

It is our belief that allowing stakeholder groups to develop their own land and resource plans enhances the sustainability of those plans. This reduces many of the shortcomings of a strictly technical approach to land and resource planning, such as the focus on land capability to the detriment of other important socio-economic and cultural factors. A participatory approach encourages the use of indigenous ecological knowledge and places decision-making capacity in the hands of groups most affected by land and resource changes.

For policy development, this implies that land and resource use is best directed at the local level. Imposing environmental management strategies from national or even district levels can be detrimental. Consequently, a methodological process based on dialogue and trust is the way forward for promoting local participation.

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part because the Hadza have detailed geographical knowledge of their traditional lands. They are accustomed to navigating using physical markers. Once

4

Who should choose? Community participation in prioritising road network rehabilitation

Nick Osborne

· Introduction

In May 1994 PRA methods were used with the people of Katuba, Ndola Rural East in Zambia with the aim of enabling communities to identify and prioritise their own District feeder road networks, a function traditionally carried out by outside 'experts'. The methodology has subsequently become standard, and has been applied and used on all further feeder road improvement programmes undertaken by the Smallholder Development Project. This paper outlines the approach taken, and explains how the approach of community participation in the decision making process has been expanded enabling local communities to take on the role of organisation, co-ordination, and management at every stage of the project cycle, with minimum external assistance. This is thus a case study where a local experience with PRA was subsequently scaled up to the level of a whole programme. It also demonstrates how initiating a programme with community planning increases the likelihood that the programme will be sustained.

· The feeder road improvement programme

The Smallholder Development Project was initiated in April 1988 to improve the productivity of smallholder farms in Ndola Rural East. A major aim has been to establish a labour intensive rural Feeder Road Improvement Programme (FRIP).

Experience has shown that more often than not improving rural feeder road networks is an important priority for rural communities. A poor road network often has an adverse effect on the livelihood security of the rural population because it leads to problems of access, especially during the rainy season. This, in turn, causes a decrease in agricultural production because it reduces availability of and access to inputs, markets for produce, health care, and educational facilities. This inevitably leads to isolation and a lack of incentives for local communities to prosper by expanding production, diversifying their farming, developing enterprises, or adopting new methods and techniques.

Feeder road studies are traditionally carried out by technical experts or consultants in conjunction with government staff. Indeed, this was the approach that had previously been taken in the project area. A road inventory would be carried out by the outside experts on a limited number of roads. Roads would be prioritised according to future population growth, development potential etc. This method is time consuming, costly, and unlikely to establish the true value and priority of the feeder roads to the community, the main beneficiaries. Farmers who were consulted afterwards commented that:

> *... although the road structures had improved movement and access, they had been badly constructed. The community should have been part of the decision-making, and using their own local knowledge, labour and other available resources would have been mobilised to implement construction work, rather than the outside domination.*

Another important issue is the future maintenance of these rural feeder road structures. If communities feel that the work

Source: PLA Notes (1995), Issue 23, pp.20–25, IIED London

done by outsiders was of a poor standard, there is little hope of community maintenance and rehabilitation in the future. It was thus decided to use a pilot PRA to assess how far communities in the project area could be effective in identifying, locating and prioritising their own feeder road network.

· Methods

Katuba Ward was chosen for the pilot because the project and District Council have done little work in this area. About 50 local people, agricultural staff and the local Councillor took part in the exercise.

The local people were asked to draw a map of Katuba showing all the main roads in their Ward, along with other facilities such as rivers, markets, schools, clinics and so on. The group were able to map and name 34 District feeder roads. Next the group was asked to list all criteria that they considered to be important when choosing roads to be improved. The results are summarised in Table 1.

Identification of key district feeder roads

To identify the most important feeder roads out of the 34 already named, the group was split into three smaller groups. Each group was asked to list the 10 most important roads and to then list the reasons for their choice according to the criteria they had identified earlier. The results from the three groups were then combined. The number of times each criterion is used is added together for each of the groups. The scores for each of the groups are added together to give a final score in order to rank the criteria in order of importance (Table 2).

Table 1. Criteria used for the prioritisation of feeder roads (in no particular order)

Criteria	
Access to clinic	Access to Chief
Access to school	Access to market
Access to railway station	Access to sand pits
Access to road for farm produce	Access to depots
Access to farm inputs	Impassable road
Access to agricultural camp	Large population of farmers

Table 2. Ranking of criteria used in the prioritisation of roads

Criteria	Number of Times Criteria Used			Total Number of Times Criteria Used	Rank
	Group 1	Group 2	Group 3		
Access to clinic	2	4	6	12	3
Access to school	3	5	8	16	1
Access to railway station	1	3	1	5	5
Access to road for farm produce		3		3	7
Access to farm inputs		1		1	11
Access to agricultural camp	1	4	1	6	4
Access to Chief	1		3	4	6
Access to market	2		1	3	7
Access to sand pits	1		1	2	9
Access to depots	1		1	2	9
Impassable road	1			1	11
Large population of farmers	1	2	10	13	2

Source: PLA Notes (1995), Issue 23, pp.20–25, IIED London

The results from the table show that three criteria were particularly important to people: access to clinics; access to schools; and the presence of a large population of farmers.

Each of the three groups were asked to prioritise the 10 chosen roads using pair-wise ranking. Each road chosen was compared against each of the other roads in turn to assess whether it is of greater or lesser priority. The results were tabulated in matrix form. When the matrix was full each road's score was totalled and was then ranked in order of priority from 1 to 10.

The scores from the pair-wise ranking for each of the groups were added together giving a final total score. These scores were ranked and the results are shown in Table 3.

A final group discussion was held to summarise and confirm the results, and to ensure that the community as a whole agreed. The group was happy with the results, and confirmed that the ranking of roads obtained from the exercise was correct according to their chosen criteria. This then concluded the exercise, which took approximately four hours to complete.

Project strategy

The methodology described above has subsequently been adopted by communities throughout the District, forming the basis for all roadwork projects implemented under the FRIP. This approach allows local communities to make decisions at the very beginning of the project cycle, which is ultimately the most important stage given limited resources, capital funds and time. Following the identification by the community of the priority roads, there are four further stages to the FRIP (see also Figure 1):

1. Planning
2. Training
3. Implementation
4. Future maintenance

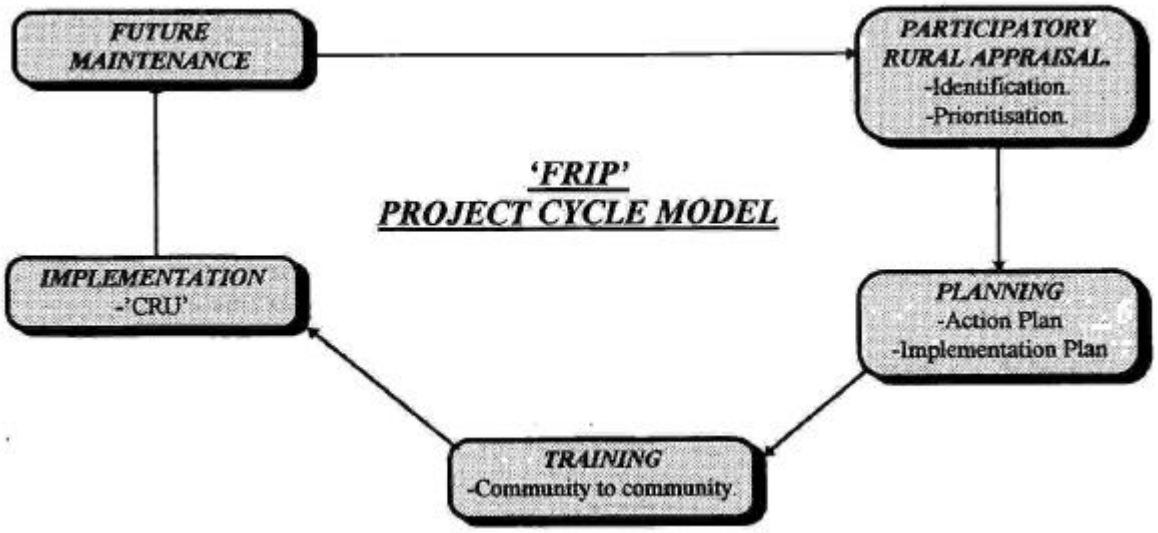
Community facilitators provide a vital link in assisting the local people with all stages of the project cycle.

Table 3. Final community prioritisation of district feeder roads in Katuba Ward

Road Name	Group Scores			Total Score	Final Rank
	Group 1	Group 2	Group 3		
Mupapa 1	9	9	7	25	**1**
Mukubi	4			4	**10**
Katuba	8	8	5	21	**2**
Mwanakonse	7			7	**8**
Senseta	1	4	3	8	**7**
Kango	2			2	**15**
Chabalankata	7	0	8	15	**3**
Chintilye	4	6	2	12	**4**
Mikula	3			3	**13**
Chela	4			4	**10**
Mupapa 2		1	9	10	**6**
Saka 1		6	6	12	**4**
Palace Road			4	4	**10**
Lamba Lima Extension			0	0	**17**
Mulobelela		6		6	**9**
Shinkonde		3		3	**13**
Chikululu		2		2	**15**

Source: PLA Notes (1995), Issue 23, pp.20–25, IIED London

Figure 1. The FRIP project cycle model



Planning

Following the prioritisation exercises, people then decide how they would like to participate in the rest of the project. Communities draw up detailed action and implementation plans and select members for a Technical Committee to be responsible for co-ordinating reconstruction works and future maintenance works. There is always a balance between men and women.

Having identified and prioritised roads, the community is set a target number of days in which they can use the Core Roadworks Unit[1] (CRU) to complete their proposed project. This period is usually 14 days, but can be increased up to 21 days, although from experience this is the maximum period of time that communities are able to continuously commit to the project. The community sets a date to start work. With the help provided by the CRU, the local community is able to plan and commit periods of their time to the intensive work programme, which would otherwise interfere with farming, business, or family activities.

Organised through the locally-selected Technical Committee, communities provide all the labour requirements for the implementation of the road reconstruction and rehabilitation works.

Training

In addition to being involved in both the planning and implementation stages of the programme, the community also gains experience in road rehabilitation and maintenance. The community sends members of the Technical Committee to visit roadworks in other areas. In this way they are taught the basic skills of labour intensive rural road rehabilitation. The members then return to their respective community prepared to implement their programme having acquired the relevant skills, which are then passed onto other community members during implementation of their roadwork programme. This cycle of training continues for all future areas.

Implementation

Local communities work on their feeder road network for the pre-determined period of days. The Project assists through the provision of the CRU. Having agreed on the identification and prioritisation of feeder roads as a community, there should be no confrontation between individuals during implementation since everyone is aware of the reasons and benefits of their working programme, with no questions of favouritism.

[1] The CRU is run by the Project, and provides tools, transport, materials and technical advice for rural road rehabilitation.

Source: PLA Notes (1995), Issue 23, pp.20–25, IIED London

Maintenance

Most road maintenance only requires the most basic of skills. A lack of maintenance by communities in the past can partly be attributed to their perception that expert technical knowledge was required.

The project enables local people to acquire all the skills necessary to maintain their own feeder roads. The fact that communities have been involved in choosing the roads themselves, and that maintenance is being carried out on their most important roads greatly improves the chances of those roads standing the test of time.

Community monitoring and evaluation

All the outputs from the PRA exercises are kept by the Technical Committee for use by the community for the following reasons:

- As a record of the decisions made by the community;
- As a management tool for planning and programming the implementation of the project;
- To enable performance indicators to be set;
- To monitor the progress of roadworks;
- To evaluate the project when completed and to plan future projects; and,
- To act as a record base for future feeder road improvements.

· Conclusions

It is clear that simple PRA methods enable communities to prioritise their feeder road networks effectively and efficiently. The methods enable people to explain the criteria that are important to them but which would otherwise have been omitted by external technical experts. For example, the external technical experts would use access to farm inputs and depots as an important factor when making an economic evaluation of feeder roads. Table 2 showed how low a rank these criteria were given by people when compared with access to facilities such as schools and clinics.

Through community participation the time spent in relation to the information gained is exponential. In just under four hours a community is able to locate, identify and prioritise the entire feeder road network in their Ward. Technical experts would find this very hard to match using their techniques. If community members were to be trained in the PRA methods described above they could conduct similar exercises in their own areas. This would enhance the technical experts' understanding of the priorities on which they can then carry out their road inventories and economic evaluations. The end result is a feasibility study that is more thorough, cost effective and has a greater chance of future success as opposed to other alternative external forms of mechanical implementation which continue to leave communities 'watching and wondering'!

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Source: PLA Notes (1995), Issue 23, pp.20–25, IIED London

5

Villagers in Sri Lanka plan their future in partnership with government development authorities

Kamal Kar, Gareth Phillips and Sunil Liyanage

· Introduction

The North Western Province Dry Zone Participatory Development Project in Sri Lanka is implemented through the Ministry of Policy, Planning and Implementation, supported by the International Fund for Agricultural Development (IFAD) and GTZ. Its main objective is to improve the standard of living of the rural poor in the dry zone of the North Western Province. It aims to do this through the formation of village resource management plans, prepared mainly by the villagers themselves using locally trained facilitators and PRA methods.

The following exercise was carried out as part of the project's training programme in which facilitators, core trainers and members of the Technical Support Team put their newly acquired skills to practical use for the first time. The seven facilitators comprised the Technical Support Team from the Departments of Agriculture, Livestock, Engineering, Land Commission and Rural Credit.

· The challenge

Notwithstanding the extent of NGO work, government departments still remain the single largest implementors of development programmes in many developing countries. As the importance of people's participation in the planning of sustainable development initiatives becomes more widely appreciated, we are thus faced with a new challenge.

Most of the success stories of participatory development approaches to date are being experienced by NGOs who generally conduct smaller programmes covering a more limited area. Although there have been applications of the methodologies in government field institutions, experiences are rather dispersed and not systematically reviewed. It appears that at present due to international demand and internal pressure the participatory jargon has entered government departments often without substantial changes taking place. Even where the governments of developing countries are gradually bringing in changes geared towards encouraging people's participation in development, the vast and old organisational set-up and traditional functioning of the departments mostly remain unchanged and are designed to implement and administer development activities from the top down.

It has been widely noted that the behaviour and attitude of government officials and field staff are vital for the initiation and sustenance of the participatory process, and are also the key reason for distortion of and resistance to attempts to introduce PRA in government institutions.

However, it is not impossible to bring about the desired change in the functioning of government departments. The participatory approach to development demands a little more time and commitment on the part of officials, a bit of flexibility in the rigid administration, a bit of freedom for the field staff, frequent mobility and also a strong political will.

If government departments are to become successful facilitators and implementors of participatory development programmes, civil servants locked into age old hierarchical bureaucracy and accustomed
to top down planning, inflexibility and even an 8 to 5 day, need to come out to the villages with

Source: PLA Notes (1995), Issue 23, pp.26–30, IIED London

a willingness to listen and learn. Many of the attitudes and aspects of behaviour of a large number of government employees need role reversal. This is the challenge facing PRA trainers in general and this project in particular.

· The location

Rajakandayaya is a small village in the North West Province of Sri Lanka. The farming is a mixture of lowland paddy and rainfed upland agriculture with some supplementary irrigation, producing seasonal vegetables and staples such as beet, chilies, pumpkin, maize, cassava and sweet potato. There are some livestock visible and shrinking forest on the tops of surrounding hills. This much is obvious, but how much more could we learn about the community in the next two and-a-half days?

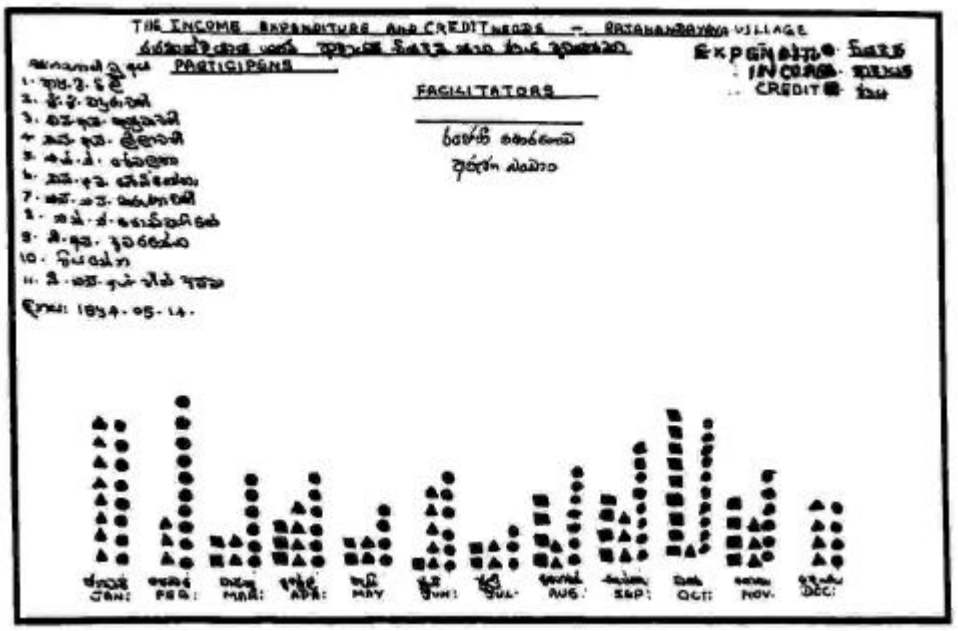
· Rapport-building and information sharing

On the first evening, the team arrived in the village and joined in friendly and informal discussion with the farmers. The team stayed overnight in the villagers' houses and the following morning we met in the community hall. When 15 or 20 men and women were present the facilitators gradually started things moving and a physical map, drawn with chalk on the rough cement floor slowly took shape. After much discussion, the map showed paddy field boundaries, roads, wells, waterways, houses, upland fields and forest. As more farmers became involved, one of us drew some away to discuss productivity trends for different crops. They identified six or seven commonly grown crops and using piles of seed, and later marker pens and paper, identified decreasing yields in several crops.

With four or five women, another team member facilitated a seasonal analysis of rainfall and cropping patterns. This showed that most rainfed crops were grown in the *maha* season from October to January. A species matrix for trees confirmed that *jak* (*Artocarpus hirsuta*) was the favourite tree, closely followed by mango and cashew. Mahogany and teak came close to last. Now familiar with the seasonal analysis technique, Ranjani and the ladies moved on to a seasonal analysis of credit demand, investment and income (Figure 1).

This shows that there is a strong demand for credit at the start of the rainy season in October. This is used to purchase seed and agro-chemicals.

Figure 1. Seasonal analysis of income, expenditure and credit needs



Source: PLA Notes (1995), Issue 23, pp.26–30, IIED London

· Chapatti diagrams

Some local people were very enthusiastic and late in the evening they came to the house where we were staying. This discussion was lively and resulted in a Venn or Chapatti diagram indicating the relative importance of the women's organisation compared to the insignificant role played by the national banks and other financial institutions (Figure 2).

The most significant organisation shown on the Venn diagram is the *seettu*. This is an informal financial institution managed by the villagers themselves or by specific interest groups. The *seettu* in Rajakandayaya was managed by a group of women. Members of the *seettu* make regular payments into the fund which is used to provide small loans to members in need of credit. Because the loans are small and made to members, no collateral is required. The money is stored in cash in the village so the loans may be made immediately. Borrowers pay 10% interest on a monthly basis and this income is distributed to members on a yearly basis.

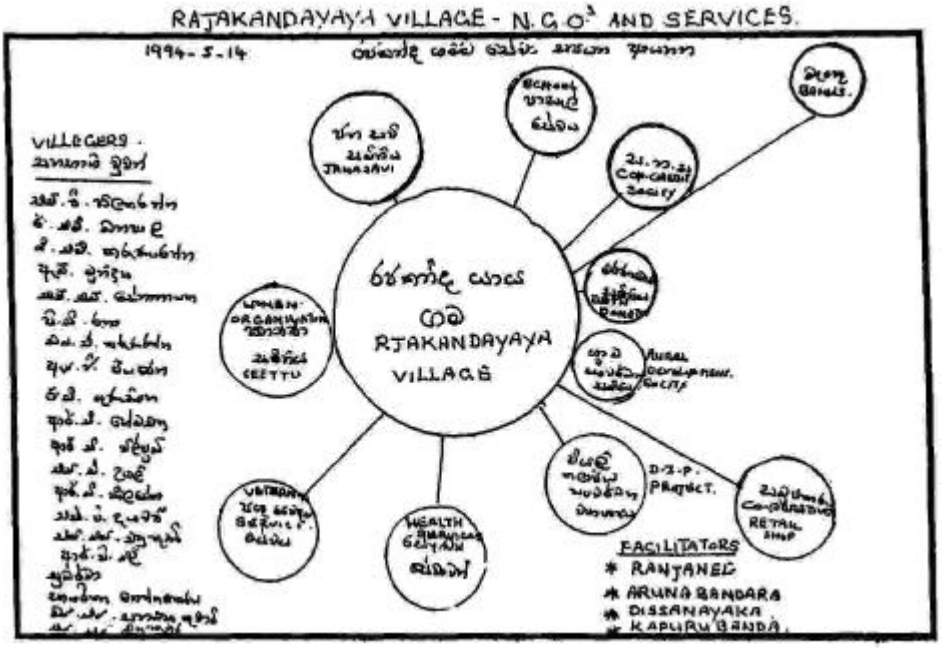
The information sharing was now complete and all the tables, charts and matrices were displayed to enable the villagers to cross-check and triangulate the information.

· Problem identification, prioritisation and participatory planning

Before breaking for lunch, a group of 11 farmers compiled a list of problems facing upland and lowland agriculture, and presented them to the rest of the farmers. This was very helpful because it focused people's minds on problem identification. When everyone returned in the late afternoon, they were quick to form groups and write down their problems on pieces of card. These problems form the basis of the Village Resource Management Plan (VRMP) (Figure 3) and as we will see, they extended beyond farming.

The importance of identifying the target group became apparent as we moved into prioritisation of the problems. For the wealthy farmers, the lack of permanent housing was the major problem. For the middle and low income farmers the market price for agricultural produce slowly emerged as the major problem, and housing was gradually moved down the list.

Figure 2. Venn diagram



Source: PLA Notes (1995), Issue 23, pp.26–30, IIED London

Source: PLA Notes (1995), Issue 23, pp.26–30, IIED London

· The village resource management plan

At this stage, the facilitators were rather disappointed because it seemed that the primary solution the villagers were working towards was one of price guarantees for agricultural products, but when they came to produce their own solutions, the picture changed. The village participants decided that the single most important problem was the poor prices received for agricultural produce. When the harvest is in full swing, prices fall very low but because the farmers are in debt, they cannot wait until the price increases (Figure 1). Without hesitation they decided that rural credit was the solution to this problem, and that all farmers could benefit from it. The other problems identified are listed, along with solutions, beneficiaries etc. in Figure 3.

· Conclusions

Our experiences from this exercise are twofold. A high proportion of the facilitators, civil servants from five government departments, found the exercise very rewarding and have demonstrated a strong commitment to the participatory planning approach. This was undoubtedly helped by the attitudes of the villagers, who were enthusiastic from the start.

The transition from the appraisal to the participatory village plan has been very smooth. The rapport building, night stay, application of PRA techniques and triangulation encouraged the villagers to speak spontaneously and without reservation about their problems. The most appropriate possible solutions to the problems, the beneficiaries, the expected costs, villagers' contributions and responsibilities were openly expressed, culminating in a VRMP that included many problems and solutions beyond the scope of what the project can provide support for, but also included problems from four out of five of the areas specifically addressed in the project.

The PRA and VRMP have created a new understanding of the problems faced by the community, and in doing so, they may have helped to encourage the villagers to act together to improve their standards of living.

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Source: PLA Notes (1995), Issue 23, pp.26–30, IIED London

6

Participation in Scotland: the rural development forestry programme

Andrew S. Inglis and Ann Lussignea

· Introduction

The use of RRA and PRA in developed countries has been increasing over the last few years, and includes examples from Austria (Kievelitz and Forster, 1994); Switzerland (Scheuermeier and Ison, 1992), Australia (Ampt and Ison, 1989; Dunn 1993), North America (Gaventa and Lewis, 1991) and the UK (Cresswell, 1992) on topics ranging from land degradation and farming research to economic education and health. However, few of the studies have examined in any detail the application of the methodology and how well it transfers to a developed country. This paper deals with one experience in PRA in the planning of forestry activities in Scotland. On the basis of that experience we also make observations on how far PRA may be more widely applied in the Scottish environment.

· Participation in Scotland

Forestry is a land use with much to offer rural Scotland. However, to date many of the benefits have accrued to interests other than local people, who see the sale of forest resources to local buyers increasing, small nurseries and sawmills closing down, and a decline in local employment prospects. It was in this context that the idea of using PRA in Scotland was introduced by the Scottish Rural Development Forestry Programme[1]. The aim was to give local people a voice in these changes.

The first activity undertaken, for which Reforesting Scotland was given sole responsibility, was to produce four case studies analysing different local situations regarding rural people and forestry around Scotland. PRA was chosen for this analysis. A major reason for this choice was that NGOs' attempts to introduce change had failed to convince policy makers in the past. We felt that presenting local people's aspirations would be a far more convincing approach in signalling that change was required.

The most widespread form of public participation in natural resource matters in Scotland at present is through the Town and Country Planning system. This is limited to the right to make comments concerning development proposals and further limited by the fact that many aspects of natural resource management fall outside the scope of planning legislation. Other participatory initiatives, such as *Planning for Real* (Gibson, 1994) have been used with great success in urban environments, but whether and how they can be adapted to encompass the diverse problems of rural areas has yet to be demonstrated.

Those involved in this programme who also have experience of overseas rural development forestry work felt that many issues facing the project were similar to those being tackled by many development projects working in developing countries. These include:

- enabling a process through which local people themselves analyse their situation; and,
- including the options and increasing the confidence of those who don't normally get involved in discussing local issues.

[1] Run jointly by three NGOs: Reforesting Scotland, Rural Forum and Highlands and Islands Forum.

Source: PLA Notes (1995), Issue 23, pp.31–36, IIED London

Thus there was no reason why PRA would not be an equally effective approach in a Northern setting.

Some of the NGOs involved were unconvinced about the value of PRA as an appropriate approach in this context. However, as described below, they too became swept up in the process and realised the value of the approach.

The case studies

The case studies were conducted from March to June 1994. They were facilitated by different combinations of people at different times. For example a team of 25 people, which included 12 forestry civil servants from India, facilitated the Laggan case study. The studies thus served two purposes; to stimulate a participatory process of analysis and discussion with local people and an opportunity for practical experience for trainees. We were honest with the community about the aims and limitations of the study right from the start. It would have been unrealistic to make false promises that the work would stimulate change. All we could provide was an assurance that we would present people's aspirations and ideas that emerged during the PRA to the policy makers.

The work was conducted in four communities.

Laggan is a small village in the Central Highlands where a group of people from the Community Association have been trying to buy a block of neglected Forestry Commission[2] forest so that they can manage it to provide employment and income for people in the local area.

Tomintoul is situated to the east of the Cairngorm mountains. Most of the land and forest around Tomintoul is owned by the state. The land is managed for tourism and recreation and local people have no involvement in administering its use. People would like to have more access and control over the land and are looking for ways in which to achieve this.

The third community, Carsphairn, is a hilly sheep farming area in south-west Scotland which has undergone rapid commercial afforestation over the past 50 years. Anti-forestry feeling in the area is strong and people want to gain more local benefits from the forests and have a greater say in decision making over planting and management.

Finally, in the crofting[3] community of Borve on the Isle of Skye, crofters were frustrated in their efforts to initiate an afforestation scheme by the owner of the land. They subsequently joined together to buy the whole township from the landowner, and now plan to go ahead with a tree planting scheme on some of their common grazing land. This is a communal venture in an area which in the past has had very little interest in or tradition of planting trees.

The process

All the case studies followed roughly the same process. Having introduced the aims and approach of the study to local contacts in the villages, a village meeting was held in a local venue (a village hall or a large room in someone's house). Local people were separated into small task groups to produce social maps, land use maps, seasonal calendars, Venn diagrams, timelines and livelihood analysis charts. These meetings took place in a cheerful informal atmosphere with plenty of tea and cakes, after which local people presented their work back to each other for comment.

The following two days consisted of more focused semi-structured interviews with individuals in their own houses (both those who attended the village meeting and those who didn't) and then a final presentation of information obtained by the facilitators back to local people for cross-checking and comments. During the process different potential benefits that would be derived from local forests were suggested by many of the people. At the end of the process people voted for those benefits they felt would be most important. Each person had a certain number of beans to vote with which they distributed anonymously.

[2] The agency which runs and manages the state forest land.

[3] Crofting is a system of small-scale farming peculiar to the marginal lands of Scotland.

Source: PLA Notes (1995), Issue 23, pp.31–36, IIED London

Table 1. Ranking of the benefits Borve Township can gain from its forestry proposals

Benefit	No. of Votes	Rank
Shelter for livestock	16	1
Pleasant surroundings	12	2
Employment	11	3
Ease of sheep management	10	4
Timber products for local use	8	5
Income from timber	7	6
Wood-based local enterprise	6	7
Wildlife conservation	4	8
Increased tourism potential	3	9

Table 1 is an outcome of this ranking exercise when conducted in Borve. The table shows that priorities are based on enhancing current farming activities and creating jobs to bring people to, or keep more people in the area.

All the methods worked well and the mapping was especially good. Most groups were very enthusiastic and inventive, others more hesitant. Getting people along to meetings proved the most difficult part but even with this, an amazing amount of information and insight was obtained in a very short time and the PRA was considered a success. At the end, all the maps and diagrams were left with the case study communities. This was a symbolic gesture to demonstrate that unlike more conventional research processes, the information collected was for the use of the local people.

After the Laggan case study we held a slide show to describe the process to the previously sceptical NGOs. Laggan residents with links to these NGOs reinforced the view that the participatory approach
had been a success.

· Sustaining the process

In November, a national follow-up seminar was held. Participants included representatives from each of the case study locations, community groups and local forestry initiatives, forestry and rural development NGOs. The aim of the seminar was to create a level playing-field on which policy-makers and local people could meet and communicate. To achieve this, the local people presented the case study findings themselves. The impact of this on policy makers was likely to be greater than if the researchers or NGO staff had made the presentation on their behalf. The presentations provoked much discussion and analysis of the opportunities and constraints of the various forestry initiatives.

Local workshops for local forest action planning are to be held in the case study locations and also in new areas. They will provide support and advice for local people in the planning of their initiatives, and PRA will again be the approach taken.

Constraints and opportunities for using PRA in Scotland

Opportunities

The use of PRA enabled Reforesting Scotland to allow local people in the case study locations to analyse the situation themselves and to include the opinions and increase the confidence of those who don't normally get involved in discussing local issues. It was found that the approach used was able to get beyond the one or two community activists who tend to do most of the talking at public meetings (Box 1).

BOX 1

Source: PLA Notes (1995), Issue 23, pp.31–36, IIED London

CONFLICT RESOLUTION IN LAGGAN

Whilst conducting the PRA in Laggan, it became clear that the local people were deeply divided in their opinions about the forestry initiative. About half of the people present were not in favour. The PRA process enabled people to analyse their livelihoods more objectively than they would without the presence of outsiders. Forestry was deliberately not highlighted as a particular issue during this process. During this analysis, it emerged that people were not opposed to the forestry proposal itself - they were against it because of the personalities involved and the domination of the process by certain key activists. The PRA process did not permit domination by these assertive individuals and so ordinary people could make their views heard.

Another advantage of the PRA approach was that it allowed local people to analyse historical changes in local resource management. Complex communal systems of resource use and land tenure existed in many parts of Scotland 300 years ago, but there have been many changes, in particular the dramatic and traumatic Highland Clearances to make way for large sheep farms. Traditional resource management systems have subsequently largely been lost. There are some who believe we need to return to the traditional resource management systems if rural areas are to have a sustainable future.

However, the past cannot be recreated and the Programme is attempting to facilitate a fusion of lessons learned in rural development forestry overseas with a revisiting of old Scottish systems.

Everybody involved agrees that in this fusion process the knowledge and aspirations of rural people are the key to success.

The methods helped to spur people on to further action and created wider local involvement, exposed conflicts, the constraints and opportunities for greater local involvement, and presented an opportunity for many people to put forward their ideas for the future potential for forestry in the areas.

Constraints

Notwithstanding these opportunities, there are also a number of constraints to the wider use of PRA in Scotland. Firstly, there is no history of participation in Scotland. People instead tend to be reserved when faced with authority. As a result, many PRA techniques can be alien to people. Furthermore, public meetings are very unpopular fora, widely regarded as boring and futile, and so are rarely attended by ordinary people.

Another problem is that at present there are few trained PRA facilitators in Scotland. The skills needed are ones that are difficult to teach - people must learn by practice and making mistakes, but to do this there must be practical opportunities to learn. Organisations which can act locally need to develop and train their staff for participation and funding bodies must provide the resources for this to happen.

Finally, in many organisations in Scotland are reluctant to incorporate PRA as an approach. They argue that it is not acceptable to transfer a methodology used in the Third World to a country like Scotland. They argue that people are more literate, are likely to be offended by being asked to play games, and do not depend so directly on natural resources.

· Conclusions

On balance, however, there is demand for more PRA work in Scotland. The Scottish Rural Development Forestry Programme will continue using PRA and developing its participatory approaches as the programme progresses. There has also been a lot of interest shown by other Scottish government agencies and NGOs in the case studies and the PRA approach used. Further training sessions will be run.

Obviously there is the need, with all this interest, to ensure that all activities carried out under the title of 'PRA' can be considered good practice. This will require a critical amount of reflection and self analysis on the part of the PRA facilitators, while at the same time being positive about the process and convincing the many sceptics of the potential of PRA for Scottish situations. Not an easy task, but one

Source: PLA Notes (1995), Issue 23, pp.31–36, IIED London

that those involved in are taking seriously. It is also acknowledged that changing institutional attitudes and working methods will be a slow process, but those involved are prepared for a long haul.

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NOTE

A version of this paper appeared in *Haramata* Issue 24 (produced by the Drylands Programme at IIED), and is also based partly on Lussignea, A. 1994. *Sowing the Seeds of Sustainability: The potential of Participatory Rural Appraisal in Scotland*. Master's Thesis, University of Edinburgh.

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7

Identifying and tackling poverty: ActionAid's experiences in Vietnam

Carrie Turk

· Introduction

ActionAid Vietnam (AAV) has been working in Mai Son District of Son La Province since 1989. In 1990 AAV conducted RRA and socio-economic surveys in which the key problems identified by the community were falling agricultural production in the uplands and resultant food deficits. AAV's response was to develop an agricultural programme in which an extension service would promote soil conservation techniques. Agricultural activities began in 1992, and by the end of 1994 there were 1069 adopters across the 2633 households.

Despite the results of the surveys, AAV felt that we had insufficient information on the causes, extent and dynamics of poverty at the village and household level. At this time, the local administration was adamant that all farmers were equally poor and that, on these grounds, there was no need to target assistance at any particular group. This did not fit with what we were seeing in the village. We knew that the agricultural activities alone would not be sufficient to address the problems confronting the poor households, but before designing any more programme components, AAV felt it necessary to conduct further research into the issues surrounding poverty. The research, which is ongoing, has two main aims:

1. to help AAV understand the dynamics of poverty and therefore assist in the design of appropriate poverty-alleviation activities; and,

2. to assist AAV to identify and target the poorest groups and monitor their participation in the project.

This paper describes AAV's work to date on the identification of poverty and the programme interventions we have designed as a response.

· Identifying the poorest households

Villagers ranked their fellow villagers according to socio-economic status (as defined by the ranker) using techniques which are now widely used by many agencies working in Vietnam. AAV had attempted this exercise as part of the RRA in 1990, but had found villagers extremely reticent on the subject of relative wealth and poverty, shy because of the continual presence of local officials. Two years later, when AAV was free to operate without an official escort, villagers were quite happy to perform this exercise. The results showed a high degree of consensus between the different respondents as to who were the richest and poorest groups in the villages, indicating that wealth differences were quite clear to villagers.

This exercise led to the production of village ranking lists, in which all households are listed along with their socio-economic positions. These lists allowed AAV to locate the poorer households who were subsequently interviewed about their poverty. Perhaps more important than the production of village lists, the wealth-ranking exercise demonstrated to the local administration that there are great differences in well-being among village inhabitants. As a training tool for both our own staff and our local counterparts, this exercise has been extremely valuable.

Source: PLA Notes (1995), Issue 23, pp.37–41, IIED London

Household categorisation and socio-economic mobility

Producing a ranked list of households indicating relative well-being is a fairly simple task. However, defining socio-economic categories to indicate absolute wealth or poverty is more complicated. There are a number of reasons for this, the most important, perhaps, being the lack of clear indicators which may be used to categorise households and the high degree of mobility between socio-economic classes which characterises village life.

Lack of indicators

The food deficit, which most households use to describe their poverty, is itself an awkward indicator to define. Some households will say they have a food deficit if they are forced to eat cassava or maize (*"animal food"*) instead of rice for part of the year. In other households the food deficit represents a real hungry period. Even wealthier households claim to have food deficits because they eat less (although still adequately) during some months than during others.

One might look at the coping strategies that households use to address the food production deficit since rich and poor households may cope in different ways[1]. This is still a formidable task, however. As an example, one might assume that households with outstanding, unserviceable loans at high interest rates might be classified as poor. However, this would exclude some of the very poorest households to whom moneylenders and the formal sector will not lend because they are high risk. It might also include some of the wealthier households who have had access to larger loans for investment. They may currently be in debt, but with the promise of increased income in the future. Their indebtedness may be a sign that their household enjoys relative stability and is in a position to embark on longer term, higher-risk investments. One could also examine the dependence on wage labour as an indicator of poverty, the assumption being that the poorest households are more dependent than wealthier households. This assumption is not yet easy to substantiate. It is possible, for example, that the returns to day labour are higher than the returns to labour in agricultural production. Work that AAV has conducted in Quang Ninh Province suggests that the returns to labour in paddy production were comparable, perhaps even lower, than returns from other activities, such as collecting shellfish or day-labouring in quarries.

Socio-economic mobility

The changes in rural Mai Son are bringing increased vulnerabilities alongside increased opportunities for improved well-being. Under these conditions, it is not surprising that relatively wealthy families might find themselves on a rapid downward spiral or that poorer households find that they are able to improve their circumstances. Unforeseen expenditure commonly means that households have to take loans at high interest. This then drains their resources. Illness, for example, may lead to an expensive loan, which may deplete household resources to the point that they cannot purchase adequate agricultural inputs at the right time. This causes reduced agricultural output, which leads in turn to an increased food deficit. The failure of an investment which has been made with loan funds can be similarly destabilising. Where, perhaps for lack of other choices, the preferred investments are fishponds and livestock and where mortality rates can be as high as 50%, this is a common occurrence. Households find it extremely difficult to climb out of this spiral, which can be largely self-reinforcing. But AAV also has tales of households moving quite rapidly in the opposite direction through good investment and, probably, good luck. The upward spiral also appears to be self-reinforcing, but fragile at the same time.

In the face of such mobility, the wealth-ranking lists present a rather static snapshot of householders' status. AAV has tried to develop categories which capture the dynamism which characterises village relations at a given moment. These categories have been helpful in enabling AAV to understand poverty, but have not been easy to apply. This is largely because field workers have had difficulty identifying the differences between the middle two groups. The four categories, which attempt to include what the villagers have told us about wealth and poverty, are described in Box 1. Employment

[1] Details of more in-depth studies on villagers' coping strategies are available from ActionAid, UK.

Source: PLA Notes (1995), Issue 23, pp.37–41, IIED London

and debt (plus the direction in which the household is moving) are the two most important factors in determining which category reflects the conditions of a household.

BOX 1
WELL-BEING CATEGORIES AND INDICATORS

A. Leading Rich
They are rich and will remain rich. They have good and well furnished houses, and large livestock. They are probably educating their children who are well-nourished and healthy. They have good contacts with commune and district officials, may have access to bank loans and may well hold or have held official positions, such as Village Manager. They may employ day labourers and lend rice or cash (probably with interest) to non-relatives. They are likely to take or seek substantial loans, invest them profitably and have no difficulty in repaying. They stand to benefit from Land Allocation Certificates (LACs), which will protect their upland cash-crop investments, but they may resist taking these up if they feel they may reduce their chances of getting more land. Their position is stable and they are unlikely to fall into the lower categories.

B. Striving Rich
These households are potentially but not yet prosperous. They are a broad category usually to be found in the upper half of the wealth rankings but some may have been ranked lower because they may live in relatively modest houses and own little furniture. They may or may not be educating their children, some of whom may be in poor health. They may be in debt through investing in new houses or in production (new fishponds, fruit trees, livestock) and would like to invest even more. They have reasonable contacts and are able to get some finance, but not enough to satisfy their ambitions. They may employ labour seasonally but may also seek to work as day labourers themselves on occasions. They do not have the resources to lend substantially to others and may face short term agricultural deficits themselves and have to borrow seasonally. They may seek LACs. They may soon move up to join the Leading Rich (whom they exceed in number) or they may fall.

C. Aspiring Poor
It is often not easy at first sight to differentiate between this category and the Striving Rich. The aspiring poor are generally found below the top third of the wealth rankings. They live in run-down houses and their children may be in poor health. They are in debt both for consumption and investment purposes. They do not lend to others. But they are ambitious and usually young households who are looking forward to prospering. They have to supplement farm income with day labouring or self-employed labouring. They are not employers. Some may lose out on the LAC system if their families are still growing and if they- have not taken much upland into use yet. They may go up or down. Their neighbours expect them to prosper.

D. Vulnerable Poor
They are invariably found at the bottom of the wealth rankings. They live in run-down houses, and have poorly nourished and often unschooled children. They are in chronic debt and are unable to finance their farming adequately. They supplement their farm income by day labouring (when they can get it) or self employed labouring and in some cases begging. The adults may well be in very poor health and may be elderly or the household may be female headed. They may lack ambition and be perceived by others – and sometimes themselves – as poor managers or lazy. LACs will not help them directly as they have trouble farming the land they hold but may affect their work habits by providing more day labouring jobs. They are a potential future landless labouring class who are extremely unlikely to move up without help.

Source: PLA Notes (1995), Issue 23, pp.37–41, IIED London

· Programme responses to the problems of poverty

AAV has designed a number of programme interventions which we believe to be appropriate to the needs of the poor[2]. The overall aim of the programme is to improve the socio-economic position of poor households, enabling them to take control over key aspects of their daily life. Some activities are designed to address the core problems and some are designed to reinforce coping strategies.

The aim reflects AAV's belief that poor households need assistance first with stabilising their economies before they can be expected to invest in new, often high-risk opportunities. Once households have addressed the fundamental problem of how to cover their annual food needs without becoming increasingly indebted, then it may be possible and attractive for them to diversify their livelihood systems. However, AAV does not expect poor households in the precarious position of insufficient food supplies and dependency on expensive loans to invest in risky enterprises which might jeopardise their livelihoods further[3]. AAV programme interventions are designed with a view to promoting greater stability and to helping households first with their consumption needs. Once the downward spiral of poverty has been halted, AAV hopes that the poorer households will be better placed to participate in and take advantage of the growing market economy in Mai Son. AAV anticipates that it may take a number of years before the poorer households feel secure enough to embark on new activities which will actually increase their household incomes.

[2] Further details of this work are available from ActionAid.

[3] Some householders have been asked the question *"how would you measure if your well-being had improved in five year's time?"* in order to gauge community aspirations. Those in lower categories felt if they had sufficient food and a tile roof they would be better off. Those interviewed from the top category felt that a fishpond and an orchard - both risky undertakings - would improve their well-being. This has emphasised the need to help poor households find greater stability so that they might then be in a stronger position to take advantage of the new opportunities arising.

Targeting activities at the poorest

ActionAid has an organisational mandate to help the poorest of the poor. In some programmes in other countries certain activities are targeted exclusively on the poor. Our attempts in Mai Son to target the poorest to the exclusion of other groups have been fraught with difficulties, in particular:

- *Community resistance.* In the communities with whom we are working there has been considerable resistance to the exclusion of households from programme activities. This stems in part from the difficulties involved in categorising the poor, given the high socio-economic mobility. Within communities there is consensus about who are the very poorest households, but above this level there is a grey area with some households moving up and some moving down. This has made AAV's cut-off point (the bottom 50% of the wealth-ranking) quite arbitrary and has led to confusion as to why some households are included in activities whilst others are excluded. Some more resentful households have caused problems for the Programme.

- *Resistance by local project partners.* Our partners have found it extremely awkward standing up to more influential villagers who wished to be included in activities, but should have been excluded on the basis of the wealth-ranking lists. Once some wealthier households were included in the activities, it became very difficult to exclude other wealthier households.

As a result, AAV is no longer excluding wealthier households from the programme. Instead, all extension efforts are directed towards ensuring the participation of the poorest households. The wealth-ranking lists are used for this purpose. Programme activities, such as the savings and credit programme, are designed in such a way as to limit the possibility of wealthier participants capturing the benefits.

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Source: PLA Notes (1995), Issue 23, pp.37–41, IIED London

NOTE

This paper draws widely on other work by AAV, available from ActionAid, UK.

Source: PLA Notes (1995), Issue 23, pp.37–41, IIED London

8

Some notes on conducting PRA training in Nepal

Saloni Singh and Birendra Bir Basnyat

· Introduction

In recent years in many developing countries PRA has gained increasing popularity among NGOs as a powerful technique to involve local people in planning, implementing, monitoring and evaluating development projects. Nepal is no exception. Increasingly, the interest of donor agencies in participatory approaches has led many professionals and trainers to conduct PRA training here in Nepal. But they would, certainly, be deeply hurt if they knew that many ex-participants of those PRA trainings argue that they would never suggest any one to participate in PRA training in future. This is, indeed, a serious matter. If anyone is to be blamed for this, we the trainers should appear on top of the list. This is sour and difficult to digest. But providing PRA training has become a 'bread earner' for many of us and lack of seriousness among trainers is a grave matter.

Nonetheless, the purpose of this paper is neither to count the strengths of PRA, nor to make attempts to change attitudes of those ex-participants who have already acquired negative attitudes towards PRA methods. This paper has been prepared in the realisation of the need to share training experiences among trainers. We report on a PRA training course that we gave recently to the field staff of World Neighbours and its collaborating local NGOs - Baudha-Bahunipati Family Welfare Project, Samaj Sewa Samuha, Tamakoshi Sewa Samiti, and the Nepal Agroforestry Foundation. The training was conducted at Hinguwapati, a village in Kavrepalanchowk District, Nepal in December 1993.

· On participants

In this training the participants were very heterogenous in terms of experience, socio-economic background, educational qualifications, position in the organisations and so on. Often trainers do not like to train heterogenous groups. In the beginning it seemed a challenge for us, but we came to realise that a heterogenous group of participants is an advantage for conducting PRA training. In our view, sharing experiences among the participants was a factor that contributed to the success of the training. For this it is essential that trainers meet some prospective participants beforehand to assess their needs, expectations and knowledge of PRA. Course materials should be prepared in advance, taking into account the needs of such diverse groups.

· On entry to the subject

Before starting the training course our major concern was how to introduce PRA to the participants. Should we start by defining PRA, or by discussing why PRA is conducted? In both cases, the danger loomed that response from the participants would be minimal and that we would be delivering a one-way lecture, counting the strengths of the PRA, as if we were suggesting a new approach to replace the old traditional one. We wanted to avoid the emergence of this top-down situation.

After hours of discussion amongst ourselves, we decided to start the session by asking the participants to list the characteristics of development workers who they feel are responsible for the unsatisfactory performance of many rural development projects. To our satisfaction this question proved a good entry point to the PRA training. The participants

Source: PLA Notes (1995), Issue 23, pp.42–44, IIED London

listed a number of practices/behaviours that we could easily relate to the professional biases often described by Robert Chambers. We passed nearly a whole morning session discussing these issues which enabled us to then introduce PRA. The participants seemed so convinced about the need for a participatory approach that their participation in the following training sessions was fully motivated and exciting for us.

The purpose of this argument is not to suggest that the question we asked is appropriate and should be used as a model or blue-print to start a training course on PRA. It is obvious that the question depends on the nature of participants and situations. But we do want to argue that it is beneficial to start PRA training by not entering directly into the subject, but with a question such as the above so as to motivate participants as to the value of learning PRA methods. A hasty introduction to the subject might lessen the interest of the participants.

· On the training session

We have observed that in Nepal, PRA training courses last anything from 3 to 15 days. Of course, the duration of training depends on the subject areas to be covered, the nature of participants and so on. However, a long PRA training seems rather a waste of resources and confusing for the participants. For development practitioners or field staff who have no earlier exposure to PRA methods, an initial training of 5-7 days seems optimal. It is our contention that one can never learn PRA methods unless one practises them. In the beginning, only a few methods should be introduced and participants should be encouraged to practise them. Indeed, PRA is a new culture to many people, demanding unlearning of many things that they have been doing/practising for number of years.

For field practice participants were taken to the settlement of Judi gaon. Judi gaon has 58 households, most of which (more than 90%) belong to the *Danuwar* tribe. Although the villagers were earlier briefed about the purpose of the training, their participation and cooperation during the training period was exciting, encouraging and motivating.

Following a set pattern of discussion, practice and reflection each day gave the participants confidence in their work and training. Participants were asked to carry out triangulation each day with the farmers before using a new method. Reminding participants regularly about the basic guidelines for conducting PRA is important. Because the core of good PRA is based on specified behaviours and attitudes, these should be restated and reinforced many times during the training session.

· On closing the training session

The closing event is very important for every training session. Our prime concern over the training period was how to close the training session so that participants would go back to their jobs, not only with continued motivation for PRA, but also committed to practising it honestly.

Firstly, discussing dangers for PRA was a good start that made all participants realise the potential problems. Secondly, we told the participants that they were now the graduates of the PRA training and therefore, eligible for receiving PRA's *Mul Mantra (Mul Mantra* is a Nepali term which approximately means fundamentals to PRA that one should not forget over one's life as *mantra*). All the participants were delighted and they seemed eager to hear that *Mantra*. For this we gave them two words: REAL and LEARN.

REAL	R	-	RESPECT FOR THE PEOPLE
	E	-	ENCOURAGE PEOPLE TO SHARE IDEAS
	A	-	ASK QUESTIONS
	L	-	LISTEN CAREFULLY
LEARN	L	-	LISTEN
	E	-	ENCOURAGE
	A	-	ASK
	R	-	REVIEW
	N	-	NOTE

Because the training was conducted in Nepali, we tried to find Nepali equivalent terminologies for the above terms. However, we could not find a better translation that would really solve our problem. Reluctantly, this time we had given this *Mantra* in English. This was liked very much by the participants. It really touched their heart. They pledged to

Source: PLA Notes (1995), Issue 23, pp.42–44, IIED London

practise it all over the rest of their life. Our search for the equivalent terms in Nepali continues.

Thirdly, in response to increasing demands for a manual by the participants, we decided to distribute a manual for PRA methods - said to be used by the Krishi Gram Vikas Kendra of India. The book was completely blank except the last page which contained the message:

"USE YOUR OWN BEST JUDGEMENT AT ALL TIMES"

Showing the cover page, we told the participants that they could ask World Neighbours to buy a book for each of them, should they think that the book was useful. Each of them was given one minute time to go over the book. Many participants were surprised. How could they assess the value of such a big book within a minute? We insisted that the book can be evaluated in one minute. Upon the circulation of the book all participants except one were delighted and happy. Since we had no way to know how participants would feel react, and whether they would take it seriously or as a joke, we had been a bit concerned and were pleased with the outcome.

However, one participant seemed angry that we were making a fool of him. His anger was a shock for us. We tried our best to explain our reasons for handing out the book. Our intention had been to stress that everyone should take responsibility for what he does. At the end he was convinced and we were pleased that we were able to further enhance the value of the training. Had he not expressed his dissatisfaction, we might not have an opportunity to further reinforce the idea what we wanted to emphasise at the end. Indeed, it was a good lesson for us. We learned many things from this last exercise. Our sincerest thanks go to him.

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Source: PLA Notes (1995), Issue 23, pp.42–44, IIED London

9

Storytelling for Participatory Rural Appraisal

Wouter T. De Groot, Franke H. Toornstra and Francis N. Tarla

· Introduction

This paper describes how we designed and tested storytelling as an approach during a PRA training course in Cameroon. Besides being the oldest form of entertainment, storytelling may well be the oldest 'method' people use to transfer culture and to discuss moral dilemmas. The rural areas of the developing world still abound in stories, hidden in people's heads and seldom told to strangers. One of the sources of our idea to test storytelling as a PRA method may have been a romantic wish to participate in this hidden world! But on a more rational level, we felt that storytelling can have three main functions in rural development work:

1. *For teaching.* Stories designed for this can convey an image in the minds of the storytellers to those of the listeners. Communicating through storytelling can be much deeper and more relaxed than through direct teaching. A good story and story-teller can easily involve people for half an hour on an issue that might normally cause embarrassment or conflict. This would not be possible using direct questioning, for example *"Don't animals have rights too?"* or *"Do you think you should protect nature?"*.

2. *To elicit discussions.* Stories can be designed to articulate a problem in the village, in which the storytelling medium serves to create an open discussion platform, enhancing the self-help capacity of the village. For this purpose, the content of a story will closely resemble the actual situation in the village, and should be told in such a way as to generate intense discussion among the villagers.

3. *For learning.* In this function, stories are designed for communication in the opposite direction to that of the 'teaching stories', namely, from the villagers to the researchers. Stories are especially appropriate here for discussing sensitive issues. Although not expressly designed for this purpose, the trial story in Box 1 can be used as an example of this, since it aims to present the issue of the role of religion in environmental matters.

· The trial stories

The storytelling exploration described here was part of a course on general problem-oriented methodology and PRA held at the Centre of Environment and Development in North Cameroon. During a preparatory meeting of the PRA group, two stories were tested for their form and content. They were told by the authors to the rest of the team. The first story is reproduced in Box 1.

The line-by-line format of the story was chosen because the stories needed to be translated into the local language in the villages. The short lines mean that the translator does not have too much to remember. This resulted in a slow but natural narrative flow. The same format was also chosen by the farmers themselves when they told one of their own stories back to the PRA researchers. Another aspect of the story's form is its 'forked' structure. Two alternative decisions are put to the people in the story, and then later to the listeners.

Source: PLA Notes (1995), Issue 23, pp.45–50, IIED London

· The village stories and discussions

After the teaching sessions the PRA group was separated into three teams to use storytelling and other PRA activities in three villages. The villages were located in landscape typical of the Sahelian zone (800mm rain per year) of North Cameroon, just south of the Waza National Park.

On the fourth day, all three PRA teams began the storytelling sessions in their villages. The basic content and structure of the stories told in the villages were essentially the same as the trial stories. However they were enriched with all kinds of agricultural and environmental details learnt from the village histories and other results of the preceding PRA work in the village.

The story-telling often took place at night, around the fire. During the preliminaries of one story-telling session, the translator spontaneously commented that the white man (one of the authors) would now relate a story told to him by his grandfather. We were concerned that this would confuse the villagers. However halfway through the second story, the village headman interrupted saying *"This may be the story told to you by your grandfather, but I have lived it!"*.

In most cases, the stories provided a useful entry point for intense discussions. In the third village the stories did not evoke much discussion, however. People merely voted for one piece of advice or another, and that was it. This may have been a result of the setting; in a special storytelling session around a fire in the dark you don't discuss agricultural problems, you want the next story to come!

The third story told by the PRA team in the third village addressed the conflict of interest between people and nature. It had been written just a few hours earlier, triggered by what people had said about their difficulties with the authorities of the nearby Waza National Park. The story focused not on the usefulness of nature for local people but on nature's intrinsic value. The role and horrible fate of the hyena, much applauded by the listeners, had been added because a hyena, looking for a goat to eat, had to be chased from the village just the night before. It is printed in Box 2 because it illustrates the flexibility of the story-telling medium (please note that due to space restrictions, the story is not arranged by line as the trial story was). This is also the story people later said they liked best.

After the story had ended the people voted to leave the animals in peace, without any discussion. Does this really indicate a general attitude towards nature? Or does it mean that people would leave the animals in peace if only they would really come and ask? Or were people just being friendly to the storytellers? Here we were left with a feeling that a story like this may be a powerful medium to involve people in the point of view of others (even nature), but that its status as a valid tool to elicit true attitudes is very uncertain. We felt we had experienced an instance of participatory teaching rather than of participatory learning, having used storytelling for the purpose it has had since time immemorial, that is, the conveyance of culture from the storyteller to the listener. But it was greatly enjoyed by both parties, and what would be wrong in participatory teaching, if there really is something worthwhile to teach?

In the third village, after three stories had been told by the PRA team the people told back two of their own. The stories told by the villagers were very similar in style to those told by the PRA researchers. They posed a moral question to the listeners and ended in a question. It is quite possible that the storytellers chose question stories as a response to the three stories they had just heard. However, it proved that the question form of our stories was not strange to our listeners.

Source: PLA Notes (1995), Issue 23, pp.45–50, IIED London

BOX 1
TRIAL STORY

A long time ago the earth was still young ...
There were many trees with all kinds of fruits ...
There were many plants with tubers you could eat ...
There was wildlife all around.
And people? They were only very few ...
They gathered the wild fruits and the tubers ...
They hunted the wild animals ...
And life was good. God provided for everything ...
People took their food straight from God's creation.

But slowly, times began to change ...
People multiplied, there were more and more of them ...
They needed more and more fruits and tubers ...
So that the fruits and tubers could not regrow sufficiently.
They hunted more and more wild animals ...
So that the animals became less and less.
People went around hungry ...
They did not know what to do ...
So they went to ask their wise men.
There were two of these wise men ...
And what they said was very different.
The first wise man spoke as follows:

"God has created everything ... He will never let us die.
Our problem is just a test of our faith in Him ...
So be patient, trust in Him ... God will provide!"

The second wise man spoke as follows:

"God has created everything ...
But if we take away all trees and animals ...
Where can His blessings go?
God has blessed the trees and animals with a capacity to grow ...
But if we take too many, how can they work for us?
We should not first take everything ...
And then hope that God will change His own laws.
So this is what we must do:
We should prepare a field and take some grains ...
Plant them and take care of them ...
So that the grains will grow in great numbers.
We should take some wild animals, bring them to our houses ...
Breed them and take care of them ...
So that they can multiply, and we will have a herd.
Then God's blessings will come to us again!"

The people had listened well to both the wise men ...
Both of them had said something really wise ...
And people wondered which of them they should follow.

.....
Now, we would like to know your opinion ...
Which wise man do you think the people should follow?

Source: PLA Notes (1995), Issue 23, pp.45–50, IIED London

BOX 2

NATURE PROTECTION STORY, NAMAREDJI VILLAGE

In the beginning of the earth, God created people ... and He also created the animals. In those times, there were many animals, But there were not many people. People hunted the animals. But because the animals were so many, they did not mind very much. After many years passed that way, times began to change. People learned how to make fields and to keep cattle. So there was less forest... And people also continued to hunt... So that there were not so many animals any more.

The animals began to worry. And they decided to call a big meeting. The lion was there, he was the chairman. The elephant was there, to keep everyone in check. The rabbit was there, running around to inform everybody. All animals were present .... Except the hyena... The hyena was away stealing a goat from the people's village! But the animals did not like the hyena very much anyway ... And they had their meeting. The animals said:

"Look at us, we are not many any more! People make fields so that our forest declines. People hunt us so that we die...What shall we do?"

After long deliberations, they reached a decision. They would send the rabbit to find out what the people were up to. So the rabbit ran to the village. He listened to what the people were saying around the fire ... He laid his ears on the walls of the huts to listen ... And then he ran back to the meeting of the animals. He said to them:

"I have listened everywhere ... I have come to know the law that people have concerning the animals. People say that they are higher than the animals. They say they are closer to God than are the animals. Therefore, it is permitted for the animals to work for the people. And it is permitted for people to make fields and animals have to go. And it is permitted for people to hunt animals. But the people also have a second law ... The donkey, they say, must work for you ... And if it does not want to work, you are allowed to beat it. But you are not allowed to beat the donkey just because you feel like it. You are not allowed to beat the donkey just for fun. Man is higher than the animals, but God also takes care of the animals. That is what the second law says ... God has created the animals not only to serve people. Therefore, people are not allowed to beat the animals, Or hunt the animals, just for no reason."

The animals listened to the rabbit, and they discussed what he had said. Finally, they agreed with what the rabbit had told them. They said:

"This must indeed be God's law!"

And they went their way. A long time went by, and people became more and more numerous ... The forest became less and less, and people hunted more and more ... So again, the animals convened a big meeting. The lion was there again, roaring loudly. The elephant was there, standing very still.

The rabbit was there, eager for a new job. Even the hyena was there... He had just been chased away from the village... The animals said:

"Look at us! How few we are now! We used to be so many, but now we are the last! There was a time that we could go everywhere ...And now we have only this single little place to go! Another twenty years, and not one of us will be left... There will be no more lions left, no more giraffes, No more elephants, no more bush pigs, No more antelopes, no more monkeys, No more turtles, no more eagles ...Not one of us on the whole earth!"

The animals discussed this situation, and they made a decision. They would go and talk to the people.

And beg them to think about their laws. So the animals discussed which of them would go. The lion wanted to go, But the animals said people would be too afraid and flee. Also the hyena wanted to go, but the animals said:

"No! You only want to go steal another goat! You cannot go!"

contd...

Source: PLA Notes (1995), Issue 23, pp.45–50, IIED London

They decided that three animals would go: The turtle because he could speak well ... The elephant because he would look impressive, so that people would listen properly ... And the rabbit to be counsellor, and to run back if things should go wrong.

So, the delegation started out towards the village. After a while, they saw the hyena ... The hyena was secretly following them. The elephant became very angry. He shouted:

"I know you only want to steal a goat when we are talking!"

Then the elephant lifted his big foot and stepped right on the hyena!
But the hyena was quick ... The elephant caught only the hyena's tail ... The hyena cried and begged:

"Please lift your foot off my tail! I promise never to steal a goat anymore!"

But the elephant did not believe him ... He stood silent like a rock, not lifting his foot.
The hyena pulled and pulled, until he broke free. But his tail was still under the elephant's foot ...
That's why the hyenas have no tail, up to this very day.

The turtle, the elephant and the rabbit, having got rid of the hyena, continued on their way ...
Until they arrived in the village. All the people gathered around, and sat down.
The turtle began to speak ... he explained:

"You have a law that says that man is higher than the animals. But you also have a second law A law that says that God also cares about the animals. We have become fewer and fewer
Now we have come to you to beg. We no longer have a place to go.
Please do not make more cropland. Please do not hunt us anymore.
Please do not bring your cattle to our forest."

The people of the village discussed this, and they said:

"We do not only hunt you ... you also hunt us! Will the hyena not come anymore to steal our goats? Will the birds stop eating our millet? You come to ask for something,
But do you give anything in return?"

The turtle said:

"We cannot promise much. After all, we are only animals. The hyena, you know, will always be a bad guy, even without a tail! But you may chase him away anytime he comes!
And maybe, if we are with more animals again, you can hunt again."

The people discussed this, and they said:

"Why do you come to us? Why don't you go and ask other people?"

The turtle said:

"We are sorry. We cannot help this. We have no other place to go.
The only place left for us is here, with you."

.....
This is the end of our story ...
Now, we have a question for you.
The people of the village could decide between two things.
Either they could take away the last piece of forest from the animals ...
Or they could decide to leave the animals in their last home ...
Even if this would mean that the people would have less fields and less cattle ...
And visits of the hyena ...
What do you think the people of the village should decide?

Source: PLA Notes (1995), Issue 23, pp.45–50, IIED London

Science Publishers, Amsterdam.

· Conclusions

Environmental scientists often find themselves in a difficult moral situation. Researchers concerned with environmental protection will often need to share, discuss and negotiate with people the difference between their problems and environmental problems, such as the impact on downstream populations, on nature and on future generations. Storytelling may be an appropriate way to enter into this process.

It is often said that PRA methods should be fun, giving back to the villagers something in return for their precious time. In that sense, storytelling is a perfect method, also for the researchers. This is especially valuable because going into sensitive or difficult matters such as village conflicts or abstract responsibilities can easily become boring or create tensions and biases. An obvious addition to the work reported in this paper would be to tell and discuss stories with men and women separately.

All in all, we hope to have indicated in this paper that storytelling can be a valuable addition to the PRA repertoire, adaptable to many questions and situations. We also hope that other researchers will apply the method and share their experiences with us.

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NOTE

This paper is based on a longer version, available from Wouter De Groot at the address below. The full version provides the entire text of 12 stories, including those told by the villagers to the researchers.

REFERENCE

De Groot, W.T. 1992. *Environmental Science Theory; Concepts and Methods in a One-World, Problem-Oriented Paradigm*. Elsevier

10

Using PRA for a radical new approach to adult literacy

David Archer

· Introduction

One of the often-quoted roots of PRA is the work of Brazilian educator Paulo Freire whose own predominant focus of work was in the field of adult literacy. It is thus surprising that developments in PRA have not fed back into advances in adult literacy methodology. ActionAid is now attempting to close the circle by drawing on the principles and visualisation techniques of PRA within three adult literacy programmes in Uganda, Bangladesh and El Salvador.

Freirean theory

Freire is now almost universally quoted as the inspiration behind adult literacy programmes. He believed that reading the word must be linked to reading the world and that adult literacy should thus be linked to a process which he called *"conscientization"*. Literacy classes should allow people to reflect on local problems which will lead to action to address those problems. To achieve this the traditional hierarchical relations between the teacher and learners must be replaced by a *"dialogue"* between equals.

Freire used *"codification"* to develop such a dialogue. Codification is a visual image which represents local conditions. In theory these codifications enable learners to gain a distance from their daily lives while allowing them to analyse them. *"Generative words"* are linked to these codifications. These words, which arise from the vocabulary of the learners themselves, are broken into syllables and rebuilt into new words by the learners, enabling them to understand the structure of written language and thus learn to read and write.

Freire's work is notoriously difficult to read. A good foundation in political philosophy helps before reading key works *"Pedagogy of the Oppressed"* or *"Cultural Action for Freedom"*. It is thus not surprising that most people who refer to Freire have not actually read his work. This has led to widespread distortions and abuse.

Distorted Freirean practice

Most literacy programmes around the world that claim to use Freire's methods are in fact seriously distorting both his theory and his methods. These pseudo Freirean programmes have reduced his method to the use of a literacy 'primer' (or textbook) which has a series of photographs or pictures on social issues linked to words that are regarded by literacy planners as socially relevant. Most primers are produced in urban areas or after cursory surveys of rural areas that are generalised for whole regions or countries. Even where primers have been produced locally after serious research, the fact that the result is packaged in a primer presents serious problems.

In most cases literacy teachers are not the expert educators Freire had envisaged. Usually they are from the same community as the learners. Often they themselves have completed just six grades of primary education, or two or three years of secondary education. They receive one or two week's training - and then they are set loose with a primer and a teacher's guidebook, expecting to generate profound dialogue on local issues using codifications (which at the end of the day are just a set of pictures), generative words (which are just words) and a list of (pre-defined) questions. In many cases the common response to their questions is embarrassed silence or single word answers. Within a few weeks most facilitators

Source: PLA Notes (1995), Issue 23, pp.51–55, IIED London

have given up trying and get on with what they see as the 'meat' of literacy, the mechanical teaching of reading and writing, often falling back on the methods they know best - those they learnt from themselves in school. The result is that adults are taught like children, literacy classes are boring and there is a high drop-out rate.

There are exceptions. In some highly politicised literacy programmes the facilitators are keen to keep the focus on social issues. But in these cases, without an adequate methodology for generating dialogue, the result is usually that they attempt to impose a new consciousness on learners rather than allow learners to analyse their own problems.

In my experience, I estimate that there is no dialogue in about 95% of literacy classes. Literacy has become detached from other development programmes and there is widespread doubt about the value of adult literacy at all. Most programmes are failing even to teach basic literacy skills. A recent World Bank discussion paper estimates that literacy programmes over the past 30 years have had an effectiveness rate of just 12.5%.

The new approach

This analysis has led ActionAid to develop a new approach to literacy, based on PRA techniques. The new approach has become known as the REFLECT approach (Regenerated Freirean Literacy through Empowering Community Techniques). The approach seeks to build on Freirean theory but provide a more effective methodology by drawing on PRA visualisation methods.

In the REFLECT approach the literacy primer is abolished. Each literacy circle develops its own learning materials through the construction of local maps, matrices, calendars and diagrams. These techniques can effectively help to create the Freirean dialogue which is so elusive in most literacy programmes. As in PRA, these maps or matrices are initially constructed on the ground using locally available materials. They are then translated onto large flipcharts using visual symbol cards as a guide.

This step is fundamental. The move from three dimensions (on the ground) to two dimensions (using pen and paper) is the first step to literacy. The problem we encountered was that literacy facilitators are not great artists and yet we could not use words to copy the maps. We have thus developed for each programme a set of about 100 visual symbol cards (simple drawings of local crops, activities, illnesses, etc. designed by a local artist and pre-tested). These act as the bridge. In many cases learners add their own cards (and even replace the pre-drawn cards with their own). Interestingly the learners can often draw better than the facilitators. This humbles the facilitators on their own territory (using pen and paper) and gives learners confidence. It is also a lot of fun!

Once a map or matrix has been transferred to flipcharts words are introduced on the flipcharts, either as labels (next to pictures) or comments and observations. Initially just one or two words will be chosen so that all essential syllables (the building blocks of language) are covered. As the course progresses more language is introduced. For example, an agricultural calendar can generate a whole vocabulary around local crops and agricultural activities. A big emphasis is then placed on learner generated writing, so learners are writing phrases to describe the graphics, or paragraphs about their discussions, from an early stage. The writing of local history in Uganda has been particularly exciting, with learners writing remarkable stories in their mother tongue (a language that had never previously been written) within a few months.

In each of the three pilot projects we have developed a sequence of about 30 different types of diagram (maps, matrices, calendars etc.), always seeking to use graphic techniques which will draw out local issues. For example land tenancy maps appear in El Salvador where land reform is a key issue after years of civil war; gender based household decision-making matrices appear in the programme with Islamic women in Bangladesh; and mobility maps are used in the isolated region of Bundibugyo in Uganda.

At the end of the literacy programme the learners have collectively constructed a detailed diagnosis of their villages with complementary records and testaments written by community members whose voice was probably previously unheard. This represents a systematisation of local knowledge, attitudes and perspectives

Source: PLA Notes (1995), Issue 23, pp.51–55, IIED London

which places literacy in its true context - not as the only real knowledge (which many literacy programmes implicitly assume) but as itself a set of techniques that can help to reinforce existing knowledge.

In the process we have found that many local community activities have been promoted. These have varied from tree nurseries to demands for focused training courses in agriculture of health (with learners outlining the training agenda), from low-cost drinking water projects to programmes to systematise knowledge of local medicinal plants and herbs. Literacy has become organically linked to wider development - with the learners as the driving force.

· Some concerns

Are we manipulating communities?

The use of PRA techniques for literacy programmes may raise some concerns for PRA practitioners. It does not appear to be an open-ended process. We are introducing the techniques with a view to teaching literacy rather than using them to let local people decide what they want.

However, it must be stressed that in all cases the literacy programme arose at the request of the communities. It was not (and never should be) imposed! We are therefore responding to one request and enabling people in the process to identify other issues and other needs. We are not using literacy or numeracy as a way of transferring development information to the community. Rather, literacy and numeracy become additional tools to help the community determine their own development. The process of the literacy programme also provides a space for them to reflect on their needs.

Literacy skills often prove useful in addressing many of the other issues that arise through this process of reflection. So the process becomes mutually reinforcing. For example, if the learners wish to receive specific training then the literacy skills help them to keep records of the training. If the learners identify the need to put pressure on a government agency which is failing then letter writing is often an effective aid. As learners begin to take control of their own development agenda, literacy skills become strengthened.

How can facilitators be trained?

One major concern is training for the facilitators. How can we expect them to use PRA techniques effectively when they have little education and training? In practice we have found that this is not such a problem. Indeed, the construction of different graphics is often a very structured process which is much easier than trying to structure a dialogue without such methods. Once the learners become familiar with the techniques they take over themselves and the facilitators do not need to play a central role. In all the pilot programmes the facilitators come from the communities where they teach so they become simply another participant. The problem of developing a rapport between 'outsiders' and the community is no longer an issue. In the three pilot programmes the facilitators have been selected by the communities where they teach, with the fundamental criteria being mutual respect (between facilitator and learners).

The pilot programmes have normally given ten days initial training to facilitators. Within this the emphasis is on practical field experience of the PRA techniques. This is a good foundation but it has to be supplemented by ongoing training. In each pilot we have fortnightly or monthly facilitators' workshops where facilitators exchange experiences of the previous period and prepare (and practice) for the following period. In Uganda these exchange workshops are self-sufficient, involving no external trainers. The training is also sustained through a manual for the facilitators, which provides a clear structure for each unit.

How can you triangulate for accuracy?

Another issue raised by PRA practitioners looking at REFLECT is how can you triangulate to verify the information? The literacy class is only one section of the community and will, in many cases, not reflect the full diversity of community concerns. Some therefore argue that the information is of limited value.

Source: PLA Notes (1995), Issue 23, pp.51–55, IIED London

This concern seems to me to be misplaced. The objective of REFLECT is not to do an appraisal to get verifiable knowledge which can be extracted and used for planning by an external agency. Rather, with REFLECT, the PRA techniques are used as part of an internal community process. The product of the group reflects the knowledge, perspective and attitudes of that group and the function of the systematisation of these is internal. If the external agency which has planned the literacy programme wishes to use the information then there may be a desire to triangulate for verification. But in such circumstances the external agency will probably be planning programmes for various communities, and by comparing the graphics produced by different literacy classes they should be able to get a more objective view.

With the REFLECT approach then, we are handing over PRA principles and methods to the communities. Over a six or nine month period the learners within the communities do their own detailed appraisal without external intervention. The issue that has arisen in some cases is not so much the objectivity of the information but rather how the literacy circle relates to the wider community. If solutions to local problems have been identified and discussed in the literacy circle it is not only for the participants in the literacy circle to engage in the consequent actions.

In this context the first step of the literacy circle is often to share the results of their analysis with others in the community, in community assemblies or through regular meetings with community leaders. The literacy participants can use the graphics as the starting point to explain their concerns and can even suggest that certain PRA techniques are re-performed with the whole community (or by separate groups within the community). In many communities in El Salvador the literacy circle has initiated monthly meetings with community leaders to discuss the issues that have arisen and plan ways forward.

· Initial results

The results of the pilot programmes using REFLECT have been very exciting. Initial observations are that REFLECT is keeping learners motivated, teaching them literacy more effectively and linking literacy to wider development based on the agenda of local communities. The three pilot projects are now being evaluated using PRA methods and a report on the projects will be available by the end of the year. The facilitator's manuals used by the pilot programmes and many other documents (including the proceedings of an International Workshop on REFLECT held in Bangladesh in November 1994) are available now.

Even before the full evaluation, REFLECT is spreading. There are now REFLECT programmes planned in ten countries. For further information (and to be put on the mailing list of the emerging REFLECT network) contact ActionAid.

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Source: PLA Notes (1995), Issue 23, pp.51–55, IIED London

11

Participatory approaches to HIV/AIDS programmes Semi-special issue

Alice Welbourn

· Introduction

Welcome to this semi-special issue on participatory approaches to HIV/AIDS. We welcome not only our regular readers, mainly practitioners of general participatory development, but also those who are directly involved in HIV and AIDS prevention, care and support work. We hope that this issue will help all development workers to increase their awareness of the influence of sexual health in general, and HIV in particular, on their work. Similarly, we hope that this issue will show HIV workers how participatory approaches can help them learn about the specific contexts of the communities with whom they work. In particular, this issue shows how the use of PRA can help people to feel empowered to address the issues around HIV for themselves. This empowerment, perhaps beyond all else, is our main weapon in the fight against the combined forces of fear and discrimination which feed the spread of AIDS.

This introduction will look first at some personal and professional aspects of HIV for development workers. This will be followed by a brief overview of the papers presented in this issue. I then conclude by returning to the mutual benefits of HIV work and participatory learning approaches.

Fear and stigma as a bar to learning

We need to acknowledge our own individual responsibility for prevention of HIV and care of those with HIV. People are often unaware that they are infected with HIV for several months, or even years, until symptoms begin to appear. Even when symptoms begin to appear, they may not be immediately recognisable as HIV. People with HIV can continue to lead normal, healthy, productive lives for several years after becoming infected. Therefore, most people do not realise that they may be infecting others (through, for instance, sex without a condom or donating blood) until a long time after the event. HIV is no respecter of different groups of people. Yet those with HIV are often greatly stigmatised and thus fear to speak openly about it. In this way, the opportunity to learn from them of their own experiences is lost. The best door to learning, through peer education, stays firmly closed. What can we as development workers do about this?

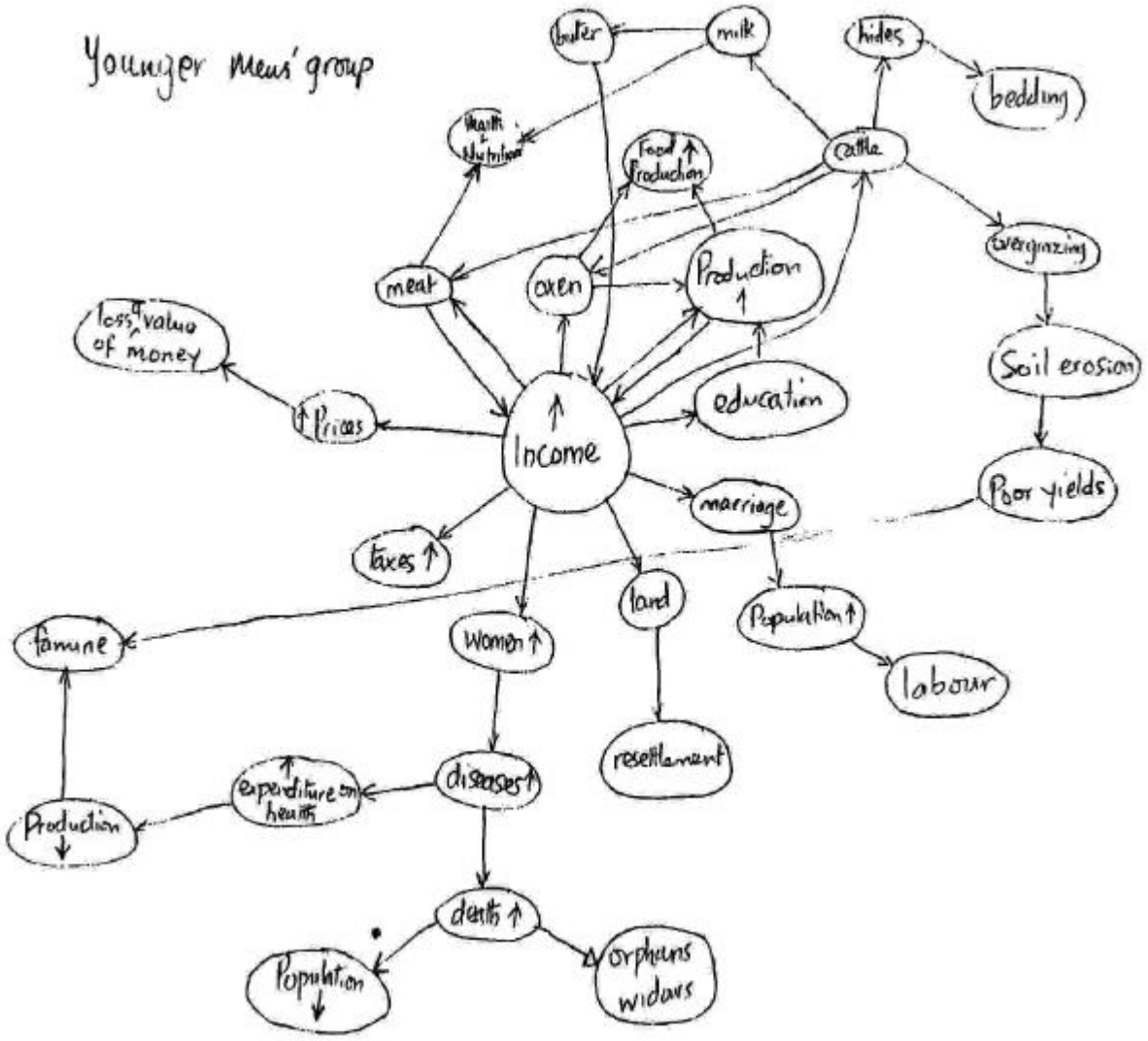
A personal level: AIDS affects all of us

As development workers we have often set ourselves apart from those with whom we work. Slowly, through the adoption of PRA and other participatory approaches, we have appreciated that community members are not different from us after all, in terms of intelligence and knowledge. The major differences between development worker and community member lie, not in these matters, but in access to opportunity, to education and to cash. Through PRA we have learnt that our role should not be to lecture at community members, but rather to empower them to develop their own solutions to the problems they face. This approach recognises that we have little to offer in the way of answers. Instead our potential strength lies in the role of facilitating a learning process in which the main actors and decision-makers are community members themselves, and in which we too as development workers have much to learn.

Source: PLA Notes (1995), Issue 23, pp.57–61, IIED London

As we see the increasing social, economic and psychological pressure which HIV and AIDS is having on individuals and communities around the world, it is our responsibility as development workers to turn our new-found learning to address AIDS. Much early HIV work focused on a top-down, ABC approach to the problem: *"**A**bstain, **B**e faithful or use **C**ondoms"*. Predictably, this approach had little effect. Thus HIV workers have started to use approaches such as PRA which begin with what community members themselves understand about the issues.

Figure 1. Flow diagram showing effects of increased income



Source: PLA Notes (1995), Issue 23, pp.57–61, IIED London

A professional level: how AIDS is a development issue

As development workers we need to recognise that our development interventions may inadvertently increase rates of HIV transmission amongst target communities. We have a responsibility to help communities to recognise this possible outcome and to define ways for themselves of limiting the possibility.

Figure 1 illustrates the kind of problem which faces many of us. It was produced by a group of young men in Seroti in Eastern Uganda, during a PRA training workshop[1]. Seroti is a drought-prone area where livestock are of great economic importance. The young men had been asked to comment on the likely effects for them of increased income, brought about by a planned re-stocking programme in the area. Such programmes, if well planned and managed, are generally considered to be valuable ways of helping livestock owners to get going again after a period of drought.

The men quickly made wide-ranging links to many different aspects of their lives, including labour, population, soil erosion, taxes, food production and so on. Of particular interest here is the direct link which they made with women. They expected the number of sexual liaisons they would have with women to increase, and described how this would lead to an increase in sexually transmitted diseases, including HIV. They foresaw that this would result in increased health costs, death, orphans, widows and famine, and reductions in production and population. A grim picture. But these kinds of perceived connections on flow diagrams are not isolated[2]. We as PRA practitioners know and have repeatedly documented the inter-connectedness of people's lives. We understand how all these things link together. So how should we respond? We need to acknowledge that AIDS is a part of the whole picture and needs to be addressed as such. Otherwise, as many parts of the world are now witnessing, the most economically productive members of communities will die out.

· In this issue...

The four papers presented here highlight some of the exciting contributions which participatory approaches can make to HIV work in Africa and in Asia.

Ssembatya et al. write about their work in south west Uganda. This paper shows how effective PRA can be in enabling community members to recognise the relevance of various aspects of their lives to the spread of HIV. Through a variety of mixed and single-gender group activities, the authors enabled people to recognise when they are most vulnerable to HIV infection. The women and men remarked on the usefulness of what they had learnt, as did the staff involved. This new-found knowledge, which included a recognition of the links between money, gender relations and sex, was then used by community members to discuss possible alternative strategies which might reduce the risks of infection.

Dusit Duangsa's article about innovative HIV risk awareness work in Thailand explains how important it is for people to learn *"that they are not passive victims of the AIDS problem, but there are things they can do to prevent, control, and live with, AIDS."* The article describes how PRA AIDS awareness sessions ask people of the same gender, age-group, social or marital status to work together to assess HIV risk for different sub-groups in their community. Through a gradual process of discussion, division and linking, participants grow to recognise that all members of their community, themselves included, are in some way at risk from the virus. This exercise has been carefully described and clearly has a powerful effect on the participants. As Dusit points out in the conclusion, this is, of course, only a starting point which then needs to be followed up with a wide range of learning activities. To leave a group with no more than this initial exercise could create more harm, in terms of fear and prejudice, than good. But Dusit is certainly aware of this.

[1] This was conducted in November 1994 by Redd Barna. Trainers were Irene Guijt of IIED and Tony Kisadha of Redd Barna.

[2] See also Redd Barna and IIED 1994 *It is the Young Trees That Make a Thick Forest* for another Ugandan example. For examples from Zimbabwe see Welbourn, A. forthcoming: *PRA, Gender and Conflict Resolution: Some problems and possibilities* in Guijt I. (ed) *The Myth of Community: Gender Issues in Participatory Development*. IIED, London.

Source: PLA Notes (1995), Issue 23, pp.57–61, IIED London

Roger Chamberlain's piece illustrates how communities in western Kenya are being challenged through drama to reconsider their attitudes towards HIV. The acting is used as a tool for exploring different people's perspectives towards traditional practices within the community (such as 'widow inheritance'), as well as towards more recent problems, such as teenage pregnancy. Through drama, actors and audience have a chance to explore different situations. The audience can directly question the motives of the actors, or can take to the stage themselves in their own attempt to handle the situation more effectively. Whilst the acting sessions were initially designed to work with young people, the work team soon found that whole villages flocked to the events. This enabled an invaluable interaction and sharing of perspectives between community members. The drama facilitated a spontaneous shift in the attitude of the audiences. As Chamberlain points out, and as with the work of all the authors contributing to this semi-special issue, it will be interesting to see if and how such attitude shifts are translated into practice.

The last article is also from Kisumu in Western Kenya, where Sellers and Oloo describe the careful strategic planning on which their HIV work is based. Their article explains how the communities with whom they work asked them for counselling and testing facilities. The authors quickly recognised the importance of providing such facilities in a coordinated framework of HIV prevention work, based on the communities own perceptions of all the related issues. This article sets out how they planned and undertook five-day exploratory sessions in each village. Once more, issues around access to and control of money between partners were perceived to influence STD and HIV transmission. And once more, the authors state *"villagers feeling powerless... is giving way to a feeling that they can take on the responsibility and actually do something to change the situation."*

· HIV and PRA: contradictions or synergies?

One thing which has struck me about good HIV workers is how much they have learnt to challenge their own beliefs, attitudes and practices in the process of becoming good listeners, communicators and facilitators. They have had to do this to develop the trust of those with whom they are working. Those of us involved in general development work have rarely faced the need to do this in the way that HIV workers have. There is much that we can learn from them about this. At the same time, however, HIV workers often face the challenge of addressing an issue which communities rarely want to discuss, let alone prioritise. How do we introduce a subject that is usually not a perceived need? Surely this contradicts all that good PRA has taught us about putting community groups' priorities first?

I believe that the use of PRA has tremendous value here. Communities are already fully aware of the inter-relationships between gender, economics, power and sexual health. If HIV workers or general PRA practitioners elsewhere ask communities the right questions, similar maps, seasonal calendars, flow diagrams and other charts could be produced in abundance. Sexual health is always an issue in every community and, though they may not be explicitly aware of it until they start to address it in this way, people very quickly describe how it links to so many different aspects of their lives. All that the facilitators then need to do is to add..*"and what about HIV?"* The communities can then already begin to see the potential impact of HIV for themselves, as they look again at their own diagrams. And as we have seen from the articles here, in communities where HIV is already of some concern, PRA can also play a central role in empowering them to take control of the situation.

In conclusion, we hope that you find these articles stimulating and we look forward very much to receiving your comments and accounts of your own experiences. If we receive enough articles, we would hope to have another semi-special issue on HIV and AIDS. Let's make it soon!

- **Alice Welbourn,** c/o IIED, 3 Endsleigh Street, London WC1H ODD, UK.

FURTHER READING

If you are a PRA practitioner wanting to learn about AIDS, here are a few good references:

AIDS Action: a regular newsletter, published by AHRTAG, at Farringdon Point, 29-

Source: PLA Notes (1995), Issue 23, pp.57–61, IIED London

35 Farringdon Road, London EC1M 3JB, UK. Free to developing countries.

AIDS is Our Problem, in six parts. Arid Lands Information Network, 1993 and 1994. Available from ALIN, Casier Postal 3, Dakar-Fann, Senegal. Cost £1 each. £6 for the set.

Living with AIDS in the Community: A small booklet outlining basic facts about HIV and AIDS, which also corrects some common misunderstandings and false assumptions about the virus and its transmission. WHO Global Programme on AIDS. 1992. Based on work done by TASO, Uganda. Free to developing countries.

Strategies for Hope: a series of booklets and videos about good AIDS prevention, care and support programmes in different parts of Africa and Thailand. The next booklets in the series will be about Ivory Coast and India. Available from TALC, at PO Box 49, St. Albans, Herts. AL1 4AX, UK.

Talking AIDS: A guide for community work. IPPF. Macmillan. 1988. A guide for those wanting to develop AIDS prevention work. Cost £2. IPPF, Regents Park, London, NW1 4NS, UK.

The AIDS Home-Care Handbook: A large manual. WHO Global Programme on AIDS. 1993. Based on work done by organisations in Uganda and Zambia. Free to developing countries.

Source: PLA Notes (1995), Issue 23, pp.57–61, IIED London

12

Using Participatory Rural Appraisal to assess community HIV risk factors: experiences from rural Uganda

Joseph Ssembatya, Anne Coghlan, Rachel Lumala and Deo Kituusibwa

· Introduction

The Rakai AIDS Information Network (RAIN) used PRA methods to help community members identify and analyse factors which put them at risk of HIV infection. This article describes the different methods used and what community members and programme staff learned about community HIV risk factors.

HIV infection in Uganda and Rakai district

Of Uganda's 19 million inhabitants, over 1.5 million are estimated to be infected with the human immunodeficiency virus (HIV). The first known Ugandan cases of AIDS appeared in 1982 in a small fishing village in Rakai District. Rakai is a rural district located in south-west Uganda two hours by road from the national capital, Kampala, and borders on Tanzania and Lake Victoria. HIV prevalence rates in Rakai have now reached epidemic proportions. The overall HIV prevalence rate in the District is 13%, however, rates vary considerably by geographic locale. For example, it is estimated that 39% of all adults in main road trading centres are HIV positive, 25% in rural trading villages on secondary roads, and 9% in rural agricultural villages (Wawer, 1991).

The major modes of HIV transmission in Uganda are through heterosexual contact and from mother to child (vertical transmission). Because of the nature of HIV transmission in Uganda, the devastating impact of the disease on geographic communities and limited government resources, it is essential that communities be involved in promoting sexual behaviour change and sustaining AIDS prevention programmes.

The Rakai AIDS information network

The Rakai AIDS Information Network is an Ugandan NGO with the goal of reducing the spread of HIV infection in Rakai District. It is run and managed by health care providers, health educators, counsellors and trainers from Rakai District. The organisation's strategy is to provide integrated AIDS prevention interventions within a community-based health care framework. Its programmes include community-based health care (CBHC) which trains village health committees, community health workers, and traditional birth attendants. The training includes basic community health care but with a special emphasis on HIV prevention. RAIN also conducts a peer education programme for village youths, consisting of a three day training on HIV prevention and condom promotion. Finally, RAIN has an HIV counselling, testing and medical treatment programme which operates through eight decentralised sub-clinics. Both the CBHC and peer education programmes are community-based, with community members selecting amongst themselves the participants to be trained. In addition, community members are responsible for implementing programme activities within their own communities.

In 1993, the Chairman of RAIN attended a Ugandan Community Based Health Care Association/World Neighbours participatory rural appraisal training. The training focused on using PRA for general community health. However, the Chairman thought the methods might be particularly useful in helping community members and programme staff explore factors which put people at risk of HIV

Source: PLA Notes (1995), Issue 23, pp.62–65, IIED London

infection. Thus, in 1994, RAIN facilitated PRA sessions in two rural high HIV prevalence areas.

· Methods used and lessons learned

In order for community members and programme staff to assess community HIV risk factors, we used several different PRA methods. These included mapping, seasonal calendars and men and women's 24-hour activity clocks.

Mapping

Participants organised themselves by village. Each group then drew a map of their village on the ground, using locally available materials such as ash, beans, maize and stones. They first identified the physical features of their communities such as hills, swamps and roads, followed by social features such as homes, churches, schools, and agricultural lands. For each house, participants also identified residents by age and sex and the number of deaths that had occurred in the past 12 months. Participants were also asked to identify which deaths were caused by AIDS. However, because of the stigma still attached to the disease, participants declined to do so.

The village maps were transferred onto paper, and then presented to the group at large. By identifying the number of deaths in the past 12 months, participants realised that there had been at least one death in each home. Although the causes of death were not identified, participants knew that many were in fact caused by AIDS. By seeing the amount of death, participants came to realise the prevalence of AIDS within the community and the implications this has for the community's survival. Next, participants identified specific locations that might put them at greater risk of HIV infection. For example, they identified drinking establishments at which residents often drink alcohol and take outside sexual partners. They also identified isolated areas, such as wells and wooded lots, where women are at risk of being raped.

As solutions to these problems, men proposed that all drinking should be done during the day and that they come home early in the evening. Women suggested that they should go in groups to collect water and firewood, and decided that no water should be collected at night. Some men also offered to accompany their wives and one even said *"I shall do the collecting of water to avoid the risk."*

Seasonal calendar

A group of about 12 community members also created a seasonal calendar on the ground to identify seasonal health risks. Participants marked the 12 months of the year on the ground and then indicated the amount of rain or sunshine within each month. Under each month, participants then identified the prevalence of both malaria and diarrhoea. When finished, participants transferred the chart to paper (see Table 1).

While analysing the chart with the group, knowledgeable participants related the prevalence of the two diseases to the amount of rain or sunshine. A good portion of the participants were surprised. They had previously thought that malaria and diarrhoea were caused by eating certain foods, such as maize or mangos, which are present at specific times of the year. The facilitator then asked, *"Does HIV transmission have a season?"* He expected participants to say no because transmission occurs throughout the year. However, programme staff and many community members were surprised when a village elder stood and said, *"Yes, in our own community here, we have found that when it is harvesting time and men have money, even a lady ... will accept (to have sex) because she knows he has money."* To investigate this further, the facilitator added a third row to the chart and asked participants to indicate the prevalence of HIV transmission in each month. They said transmission was greatest in June, July and August. The facilitator asked why and participants explained that these are the harvesting times for maize, beans and coffee. Thus, these are the months men have money to spend on alcohol and additional sexual partners. Participants added that transmission is also higher in March and December. This is because men often sell their stored crops to prepare for the Easter and Christmas holidays.

Source: PLA Notes (1995), Issue 23, pp.62–65, IIED London

Table 1. Seasonal calendar

	Jan	Feb	Mar	Apr	May	June	July	Aug	Sep	Oct	Nov	Dec
Rain or sunshine	##	\	\\\	\\\\	\	#	###	##	\	\\	\\	\
Malaria	mm	o	o	m	o	mmm	mm	o	o	o	o	m
Diarrhoea	d	ddd	d	x	x	d	dd	d	x	x	x	d
HIV	h	h	hh	h	h	hhh	hhhh	hhhhh	h	h	h	hh

Key: #=amount of sunshine \=amount of rainfall m=prevalence of malaria o=absence of malaria h=prevalence of HIV transmission d=prevalence of diarrhoea x=absence of diarrhoea

Community members, and particularly housewives, then realised that there are certain times of the year when they are at greater risk of becoming infected. To counteract this risk, members proposed different solutions. As one women said, *"I have learned that ... during harvest season, people need to safeguard one another."* Another women said, *"Men should take precautions, they are the ones going out."* This finding also has important implications tor RAIN's programmes. As said by a staff member at the exercise, *"This is new to me. Now I know we have to intensify educational efforts and distribute more condoms at specific times of the year."*

Twenty-four hour activity clocks

The final exercise was for women and men to create their own 24 hour activity clocks. The purpose was for participants to identify the differences between the amount of work women and men do and to reveal leisure time which might lead to risky behaviours. Men and women formed separate groups of about 15 people each. Each group discussed what they generally did for each hour of the day and an elected person took notes. Members of the two groups then transferred the notes onto paper and presented them to the group at large for analysis and interpretation.

The clocks revealed that in the morning hours women generally wake up, *"play zigido"* (a reggae-type of dance used as a euphemism for sex), clean the house, prepare tea, cultivate, collect firewood and water, and prepare lunch. In the afternoon, they usually eat lunch, make handicrafts or *"play zigido"*, cultivate, collect firewood and water, and prepare dinner. At night, the women continue preparing dinner, feed their children and husbands, eat, sleep and *"play zigido"*. In the morning, men generally wake up, *"play zigido"*, take tea and cultivate, trade, fish or repair bicycles. In the afternoon, they bathe, eat lunch, and rest. Some will then resume work, or *"go boozing"*, play board games or *"go looking for sexual partners"*. At night men listen to the radio eat supper sleep and play zigido.

After each group presented their clocks the general question, *"What have we learned?"* was asked. An elderly man stood and said, *"I have learned that women have more activities than me".* Another said, *"We give them all the work and I only realise that now."* A lively debate then ensued about what constitutes men and women's work. Some men saw the need to better share the work and started to negotiate with the women. One man said, *"If she goes for firewood I will go for water"*. But another man added *"We need to help one another but do not let It lead to conflict. If we get water then don't tell us to also get firewood."* A woman then boldly added, *"Men, we work and work and work and then you ask for sex. We are tired. Men should reduce the time for zigido."* A man then asked, *"Women which should we reduce sex or work?"* Another man said, *"We need to sit together with our wives and decide ... We should schedule the activities including sex."*

By comparing their activity clocks, participants also identified several HIV risk factors. First they saw that men have a lot more leisure time than women some of which is spent drinking alcohol in local bars and having outside sexual partners. The facilitator pointed out that, *"You men leave all the work for the women and then you go out and bring back the virus."* Men also came to realise that because their wives are so tired they sometimes go to other women for sexual satisfaction. As one participant said,

Source: PLA Notes (1995), Issue 23, pp.62–65, IIED London

"The women because of all the work get old soon and look not so nice so we go for other women." However the group realised that by having partners outside of their marriage they put themselves and their wives at greater risk of HIV infection.

The proposed solution was again for husbands and wives to sit together and decide how to better share activities. That way women would be less tired and the men more occupied.

· Conclusions

PRA methods were useful in getting community members and programme staff to identify, analyse and address sexual practices which put people at risk of HIV infection. Through mapping, participants were able to identify physical locations where they would be at greater risk. By creating a seasonal calendar participants saw that they might be at greater risk at certain times of year. The 24 hour activity clocks revealed that men have a fair amount of leisure time in which they can and do engage in risky behaviours and that women have an unfair burden of work.

These methods enabled community members to identify problems and find solutions themselves. This in turn may lead to more sustained behaviour change than conventional education information campaigns. Staff also learned more about local sexual practices and were then able to make educational and condom distribution programmes more appropriate. Finally PRA provided the means for men and women to discuss and even negotiate the sensitive issues of work and sex.

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13

A participatory approach to promoting AIDS awareness in Thailand

Dusit Duangsa

· Introduction

An educational war on AIDS has been declared. Sort of. Newspapers, radio stations, and television channels have been bombarding the public daily with frequent slogans and statements on AIDS. It is difficult not to be subjected to such ubiquitous slogans as *"AIDS is incurable; once you have AIDS, you?re bound to die"* and *"AIDS can be transmitted in 3 ways: through sexual contacts, sharing needles, and from mother to baby"*. People from all walks of life, including schoolchildren and rural folks, can recite these slogans, correctly and proudly. As in the case of parrots, however, the head is not really registering what the mouth is reciting, and the heart is far from feeling moved.

The problem with the AIDS prevention and control campaign in Thailand, as we see it, is not that people do not know about AIDS. It is that people do not feel personally involved. Yes, AIDS is incurable, and it can be transmitted in three ways. But it is somebody else who is at risk. It is somebody else's problem. So let it be somebody else to do something about it. It is this none-of-my-business attitude that seems to be prevalent, despite the enormous amounts of money already spent on trying to educate the public about AIDS.

· Critical principles for addressing AIDS

We have learned that in order to have an effective AIDS educational campaign, it is important and necessary to adopt different approaches and techniques, based on different concepts and principles. Some of the concepts and principles we have found to be critical in addressing the AIDS issue are as follows:

- That AIDS is not a medical problem that can be solved through medical measures complete with medical facts and figures. Rather, it is a social problem that needs to be tackled with a good understanding of its socio-cultural dimensions and implications.

- That AIDS is not only a global or national problem. The important thing is that, in our local community, there are now people who are infected or who are dying of AIDS, and there will be AIDS babies and orphaned children whose parents will have died of AIDS. Therefore, AIDS is a local problem that is very real and that we cannot run away from. And efforts must be made to bring the problem to a local level.

- That AIDS can be contracted by anybody, not just the so-called risk groups such as homosexuals, prostitutes, and intravenous drug users. Hence, it is imperative to personalise the AIDS problem, to convince people that each one of them can be at risk in one way or other.

- That people learn less from listening passively to an expert's lecture, and learn more from being actively involved in their own learning, investigating the problem, searching for alternatives, and planning for action. Therefore, AIDS education must be highly participatory in its approach and process.

Source: PLA Notes (1995), Issue 23, pp.66–68, IIED London

- That people learn best in a group situation, where data and information can be discussed and validated, problems and experiences can be shared, solidarity and support can be counted on. A good group process not only promotes intense individual learning but also a powerful group learning that can lead to significant action;

- That people have to know they are not passive victims of the AIDS problem, but there are things that they can do to prevent, control, and live with, AIDS. It is of utmost importance that an AIDS education campaign be an empowering process, with a stress on the positive, and a focus on action.

With these concepts and principles in mind, we have found PRA to be a useful tool for creating AIDS awareness. Using PRA to promote AIDS awareness is still quite new, but it holds considerable promise. During the past few years, in various AIDS-related projects funded by Redd Barna-Thailand, we have tried it with different target groups in different contexts, including rural and urban school children, young people in urban slum communities, migrant construction workers, and housewives in rural villages. It has always worked.

Using PRA to promote AIDS awareness: techniques and outcomes

A PRA AIDS awareness session is usually conducted with a group of between 8 to 12 people. Members of the group may be of the same gender (such as an all-woman group), age bracket (such as youth members), social status (such as community leaders or health volunteers), or marital status (such as housewives or male heads of households); or the group may consist of members of different sub-groups. Members of the group should be familiar and on friendly terms with each other, as well as with the PRA facilitator(s).

PRA sessions are conducted, ideally, with participants sitting in a circle, on the ground or floor, with the facilitator sitting on the same level, to help establish an atmosphere of equality and mutual respect. Materials used consist of various kinds and sizes of seeds and beans, leaves and sticks, stones and pebbles, paper and markers. In brief, items that are available locally and that participants are familiar with.

Through a process of discussion and validation, the participants divide members of their community into as many groups as possible. These groups, typically identified as housewives, male heads of households, young people, babies, schoolchildren, pre-school children, the elderly, and community leaders, will be further categorised into smaller sub-groups. For example, 'young people' may be divided further into such sub-groups as teenage boys studying in school, young men working as hired hands during the day, young men working night shifts at the local slaughterhouse, young intravenous drug users, young girls commuting to work in town, and so on. Likewise, 'housewives' may be divided into such sub-groups as fun-loving and promiscuous wives, bingo-playing housewives, housewives working in factories, etc., and 'male heads of households' may be divided into such sub-groups as men patronising prostitutes, men working night shifts, long-distance truckers, day labourers, etc. Participants are encouraged to formulate their own definitions and criteria for creating groups and sub-groups based on specific realities of their community contexts.

When all the participants are satisfied with the categories of groups and sub-groups they have created, they are asked to rate and rank these groups and sub-groups in terms of degree of risk for contracting the HIV virus. This usually involves a lively session of discussion and debate on who may be at risk, through what means, who is more at risk than whom, and why. The degree of risk perceived for each sub-group is indicated by the number of seeds (beans, pebbles, or whatever is used) allocated to it. Thus the sub-groups with the most seeds are perceived to be at most risk. All the sub-groups are then ranked by the number of seeds allocated, to see which sub-group is perceived to be at the most risk, and so forth. The participants will look again at the finished rank-order, to make sure that it is acceptable to them. Any objections will be settled through more discussion and debate.

It is interesting to note that, at this point, participants of all PRA AIDS awareness sessions we have conducted have arrived at

Source: PLA Notes (1995), Issue 23, pp.66–68, IIED London

typically the same pattern of ranking. Highest on the list, thus perceived to be at highest risk, are always the prostitutes, the young gay men, the intravenous drug users (both young men and male heads of households). These are followed by men who patronise prostitutes, promiscuous housewives and men, long-distance truckers (who are said to drink and frequent brothels en route), young men and young women who go to work in town, and practically all others who are highly mobile (who are said to be more involved in risk situations). Ranked lowest on the list, on the other hand, are always the housewives who stay at home, the babies, the pre-school children, the schoolchildren in early grades of primary schools, and the elderly (who are said to be *"too old for that kind of thing"*). These sub-groups are perceived to be at no risk or at very low risk for contracting the HIV virus, because they do not practise risk behaviours at all.

This pattern typically changes, however, in the next exercise, when participants are encouraged to take another look at the sub-groups and try to make connections between and among them. Lines are drawn to denote relationships between the various sub-groups. As participants start to see more and more lines connecting different high-risk sub-groups of men with 'housewives who stay at home' and young women, and then on to babies and pre-school children, it gradually dawns on them that even the sub-groups who are not engaged in any risk behaviours at all are not risk-free. The housewives/young women are likely to contract the HIV virus from their roaming husbands/boyfriends and probably pass it on to their babies. Even the pre-school children and schoolchildren who do not contract the virus will most likely become orphans if both their parents have AIDS. The exercise typically ends with the startled realisation that practically everybody is at risk, and that actually everybody will be affected by the AIDS problem. Including himself or herself.

· Conclusion

Such is a basic PRA AIDS awareness session. Other variations and improvisations have also been tried on various occasions. We have tried shifting the focus to assessing risk situations and risk behaviours in the local community, or assessing the potentials of different groups and sub-groups in managing the community's AIDS prevention, control, and/or living-with-AIDS campaigns. We have also tried to combine using PRA with other media and activities, thus turning the basic awareness session into a complete learning process, by adding the use of flipcharts to provide more knowledge and information on AIDS, showing a selected AIDS video-drama to induce more emotional response, demonstrating how to use condoms properly and having the participants take turn practising, and distributing easy-to-read and simple-to-understand leaflets on AIDS for future reference. We have also combined PRA with other participatory techniques, to involve the participants in prioritising and planning the action to be taken in their own community regarding the AIDS problem. It is believed that there are countless possibilities for using PRA in AIDS education.

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Source: PLA Notes (1995), Issue 23, pp.66–68, IIED London

14

Participatory educational theatre for HIV/AIDS awareness in Kenya

Roger Chamberlain, Mindy Chillery, Lenin Ogolla and Ochieng Wandera

· Introduction

CARE Kenya's CRUSH project on HIV/AIDS works in Kisumu District in Nyanza Province, Western Kenya. CRUSH stands for Communication Resources for Under 18s on STDs and HIV. It is a programme for out-of-school youths which aims to prevent and control STDs and HIV. The programme also seeks to enlist adult support from communities for youth education programmes for AIDS prevention and control. I was approached by CRUSH to collaborate with them on developing the drama and theatre component of their project.

Drama, being one of Kenya's most popular and accessible communication mediums, has great potential as a more effective, interactive approach to HIV/AIDS. Being the most social of the art forms, drama uses the tools of myth and metaphor, which are common to all societies but are a particularly familiar and real part of the society and cultures of Kenya. However, many of the dramas previously produced in Kenya for HIV/AIDS work have consistently assumed a non-participatory, lecturing approach which has been unsuccessful at attracting and sustaining audience and participant interest.

Participatory educational theatre

CRUSH and I proposed that one way to strengthen Kenya's present HIV/AIDS efforts would be through Participatory Educational Theatre (PET). PET is an educational theatre methodology which uses a participatory approach to allow the audience to probe, reflect on and respond to issues which concern them.

This approach poses questions and problems, rather than supplying answers and solutions. The aim is to bring about change in the target community's perception of the world and themselves as individuals within it. By changing perceptions we do not simply mean raising awareness, but allowing the community to examine their attitudes towards the unresolved dilemmas and contradictions presented in the drama which reflects their lives.

A PET project aims to communicate first to people through their emotions and to then allow the participants to reflect on and examine these feelings objectively. The PET projects thus form two main stages:

- The scene is set by the actors/educators through short episodes of scripted theatre; and,
- Through the role of the facilitator, the audience is invited to participate to help solve the dilemmas presented in the initial scenes.

This participatory approach provides opportunities for:

- community members to interrogate both characters and situations within the drama;
- empowerment, by allowing the participants to intervene and determine the narrative sequence of the drama;
- involvement of the participants in the contradictions and paradoxes raised by the drama; and,
- improvisational role-playing to allow participants to put themselves in the position of the characters in the drama.

Source: PLA Notes (1995), Issue 23, pp.69–74, IIED London

· PET in Kisumu

My collaboration with CRUSH involved working with two groups - the Kama Kazi youth group in urban Kisumu and the Apondo youth group near rural Ahero. My brief was to direct an educational theatre piece for each group to perform in the 14 sub-locations of Kisumu District where CRUSH works. Both projects had to be in the local language and would be performed outdoors during the day. The target group was to be young people between the ages of 12 and 18. However, this changed once we began touring as we found it impossible to separate the rural youth from the village as a whole.

An initial month was spent talking to the two groups about the impact of HIV and AIDS on their communities. During this time I also met artists and educators working locally from whom I recruited two local counterparts and an expatriate volunteer[1]. Following these discussions, we started the two PET projects. The aim of each project was to address the issues relating to HIV and AIDS which CRUSH had identified as priorities for the under 18s. These issues included child and youth sexuality; modes of transmission and prevention; and barriers to the adoption of preventative measures such as peer pressure, traditional customs, religious objections and other personal and social dilemmas.

The starting point for both projects was the imaginative ideas about HIV/AIDS that the two groups of young unemployed school leavers created. From the material they generated, we structured a series of improvisations and other drama tasks. The important aim in developing the material was that it always remained the groups' own. Whilst we provided the structure, they provided the content. After working on the material we would always take it back to them to discuss and to develop further.

Red ribbons for you? Sigand Tom - Ngimani gi Thoni?

The above *Dhuluo* title for Kama Kazi's PET project means *"Tom's Story - Your Life and Death?"*. The narrative traces the life of a young man, Tom Omondi, through infancy, puberty, adolescence and young manhood up to and immediately following his death at the age of 23. He contracts the HIV virus whilst studying at university. Some other members of his immediate family and friends, whose stories are interwoven with Tom's, also contract the virus at other points during his life. In fact it is Tom's father, Samuel, who is inadvertently infected, who triggers off the chain of infections in this particular group of people.

The creative process: participatory decisions and discoveries

A storyboard provided the central educational, aesthetic and visual stimulus for Tom's story. The storyboard is neither a conventional theatre set nor a conventional teaching blackboard but a three-dimensional resource which combines both. For *Red Ribbons For You?* the storyboard consisted of three joined sheets of plywood which were painted with an overall design, onto which the central questions relating to each of the nine scenes were hung separately using hooks (see below). A storyboard is intended to invite informal interest, provide a focus, and ensure a common theme runs through that day's participation. Rather than perform the project on a raised stage with distance between the audience and the drama, it is better to present the project outside, perhaps under a tree with audience on three sides and the storyboard making up the fourth side.

[1] The other authors of this article.

Source: PLA Notes (1995), Issue 23, pp.69–74, IIED London

The storyboard questions

THE FUNERAL	CHILDHOOD GAMES	TEENAGE ANXIETY
Why is everyone fighting at Tom's funeral?	Are children aware of sexuality when playing "Mothers and Fathers"?	How did Tom and his friends first learn about sex when they were young teenagers?
PEER PRESSURE	**GREAT EXPECTATIONS**	**THE TRIANGLE**
What were the pressures on Tom to make love for the first time?	What went wrong for Tom after he'd made love for the first time?	What is Tom suffering from? Is it demons? Is it AIDS? Is it *chiraa**?
THE MEDICINE MAN	**REJECTION**	**DELIRIUM**
Can the Medicine Man, or religion, cure Tom of AIDS?	Why did Tom's younger brother, Mike, kick him in the teeth when he was down?	Why did Tom attempt to commit suicide?

*Chiraa is a traditional Luo illness resulting from the breaking of a cultural taboo. If it is not dealt with in time by the performing of certain culturally prescribed rituals, then death will be the certain outcome. Naturally, the HIV/AIDS pandemic in Western Kenya is complicated by such customary beliefs, together with others such as wife inheritance by one brother on the death of another; and Ke, the obligatory performance of sexual intercourse by all immediate members of the family before dispersal following a funeral.

Tom's story was broken into nine separate free-standing sections, each of which would make sense in their own right, but when linked together would equally make sense as a whole, rather in the same way a jigsaw does. This element of puzzle-solving is a very important element in encouraging participation. Each section of scripted theatre varies in length between 7 and 15 minutes. The duration of the participatory drama which follows each section is entirely in the hands of the community and facilitator. It usually lasts between 15 and 75 minutes. There is no reason why the project has to be confined to a single day. It could be phased over a week or even two months. This is especially so if you want to integrate the project as a specific educational resource within a broader pattern of PRA activities.

Allowing the community to choose the sequence of the nine sections themselves gives them control over the process. We select the first and last section for structural clarity and they determine the seven sections between. They choose a section they want to watch by selecting a question they want to answer. When a question has been selected that particular question board is unhooked by the facilitator to reveal a symbolic design[2], visually summarising the question, and the actor/teachers act the chosen section.

The nine central questions are carefully selected and phrased to penetrate the heart of the specific strands of CRUSH's HIV/AIDS aims and objectives. The questions are designed to be provocative and alluring, thereby engendering informal discussion amongst the community and with us from the moment of our arrival when the storyboard is put up.

The role of the facilitator and the actor/teacher

A facilitator acts as a bridge between the actor/teachers and the community to assist with their understanding and eventual participation. The facilitator's role is crucial in the steady development of the community's active involvement. After each of the nine scenes is acted, the facilitator encourages the community to participate in the drama themselves. By putting themselves into the

[2]The symbols were designed and painted by a local artist who is a primary school teacher, and therefore in touch with the community.

Source: PLA Notes (1995), Issue 23, pp.69–74, IIED London

shoes of one or more of the characters' predicaments community members can try to stop them contracting the HIV virus (see Box 1).

This allows the participants to view themselves from the safety of an 'other'. Instead of feeling exposed and vulnerable, as often is the case when we are being ourselves, under the guise and protection of a role we can express and explore our attitudes and emotions without fear of being laughed at. The facilitator's style must genuinely indicate at all times an openness, a humour, an egalitarianism and an unselfconscious lack of authoritarian status if he/she is to establish and then sustain a meaningful rapport with the community.

In the case of these two PET projects the two local language speakers in our team of four initially acted as facilitators. Over time they trained the volunteer members of the youth groups to take over this role. In subsequent PET projects, facilitators have been drawn from volunteer community health workers recruited from local villages.

The actor/teachers must be able to interact with any new character the community deem as being necessary in their attempts to resolve the particular dilemma, for example a neighbour, relative, elder, chief, counsellor, doctor, medicine man, peer, etc. They must also be open to partially or wholly changing either their attitude and/or behaviour, but only when the community has provided persuasive enough arguments. When this happens it invariably results in a moment of spontaneous applause and celebration. Those are the moments to cherish, when you really know what PET is about and what can achieved with any community (Boxes 1 and 2).

BOX 1
PET IN ACTION

At one point the community watches a scene where one partner has the HIV virus (in this case a nurse, Joan, Tom's sister) while her husband does not. In the drama the husband's dilemma is whether to keep Joan as his wife or insist that she should leave the home. After the scene, the community felt strongly that she should not stay with her husband, especially as they did not yet have any children. However a small number of people felt that her husband should keep her. One member of the audience suggested that a friend should talk to him. The facilitator asked him to come and help by stepping into the shoes of the friend. The friend spoke to the husband for approximately 20 minutes, during which time the audience remained acutely attentive. Gradually the husband began to reconsider and, finally agreed that he may be able to keep his wife and use condoms. There was a spontaneous round of applause from the audience. In the discussion that followed the facilitator asked the audience what had changed their minds and they repeated some of the arguments the friend had used such as marriage is not just about having children, he had not married her just for sex, if he was sick he would want her to care for him and so on.

On another occasion Samuel, Tom's father, a middle-aged conventional man and perhaps the most difficult character for the community to move from his position, was persuaded by a member of the community who stepped into the shoes of an AIDS counsellor, that Tom was not suffering from *chiraa* but from AIDS and should receive proper treatment in hospital. The detailed arguments, sensitive ideas and persuasive truth that the community member had brought to the drama had been so convincing that the actor/teacher was able, while remaining true to character, to change his position.

Source: PLA Notes (1995), Issue 23, pp.69–74, IIED London

BOX 2

A SCENE FROM *POSITIVE PEOPLE*: THE APONDO YOUTH GROUP'S PET PROJECT

The 12 positive people are at an HIV/AIDS counselling centre. Members of the community are then given the role of their counsellors. The project allows people to choose whose story they want to hear first and whom they want to counsel first.

A sceptical old man, who does not believe in the existence of AIDS, suddenly clears his throat. He can neither read nor write but is attracted to the story of the village carpenter who on his elder brother's death is forced by the elders to inherit the widow. He has been attracted to this character by the symbolic graphic design that illustrates the carpenter's dilemma. A sudden hush falls on the 400 members of the community. Here is a village sage, whose word on custom and tradition is faultless. He explains the philosophy behind wife inheritance slowly but firmly, citing a wealth of ageless ancestral wisdom. The old man sits down after 20 minutes and there is no doubt in the minds of the people that wife inheritance is blameless, as far as AIDS is concerned.

The carpenter begins to tell his story to a keen and curious community. There is nothing unusual in his life. His story is the community's story until he tells how he discovered that his elder brother, whose wife the elders forced him to inherit, committed suicide after he was diagnosed to have AIDS. Without pathos, he declared that he himself has since tested positive, together with his first wife, their last born baby and the second wife he inherited from his late brother. Nobody speaks for a long time, until a teenage schoolboy begins to point out the contradictions of wife inheritance. For the next half hour a discussion ensues between the youth and the elders. What was accepted before the drama as sagacity is slowly reconstructed in the light of HIV/AIDS. There seems to be an impasse until a woman steps forward. The facilitator is quick to notice her, for women rarely stand to give their opinions in such weighty matters in this village. She brings a different angle to the stand-off between youth and elders, challenging the assumptions of tradition and custom about the place of a woman in marriage and society. AIDS is for a moment put on one side as the spotlight is turned full glare onto the rights of women to inherit property, including land. People listen, people argue, people venture into the performing area to wear the cap of the carpenter at the crossroads of his life. Attempts are made at changing the outcome of events. This culminates in instantaneous applause when the elder who started the argument declares he has been convinced by a doctor (played by another member of the community) that AIDS does exist.

As always, the actor/educator has to determine how far to push the boundaries of what is culturally acceptable in any given place, whilst not compromising the integrity, truth and principles of the theme. This has a direct bearing on drama's usefulness in this field of community education as it is through doing this that real social change can be achieved. In this Luo community people do not often talk openly about sex and sexuality, yet during the PET they were able to talk very freely about it in a community gathering of both sexes, all ages, and most classes (Box 2). These projects have demonstrated the power of participatory drama for cutting through the cultural barriers to communication.

· Conclusion

We didn't know how this PET initiative was going to be received by the communities. There were large elements of risk involved for us all but, in the event, it has proved highly successful, both with large community audiences (up to 400 people) as well as with the same numbers in secondary schools. In six months no single performance has been like another. The audience is always bringing into the dramatic situations new and exciting possibilities encouraging a feeling of strength and success where they previously felt powerless and confused.

Our aim now is for PET projects to become more integrated into the work of NGOs and other organisations actively involved in using PRA, not only in the HIV/AIDS field but also in any area of development that involves people and their interactions. However we remain unsure about the extent that behavioural change can be brought about through any short-term project. It is a highly difficult matter and there are many questions which need to be explored further. By undertaking more preparation and follow-up work, we hope to establish an

Source: PLA Notes (1995), Issue 23, pp.69–74, IIED London

effective monitoring and evaluation system to determine this.

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NOTE

Roger Chamberlain is an Educational Theatre and Community Drama Specialist sponsored by the British Council.

Source: PLA Notes (1995), Issue 23, pp.69–74, IIED London

15

Community mobilisation against HIV infection in Kenya

Tilly Sellers and AJ Oloo

· Introduction

There are few successful models of rural HIV counselling and testing in Africa. Work in Uganda has shown the difficulties of setting up rural access to counselling and testing without the villagers themselves participating in decision making and planning (Seeley et al., 1991). When, in 1993 villagers in 15 villages in Siaya District, Kenya asked CDC/KEMRI to provide access to HIV-antibody testing, a participatory methodology was sought that would involve the villagers and which would be culturally sensitive. Furthermore, subsequent meetings established that the needs of these villages in relation to HIV and AIDS went beyond a simple request for access to HIV testing.

An initial survey of knowledge, attitudes, practices and beliefs (KAPB) about AIDS revealed that villagers felt the responsibility for HIV prevention lay with the government or with health officials, and that communities and individuals felt powerless in the face of the threat of HIV infection. We wanted the participatory activities to empower these communities to do something for themselves. We realised that there is only so much a community can do in a situation where they may, for instance, not have access to condoms or safe blood. However, we hoped that participatory mobilisation would reveal gaps in knowledge, attitudes, risky practices and beliefs, which the villagers have the potential to change without a huge resource input.

Developing the methodology

We knew of only a few examples of the use of participatory approaches for mobilising communities against HIV infection (Barnett, 1994; Duangsa, this issue). We thus decided to use a modified form of Participatory Rural Appraisal (PRA) to which we added selected SARAR[1] techniques and our own activities. To emphasise that it is the villagers themselves who collect and analyse data and make decisions based on what they find, we called the new methodology Participatory Rural Research on AIDS (PRRA - yet another acronym).

Appendix 1 summarises the range of PRRA activities involved, also described in a handbook (Sellers, 1994). The approach is used to assist villagers in finding out what it is that stops them from protecting themselves and others from becoming infected with the AIDS virus. Once they know this, it helps them to look at solutions and actually make a plan against the spread of AIDS within the community.

PRRA is not designed to change behaviour. It hopes instead to allow communities to make informed decisions about future interventions against HIV infection, although we do expect to see some change in behaviour as a result of PRRA.

[1] From PROWESS, developed by UNDP for water and sanitation.

Source: PLA Notes (1995), Issue 23, pp.75–81, IIED London

· Implementing the methodology

From the beginning it was made clear by village leaders that to discuss sensitive topics such as sex and cultural practices involving sex, all the participants should be from the same ethnic background. Thus we decided that all project team members should come from the target villages themselves. In other words, we would train 'insiders' and eliminate the need for foreign 'experts'. However, since we realised that poverty, development issues and lack of resources would all be identified as contributing to the spread of HIV infection, representatives from other organisations were invited to participate (with agreement from the village concerned) as long as they came from the same ethnic background.

Six local men and women were selected for the project team by the villagers. The method of selection was left to them (usually it was done through the clans and sub-clans), but the criteria included a minimum educational level, being respected by the villagers, a certain maturity regardless of age and an interest in helping to prevent the spread of HIV infection. HIV counsellor training was given to project team members over a period of six months, part of which involved the trainees taking placements with local HIV/AIDS support organisations and in the District and Provincial hospitals.

The PRRA process took place over five days in each village. Appendix 1 summarises the main activities carried out during the process. Examples of the findings of some of the activities are discussed below.

KAPB pocket charts

Kaminogedo is one of the villages which participated in the PRRA. On the second day project workers dispersed in pairs throughout the village to facilitate activities with different informal and formal groups. One pair met with a group of men and women of mixed ages to facilitate an activity called KAPB Pocket Charts. As with all the KAPB activities (activities which explore the Knowledge, Attitudes, Practices and Beliefs about AIDS), the discussion is the most important part. While the outcomes of these activities provide villagers with baseline information, the discussions pave the way for them to identify the barriers to prevention and finally to look for solutions to these barriers.

The project workers displayed two pocket charts written in the local language. One has pictures of people across the top, the other lists places and events (see Table 1). The project workers explained the activity carefully and six people were chosen to vote. The pocket charts were hung in such a way that voting was confidential. Each person voted once for each question in the two charts by placing a small disc in the pocket corresponding to their belief. When they had finished, the votes were quickly counted by the participants and a chart of the results was made (Table 1).

The important part of the activity began as the facilitators asked whether the group agreed that the results accurately reflected the situation in Kaminogedo. First discussion was carried out in age/sex groups, then the whole group came together and agreed on the following points:

- Old people don't have the strength to play sex so they can't contract AIDS or other STDs;
- Old people should be responsible for AIDS prevention, especially the adults;
- Mothers can help prevent the virus from spreading by educating husbands and children;
- Alcohol and drugs speed up the sexual urge in men;
- Men shy away from family health matters and show their denial of AIDS by remarrying;
- Drinking and dancing places promote sexual immorality which leads to getting STD/AIDS;
- In a polygamous family it is only the first wife who is responsible for sex related cultural practices like having sex at the time of sowing, planting etc.;
- Condoms cannot be used during wife inheritance practices for fear of breaking a taboo and contracting *chiraa*[2] (but the

[2] *Chiraa* is a traditional wasting disease caused by breaking taboos. AIDS and *Chiraa* are often thought of as one and the same in this culture (see also page 71 of this issue).

Source: PLA Notes (1995), Issue 23, pp.75–81, IIED London

women felt it would be better if condoms could be used);

- Traditional stools and tobacco could be used instead of sexual wife inheritance (see page 73 of this issue);
- AIDS education can only be got from health centres outside Kaminogedo;
- Men are most responsible for transmitting STD since they have more partners than their wives;
- Women take a long time to discover they have an STD and therefore risk re-infecting their partners; and,
- Everybody would like counselling/education on AIDS.

Table 1. KAPB pocket charts

WHO (pictures)	Man	Old man	Young girl	Young boy	Woman	Old woman	All of them	None of them
Is least likely to get STD?	0	4	0	0	0	2	0	0
Is responsible for AIDS prevention?	0	0	1	1	0	1	3	0
Is responsible for family planning?	2	0	3	0	0	1	0	0
Is responsible for health in the family?	2	1	0	0	3	0	0	0
Would like AIDS counselling & education?	0	1	2	2	0	0	1	0

WHERE (pictures)	Church	Farm	Clinic	Beer party	Disco	Homestead	Lake shore	Barber	All	None
Is one most likely to get AIDS?	0	0	1	1	3	0	1	0	0	0
Can one get an HIV test?	0	0	6	0	0	0	0	0	0	0
Is one least likely to get AIDS?	5	1	0	0	0	0	0	0	0	0
Can one get AIDS counselling & information?	1	0	4	0	0	1	0	0	0	0
Can one get general STD information?	1	0	4	0	0	1	0	0	0	0

Source: PLA Notes (1995), Issue 23, pp.75–81, IIED London

Barriers to prevention

On day three of the PRRA, after sharing information about modes of transmission and prevention of HIV infection, a specific activity is facilitated in sex/age groups which aims to elicit barriers to prevention from villagers themselves. This activity follows on from the previous exercises with the question *"given that villagers clearly know how to protect themselves from infection, what actually stops them from doing so?"*.

In Kaminogedo, Damarice and Eudiah (project workers and both married women themselves from nearby villages) sat with a group of ten other married women to discuss what they felt to be major barriers to prevention/protection for them. Sitting in a circle, a picture of a cart (a traditional hand cart known as a *cocoteni*) was placed in the middle of the group. A pile of blank coloured paper circles of different sizes was used to represent barriers/rocks. Eudiah told the group to think of all possible things (attitudes, resources etc.) that would stop them from using those methods of prevention that were mentioned in the previous activity. Each statement was recorded on a 'rock' of a size selected by the group and then placed into the back of the cart. The resulting barriers were finally discussed and verified (they could also be ranked). The barriers this group came up with are shown in Table 3.

The women strongly believed that their main barrier to protecting themselves and their families from HIV infection was poverty or lack of money to buy syringes, needles, condoms, safe blood, medicines and so on.

Table 3. Barriers to prevention

Problems sticking to one sex partner	Problems with condom use	Problems getting safe blood	Problems not sharing toothbrushes and razors	Problems keeping wounds covered
• Lack of money • Desire	• Leave you with a lot of sexual desire • Can enter womb • Not available in village • Difficult to discuss with partners • Can burst • Brings scratches to private parts • Are slippery • No money to buy them • Prevents pregnancy • Men don't like them • Men think you are prostitute	• No money • Lack of places which screen • Timing, if patient is critical	• No money to buy for each member of family • Lack of knowledge, people don't know they shouldn't share or should sterilise	• Bandages not available • No money to travel and buy them • General lack of medicines

Source: PLA Notes (1995), Issue 23, pp.75–81, IIED London

Finding solutions

The day after barriers to prevention have been identified, all the barriers recorded throughout the week are presented at a full village meeting by the village volunteers to be verified by the villagers. Once they have a list of barriers which they feel apply to their situation, activities to find and categorise solutions are facilitated. Finally, these categories are ranked according to their impact on the spread of HIV infection and according to how easily the villagers themselves can do something about it.

Obadiah and Richard looked for solutions to barriers with a group of nine married men in Kaminogedo. The barriers had been posted across the top of a sheet of newsprint and the group were asked to split into two and to brainstorm solutions to each barrier. Whereas married women in Kaminogedo had stressed poverty as a barrier to prevention, married men had also included *"too much money"* as a barrier (Table 4).

Table 4. Solutions to barriers

Barriers	Solutions
Lack of money	Hard work, giving condoms at a fair price, free syringes and needles, bringing health facility within reach of community
Lack of knowledge	Workshops, *barazas*, radio, training through women's groups etc
Lack of HIV testing places	Bringing HIV testing and counselling to the village, training counsellors from Kaminogedo, avoiding blood transfusion by eating well and treating malaria promptly
Commercial sex work	Go for zero grazing, always live with your wife, don't work away from home
Too much alcohol	Getting saved, not drinking too much
Too much money	Becoming calm over your wealth, be loyal to God
Living far from wife	Stop working away, creating real love and trust atmosphere in the family
Lack of children	Adding another wife, taking HIV test
Traditional practices	Use condoms, both parties to have HIV test before wife inheritance
Problems with condom use	Mass education, demonstrating them, make them free, make them more accessible, make people understand the need for them

Source: PLA Notes (1995), Issue 23, pp.75–81, IIED London

Selection of village AIDS forum members (VAF)

Originally, the PRRA week ended with the village selecting a Village AIDS Forum. Village AIDS Forum members are charged by the village to plan and implement the solutions to barriers identified during PRRA, and to report back to the village. They are not organised, supported or funded by CDC/KEMRI, but are welcome to negotiate access to training. The first VAF requested training to give them more facts about HIV/AIDS and to help them to use their PRRA outcomes to plan solutions to barriers identified by the village.

However, after the first three PRRAs, it was clear that the villagers regarded the VAF as an extension of the project. This had not been the intention. Consequently, this part of the project has been handed over to members of one very active VAF and is no longer part of PRRA. Now, existing VAF members visit villages where PRRA has been carried out and talk about their own AIDS Forum, how it was set up, the training it has received and the work it is doing.

· Conclusion

There seems to be enormous enthusiasm for this approach to HIV prevention from the villages concerned. Although it is still too early to tell, our personal feeling, based on feedback from the PRRAs to date is that 'learned helplessness' (ie. villagers feeling powerless in the face of this potentially enormous threat to themselves and their families) is giving way to a feeling that they can take on the responsibility and actually do something to change the situation. Only monitoring behaviour change will prove whether this is really the case. What has become clear, however, is that access to HIV counselling and testing is a priority for the majority of villages and that they see it as a way of promoting behaviour change.

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Source: PLA Notes (1995), Issue 23, pp.75–81, IIED London

Appendix 1. PRRA objectives and activities

Objective	Activities
1. Giving villagers enough information to decide whether to be involved in the project	Distribution of field work schedules to groups and village leaders and visiting a variety of groups and individuals culminating in a meeting where questions are answered and at which a decision is made Inclusion of villagers in PRRA training course
2. Establishing that AIDS is a problem and that the community want to do something about it	Disease ranking by sex/age groups Presentation and verification of findings Finding and ranking solutions to barriers to prevention
3. Sharing expectations of the PRRA period and of the project as a whole	Eliciting expectations from sex/age groups and addressing these expectations on the spot
4. Establishing links and ensuring representation of the different formal and informal groups that make up the community	Pre-mobilisation activity Inclusion of villagers in PRRA training course Community walk/ self-selection of volunteers Identifying formal and informal groups through mapping Migration calendar (identifies when migrant workers and students return home so that interventions can be planned to include them) Homestead semi-structured interviews (usually 10)
5. Personalising the risk of HIV infection; sharing information on modes of transmission and on the ways in which different individuals can protect themselves, their partners and families from HIV infection	Expectation sharing TAPWAK personal experience (a member of The Association of People with AIDS in Kenya gives a personal experience of HIV infection) Family Story transmission exercise (looks at how each member of a typical family could become infected by HIV, and how they could infect each other Pasting for prevention (uses the individuals from the same family to determine the best ways of protecting each one from HIV infection) Discussions
6. Sharing information about counselling and testing (C and T) and about attitudes to confidentiality	C and T open-ended story Confidentiality focus group discussions Homestead semi-structured interviews KAPB pocket charts (see Table 2)
7. Understanding cultural beliefs and practices, gender issues relating to negotiating safer sex and gaps in community resources (ie. STD services, condom availability) which may create barriers to prevention or protection	KAPB pocket charts Odindo's Activity (examines cultural/ social factors which promote sex) Three-pile attitude sort (looks at practices and beliefs) Mapping Services activity (looks at where villagers go for STD diagnosis and treatment, access to safe blood transfusion, condoms and clean needles and costs involved) Homestead semi-structured interviews Community walk (verifies map) Rocks and Cart - Barriers to Prevention (see Table 3)
8. Verifying barriers to the prevention of HIV - do they really apply to these villagers?	Presentation and verification of findings
9. Identifying and prioritising solutions for the removal of these barriers	Finding solutions (sex/age group brainstorming of barriers) Categorising solutions (eg. general HIV education). Categories are ranked according to the number of times a solution is allocated to each one Ranking categories according to their impact on the spread of HIV infection and according to how easily the village can do something about it Mapping (maps can show where condoms, needles and syringes are available in the village; meeting places of sex/age groups; location of artists and musicians; homesteads with deaths between 15 and 40 years in the past year; child or grandparent headed households etc.)
10. Choosing one or more solutions and making a detailed plan for its implementation, monitoring and evaluation	Choosing a starting point by discussing the highest ranking category to see if it falls into the high impact/easily achievable part of the matrix Village selection of Village AIDS Forum (VAF) members Training the VAF to use PRRA outcomes for planning Training the VAF in participatory monitoring and evaluation
11. Implementing the plan	Supporting VAF where requested with training Providing access to HIV counselling and testing where requested, along with relevant support for those affected by AIDS

Source: PLA Notes (1995), Issue 23, pp.75–81, IIED London

16

Tips for trainers: leadership circles

Adrian Jackson

· Objective

To generate discussion about what leadership is, can be, and should be; to identify positive and negative aspects of leadership; and to establish group norms about leadership.

· Time

20 - 30 minutes

· Procedure

1. Ask the group to form circles of about 6 - 8 people, looking inwards and holding hands (if culturally acceptable).

2. Tell them that when they close their eyes, you will walk around the circles and tap someone in each circle on his or her shoulder. They are not to tell each other whether they have been tapped or not. After they open their eyes, the person who was tapped on the shoulder acts out the role of leader, and the rest act as followers. At the same time they should try to guess who the leader is by observing each other's behaviour.

3. In round one, after walking around the circles several times, you should have tapped everyone on his or her shoulder (ie. everyone should be trying to act as a leader).

4. Allow them to act out their roles for about 5 minutes, ensuring that no-one starts guessing out loud who the leader is.

5. Repeat steps 2, 3 and 4 a second time. This time, do not tap anybody on the shoulder (ie. no-one should be acting as a leader).

6. After both rounds have been played ask them to sit down in their circle. Explain that when you count to three you want them to point to the person in the circle who they think was the leader in the first round.

7. Count to three. Most people should be pointing to someone. Go around each circle and ask them what it was about the person's behaviour that made them a leader. If you have enough time, write down different aspects of leadership on a flipchart.

8. Repeat step 7, but this time asking them to point to the person who they think was the leader in the second round.

9. Debrief thoroughly about aspects of leadership, and also how it felt to be a leader with no followers, or a follower.

· Comments

It is important that people don't start guessing out loud and that they really don't know who you have or have not been tapping.

Source: Adrian Jackson, pers. comm.

Source: PLA Notes (1995), Issue 23, pp.82, IIED London

THE MYTH OF COMMUNITY

Gender issues in participatory development

Edited by Irene Guijt and Meera Kaul Shah

With a foreword by Robert Chambers

By Tessa Cousins in Guijt & Shah eds 1998

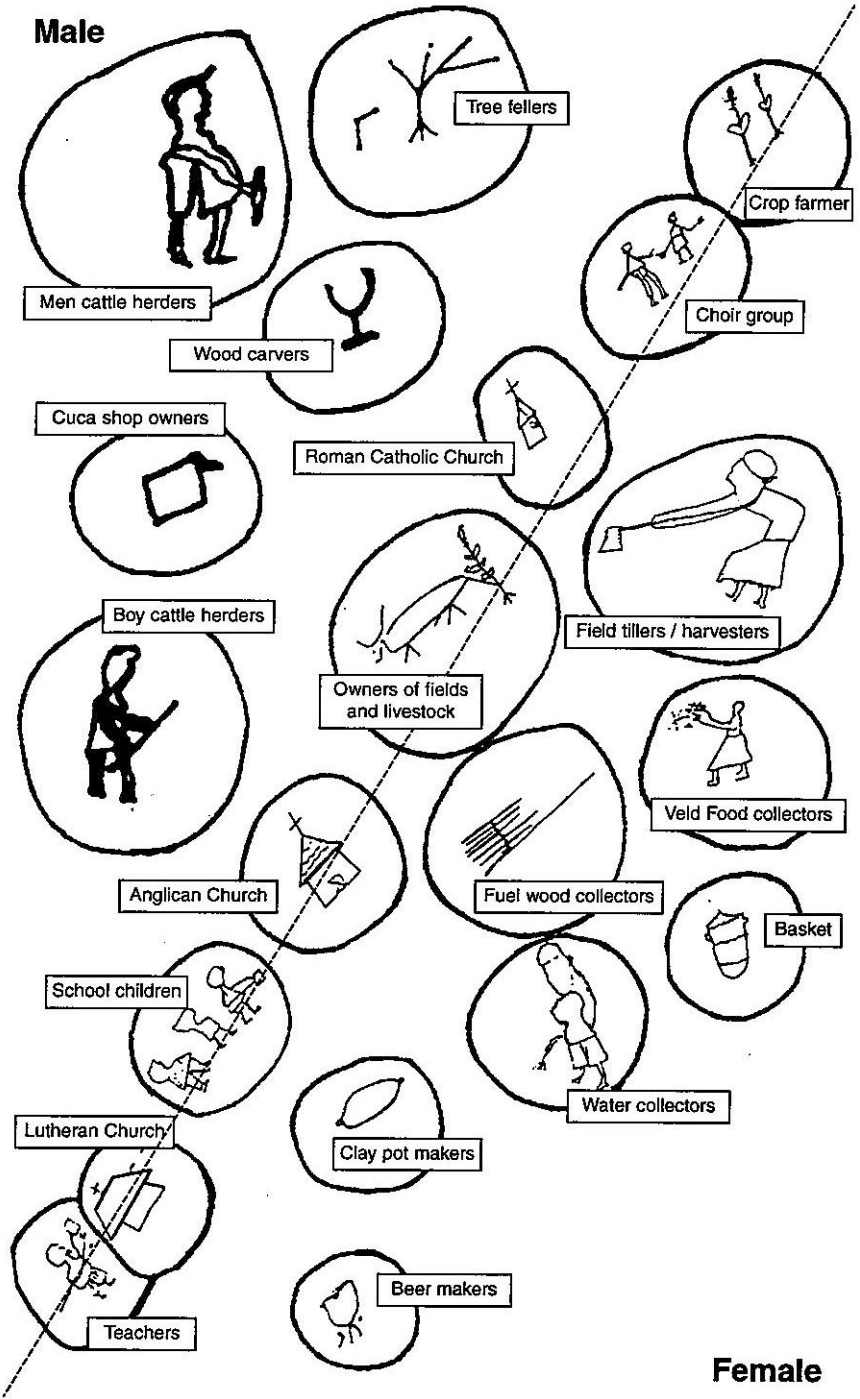

Figure 5.1: Institutional analysis in Okambuga, 24 April 1994

- *Biological benefits* (2 responses): not having to go through the pain of childbirth (note that this derives from the social norms on compulsory motherhood); and
- *Religious benefits* (1 response): within the Hindu religion, the higher place accorded to men in religion and the power to light the funeral pyre of one's parents on death.

Of the five *dais* who wanted to be born again as a female, two felt that women play an important role in producing life and sustaining generations. One of them said, 'If all of us became males, how will life continue? We play an important role in society'. Two *dais* felt that women have a closer and, therefore, more fulfilling relationship with their children. Another two cited that women do not need to go out and strain themselves as much as men. Thus on the issue of the gender-based division of labour, it appears that some of the *dais* had struck bargains with patriarchy (cf. Kandiyoti, 1988), enjoying some of the privileges which the system has to offer, although at the cost of access and control over resources. On the positive side, it was encouraging to note that some also felt that women play a key role in society.

We used a pictorial representation to synthesize this discussion. The *dais* who felt comfortable with drawing made pictures to show why most of them prefer not to be born again as females (Figure 7.1). This exercise allowed us to discuss more specific forms of gender discrimination in Katihar district, as a gentle introduction into later exercises dealing with female infanticide.

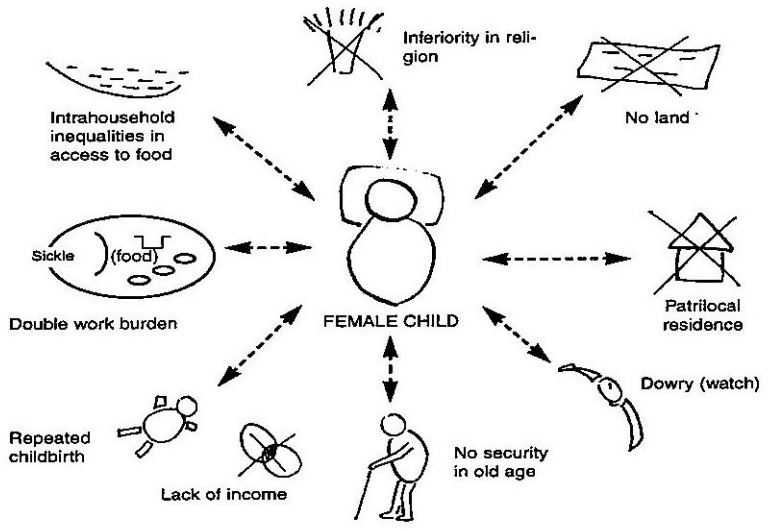

Figure 7.1: The *dais*' experience of gender discrimination

way, the questions and discussion led to the steady development of the profile of women's activities (see Figure 8.1).

Defensive men in disbelief

When the men felt satisfied that they had identified all the activities, they counted the number of leaves to see how many hours of work the women do each day. They were astonished to realise that all these activities totalled 19 hours a day.

Margabhai (to Meena): You mean to say that women work 19 hours a day?
Meena: I am not saying anything. It is all your information.
Margabhai: How can that be? If women worked for 19 hours, they would not be able get up in the morning, they would become ill.

When we asked what they wanted to do after reaching what was, for them, an unbelievable outcome, the men said they wanted to redo the exercise. They started to take off five minutes here and ten minutes there, and seemed quite baffled by this discussion. Finally, when they calculated the number of hours worked by women again, they found that they had only reduced the total by one hour!

And then they became defensive. The men said that women's work was less difficult and arduous than their own work. For example, it was very tiring to plough or to let the cattle graze under the hot sun. They claimed that cooking, washing and the other activities did not involve as much work for the women.

Realizing the difficulties

We then probed further by referring back to the different tasks and asking them to imagine what women experienced as they undertook each of the tasks. For example, we asked what they think happens to the women as they go to the forest to collect wood or cook food. They were silent and we repeated the question, asking if they thought it was an easy task or not. One man started by mentioning that women have to walk long distances often with bare feet.

Poolsingbhai: Even in summer, she walks barefoot in the heat. My wife once got boils on her feet.
Another man said: Sometimes the forest guards behave very badly. Once when my wife tied the bundle of wood and was about to leave, a guard snatched her sickle.
Ramsingbhai: They don't even get water to drink. It is especially difficult in the summer. When my wife arrives at home, she is very thirsty.

We probed further and other men mentioned various difficulties that their wives and daughters face when collecting firewood. One man's daughter had sustained a head injury from carrying heavy wood. Others

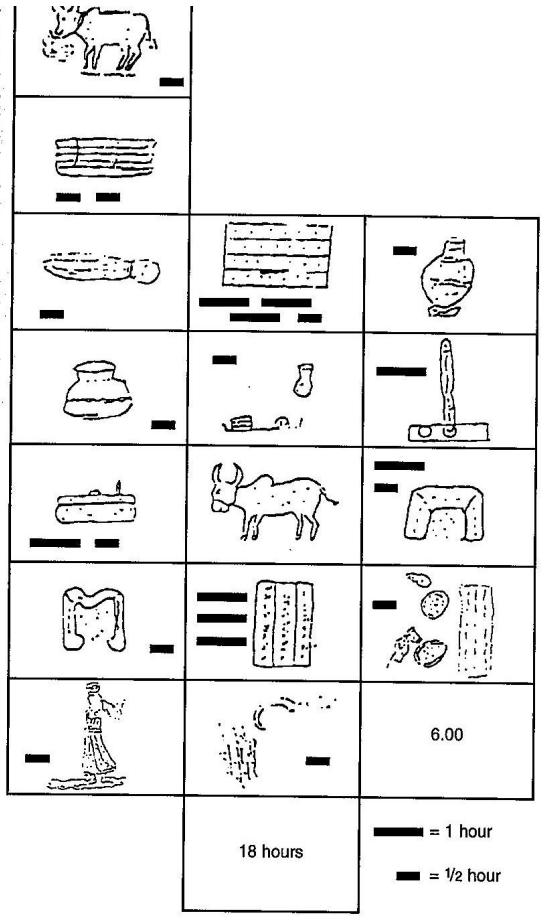

Figure 8.1: Diagram of women's daily activities, according to the men in Boripitha (redrawn from original for purposes of publication)

"Entering women's world through men's eyes" by Meena Bilgi in Guijt & Shah eds 1998

"Brides have a price: gender dimensions of objective-oriented project planning in Zimbabwe" by Regine Debrabandere and Arnout Desmet in Guijt & Shah eds 1998

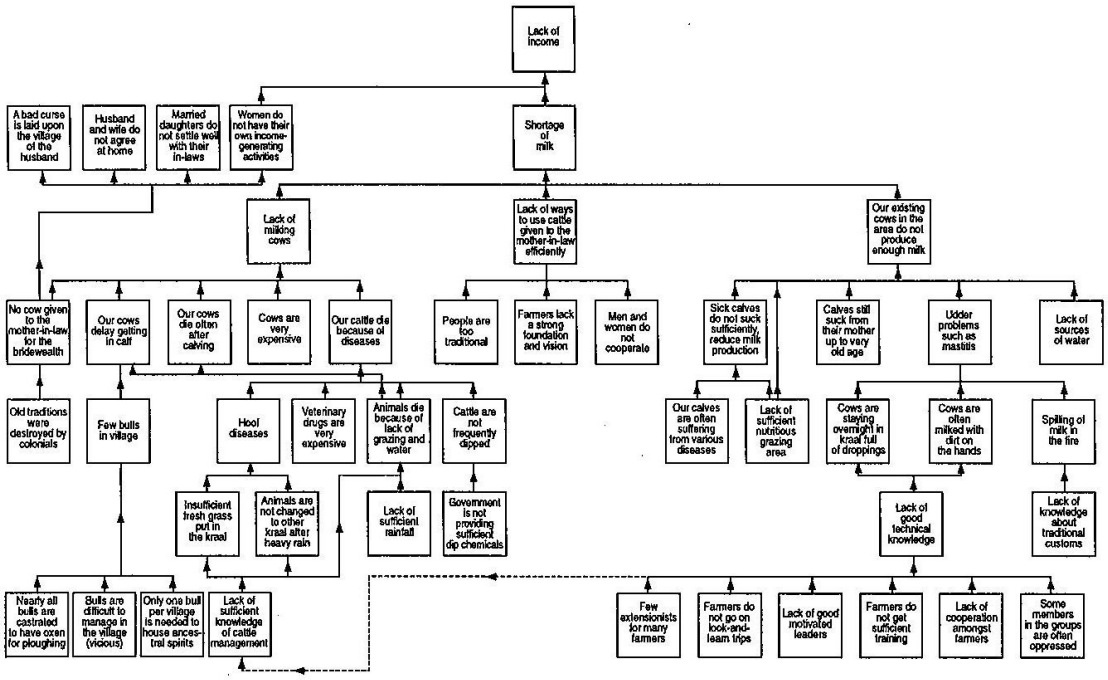

Figure 9.1: Problem tree of lack of milk for sale and home consumption, Mutoko, Zimbabwe

said that he had now realized that life has much more to offer him, and that a number of friends have now formed a young men's income-generating group, in order to build a future for themselves. The young men also said that they used to blame girls for AIDS, but that they have now seen that it's no use blaming anyone; and that a number of the young women had now become their friends with whom they could discuss these things. In fact, they said, when it came to marriage, they would rather choose one of these young women who had gone through this workshop process than a young woman from elsewhere, as it would be easier for them to relate to each other.

Table 12.1: Changes in Buwenda after Stepping Stones process

Changes mentioned	*Old men*	*Old women*	*Young women*	*Young men*
less quarrelling between couples and more sharing of household costs	✓	✓	✓	
less wife-beating	✓	✓		
a respect for the wills of those who have died, regarding the rights of their spouses and children	✓	✓		
a greater sense of well-being and respect for others	✓	✓	✓	✓
greater mutual respect between young men and young women			✓	✓
greater ability of women to discuss sexual matters with their children		✓	✓	
greater self-esteem among young women	✓		✓	
a reduction of alcohol consumption, by older men especially	✓	✓		
a sustained increase in condom use by participants from all peer groups and others	✓	✓	✓	✓
continued peer group meetings		✓	✓	✓
wish to become economically self-sufficient			✓	✓
improved relations amongst others in the community who had learnt about the workshop from participants	✓	✓	✓	✓
development of care and support for HIV positive people and their carers within the community		✓		✓
enquiries from other communities about the workshop process		✓		✓

"Gender, Participation and HIV" by Alice Welbourn in Guijt & Shah eds 1998

and men to share their ideas and knowledge. Box 17.2 gives an overview of the methods we used in the research process and the role of women and men in the research sequence. We also selected methods which could be managed by the fieldworkers and were feasible to use, given our time restrictions. The questionnaire was used to understand the perspectives of the heads of households on issues of rice production and irrigation. It provided quantitative information complementary to that from the other research methods.

Many of the methods we chose are associated with PRA. However, the study was clearly a research activity and was not directly linked to project implementation. We make no claim at having been involved in a PRA

Box 17.2: Methods used in the study

Method	Field phase	Number of participants							Gender-differentiated
		TS	PP	Kr	Sa	KK	PS	Total	
Mapping group	1 and 2	3	3	3	3	3	3	18	yes
Transect walks	1 and 2	2	2	1	1	1	1	8	no[a]
Seasonal calendars	1 and 2	3	3	2	2	2	2	14	yes
Well-being (group)[b]	1 and 2	3	3	4	4	3	4	21	no[a]
Semi-structured interviews	1 and 2	10	11	11	11	10	12	65	yes
Questionnaires[c]	1 and 2	50	31	46	29	37	46	239	yes
Life stories and time lines	1 and 2	2	2	2	2	2	2	12	yes
Venn diagrams	2	–	–	6	–	–	6	12	yes
Key-person interviews	1 and 2	3	2	5	2	3	4	19	no
Daily time lines	2	–	–	29	–	–	34	63	yes
Rice matrix (group)	1 and 2	1	1	1	1	1	1	6	no[d]

TS – Toap Sdach, Prey Veng; Sa – Samraong, Takeo
PP – Po Pluk, Prey Veng; KK – Kampluong, Takeo
Kr – Krang, Prey Veng; PS – Prey Sambuo, Takeo

a. For the transect walks and the wealth-ranking exercises extra care was taken that women were represented. In several cases we spoke only to women as there were no men available and vice versa. Participation of mixed groups was encouraged.
b. The households for the wealth-ranking exercise were taken from a census list provided by the village leader. The maximum number of households ranked was determined during the field training days to be sixty. Village size varied from about 600 to 1200 inhabitants.
c. We used questionnaires to cover 25 per cent of the households in each village. Respondents were randomly selected.
d. Matrices on rice varieties were carried out only with the women as they are the ones who select the seeds.

By Sonja Vlaar and Rhodante Ahlers in Guijt & Shah eds 1998

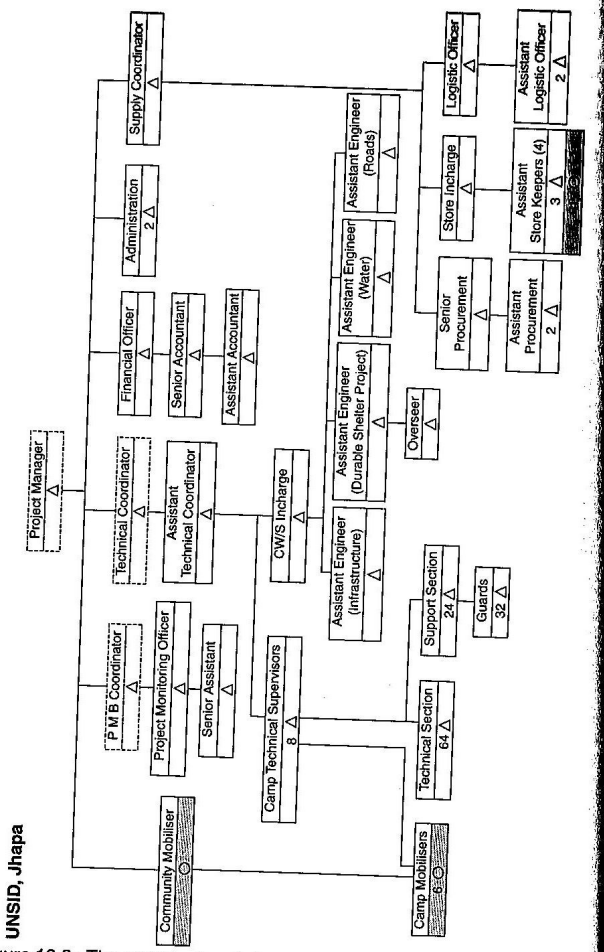

Figure 19.3: The organizational structure of the UNSID office

"Gender, Participation & Institutional Organisation" by Justin Greene-Roesel & Rachel Hinton & others in Guijt & Shah eds 1998

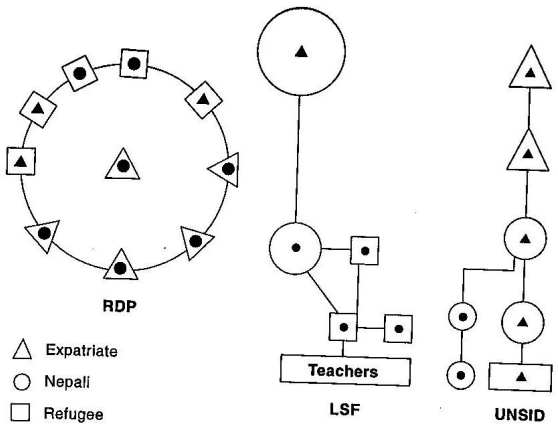

Figure 19.4: Employees' representations of the organizational structures of three NGOs

superior, in reality, the male administrators of UNSID camp-based activities directed their work. These nine new posts were conceived quickly and were poorly planned, designed specifically to resolve perceptions of inequality in the institution's management. This tokenistic treatment of women's absence from decision-making produced artificial roles and few responsibilities for the women, leaving them largely unoccupied and subordinate to male authority. Yashodha, one of the camp mobilizers, explained: 'I just have to sit here. They do not tell me what to do. I must mobilize the community . . . so I speak with the women in the committee.'

Fieldnotes describe her predicament:

> Yashodha is becoming very despondent, and sits in her room for hours on end. When she is bored she wanders into our research room to observe the activity. She knows the overall goals of her post, yet has not been equipped with the skills and does not command the authority to approach the community.

Despite intentions to the contrary, authority at UNSID flows routinely from men to women who implement decisions, and from expatriates to Nepalis to refugees. Simply placing women in high positions of authority and inviting their participation in decision-making and initiating action

Editorial

• Theme issue

Welcome to this, the first issue of *PLA Notes* of the new Millennium. IIED would like to take this opportunity to wish all our readers a healthy and prosperous Year 2000.

Since it was established in 1988, this series has reported many trends and changes in social science research and development work. As the 20th Century came to a close, interest in participatory approaches had grown from a fad to a phenomenon. We have also seen the spread of participatory approaches from the South to the North, where increasingly, projects are seeking to adopt a 'bottom-up approach' to ensure greater involvement in, and ownership of, the development process by communities. This also comes at a time when citizenship, empowerment and social inclusion are becoming increasingly important to policy-makers and practitioners of community development alike. Today, the use of participatory approaches is now viewed as critical to the success of community development efforts worldwide. Similarly, in action-oriented research, participatory approaches are being applied in wide range of sectors and contexts, both rural and urban. This, in turn, is leading to new methodological innovations.

Fields such as health, micro-credit and finance, planning and assessment, adult education and literacy, small enterprise development, and gender analysis, amongst others, adapted and developed their own powerful sets of participatory tools and techniques. Many employed visualisation methods as part of this growing family of approaches. To reflect this growing diversity of approaches and applications, *RRA Notes*, the original name for this series, was renamed *PLA Notes* in 1995.

With the rapid increase in new methods and approaches invariably comes the explosion of new terms and acronyms to represent them. In *PLA Notes*, the Editorial Team has chosen to use the term '*Participatory Learning and Action*' or '*PLA*' in a generic sense. Thus, we view it is an umbrella term under which the vast array of participatory approaches now being used throughout the world (e.g. Participatory Action Research (PAR), Participatory Rural Appraisal (PRA), Participatory Technology Development (PTD), Theatre for Development etc.) can be encompassed.

However, as the Guest Editors of this Special Issue note in their overview (Cornwall and Welbourn, this issue), the term 'PLA' has been, and continues to be, interpreted differently by practitioners in different places, according to their own experience and understanding. Some view PLA very much as an overarching term covering all participatory research and development approaches, while others see it as an approach it its own right. Thus, our Guest Editors have chosen an open-ended definition of PLA to reflect this range of opinion.

At the start of this new century, what is perhaps important to keep in mind is not how we develop and maintain clear 'brand names' for our methodologies nor how we get our terminology right. It is how we can new find ways to learn together, to observe good behaviour and attitudes in our work and ultimately, to ensure good practice and quality in the use of participatory approaches, whatever we may decide to call them. If this is where we concentrate our efforts, then this can only be a good thing for the future of participatory research and development.

This issue of *PLA Notes* is devoted to an assessment of the use of participatory approaches in Sexual and Reproductive Health. It builds on previous *RRA/PLA Notes* issues on Health (RRA Notes 16, 1992) and HIV/AIDS (PLA Notes 23, 1995).

The Guest Editors for the theme section are Andrea Cornwall and Alice Welbourn. Andrea Cornwall is a Fellow at the Institute of Development Studies, University of Sussex.

Her current work focuses on the use and abuse of participatory approaches, public participation in health and issues of difference in participatory development. She has guest edited two previous *PLA Notes* issues on 'Critical Reflections from Practice' (*PLA Notes 24, 1995*) and 'Performance and Participation' (*PLA Notes 29, 1997*). Alice Welbourn works as a part-time writer, adviser and trainer on issues focusing on sexual and reproductive health, (including gender, HIV, communication and relationship skills). Based on her 16 years of community development experience, mainly in Africa, she is starting to look at ways in which local projects in Britain can benefit from what she has seen and learnt elsewhere in the world.

• In this issue

As usual, this issue opens with a general section. The first article provides an overview of the relatively recent developments in participatory research in China and the work of the Yunnan PRA Network (Xing, this issue). The author discusses how participatory approaches were adopted in the region and presents a review with examples of where they have been used, but also, sets out what is required in terms of attitudinal and institutional change for them to be successful.

The second article in this section provides a review of the recent 'Dare-to-Share Fair' held in The Hague, The Netherlands, October 13th-14th 1999. This event provided the opportunity for practitioners of participatory development world-wide to present their work, and offers insight into the variety and spread of participatory approaches around the world. (Lammerink, Posthumus and van Weperan, this issue).

Regular features

The *Feedback* section for this issue is provided by William Fielding and Janet Riley, with an interesting account of comparing scoring and ranking techniques. With a thoughtful response from Robert Chambers drawing from his work in the field, he emphasises the equal importance of non-numerical aspects of ranking and scoring techniques and states that numbers, whilst undeniably useful, should not be used to side-track practitioners from looking at process and learning. The *In Touch* pages towards the back of the issue share experiences and publicise new and relevant materials and training events. Please feel free to send items for this section to the *PLA Notes* Editorial Team at IIED.

The *RCPLA Pages* provide information concerning the first Francophone Exchange to be held in Dakar, Senegal, later this year, co-organised by RCPLA member, IIED-Senegal. This event will provide a space for practitioners of participatory approaches to share and exchange experiences, to review the use and development of participatory methodologies in the Francophone world and to suggest ways forward in the future. This section also announces a new publication from another member of the network, the Asian Coalition for Housing Rights (ACHR), with the arrival of the first issue of *'Face-to-Face – notes from the network on community exchange'*, a new journal in which strategies for exchange and participation between the many levels existing between and within differing communities are identified and explored.

Finally, you will find a *Readership Survey* enclosed with this issue. This is the 3rd Readership Survey of the *PLA Notes* series since its birth in 1988. We would be very grateful if you would spend some time to complete the questionnaire, as it is the input of the audience which keeps the *PLA Notes* up to date with new experiences and innovation in the world of participation. The deadline for returning the questionnaires is July 31st 2000 and we are planning to report back the findings in the October 2000 issue of *PLA Notes* (issue 39).

As always, we do welcome your comments and contributions for any of the sections in *PLA Notes*. Happy Reading!

Call for experiences!

We have planned some new theme issues of *PLA Notes*. In June 2000, we will explore the use of participatory approaches in community development in the North, learning from the long history of participation in the South. October 2000 will look at GIS, mapping and modelling. Please send us contributions on any of these themes. Articles should reach us at least two months before the publication date.

1

Searching for participatory approaches: findings of the Yunnan PRA Network

Lu Xing

· Introduction

Participatory approaches were introduced to Yunnan Province, the People's Republic of China in 1993. Since then, a group of practitioners in Yunnan has started to search for ways of implementing participatory approaches within the Chinese context. This paper summarises the major findings of the practitioners' experiences in research, action and extension projects, and presents the current state of the practitioners' theoretical thoughts on participation.

· Challenges in rural development

Demand for participatory approaches in Yunnan Province of China arose during the experiences of the Yunnan Upland Management Project, a Ford Foundation funded project initiated in 1990. The project, whose staff of more than 50 researchers and officials came from 13 institutes, aimed to develop approaches to sustainable development in Yunnan's Upland areas. The project selected four sites that reflect different geographical conditions in which to work. From 1990 to 1993, project staff were trained in and practised interviewing skills, RRA, monitoring and evaluation. Projects in each of four sites went through processes of surveys of households' demands, design of project activities including agricultural and livestock interventions and other income generation schemes. They undertook a technical feasibility appraisal of these activities, plan formulation, and motivation of villagers to join the activities with local officials.

Throughout this process, the project staff and local officials decided what activities to do and when to conduct them. The villagers were only involved in so much as they could present what they needed to the project staff. In 1993, we found that project staff were happy about the project's outputs, such as increases in grain yields, household incomes and services to the poor. These outputs met some of the villagers' needs as well as the project's set objectives. However, project staff also felt that through this process, the villagers often ended up in a passive position, either waiting, or being motivated by staff, to join in the designated activities.

"Thank you very much for your help, but what do you want us to do next?" said one villager.

At the same time, the project staff discovered the richness of the villagers' knowledge about their farming systems; knowledge which, until that point, had not been fully recognised in the project. Villagers often used their knowledge and skills to solve difficulties during the implementation of certain project activities. The project staff saw that the approach that had been adopted in the project thus far actually served to strengthen villagers' dependence on outsiders and could not lead to sustainable development in the long term.

Around this time, a book came to our attention: *Rural Appraisal: Rapid, Relaxed and Participatory* by Robert Chambers. The theory and methods presented in the book appeared to be very relevant to the issues identified through the project. Therefore, on behalf of the Rural Development Research Center (RDRC), the author wrote a proposal to the Ford Foundation to request support for the introduction of participatory approaches in Yunnan. Dr. Robert Chambers was then invited to hold a training workshop on Participatory Rural Appraisal (PRA) in Kunming in December 1993, signifying the formal introduction of participatory approaches in Yunnan Province, China. The Yunnan PRA Network was established after the workshop to learn about and promote

participatory approaches to rural development in China.

The Yunnan PRA Network funded ten pilot projects to help some members apply PRA in their research. Other members started to apply PRA in their own projects. This paper summarises their findings.

· Applications to research projects

Surveys and assessments

PRA provides very useful methods and tools for survey and assessment although it has some weakness. Participatory approaches were applied to surveys on, and assessments of, biodiversity, rural informal financial systems, maternal and child health care, indigenous knowledge of women, community-based natural resource management and conservation and development by the Network members. The studies concluded that the visual, open and flexible methods and tools could help researchers access the required information from villagers, and check it immediately after thorough discussion, a process which generally took three to five days. However, the studies also identified some limitations of the approach. The quality of a survey is highly dependent on the researcher's subject knowledge and level of facilitation skills and on villagers' interests and knowledge (Du, 1997). When applied to health surveys, the researchers found that questionnaire surveys provided information on the needs of human beings, while participatory surveys reflected the desires of villagers (Fang et al, 1997). Therefore, 'needs' seem to be more scientific, while 'wants' are cultivated by villagers' knowledge, community culture and values.

Planning

Participatory planning can involve villagers in the decision-making process and also counter difficulties when stakeholders have differing opinions. A poverty alleviation planning exercise, funded by the Network, was undertaken in Qianmai Township. Local officials were trained in participatory methods and undertook in-depth planning exercises in sample villages as well as extensive consultations on specific topics to increase the scale of the planning. These measures can fill the gap between information gained from villagers at the local level and the requirements of planning on a larger scale, leading to better quality planning (Shen, 1997). The trial, conducted as part of the Network's learning about participatory approaches, also identified several issues. For example, the need to take account of the perspectives of different stakeholders and their roles during the planning process and issues concerning the integration of participatory plans with existing and conventional ones. Applications to village-level forest resource management found that villagers can put forward very practical plans (Lu, W. B., et al, 1998), but that government bureaux and villagers may have differing objectives. The study suggests it must make the rights of the community very clear prior to undertaking such exercises.

Participatory monitoring and evaluation

One study of county level poverty alleviation programmes concluded that government initiation and implementation of programmes or projects was done in a top-down manner (Zhao, et al, 1997). The local communities generally play a passive role in programme activities and the project staff are responsible to their superiors rather than to the local communities themselves. Planning and implementation are given more attention than monitoring and evaluation, leading to the repetition of mistakes, and conflicts among governmental bodies not being addressed. The study also identified institutional constraints as a barrier to the application of participatory approaches in governmental poverty alleviation projects. Another monitoring and evaluation exercise of government projects at the township level, using villagers' evaluation criteria (Cai, et al, 1998) found that participatory monitoring and evaluation could reveal practical constraints hindering project achievements, many of which would not have been thought of by outsiders. Local officials are willing to accept such results and have appreciated the capabilities and knowledge of villagers.

• Applications to action projects

In 1995 practitioners in Yunnan gradually realised that the potential of participatory approaches lay as much in action projects as in surveys and assessments. It was recognised that communities should be seen as key stakeholders in decision-making processes, in operational management and in the sharing of benefits. The following section describes several applications to action projects while some of the key outcomes are summarised in Table 1.

Social forestry projects

Although simple and quick for Forestry Department operations, the conventional approach to reforestation projects excludes villagers from decision making about where to plant what kind of trees and how to manage them. This often leads to low rates of tree survival. With the financial support of the Ford Foundation, the Yunnan Forestry Department has experimented with social forestry approaches in three villages. Beneficiaries are now involved in the whole project cycle, and most important of all, share in the distribution of benefits (Zhou, 1998). One current concern is to develop suitable methods and criteria to evaluate the impact of the new approaches in relation to the conventional ones.

Community-based conservation and development

The Caohai Nature Reserve in Guizhou Province has a dense and poor population. Villagers around the Lake Caohai have to produce grain by converting wetland to farmland. They are regarded as destroyers of the environment because this activity endangers the habitat of protected birds. Facilitated by outsider PRA practitioners including the reserve staff, the local villagers have developed their own systems and rules for the management of 'community trust funds', thus creating a mechanism for creating opportunities for non-farming income generation. This strategy has bought the benefits of environmental conservation to the villagers, whilst they are also involved in the conservation process themselves (Wang, 1997). The reserve management office has had to adapt its management style from that of controller to that of facilitator, even to the point of accepting being monitored by the villagers. This change in institutional approach has been essential to sustaining the villagers' action (Lu, X., et al. 1998). Similar findings have been shown by the experiences at Zixishan Nature Reserve, Yunnan Province (Long, 1998).

Improvement of shifting cultivation practices

Villagers see shifting cultivation as an important part of their livelihood and farming systems. Bio-diversity specialists regard shifting cultivation as a central practice for maintaining bio-diversity in tropical uplands. Officials believe that shifting cultivation destroys forests and must be replaced by sedentary practices. Shifting cultivation systems can no longer meet the demands being placed on them, so the challenge is to seek improvements or alternatives. Participatory approaches have been applied to this issue in one action research project which involved villagers, local officials and researchers in a joint search for solutions (Xu, 1998). The action research has recommended certain solutions to decrease the negative impact of shifting cultivation, which are acceptable to all stakeholders.

Table 1: Key learnings about participatory approaches from selected action projects in Yunnan

Social Forestry projects	Participatory approaches require: • changes in attitude and behaviour of foresters • skills in participatory approaches and community organisation • openness and flexibility in project design and management • mechanisms for community-based management BUT also require: • more time investment and human effort in the initial stages
Community-based Conservation and Development projects	Participatory action requires: • respect for villagers' desires and trust in their capabilities • transparency in the process of development • an enabling environment within which villagers can operate • staff capabilities, institutional capacities and management styles being key institutional elements to support participatory action
Improvements to shifting cultivation practices	Key factors for success include: • building communication channels between the different stakeholders, transparency of project components and funding arrangements • drawing on indigenous knowledge and practices • strengthened conflict resolution mechanisms • appropriate training • appropriate service delivery systems

Sources: Zhou 1998, Wang, et al. 1997, Lu, X. et al. 1998, Xu 1998

· Application to other projects

Through the Network activities of training, learning by doing, and exchanging experiences, Yunnan PRA practitioners now provide services to projects initiated and funded by the donor community, or advocate and provide support to projects initiated by the government. Thus, extension of participatory approaches within the region through the work of the Network has begun. Practitioners introduce participatory approaches through training and providing technical assistance at different stages of the project. Such projects have included those of a wide range of donors and international NGOs[1]. Several provincial government agencies such as the Forestry Department, the Education Commission, the Scientific & Technology Commission, the Health Department, the Yunnan Office for Poverty Alleviation, the Environment Department etc., started to use participatory approaches in their projects. Our main learnings are that it is not enough for practitioners to have knowledge, skills and experience of participatory approaches. They must also be equipped with training capabilities, co-ordination and facilitation skills, advocacy tactics, organisational management, project development and consultancy skills (Lu, Xing., et al.,1998). Many Yunnan PRA practitioners now recognise the change of their roles; to be trainers, facilitators, project managers or advocators. However, few practitioners have reflected on the effectiveness and efficiency of these measures for extending participatory approaches in the past.

· Thoughts on participatory approaches

Theory and philosophy

Perspectives on participatory approaches differ slightly among Yunnan PRA practitioners. Some regard participatory approaches as a method which is of great use in conducting surveys or assessments. But an increasing number see participatory approaches as a philosophy, and an important part of development theory.

[1] For example the Asian Development Bank (ADB), the United Nations Development Program (UNDP), The International Fund for Agricultural Development (IFAD), the Food and Agriculture Organisation (FAO), the European Union (EU), The German Agency for Technical Cooperation (GTZ), the Dutch Government, as well as Oxfam Hong Kong, Save the Children, the Salvation Army, World Vision, World Wildlife Fund, etc.

Table 2: Summary of changes needed to support the practice of participatory development

Government changes required	Community changes required	Development worker changes required
Decentralise decision making processes and focus on macro measures; Make policies, procedures and management styles more open and flexible; create space for bottom-up approaches.	Develop their own organisations, and institutional mechanisms for conflict resolution; Enhance their abilities and skills to tackle problems and opportunities.	Change their attitudes and behaviour; Enhance their capabilities in advocacy, training, co-ordination, facilitation and management as well as participatory practice.

The theory of participatory approaches is based on assumptions which imply that, given the opportunity, one would participate in discussions or actions that affect one's interests (Zhou, 1997). Being concerned with one's own interests, one also participates in collective initiatives and hopes to achieve gains during the process. This theory further implies that as the subject (not object) of development, development project beneficiaries (not others) should make decisions about their own destinies. But many PRA practitioners in Yunnan also point out that for effective and sustainable participation, it is necessary for government officials and scientists, not just communities, to co-operate in planning, decision making and implementation (Tian, 1998).

Enabling environment

The adoption and application of participatory development challenges current development thought in China; its policies, institutional arrangements and working procedures. Moreover, a person's role is largely determined by institutional policies (Wilkes, 1998). Thus, although essential, changes in personal behaviour and attitude are not enough. Participatory development requires an enabling environment, which differs from country to country due to differences in culture and political system. In debating the required changes, Yunnan PRA practitioners often focus on the respective roles of government, communities and development workers (see Table 2).

· Future directions

Through two meetings in 1998, Yunnan PRA practitioners reformulated the direction of the Yunnan PRA Network. They positioned the Network as a learning network. Its purpose is to promote participatory development and its objective is to enhance the Network members' training, facilitation, advocacy, management and consultation capabilities. In order to achieve its objectives, the Network has designed four programmes:

- a training programme;
- an action-fund programme to help members to learn action skills in addition to research skills;
- an information exchange programme focusing on meetings; and,
- a publication and co-operation programme to promote members in the development field.

The Network encourages its members, representing both themselves and their institutes, to be involved in development projects. A systematic review of practitioners' experiences with applying and promoting participatory approaches is now underway with the support of the Institute of Development Studies, UK. Through these various activities, practitioners in Yunnan will be better equipped to develop procedures for promoting participatory approaches in ways suited to the Chinese context. The Network also plans to undertake an evaluation of its work in late 2000.

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2

‘Trading places, trading ideas’: Review of the second ‘Dare-to-Share Fair’ on participatory development

Marc P. Lammerink, Bram Posthumus and Willem van Weperen

• Introduction

The formal atmosphere of the foyer and conference hall at the Dutch Ministry of Foreign Affairs, home to the Netherlands Development Agency DGIS, found itself transformed. Based in The Hague, The Netherlands, on an average day the ministry building, would have people quietly cruising through, but on the 13th and 14th October 1999, it contained a noisy, bustling and at times, quite festive, market place. The subject of the event was sharing experiences around participatory approaches to development and learning from the field how to assist people in their development in such a way that they actually own the process. The catch phrase of the event was ‘Dare To Share’.

A brief history of the fair

Trade fairs and markets all over the world attract people from near and far as buyers and sellers of goods. But fairs have also been good media for information exchange and innovation. In the field of participatory development, the time seemed right to stimulate an exchange of ‘approaches that work’ among many people. If held close to the donor organisations, a fair-like set-up could enhance a trickle-up effect towards policy making circles within governments and large NGOs, thus having an advocacy role for participatory approaches to development. So in 1994, the idea to hold a fair that would ‘showcase’ participatory development was born at an informal meeting of European practitioners and researchers working in this field. This event was named ‘The Dare to Share Fair of Participatory Development Approaches’. It was decided that Fairs would be held in the ‘homes’ of European donors in different countries to state the case for participation.

The first Dare To Share Fair was held in 1995 in the German town of Eschborn, the home base of the German Agency for Technical Cooperation (GTZ). This event was described as a success. The second Fair would be organised in the building of another major donor, DGIS, the Dutch government’s development aid agency. It took some time to organise this, as the organisers explained: “*We needed to build support within DGIS. Eventually, we got commitment from key people in the various departments”*. DGIS and the Dutch development organisation SNV[1] funded the Fair and were actively involved in its organisation, together with the consultancy firms FMD and ETC Ecoculture. During almost eight months, a small core group consisting of representatives from all four organisations met regularly for the conceptual preparation and to take the main decisions.

FMD and ETC carried out the main organisational tasks, including the world-wide mobilisation of organisations and people working with participatory approaches, sending out invitations, selecting participants for possible sponsorship, dealing with the budget and administrative matters and all other practical and logistical aspects of organising such an event. For this they prepared an extensive scenario, which may be useful for those involved in organising such events in the future. During the last months in the run up to

[1] A government funded organisation with an independent policy-making board.

the Fair, support was provided by a group of designers who helped create posters and draw the market layout. They put much emphasis on developing an attractive, stimulating and lively environment, where visitors would be directed by clear signposts, ensuring that no participating organisation would end up in a hidden corner. The area of the market within the ministry was compact, with some additional common space for a café, where people could meet, rest and discuss any issues which had been stimulated by the organisations exhibiting their work. The main aim was that the Fair should be wholly interactive, affording participants and visitors the maximum opportunity to engage in a broad variety of exchanges with participating organisations and representatives from across the world.

The objectives of the 1999 Fair were by and large the same as those in 1995:

- to present ways of formulating and implementing development programmes that use participatory and interactive approaches, with a special focus on experiences from Dutch-funded development programmes in this case;
- to demonstrate the effectiveness of these approaches and take away some prejudices that still exist towards participatory methods;
- to enable the various groups present at the Fair to exchange their methods and ideas; and,
- to identify and analyse future challenges as regards further developing and implementing these approaches.

A market of ideas

There were representatives of 43 organisations from approximately 25 countries in four continents; action researchers, popular educators, project directors, grassroots activists and consultants. There were stands, graphs, charts, photo-exhibitions, maps drawn by local people and products from the areas represented. A variety of presentation media, including papers, flyers, slide-shows, books, games and CD-ROMS etc., were used to deliver a message; the message being simply that 'development, whatever that may mean, shall be done in cooperation with the people who are the intended beneficiaries - or it shall not be done'. Away from the market place, in some quieter corners, there were videos, workshops and an Open Space, where anyone who felt compelled to do so could raise and discuss a subject. Jargon filled the halls and rooms: Participatory Action Research, Process Approach, Mesas de Concertación, Rapid Appraisal of Knowledge Systems, Groupe de Recherche et d'Appui pour l'Autopromotion Paysanne, Farmer's Field School etc..

Figure 1. Presenting participatory work and information at the 'Dare-to-Share Fair' [Photo: L. Greenwood]

It provoked Pauline Ikumi of NETWAS Kenya into saying:
"*I hear all this different terminology. But I think we're all talking about the same thing*".

And talk they did. As always, the interactive method most frequently used was 'The Conversation'. Policy makers from the North talked with practitioners from the South, activists made contact across the continents, researchers exchanged views.

The end of the Fair consisted of a different type of activity: 'The Auction'. All visitors were invited to come to witness six presentations of different participatory development approaches and then judge them by piling on bids, auction-style. Coloured cards representing Dutch money were used for that purpose. The audience, consisting of a heady mix of development bureaucrats, international students, organisers and participants, was also asked to synthesise the six approaches into one new participatory approach. But time had started to run out and the technical services department of the Ministry, which had been instrumental in the smooth running of the event wanted the venue cleared and swept. Around 100 representatives at the stands had been able to present their case to a total of some 400 visitors.

• Scale matters

A wealth of experience, a wealth of variety in local organisations, and mostly shared visions and objectives were on display in The Hague. But they remain local and relatively small. There seem to be few concrete success stories of community-based development, management that has been scaled up, and even less documentation around participatory processes that were started locally and have been successfully scaled up. There is a gap to be filled because scale clearly matters. Several examples of the possibilities in this area were presented at the fair and follow in the next section.

1. Large-scale in-country focus
In Sri Lanka, the massive Mahaweli Programme is the single largest integrated rural development programme in the country, run by the government and supported by several foreign donors. It revolves around a huge irrigation scheme. Landless peasant families were resettled into the area and at the household level, the implementation is making use of participatory methods, LEISA[2] agriculture and local community organisation. The results appear to be encouraging.

2. Regional focus
This is what organisations such as ALFORJA, the Central American public education organisation, have been doing, each in their own regions. Alforja has a mission: to build a political culture that changes power relationships. Alforja's community worker, Emma Hilario from Costa Rica, explains : "*We work with people's organisations, trade unions, government workers, teachers and local authorities. Citizen's participation in shaping their own environment is not only a civil duty - it is in fact a civil right. Civil organisations are trying to break through the traditional ways of doing things*". Sometimes it works: ALFORJA (the name refers to the small bag of utensils and other necessities people take with them when they go and work in their fields) has managed to ensure that women can own land in Costa Rica.

3. Repetition and/or replication.
This is especially useful in terms of applicable research, like biotechnology research from Zimbabwe, Kenya, India and elsewhere. UPWARD[3] is a regional Asian organisation involved in locating and harnessing homegrown practices of crop improvement in tubers (root crops). Along similar lines, there is agro-research going on in much of Francophone Africa, assisted by the Free University in Amsterdam. Farmers Field Schools can be found all over Asia and have now been introduced in Zanzibar. Exchanges like this Fair facilitate the spread of useful ideas and may facilitate adapted replication. And, finally, development workers can of course tap into practices that have been around

[2] Low External Input and Sustainable Agriculture
[3] Users' Perspective with Agricultural Research and Development – this organisation attempts to incorporate the perspectives of farmers, traders, food processors and consumers in its research agenda.

for a long time in a large geographical area. A Cameroonian consultancy firm did just that: it harnessed the age-old African revolving credit scheme called the 'tontine', which is especially popular among women, and turned it into a credit scheme for agriculture and hawking.

• Is the message getting through?

The Western model upon which the development models are based has been successfully exported to most parts of the world but underneath this perceived universal acceptance, many local, indigenous practices and beliefs remain. In the past, the under performance (some would call it failure) of development projects was, at least in part, blamed on the beneficiaries, who were hampering progress by stubbornly clinging to their old ways. That notion is slowly being abandoned; witness trends among donors towards attributing value to local culture and supporting decentralisation in many countries, shifting the focus away from the centres of administrative power, often inherited from colonial times. Some space has become available for the views of the intended beneficiaries, and for what they have already achieved prior to any 'developmental' intervention. As David Millar writes in his contribution to *Food for Thought, ancient visions and new experiments of rural people* (Compas, 1999), *"When we intervene...what we encounter is a 'best option scenario'... an endeavour [that] would continue with or without us"*.

There appears to be growing support for participatory development among major donors who set aside part of their budgets for this kind of activity. Equally, some of the work that is done by the various organisations in the UN system (UNDP and UNICEF among others) appears to have a participatory agenda. International research institutes are supporting participatory development. Dutch minister for Development Co-operation, Eveline Herfkens, who opened the Fair, officially, noted that progress has also been made in terms of accepting participation in the world's leading donor agency, the World Bank.

"But," she added immediately, *"We are not there yet. There is still not an interactive dialogue at the bilateral or multilateral level"*. And on the role donors should play she said: *"We should hand over and retreat. We are not good at this. I'll admit: I'm not good at it. We really must stop knowing better"*.

She advocated a fundamental and comprehensive change in donor mentality, including at DGIS itself. Among her concluding remarks was this one: *"I would be very happy if I could implement this in my own Ministry"*. It will be interesting to see how the implementation will take shape at DGIS.

Still, blockades and barriers remain. Chris Rey of the Centre for Development Cooperation services at the Free University in Amsterdam thinks it has to do with peoples' mind-sets.

"It has partially to do with the educational background of people. Scientists feel superior to farmers. They have always gone out to teach and to train. What we do now is to train researchers how to discuss, eye to eye, with the farmers".

It is a problem that is echoed by ETC India's Ravi Prakash: *"Researchers feel they know all the problems and the solutions too, at the same time not recognising that farmers do know"*.

FMD's experience in facilitating the setting up of a biodiversity research programme in the Philippines is also indicative: the people in the country set the research agenda and their Dutch counterparts can make contributions to this process. For some Dutch researchers from universities, this was the first experience with demand driven research. For them it was not always easy to accept that Filipinos knew very well what research needed to be done .

The same mental barriers exist in the policy-makers of the world's development bureaucracies. In spite of some very real commitment, some awkward questions must be asked: 'Who selects the regions and the countries where development will be done?' 'Where and by whom are the Terms of Reference for field trips written?'.

Fairs like these do demonstrate that the belief, still widespread, that local groups have no capacity to participate in these highly complex decision-making processes is in urgent need of

a permanent resting place. NGOs also fall for their own mythologies. Sharmeen Murshid of the Bangladeshi consultancy firm Brotee puts pay to some of the pretenses doing the rounds there. *"We differ from NGOs in that their focus is on the poorest of the poor, the disadvantaged women. We do not kid ourselves. We will say that we will work with the literate group in a village so that in the process they will learn participatory work, together with their people. So the village will take responsibility of their poor. We don't pretend to be responsible for the poor".*

So the question 'Is the message getting through?' can therefore be answered with a qualified 'Yes.' Paul Mincher of IIED (the International Institute for Environment and Development), says: *"Nobody at IIED is really satisfied at the moment. I think we must get our message out further, communicate better".*

• A future fair - lessons learned

Pauline Ikumi said: *"I am learning from others. There are a lot of similarities and things I see here I will have to adapt to the local situation. But these exchanges really work".* This bears testimony, if any were needed, to the interactive character of the Fair. To her and many of the Southern representatives, the added value of these two days had been that they had learnt from each other. In terms of the four objectives stated earlier, the ones concerning presentation and exchange were attained. Prejudice, which according to the second objective, was to be removed, is likely to persist and it is illusory to think that one event like this can take that away. This may be an identifiable future challenge, something the event was also supposed to have elicited as per the fourth objective.

The next Dare To Share Fair is planned for 2002 and ideally should build on the experience gained so far. Two observations were sent to the organisers after the Fair. *"There should have been more time to discuss major issues",* read the first. *"Many workshops were mere presentations",* was the second. A further remark concerned the amount of events on offer. *"Too many interactive events were going on in parallel".* Some workshops, fora or discussions were better attended than others and delegates missed events because they had to choose.

The organisers have, in the meantime, completed their own evaluations. Here are some more ideas that may be useful for the planners of a new Fair. First of all, they noted that having had the Fair at the ministry was a feat it itself. The excited atmosphere that had been hoped for in the big foyer indeed materialised. The stands looked good, the atmosphere was lively. The cooperation among the organisers was seen as positive and the fact that many visitors from outside the building could attend (especially the international students) meant that even more South-South exchanges were possible than previously envisaged.

Clearly, publicity was one of the main concerns during the evaluation. The number of ministerial visitors in attendance was slightly disappointing. One reason for this could have been the lack of adequate publicity. While small Dare To Share displays had been placed on all the tables in the large ministerial canteen, it was unclear what the Fair was about, as one ministry official observed. Putting up posters was restricted within the ministry building, making it less obvious that there was something special going on. The organisers concluded that it would perhaps have been better to hire professionals to do the publicity for them.

In sum, the second Dare to Share Fair was a qualified success: there was much enthusiasm among the direct participants and organisers, while the response from the intended visitors could probably have been better, given the right amount of publicity. The next Fair will hopefully demonstrate whether the results achieved on the ground have continued to trickle up to the level of the policy-makers.

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Sexual and reproductive health

From reproduction to rights: Participatory approaches to sexual and reproductive health

Andrea Cornwall and Alice Welbourn

Introduction

This special issue of PLA Notes focuses on participatory approaches to sexual and reproductive health[1]. It brings together accounts of exciting initiatives from around the world that hold the potential for transforming an arena that has tended to provide information and services rather than seek to engage people more actively in processes of change. Ranging from innovative uses of participatory methods to enhance communication and understanding to strategies to amplify the voices of people who would otherwise remain unheard in policy and institutional processes, the articles in this issue offer food for thought and lessons from experience.

Reflecting a wider shift from reproduction to rights, the use of participatory approaches poses important challenges for sexual and reproductive health (SRH) work. It is always easy to criticise with hindsight, but ten years ago, crudely speaking, mainstream agencies viewed women largely as breeders and therefore, focused narrowly on family planning, maternal/child health and traditional birth attendant training as part of their health programmes. Only women in the 15-45 years cohort were the 'targets' of this work. Little attention was paid to younger or older women's sexual and reproductive concerns. Men's involvement and *their* SRH needs remained unaddressed.

Similarly, any mainstream agency working on sexually related illness focused on HIV prevention with female sex workers and male truck drivers (their clients). Whilst epidemiologically, they may have been the groups who appeared then to be most 'at risk', sex workers, already stigmatised by society, were then ostracised yet further by others for their apparent association with HIV prevention work. Ironically, in many cases, sex workers became champions of safer sex practices, while the rest of society which had condemned them, continued to ignore its own vulnerability.

In such an approach, mainstream agencies also assumed that *heterosexual* transmission of HIV (and other sexually transmitted infections, STIs), was the only sexual route. Now we are much more aware of the diversity of sexual orientations, not just homosexuality but others as well, and of the diversity of SRH needs which people have, rather than just using a narrow Western model of health care, sickness control and 'simple' heterosexuality, which influenced the approach of agencies a decade ago.

Much has changed; and much still needs to change. More work is needed to break open the boxes that surround 'target groups' and recognise the complexity and fluidity of sexual and reproductive identities and experiences in different

[1] This issue builds on previous RRA/PLA Notes issues on Health (RRA Notes 16, 1992) and HIV (PLA Notes 23, 1995). Further resources include the excellent field guide by Kaul Shah et al. (1998), the IDS Sexual Health Information Pack (SHIP) and the IIED Trainers' Guide (1995).

cultural contexts. The articles in this issue address some of these broader concerns, from body image to breast cancer, from vasectomy to gender-based violence.

There remain a number of SRH issues on which we have sought, and failed, to find accounts of participatory initiatives, including abortion, female infanticide, female circumcision, work with men who have sex with men etc.. The methods and processes that the articles in this issue describe, however, have relevance beyond the specific SRH issues that their authors focus on. They offer a range of ways of opening up the space to rethink ideas about sexuality, gender and sex, and to engage people *as people* in strategies for change.

Breaking down walls: SRH, rights and development

Ten years ago, very little attention was paid to SRH issues by anyone outside the health sector. But we can now see how SRH intersects with everyday livelihood issues, whether in terms of agricultural cycles (Howson and Smith, this issue) or access to and control of money and other resources (Simasiku et al., this issue). It has become evident that SRH is more than a 'health issue'. There is also increasing recognition of the links between different aspects of SRH. Recent research in India (Martin et al. 1999) draws attention to significant levels of wife abuse in Northern India. They found that abusive men were more likely to engage in extramarital sex and have STD symptoms, thus placing their wives at risk of STD infection as well as unplanned pregnancy. Such research supports informal findings from many different countries (Shaw and Jawo, Howson and Smith, this issue) and highlights how essential it is for us as development workers to make these connections in our work.

Connections need to be made beyond the domain of SRH work. Rethinking SRH as a development issue allows us both to focus on the rights dimensions of SRH work and its relevance to broader development concerns. The need to do so becomes all the more pressing with the spread of HIV and the devastating threat that AIDS presents for livelihood security and for the safety and survival of those most vulnerable to infection. It raises issues that lie at the heart of the development process itself; and with that, implications for participatory work that go beyond sectoral boundaries. SRH is closely related to and spills over into so many varied aspects of our lives; our self-esteem, our livelihoods (Butcher, this issue), our environment (Lynn, this issue), our education, our life prospects and so on.

SRH - A human rights issue

In South Africa, UNAIDS recently reported the death of Gugu Dlamini, a 36-year-old mother. She died in December 1998 due to a beating delivered by neighbours in her own home. They had accused her of having brought shame to their community, Kwamashu, in the outskirts of Durban, after she openly revealed on December 1, World AIDS Day, that she was HIV positive (UNAIDS press release, 5 Jan 1999). The stigma faced by those infected with HIV and by their families and friends is a huge problem to be overcome in the fight against the virus. Yet until positive people feel confident enough to be open about what has happened to them without being vilified or killed, we will never benefit from the lessons which they could share with us.

As this example so powerfully illustrates, SRH is an issue of human rights, one that is central to any other development efforts. Millions of girls and women suffer the multiple hardships and consequences of physical, sexual or psychological abuse, such as beating, rape, or abuse of their children, with no opportunity to escape from the abusive relationships in which they find themselves (Heise et al. 1999). Unwanted teenage pregnancies, domestic violence, untreated and undiagnosed sexually transmitted infections and the spread of HIV are issues that spill over into all dimensions of people's lives, with

far-reaching consequences. These issues raise challenges for every dimension of development work. And the challenges of change, in turn, stem from addressing fundamental questions of equity, access, rights, inclusion and control.

A triple taboo: gender, sex and death

There is increasing recognition of the need to be innovative, exploratory, daring in our participatory development work. Nowhere is this need more challenging than when addressing SRH issues. In SRH work we face a triple taboo of gender, sex and, in the cases of gender violence, breast cancer, some childbirth, some female circumcision and HIV, death.

Gender equity is a subject of much contention around the world. And, as many of the articles in this issue show, gender issues are often at the heart of many SRH problems. In some cases, such as the example of the Supreme Court of Zimbabwe's recent decision to withdraw women's rights to equal inheritance with men, a right gained 19 years ago at Independence, the barriers to addressing key concerns in SRH lie in institutionalised male dominance. In others, reluctance to move beyond everyday forms of interaction can in itself provide a potent obstacle to even beginning to raise gender issues within contexts of SRH work.

Talking openly about sex and desire remains a taboo in many cultural contexts. Often the language of sex is an area of contention. Words in common use by young men, for instance, about sexual parts of the body or sexual activities, may be totally unacceptable to older members of the same community. Challenging the boundaries of acceptability raises a number of uncomfortable issues; it also creates significant difficulties for SRH work in contexts where taboo and silence limit the possibilities of opening spaces for people to be able to express themselves and share their experiences. We find it even harder to discuss death and its consequences for loved ones and dependants. In most communities, death is something which we fear and which we try not to think or talk about, in case we will hasten its arrival by so doing.

A fourth problem: whose priorities?

A fourth problem that some of us face as development workers is the fear by many that all SRH work, be it concerning HIV, family planning or whatever, is based on a preoccupation with population control driven by priorities set elsewhere (Shaw and Jawo, this issue). A concern with addressing the gender issues that lie at the heart of SRH is equally seen by some as an attempt to impose the norms of one culture onto others. In Africa, AIDS has come to be known in many places as '**A**merican **I**nitiative to **D**iscourage **S**ex', indicating perceptions that place a concern with HIV prevention, as with gender equity and other SRH issues, as a project inspired by Northern agendas.

These issues raise a number of dilemmas. On the one hand, they demonstrate the ethical importance that we should attach to enabling people to determine their own concerns and form their own opinions, rather than rushing in with an outside agenda. On the other, thorny questions remain about our own perceptions of 'right' and 'wrong', and where we might legitimately intervene to bring about change. These are challenges that run through participatory work more broadly, but are especially significant in the domain of SRH.

So SRH work is faced with multiple dilemmas. How can we enable people to learn about how their bodies work and about their relationships with others, in order to help themselves to lead healthy and safe lives, whilst at the same time minimising the extent to which others are alienated by the frankness of those discussions? How do we respond when there are direct conflicts of views and values? And how do we work in ways that minimise the extent to which we, as outsiders, are tempted to impose our own

opinions on others, on issues where we clearly are 'taking sides' and, in doing so, challenging dominant values?

HIV – a growing picture

The growing threat of AIDS has now challenged us to face up to these taboos and grapple with these dilemmas. In most countries, the momentum of the HIV epidemic continues unabated. In 1999 an estimated 5.6 million people worldwide were newly infected with HIV, one every six seconds (Kaleeba et al., 2000). Although HIV is a global phenomenon, sub-Saharan Africa is bearing the main brunt of the epidemic (Hunter and Williamson 1998, UNAIDS 1999). In the last twenty years, the HIV epidemic has swept through sub-Saharan Africa with increasingly destructive force. It has so far killed over 13 million men, women and children in Africa south of the Sahara (UNAIDS 1999). Families and communities have been devastated and in some African countries, the course of human development has been set back by decades and life expectancy rates are falling dramatically.

Asia too is suffering the consequences of a rapid rise in HIV infection. India now has an estimated 4 million infected people, the greatest for one country in the world (UNAIDS 1999). A recent study of married monogamous women found that HIV infection amongst them is increasing and that the most likely means of infection is through unprotected sex with their husbands (Gangakhedkar et al. 1997). Elsewhere in Asia, though, there is cause for hope. In Thailand and the Philippines, a sustained success is reported in the reduction of HIV risk and in lowering or stabilising HIV rates (UNAIDS 1999).

There is no cause for complacency elsewhere in the world. The greatest increases in HIV infections in 1999 were in the former Soviet Union (UNAIDS 1999)[2]. In the USA, what began as an epidemic amongst a particular group, gay men, has now spread to other marginalised groups, including poorer populations of African Americans (Batchelor, this issue). Britain has the highest teenage pregnancy rates in Europe and a new HIV infection every 5 hours.

· Participatory approaches – what can they offer?

Over the last few years, there has been an explosion of interest in participatory methodologies. This has been supported by the realisation that involving people more actively in setting priorities and determining needs can make a difference. In SRH work, there has been recognition of the need to move beyond simply giving people information to enabling them to gain the 'power within' to begin to bring about change in intimate relationships that put them at risk.

Many of the articles in this issue address directly the potential that participatory methodologies and approaches offer SRH work. Most draw on the corpus of techniques that has come to be known as 'PRA' (Participatory Rural Appraisal) or, more recently, 'PLA' (Participatory Learning and Action). What does 'PRA' or 'PLA' mean in practice? The answer to this is many things to many different people! The contributors to this issue use 'PRA' and 'PLA' in different ways too; rather than put forward any definitions, we use a generic term 'PRA/PLA' here[3].

Addressing vulnerability

Edstrom et al. (this issue) set out the context in which this change in approach has come about, highlighting the limitations of conventional Information Education and Communication (IEC) strategies and illustrating the opportunities participatory approaches open up for

[2] Many of these new infections were related to intravenous drug use as well as sex.

[3] Some people distinguish PLA from PRA in terms of the kinds of techniques used; others according to what the aims of the process might be and so on. By retaining a general category PRA/PLA, we recognise that each reader and contributor may interpret these terms differently.

analysis and action. Starting with the concept of vulnerability as central to effective HIV prevention, the article emphasises the need to go beyond individual behavioural change to address the complexities of HIV related vulnerability within communities. In a summary of a seminar on girls and young women and HIV, the UK AIDS Consortium raises issues that are central to SRH work more broadly. From vulnerability being rooted in inequalities, to strategies for engagement, to the need for advocacy at different levels to build accountability, their article also points to the need for an integrated and multi-dimensional approach to SRH.

Against this backdrop, the articles in this issue offer a rich array of ways of addressing issues of vulnerability at a range of levels and in a variety of contexts. All draw on participatory methodologies and many contribute new and innovative methods.

Creating space for voice

Highlighting both the centrality of gender and also the need to go beyond describing 'how things are' to analysing root causes, the article by World Neighbors and their programme partners describes practical tools for facilitating reflection and analysis on reproductive health issues in Nepal. Rull Boussen et al. (this issue) describe, how the use of PRA/PLA tools in needs assessment enhanced collaborative planning between NGOs, government and community members in Egypt. As in the Nepalese example, the authors describe the integration of PRA/PLA with methods from popular education, such as problem-posing sessions and root causes analysis. This facilitates moving beyond simply gathering 'voices' that describe how things are, to critical reflection on underlying causes to engage people as active shapers of how things might be.

Simasiku et al. focus directly on the vulnerability of young people, illustrating the use of PRA/PLA methods as an entry point for exploring sensitive issues with adolescents in Zambia. Kaim and Ndlovu also describe how such methods can be an entry point for a process that sought to engage young people in determining their needs and identifying solutions. Using the medium of a popular 'agony aunt' column in a Zimbabwean magazine suggested in initial PRA work, young people's own stories and experiences formed the basis for materials on SRH for use in schools. Kaim and Ndlovu's article highlights the importance of ensuring 'buy in' from a range of stakeholders for SRH work, illustrating the impact that the project had on changing relationships between students, teachers and community members. This is reflected in Kaleeba et al. (this issue) who show how an innovative School Health and AIDS Prevention programme has been enhanced by the involvement of parents, local government, religious leaders, youth representatives and health organisations through a District Level Steering Committee. Forder (this issue) also focuses on the gendered vulnerability of young people, in this case female Cambodian factory workers, where participatory methods have opened spaces in which voices can be heard.

Facilitating interaction and learning

Forder draws attention to the importance for facilitators to have dealt with some of their own issues around sexuality; yet the time and space to do so is often limited. She highlights some of the ambiguities that surround the role of the facilitator: when and whether to intervene, how to model behaviours that participants can feel freer to adopt and the ways in which the attitudes of facilitators may both block communication and be a perceived problem by participants. As Edstrom et al. and others also point out, skilled facilitation is of key importance in participatory SRH work. Yet what happens when organisational and other constraints make those skills scarce, as Shaw and Jawo, for example, demonstrate in the Gambian context? Hobbs and Simasiku address this issue, offering a pragmatic approach that seeks to

overcome some of the difficulties that can be anticipated.

Gordon and Phiri take up the question of facilitation involved in tackling some of the sensitive issues that surround SRH work. Echoing the point made by Edstrom et al. that information alone cannot change behaviour, their article describes the innovative use of a range of participatory methods in work with Zambian family planning Community Based Distributors (CBDs). These ranged from PRA/PLA to drama, to the use of pictures and stories, to non-directive peer counselling. They focus on the dynamics of interaction between and within groups of men and women, offering important lessons for the facilitation of peer and open group sessions. One important lesson from this insightful piece is the importance of recognising that while a neutral space may be created in the moment of an externally facilitated activity, once people return to their private spaces, things that are said and done in public may have serious repercussions.

Opening up dialogue

As Shaw and Jawo demonstrate, by making space for women and men to express their concerns, participatory processes can also begin to address vulnerabilities at a community-wide level. Shaw and Jawo's article, based on ongoing work in Gambia, describes the adaptation and use of 'Stepping Stones[4]', an interactive training process that brings drama, assertiveness training and visualisation together to open up dialogue between different gender and age groups. In this context, a positive association was found between participation in these activities and a reduction in wife beating, and raised awareness of risky behaviours associated with HIV and STDs.

Highlighting issues that resonate with many of the papers in this issue, Shaw and Jawo's paper describes some interesting innovations, both in terms of method and strategy. They emphasise safer sexual practices in the prevention of infertility as an entry point to preventive sexual health work. The authors describe innovations they used: from 'secret ballots' (see also Simasiku et al., this issue) and body mapping of 'turn ons' and 'turn offs'. As a similar illustration of how the flexibility of participatory methods offers scope for innovation and adaptation to the purpose and context, Butcher et al., (reprinted in this issue[5]) describe an innovative approach to condom promotion and evaluating peer education amongst sex workers.

Batchelor's article (this issue) takes body mapping a step further in its use to explore issues of desire, sensuality and body image with front-line health workers in the southern United States. All too often, discussions about sex are couched in terms of preventing diseases/pregnancy rather than in terms of pleasure and desire. What Batchelor's article so powerfully reminds us is that unless people are treated as people with emotional and sexual desires and needs, rather than as victims or vectors of disease, sexual health work can so easily fall into 'medicalising' the problem and missing the mark. Sturley's article is also an important reminder of the need to locate medical interventions, in this case vasectomy in Nepal, within the complexity of cultural meanings associated with their perceived and actual impact. Again the use of body mapping provided an entry point to exploring experiences that might otherwise have been ignored.

Building bridges

All too often, project evaluation marginalises the voices of those whom projects are designed to help, missing opportunities for building better relationships between agencies and those they work with. As Batchelor and Sturley's articles make clear, there is much to be gained from this interaction. Sellers and Westerby's article describes how young people and service providers came together in a participatory evaluation of sexual health provision. As well as

[4] See Welbourn, A. (1998).

[5] Reprinted from *PLA Notes* 33, October 1998.

detailing useful tools, and an innovation that has wider use in monitoring, the 'barriers wall', they demonstrate the value of participatory approaches in building bridges between service providers and users. Smith and Howson's account of participatory evaluation of CAFOD and partners' HIV prevention work in Southern Africa also contributes tools, such as the significant changes matrix, with the potential for building closer relationships between stakeholders. It also highlights the empowering aspects of this process for workers, as well as participants.

Making connections

Many of the articles in this issue make explicit the links between SRH and gender. Lewis' article provides a powerful example of a process that integrates a more subtle approach to gender. Aiming to build 'critical literacy about gender and power' with young people in Estonia, workshops integrated a range of levels, approaches and techniques: academic input with participant's own experiences, films and theatre with participatory drama, newspaper collage with young people's own messages and stories.

Lastly, Lynn et al., describe a process in the UK that made connections between the national and the local levels on a women's health issue that is a growing concern: breast cancer. This article demonstrates the links that can be built between advocacy and empowerment through a participatory process.

· Lessons learnt – we need to:

Why…

- Recognise that SRH issues touch all aspects of our lives and therefore the overall physical, material and psychological quality of our well being. Bad SRH can be both a cause and a result of a poor quality of life (Wanduragala – see Tips for Trainers, this issue).
- Acknowledge universally widespread gender violence, physical, sexual and psychological, and recognise that sexual and reproductive health is a human rights issue...

Who…

- Work with boys and men as well as girls and women.
- Don't put people in 'boxes' and label them as 'heterosexual' or 'homosexual' but work with their own self-definitions, their own experiences and identities.
- Acknowledge the importance of gaining support from gatekeepers and the opportunities of making them 'champions' of change; include parents, teachers, religious leaders, community leaders, government officials etc.
- Acknowledge that young people are often sexually active before parents and others realise (or want to accept) and that they are at risk through lack of information and support
- Build on the clear evidence that good sex education for young people, which also includes relationships, assertiveness and communication skills, delays the onset of sexual activity and makes it safer when it starts. Denying young people access to information is to deny them the right to have safer sex and reduce their vulnerability to infection and pregnancy
- Acknowledge that young women are particularly vulnerable to infection and exploitation
- Recognise that ordinary people, if given the right support, are quite capable of developing their own workshop material.
- Don't forget that older people have sexual health concerns, both related to the life-course (such as menopausal and impotence symptoms) and as part of a wider adult population (such as STIs, HIV and AIDS)

How…

- Recognise that there is a need for active collaboration and co-operation between different agencies and institutions at different levels of the

system, e.g. youth friendly clinics, sex worker-protective laws.

- Always include gender awareness as part of processes designed to bring about changes in attitudes and behaviour towards SRH issues.
- Recognise that 'gender' is not simply a 'women's issue' and that strategies may be needed for enabling men to address their gender issues and SRH needs *as men.*
- Create opportunities for trainers/facilitators to process and internalise issues for themselves before facilitating/training others.
- Make spaces for people to work in peer groups as well as to come together in open sessions; recognise the importance of working sensitively with this structure to ensure confidentiality and positive outcomes.
- Be open to new methods of learning: PRA, drama/role-play and assertiveness.

What…

- Avoid blueprints: adapt existing materials or develop new materials to suit the cultural and social settings in which SRH work is done.
- Recognise the range of levels/contexts in which participatory activities can make a difference; from work with local communities and particular interest groups, to work with health, education and social care workers to work on national policy issues and campaigns.

Where…

- Start from where local people are; e.g. infertility, rather than STIs, unwanted pregnancies rather than HIV etc.

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4

Ain't misbehavin' : beyond individual behaviour change

Jerker Edström with Arturo Cristobal, Chulani de Soyza and Tilly Sellers

• Introduction

The International HIV/AIDS Alliance supports 'linking organisations' in various developing countries which, in turn, support local non-governmental organisations (NGOs) to carry out HIV/AIDS activities with local communities. Such linking organisations include HIV/AIDS/STD Alliance Bangladesh (HASAB), the Philippine HIV/AIDS NGO Support Programme (PHANSuP), Alliance Lanka in Sri Lanka and the Khmer HIV/AIDS NGO Alliance (KHANA) in Cambodia. As linking organisations started mobilising community groups to respond to AIDS in their respective countries (in the mid 1990s) they found that the majority of NGOs wanted to continue to focus, often exclusively, on basic information provision (such as awareness seminars).

However, experience and accumulated evidence has shown that information, education and communication (IEC) alone is often insufficient to bring about sustained behaviour change, or substantially impact on people's ability to protect themselves from HIV infection. This might have to do with the fact that many IEC initiatives were either technically weak or socially inappropriate, or both. However, a fuller explanation is likely to be that many programmes lacked strategies beyond awareness raising, or focused merely on individual 'behaviour change', which brings us to our starting point.

• 'Ain't misbehavin' – what's your problem, anyway?'

We should start by noting a range of factors, which also influence an individual's risk of infection, but are not directly related to her/his behaviour. Some obvious examples would include:

- access to risk/harm reducing technology, such as condoms or clean needles;
- power of the individual to make her/his own choices;
- elevated biological vulnerability to infection; e.g. as a result of having a pre-existing Sexually Transmitted Disease (STD);
- infection levels within the broader community and partners; and
- lack of knowledge of own or partners' HIV sero-status (i.e. whether infected or not).

Whilst there are certain behavioural aspects to some of these 'problems' and some themselves present obstacles to behavioural adaptation, it is not useful to describe them as mainly 'behavioural' issues. Each problem listed can be addressed with dedicated or combined strategies, which are not only awareness raising or behaviour change strategies. Indeed, there is a whole range of types of valid strategies beyond awareness raising or behaviour change communication (see Figure 1).

• Shifting the primary focus to vulnerability

By shifting our focus away from the behaviour of individuals and concentrating on HIV related vulnerability within communities, the *communities themselves* are more likely to be able and willing to help *us* identify relevant and effective responses.

Vulnerabilities may involve factors both independent of behaviour and factors underlying behaviour, which are often more

important to address than the behaviour itself, (see Figure 2). Whether a particular vulnerability affects risk of infection independently of behaviour or presents an underlying obstacle to behaviour change, the point is that it is the real vulnerabilities that are important to address primarily.

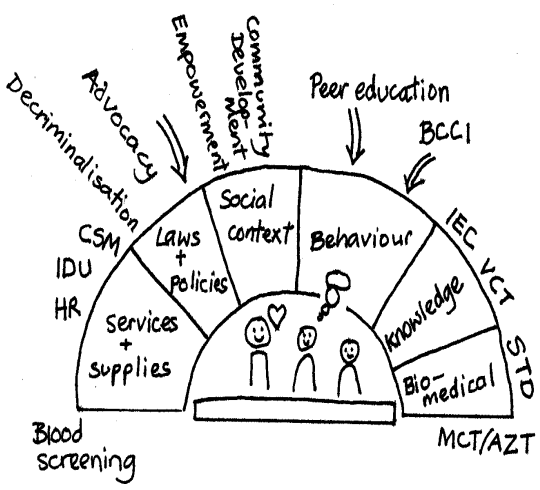

Figure 1. Examples of types of factors affecting likelihood of HIV infection, and related types of strategies to affect change

IDU,HR = harm reduction (HR) strategies for injecting drug users (IDU); CSM = Condom Social Marketing; BCCI = Behaviour change communications interventions; IE&C = Information, education and communication; VCT = Voluntary counselling and testing (for HIV); STD = treatment of sexually transmitted diseases (here); MCT/AZT = Reduction of mother-to-child transmission through treatment of pregnant women with AZT (anti-retroviral for HIV infection).

Rather than working as outsiders coming in to solve the behavioural problems of 'the locals', it is crucial to recognise that the sources of HIV related vulnerability tend to be very complex indeed at the local level. It is when *those* vulnerabilities are mitigated that people can respond to knowledge and information.

Addressing vulnerability through participation and empowerment

It is primarily as a result of this realisation that the Alliance has turned away from asking the 'experts' for the answers and turned to local communities themselves. From 1996 onwards, we have increasingly focused on using a more flexible approach, with a 'tool bag' of both participatory methods and processes. These include tools and approaches used in Participatory Rural Appraisal (PRA), or participatory action and reaction, which may be a more appropriate phase, since it better encapsulates the application of participatory methodologies in sexual health, in different types of activities and in different contexts.

The key components of the 'tool bag' include social maps, discussion groups, Venn diagrams, ranking and scoring, body mapping, causal analysis flowcharts, life-lines, historical time-lines, trend diagrams, income and expenditure charts, and HIV wheels (where vulnerabilities are identified as segments in a pie chart, and filled in according to their significance) etc. These 'tools' have been used by, or with, community members to describe and analyse the issues of concern to them, and to explore how those issues link to sexual vulnerability and HIV/AIDS. This has enabled local grassroots NGOs to actually involve community members in all stages of projects; community assessments, project design, implementation and monitoring and evaluation.

Figure 2. Some causal flows between community factors, behaviour and infection risk

The mere use of participatory tools *can* cause shifts in perceptions as well as spark off participatory processes in different ways. However, the tools are no guarantee for success by themselves. Their effectiveness also relies on skilled facilitation, as well as on adopting enabling processes and frameworks.

Participatory community assessments formed a starting point for longer interactive processes, where project responses were jointly identified and tried out, then reviewed in order to revise project strategies and approaches. The important point was to adapt the process to the capacity and situation of the local NGOs and their communities, in order to allow for effective participation.

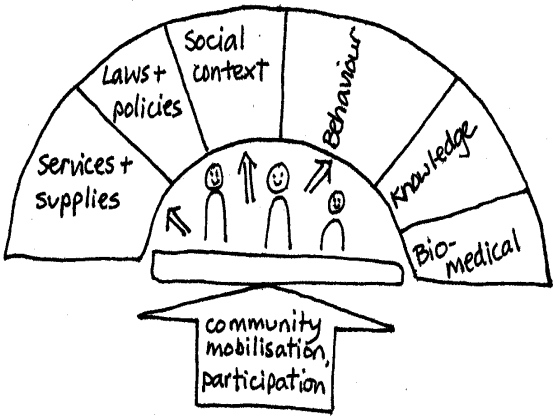

Figure 3. Capacity building to support participation in community assessments and designing responses to HIV/AIDS vulnerability

• Examples of community-identified strategies responding to HIV/AIDS

The following section describes a range of different types of ways in which local NGOs have been helped to address HIV/AIDS related vulnerability and move beyond awareness raising or individual behaviour change.

Addressing social contexts and peer norms in participatory group work

As a result of the increasingly participatory approaches used in supporting NGOs to carry out community assessment in different countries, a natural development has been for many NGOs to start to develop strategies for responding to AIDS with group activities, also using participatory techniques in the process.

One example of this is the work of Rajarata Sahabagitha Padanama, in Sri Lanka, which now uses a very participatory and gender sensitive group work approach to peer education and condom promotion/distribution. The organisation now has a very effective programme, which supports the community in facing the challenges identified by them. Even the local government health worker seeks support from the leaders to reach and support the community.

Such group work can be particularly effective in gender specific groups of similar ages and they can help women or men explore their own issues, attitudes and options, whilst learning about HIV/AIDS and STD through working together.

Addressing people's vulnerability by working with other sexual partners

In some cases, however, it can be harder to help community members respond to their own vulnerability without also working with other groups who may be sexual partners from outside the community, who are away for long periods or who may be harder to reach in the same way as described above.

In Cambodia for example, certain environmental factors, such as conflict and the presence of armed personnel etc., limit the capacity of local young women and men in putting their knowledge and skills (in safer sex) into practice. NGO project staff and volunteers in some communities work on these 'other' factors, rather than merely on the skills of the local young women and men themselves. Kasekor Thmey and the Khmer Buddhist Association (KBA) are two NGOs now working with young police and soldiers to

reduce their vulnerability to HIV/STD infection, as well as that of the young women in the community. They do this by working with the uniformed men to explore their own knowledge and attitudes on sexuality and on condom using skills, as well as by negotiating with senior officers to increase access both to condoms and to STD services.

Conversely, it can be useful to work with local sexual partners of mobile people in order to obtain access to an otherwise hard-to-reach group. In the Philippines, for example, overseas Filipino contract workers are a group of people considered to be at high risk of HIV infection. This is a result of higher risks of exposure to HIV when away from their families for long period and working in other countries in the region. One local NGO, Kaaraydan, who mainly support male Overseas Filipino Workers (OFWs) and their loved ones, designed a very simple but innovative project. Kaaraydan has developed, designed and provided partners with stationery, aerograms and postcards to enable the loved ones to write letters to their OFW partners. Furthermore, on the stationery are statements and captions about HIV/AIDS. As a central part of the project, Kaaraydan has also been conducting participatory group discussions in the communites of the loved ones of OFWs, which has helped them explore and understand the plight of the OFWs abroad, why sexual relations outside of the primary 'home' or partnership occurred etc.. They learned how loneliness may put OFWs at particular risk and that communiction is very important to their OFWs, which is why the strategy of supporting letter writing was developed. As a result, the loved ones, especially those married to OFWs are now able to negotiate for condom use with their OFW partners or husbands when at home and 'encourage' them to reduce sexual risk when abroad.

Addressing gaps in service provision

As NGOs have developed stronger responses to HIV/AIDS in their communities, a fairly common theme has been to find ways of improving community members' access to services, such as STD treatment, and supplies of condoms.

As mentioned briefly, several NGOs, supported by HASAB in Bangladesh, developed clinical STD service components of their HIV/AIDS projects, in response to community felt gaps in government service provision. One NGO, Assistance for Slum Dwellers (ASD), found it challenging to conduct both effective participatory outreach work and provide quality clinical services, but instead broadened their review and assessment approach to include a wider range of stakeholders, allowing them to develop more strategic partnerships. In particular they were now able to refer community members to the clinic of another HASAB partner NGO, Al-Fallah. This allowed them to help bridge the service gap whilst also focusing their energies on working more closely with their communities.

Addressing other contextual factors and linking those to HIV/AIDS

Aside from working on the most directly relevant factors of vulnerability to HIV, many NGOs have also worked with community members to either address broader contextual factors, such as discrimination, or used meeting community needs for recreational facilities or income generation schemes as entry-points for education, services and discussion on HIV/AIDS and STD.

For example, the NGO, Association of Farmers Development (AFD) in Cambodia, works with their rural poor community in many ways to meet their different needs, placing HIV prevention into the broader context of the community. Aside from a range of reproductive health work with both women and men, AFD also supports a women's income generating group (funded from other sources) and links the two projects to organise drama performances, using both for opportunities to have in-depth discussions about sexuality and sexual health.

Whilst poverty, for example, is often identified as the contextual root cause of most vulnerabilities, it is not always possible or realistic to try to impact on HIV by focusing scarce HIV/AIDS resources on, for example, income generation.

On the other hand, where NGOs are closely involved with their communities in addressing various aspects of their lives with different projects, it is often useful to draw strategic links between these to gain access to and time with a particular group. It can also be useful to make the HIV/AIDS work more relevant to the more keenly felt needs of communities.

Mobilising and empowering marginalised groups

To go even further, some NGOs have focused on mobilising and empowering marginalised groups such as gay men, drug users or sex workers. Such projects usually need to address a broad range of the needs of these groups to be truly effective, since their needs tend to be closely interlinked with their vulnerability to HIV/AIDS.

For three years now, PHANSuP in the Philippines has funded an NGO called IWAG Dabaw to run a centre for gay men in Davao, where the gay community can make use of its services including:

- counselling;
- a resource centre;
- STD referrals that include subsidy provision for the medicine; and
- a venue for activities, such as small group discussions on relevant issues, stepping stones sessions, film showing, condom distribution, etc.

This is a very innovative project, as the gay men have developed a sense of ownership of the project. The centre also helped them develop their self-esteem as it provides a place where they can go freely and be themselves, without the fear of either being discriminated against or abused. As the importance of the centre was enhanced by the project, gay men themselves established other such centres in the communities. These served as a 'local response' to the needs of the gay men and other stakeholders (e.g. gay men's parents, lovers, police, local executives and others).

One NGO in Bangladesh named SHEASS identified strategies for harm reduction among injecting drug users as a priority. SHEASS addressed this through involvement in outreach work and awareness raising on issues such as risk reduction, sexuality and STDs, and HIV/AIDS. Local leaders and members of the broader community were mobilised to help fight discrimination within the community. A drop-in centre providing a wide range of services for injecting drug users and their families, including needle exchange, condom distribution and education about general health, HIV/AIDS and harm reduction, was also established.

Not all NGOs are well placed to mobilise and empower marginalised groups, as this work requires excellent contact and credibility with the community in question. Offering practical services, as shown by the work of SHEASS and IWAG, can help to gain that trust and respect. Often, however, fundamental shifts in the perceptions and attitudes of NGO workers themselves are needed for this and, although participatory training and skills can help this, it does not take away the need for other skills and understanding of the deeper issues in relation to the particular community in question.

Ten lessons learned

- Behaviour is not the only relevant variable as a core-problem affecting vulnerability to HIV; nor is it the only, or even necessarily the main, factor to address.

- Vulnerability as a concept forces us to adopt a context-specific approach to situation and problem analysis.

- Vulnerability needs to be understood as being complex and working in different ways, through behaviour and independently of behaviour.

- A participatory bottom-up approach allows for more appropriate identification of the complexities of vulnerability; jointly 'owned' responses and project solutions with communities; better dynamics between NGOs and their communities, as well as mobilisation of members to work together for the changes required.

- Drawing a distinction between 'contextual' and 'linked' interventions is useful for understanding how certain

AIDS strategies beyond awareness raising or behaviour change deal with vulnerability to HIV and broader community issues.

- Participatory facilitation requires considerable skills and capacity building, but good facilitation of these processes also requires good HIV/AIDS skills.

- The process needs to be honest and sensitive, but firm in guiding assessments and reviews towards HIV vulnerability rather than ending up focusing on any community issues.

- There is often a need to purposely design and sequence the assessment process to involve particularly marginalised or at risk groups from early in the process.

- Scaling up capacity building and participatory processes may in fact be more important than scaling up 'intervention packages'. It is a common mistake to assume that it is the resulting strategies which primarily need scaling up to achieve an impact, when successful strategies usually derive their success from the process adopted.

- The first and most important attitudes and behaviours to address in good HIV/AIDS work are our own (as health, development and NGO workers).

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5

Seminar on HIV and girls and young women, November 1999, London

Report compiled by the Working Group on Children and HIV; UK NGO AIDS Consortium

· Introduction

The working group on children of the UK NGO AIDS Consortium held an international seminar recently in London on the vulnerability of female children to HIV/AIDS. The UK NGO AIDS Consortium is a group of UK based organisations who work together to understand and develop effective approaches to the problem of the HIV epidemic in the South. It enables each agency to share its experiences and help all the members improve their responses to the epidemic. The Consortium represents 50-55 UK-based development organisations working with HIV/AIDS issues in all parts of the world.

This seminar was organised in response to growing concern around the world about the impact of HIV/AIDS on young people and, in particular, the differential effect it appears to be having on girls and young women. According to estimates by UNAIDS, 60% of new infections occur among young people. However, data disaggregated by sex also shows that girls have consistently higher rates of infection than boys do. This is due to the greater social and biological vulnerability of girls to HIV/AIDS. While both boys and girls are vulnerable to sexual coercion, girls appear to be more often victimised by sexual abuse and exploitation because of their gender.

The seminar was therefore designed to address issues related to the vulnerability of girls to HIV/AIDS and was concerned in particular with sexual abuse, exploitation and violence. It brought together practitioners and advocates from around the world who shared their experiences and came up with recommendations to improve service delivery and advocacy. Speakers and participants came from a wide range of organisations and countries, representing Africa, Asia, Latin America, Europe and the USA. A number of cross-cutting themes emerged from the seminar which underline many of the concerns raised by practitioners from around the world. These emphasise how the experiences of girls from around the world are universal.

Some of the major themes

- Deepening poverty, structural and social inequalities are some of the major causes of girls' vulnerability to HIV. For example, girls living in poverty and with limited opportunities for education and income may resort to selling sex in order to survive.
- Unequal power relationships based on gender and age provide the context in which abuse takes place.
- Apart from economic needs, girls fall into relationships with men to meet their need for protection, affection and love.
- The social isolation of girls also serves to increase their vulnerability to sexual victimisation and HIV.
- A silence surrounds the issue of sexual abuse, which makes it difficult to identify and address.
- Some cultural traditions and attitudes often provide a sanction for abuse and represent some of the greatest challenges to NGOs.
- A major barrier to the advancement of women and girls is the support that still exists for traditional gender roles. Without a critical mass of women involved in the decision-making process, changes are likely to occur slowly.
- A lack of political will exists to enforce laws and principles adhered to in international conventions. NGOs have an important role to play in advocating for the implementation of conventions such as the

Convention on the Rights of the Child (CRC) and Convention on the Elimination of All Forms of Discrimination Against Women (CEDAW).

- **Recommendations for service delivery and advocacy**

Some key principles

Programmes need to address the social and political environment in which girls live, but also the psychological causes and effects of abuse and vulnerability to HIV/AIDS.

As explained by Randini Wanduragala of World Vision, an integrated approach seems to work best. An example of this approach is demonstrated by Plan International India, which organised a programme in collaboration with an NGO in India and Nepal to return Nepali girls to their homes who were sold into prostitution in India. After girls were rescued from the brothels, they were taken to centres where they received counselling and medical care. Counselling was given to girls as well as their families at every stage of the process. Activities were also organised to provide basic literacy skills and training in various trades so that girls might find alternative sources of income. Once back in their communities, girls continued to be supervised but were also provided with credit assistance to start small income-generating projects.

In addition to re-integration, the programme also included a focus on prevention. ABC Nepal, the NGO counterpart in Nepal, organised activities in communities to raise awareness of the problem of trafficking and HIV/AIDS. One important outcome was the formation of 'pressure groups', made up of individuals from different sections of the community, who have implemented their own activities with financial assistance from the project. Some of the activities of pressure groups include street drama, rallies, public forums, and lobbying of local government to encourage the arrest of traffickers.

Change is possible if we start with women and girls as the catalysts for change.
Thoko Ngwenya of The Musasa Project in Zimbabwe explained that their 'interventions with women centre on the individual woman so that she can focus on her needs and become aware of her abilities, decrease victim behaviour and develop an awareness of the socio-political context of the violence she has suffered'. Each woman is treated as the best expert in dealing with her situation and decides what she wants to do with her life. The goal is to encourage her to build her self-confidence and eventually regain control over her life and circumstances. The centre provides counselling but also training on HIV/AIDS, communication and assertiveness, and gender. After six months in the programme, noticeable changes were found among women who were assisted.

Programmes need to provide an environment that raises the possibilities for girls and enables them to change their lives positively.

As Judith Musick of the Ounce of Prevention Fund explained, 'those working with disadvantaged girls cannot break the hold of their difficult or toxic life circumstances without serious, sustained efforts to expand girls' horizons and increase their knowledge and skills'. Girls need to be exposed to other possibilities and given the chance to exceed their own expectations. This could consist of social activities (i.e. drama, arts and crafts, sports or social activism) and/or non-formal or professional education. Judith Musick also pointed out that in working with girls who have been sexually abused or exploited it is important to remember that, as children, they will have needs and interests that are similar to other children their age. Programmes should not just focus on their sexuality, but encourage other activities that girls may be interested in, such as sports or drama.

- **Other recommendations for NGOs**

General

- Involve children as decision-makers in programmes and provide opportunities for them to become their own advocates.
- Follow a participatory approach to planning, implementation and evaluation.
- Approach the issues from a rights-based perspective, e.g. defending the right of children to be protected from violence and

abuse as fundamental human rights principles.
- Use mentors or alumni in programmes as teachers. Girls need positive role models who can show them other possible futures.
- Carry out research to inform planning, especially the collection of disaggregated data.
- Document and share experiences with other NGOs. In particular, examples of good practice or successful programmes should be disseminated.
- Ensure sufficient quality of care in service provision.

International

- Make governments accountable to the UN conventions they have ratified to accelerate their implementation.
- Integrate programmes into the wider development framework to address the larger causes such as poverty and structural inequalities. For example, lobbying government or donors to increase the allocation of resources to HIV/AIDS programmes and education.

National

- Strengthen partnerships with the private sector, trade unions and the media. Journalists and media institutions can be valuable allies in making issues known to policy-makers and the wider public. Trade unions and private corporations may also provide important material and moral support for causes.

Regional

- Challenge cultural attitudes to create an environment that does not tolerate violence, abuse and exploitation. Organisations need to work continuously with the public to shift attitudes, and while this may take time, change is possible, as examples in changing attitudes to Female Genital Mutilation have shown (where negative aspects have been discouraged while positive aspects, such as puberty rites, are maintained).

Local

- Mobilise all sections of the community to raise awareness of the issues. A greater focus is needed on men's and boys' involvement and awareness in particular.

Recommendations for strengthening advocacy include:
- research to find out what is being done, to link up with organisations and to know what resources/information are available;
- developing 'strategic' alliances with other organisations and agencies (i.e. government, social service agencies and law enforcement may be particularly useful to make sure that issues are dealt with and services reach girls that are appropriate and gender-sensitive);
- strengthening partnerships with other NGOs and networks;
- investigating points of entry which can be approached to have an influence on policy in government or international institutions.

To contribute to raising awareness at the local and international level, organisations should look for and use every opportunity available to raise the issues onto the agenda. This means informing individuals within our own organisations as well as outside. With this objective in mind, the Consortium is hoping to maintain contact with agencies who were involved in the seminar and others concerned with the impact of HIV on children and girls to keep these issues high on the agenda and to make they are raised at relevant international fora and debates (i.e. the upcoming international conference on HIV/AIDS in Durban and Beijing +5, which is the follow-up to the UN Fourth World Conference on Women held in Beijing in 1995).

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NOTES

A fuller report of the seminar is available (February 2000). For more information, please contact the Consortium at: ukaidscon@gn.apc.org

6

Helping NGO staff (& then community groups) analyse reproductive health & gender issues

Developed with World Neighbors programme partners in Nepal

· Background

World Neighbors has teamed up with national and local non-government organisations (NGOs) in rural development efforts in Nepal since the initiation of its programme there in 1972. From the beginning, World Neighbors programmes in Nepal have included strong family planning and primary health components, along with agroforestry, livestock and assistance in the construction of drinking water systems. Our strategy has long been focused on strengthening local, community-based groups to implement and manage these integrated efforts.

One of World Neighbors' first partnerships in the region was with a project of the Family Planning Association of Nepal (FPAN), the Baudha Bahunipati Family Welfare Project (BBP). BBP responds to communities' expressed needs with an integrated set of initiatives, including, among others, improved livestock health, safe drinking water, women's group formation, and access to primary health care and family planning services. Evaluations of the programme indicate that marginalised communities with three to four years of association with BBP have shown contraceptive prevalence rates approaching double the national average.

Assessments of women's savings and credit groups involved in the programme revealed that some of the groups were making loans for health referral costs , up to 15 percent of loans in some groups, indicating a greater demand for health services than expected. The time seemed right to conduct a comprehensive, in-depth assessment to determine women's health concerns and develop some strategies to address these needs.

· Assessment & action

In March-April 1996, a Reproductive health Needs Assessment was conducted that has been a key part of the institutional and programmatic learning process. Based on the findings of this assessment, a 'Training of Trainers' (TOT) workshop for NGO staff was convened in March 1997, facilitated by the BBP advisory support team. Objectives of this workshop were:

- to enable participants to better understand reproductive health from a gender-sensitive perspective;
- to help participants analyse their current activities in terms of an reproductive health/gender approach;
- to build skills in facilitation and the use of participatory tools; and,
- to develop an action plan for working with NGOs and women's savings and credit groups.

The participatory methodology used during this workshop was created and adapted based on the content of the Needs Assessment and in keeping with the principles of participatory learning or PRA. Participatory exercises were repeated numerous times during the workshop to enable the participants both to explore new ideas about reproductive health and gender as well as to become more comfortable facilitating the exercises for their own future fieldwork

Training format

The workshop was designed to generate ideas on how to address reproductive health and gender issues at both the NGO level and with women's savings & credit groups at the community level. Review exercises were used

both to revise plans and to reinforce the participants' understanding of the material covered. Participants also worked in teams to develop an action plan, including making decisions about with whom they would work, when, what would be done and using what tools. Evaluations were conducted at the end of each day and at the end of the workshop.

Tools & exercises

The 15 exercises developed for the TOT workshop can be organised into the following categories, based on their primary purpose.

- Identifying reproductive health and gender issues and problems
- Analysing reproductive health and gender issues and problems
- Prioritising
- Planning

In this article, we focus on the tools that were developed and employed to analyse reproductive health and gender issues and problems. These exercises include:

- problem trees;
- root/consequence analysis: social context versus medical/services context;
- root/consequence analysis: gender differences; and
- root/consequence analysis: weighting the gender differences

They are designed to identify and analyse the causes and consequences of reproductive health problems. While we only present one example of each exercise, all of these tools can be used to examine both the root causes and the consequences of reproductive health related issues.

It is important to remember that the exercises were designed for the particular context and needs of the Nepali NGOs participating in the TOT. They can, however, be useful to development practitioners in other situations if they are shaped and adapted to the specific needs and objectives of the participants.

Problem trees

Objective: To identify the causes and consequences of specific reproductive health problems.

Materials needed: Posters with a sketch of a tree showing both its roots and bare branches, blank cards (three colours).

Procedure: Participants analyse the causes and consequences of reproductive health problems, using the image of a tree's roots, trunk and fruit. The trunk of the tree represents the problem being discussed, the roots represent the causes and the fruit symbolise the consequences.

1. Ask the participants to name a reproductive health related problem faced in the communities with which they work. Write this problem on a card (colour A) and tape it to the trunk of the first tree diagram.

2. Brainstorm with the group on the causes of the problem being discussed. Write each cause on a separate card (colour B) and tape them to the root area of the diagram.

3. Now brainstorm with the group about the consequences of the problem. Again, write each answer on a separate card (colour C) and tape them on the branches of the tree.

4. The first problem tree is examined and discussed by the whole group, followed by small group work on other problem trees.

5. Assign a letter or number code to each problem, and then code the roots and fruit cards with their corresponding Problem Trees (e.g. AF1 etc.).

6. The results of all the small groups are displayed, and participants take a 'walk through the forest' as groups present their problem trees to one another.

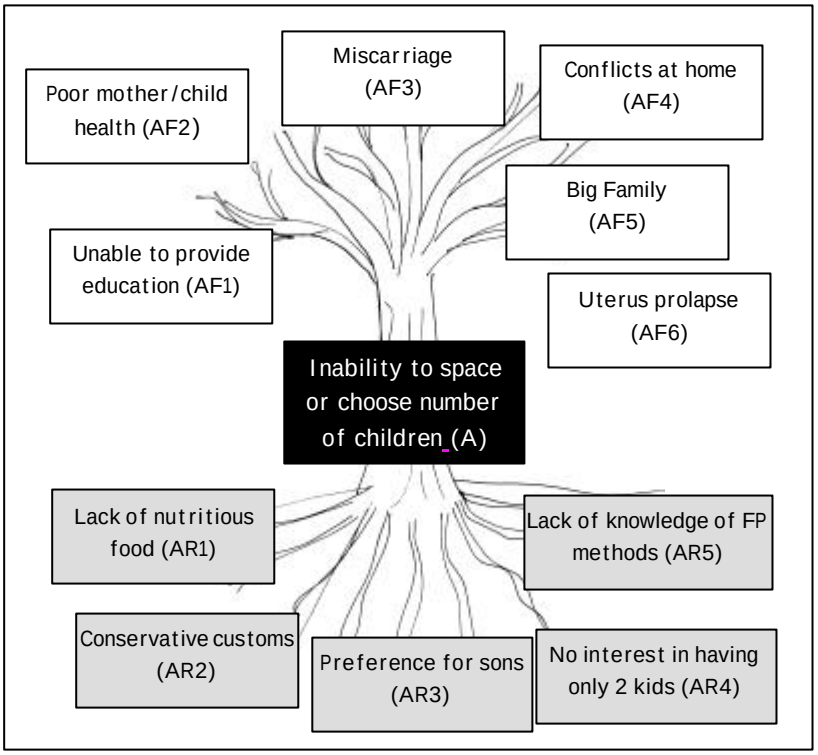

Figure 1. Example of a problem tree

Workshop experience

Workshop participants 'grew' 15 Problem Trees, addressing both 'biomedical' (e.g. access to family planning services) and 'social' (e.g. violence against women) issues. Figure 1 shows the tree generated from a discussion about spacing children.

After the participants generated and presented their Problem Trees, they formed 'training triangle' groups to simulate facilitating the preparation of such trees with other groups. In a three-round rotation session, each group member served as facilitator, participant and observer.

· Root analysis: social context versus medical/services context

Objective: To analyse the root causes of reproductive health problems in terms of the context in which they originate and in which they may best be addressed: either medical, social or both.

Materials needed: The completed, coded root cards from the problem trees, a 3-column matrix prepared on the floor or table. Column headings are visual representations of a social context (a village scene), a medical/services context (a clinic) and, in the middle, a mix of both (a village and clinic in one picture).

Procedure: Participants mix the root cards from the various problem trees and sort them into the three categories.

1. Explain the three categories represented on the matrix and confirm that the participants have a clear and shared understanding.

2. Demonstrate sorting a few root cards into the three columns.

3. All the participants then work together to sort the root cards, first finding any repeats and then placing the cards on the matrix according to their domains.

Code each card with its appropriate context category (i.e. (M, M/S and S)

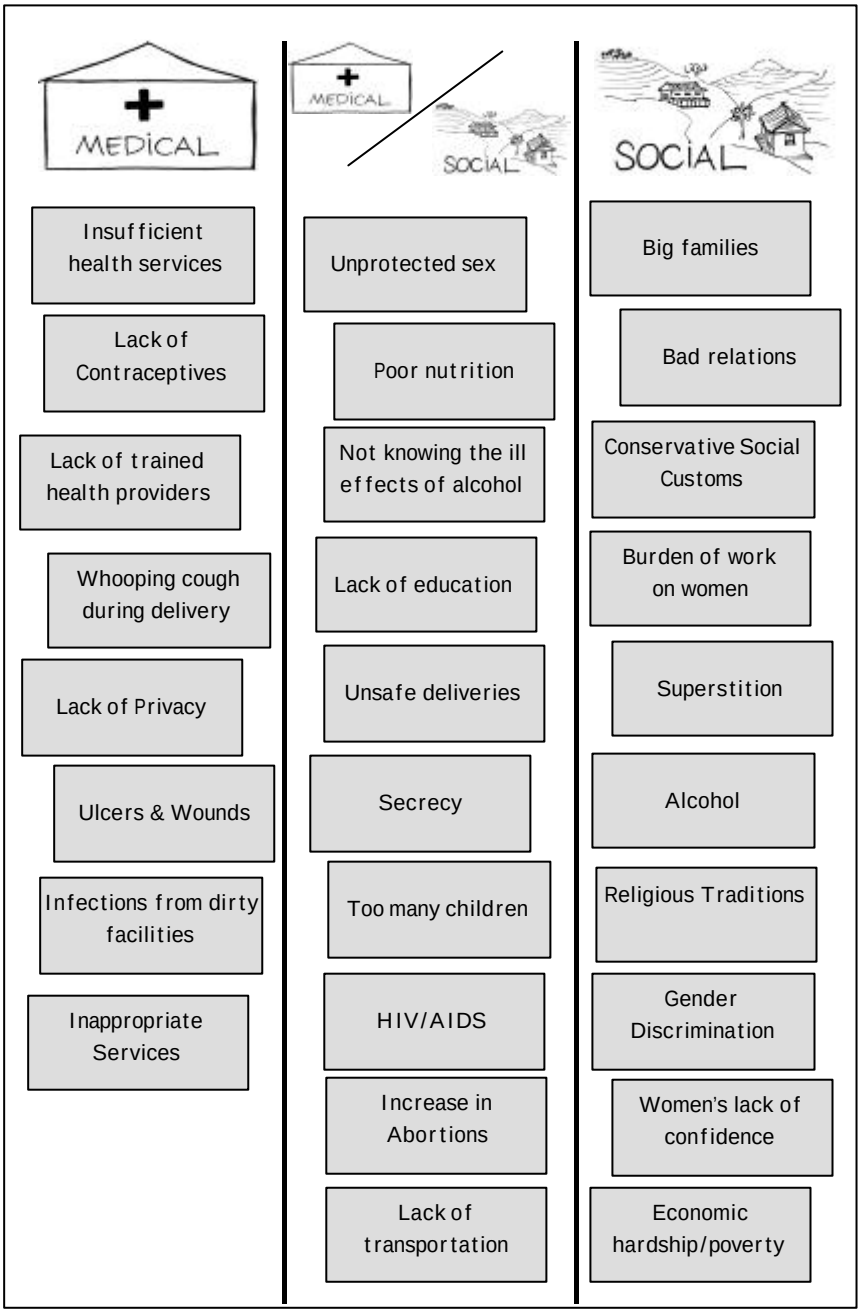

Figure 2. Example of root analysis: social context versus medical/services context

Workshop experience

Once all the root cards were sorted on the matrix, the participants reflected on the results. It was observed that Medical/Service issues were what they usually thought about and dealt with in their programmes, whereas the Social Context issues were generally not intentionally or systematically addressed. Also, it was noted that there were many similar roots across the different problem trees, indicating that different problems have similar underlying causes.

- **Consequence analysis: gender differences**

Objective: To analyse the consequences of reproductive health problems in terms of their differential effects on men and women.

Materials Needed: The completed, coded consequence cards, a 3-column matrix prepared on the floor or table. Column headings are visual representations of a woman only, a man only and, in the middle, a man and a woman together.

Procedure: Participants mix the consequence cards from the various problem trees and sort them into the three categories.

1. Explain the differences between the three columns and the objective of the exercise.

2. Demonstrate sorting a few cards from different problem trees into three columns, according to those that affect women only, men only and both.

3. All the participants then work together to sort all the consequence cards, first clustering together all the repeats and then placing the cards on the matrix according to gender implications.

4. Code each card with its appropriate gender category (i.e. F, F/M or M).

Workshop Experience

When the workshop participants categorised their consequence cards, almost all of the cards were placed in the middle column, indicating a shared impact on both men and women.

Here is a partial list of the participants' identified consequences and how they categorised them.

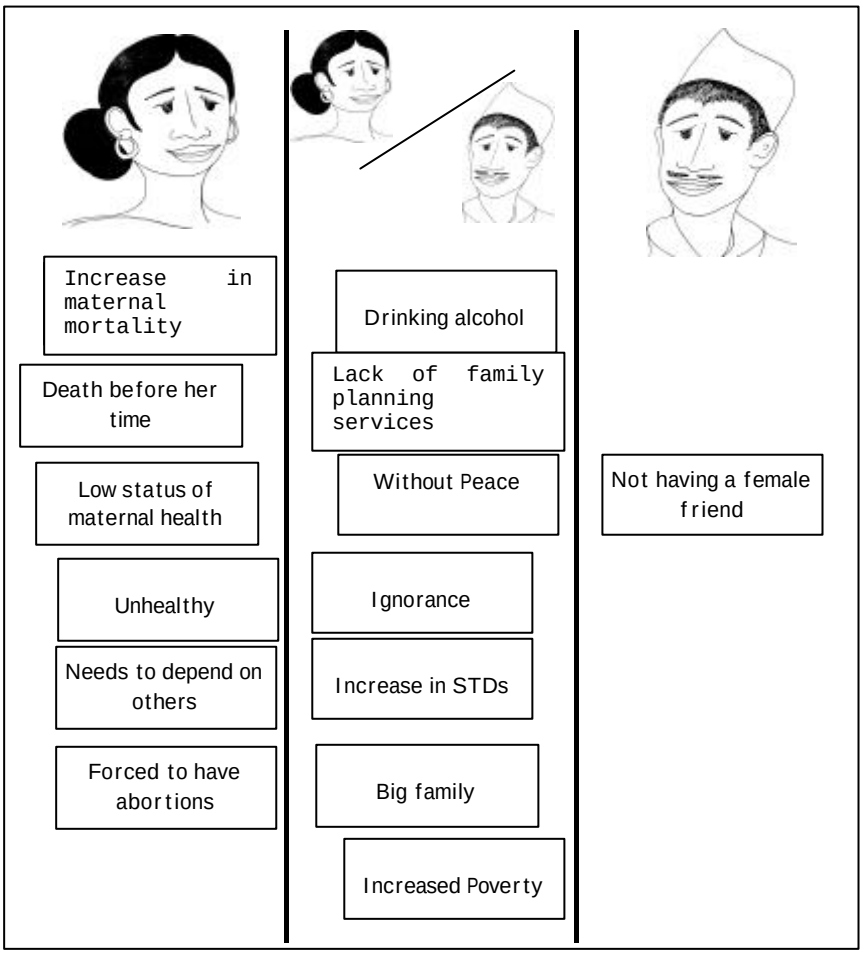

Figure 3. Example of consequence analysis: gender differences

- **Consequence analysis: weighting the gender differences**

Objective: To analyse more deeply the gender differences regarding specific reproductive health problems.

Materials needed: The same three-column matrix used in the Gender Differences exercise, the completed, coded consequence cards from the centre column (those affecting both men and women) and 10 beans or small stones for each card.

Procedure: Participants use the beans or stones to weight the relative impact of each consequence on men and women.

1. Remove the consequence cards from the 'Men Only' and 'Women Only' columns of the matrix. Leave the cards in the centre column.

2. Explain to the participants that they can distribute 10 beans or stones for each consequence between the Men and the Women columns. This distribution should demonstrate what proportion of the impact is experienced by women and by men. For example, if the impact is shared equally, they would put 5 beans or stones on either side of the card.

3. Demonstrate weighting a few consequences with the full group.

4. All the participants then work together to weight remaining consequence cards.

5. Once the beans have been distributed, write the 'votes' on each consequence card (i.e. M3/W7).

Workshop experience

The participants found that this exercise allowed them to analyse more accurately the differences in impact based on gender. For example, while lack of family planning services affected both men and women, the issue was seen to have a significantly greater impact on women.

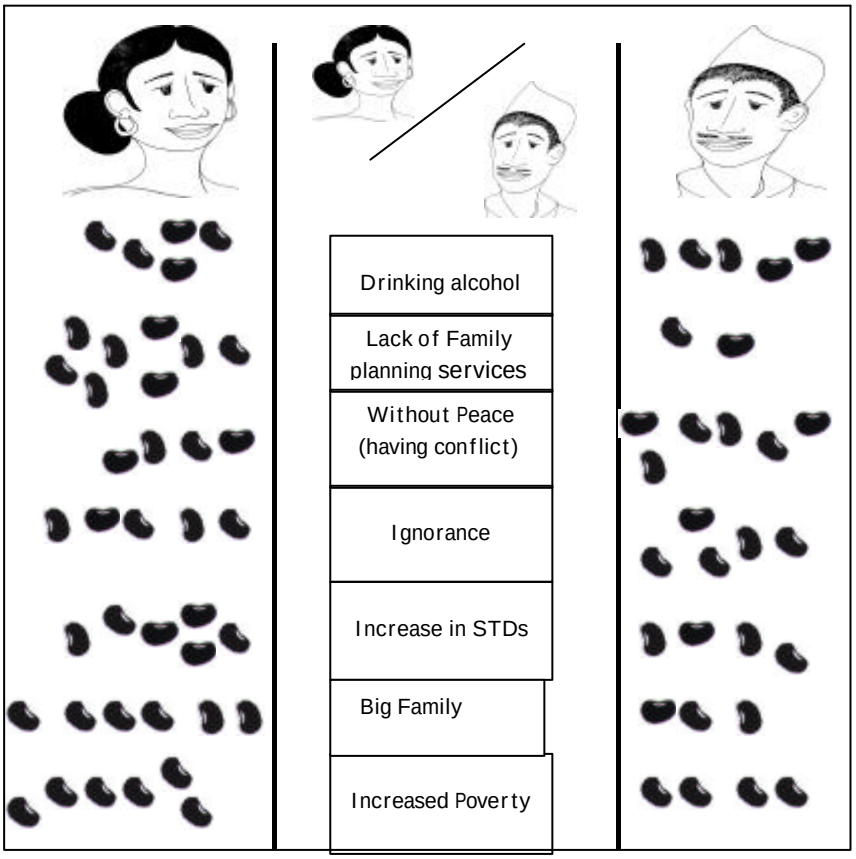

Figure 4. Example of consequence analysis: weighting the gender differences

· Conclusion

In the months following the TOT workshop, the participants implemented the work plans they had prepared during the workshop and conducted awareness raising sessions with board members, staff and at least one affiliated women's group. During these subsequent sessions, the workshop tools and exercises were used to facilitate group discussions around reproductive health and gender issues as well as to identify areas on which to focus clinic, outreach and community efforts.

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NOTES

This article was based on the publication, *Responding to Reproductive Health Needs: Participatory Approach for Analysis and Actio*n. Denise Caudill and Nicole Haberland designed the methods and facilitated the training along with Saraswati Guatam and Gopal Nakarmi.

Responding to Reproductive Health Needs is a report and methodology guide with activities designed to enable NGO staff to better understand health from a gender sensitive point of view, analyse their current reproductive health activities, use participatory learning tools and develop action plans. The guide is well illustrated and contains brief reports, descriptions of 15 training exercises, simple explanations of procedures for facilitating the trainings and specific examples of project results. (1999, 76 pages, US$10.00)

World Neighbors is a people-to people, non-profit organisation working at the forefront of worldwide efforts to eliminate hunger, disease and poverty in Asia, Africa and Latin America. Our purpose is to strengthen the capacity of marginalised communities to meet their basic needs. We affirm the determination, ingenuity and inherent dignity of all people. Working in partnership with people at the community level since 1951, World Neighbors is recognised as a leader in participatory community development.

For more information or to order a copy of Responding to *Reproductive Health Needs*, contact World Neighbors.

7

Collaborative planning to improve women's health

Carla Rull Boussen

• Introduction

Since the mid 1980s, we have been working to ensure that people are involved at each step of the development process, from programme design to evaluation. Through planning workshops, we have brought together communities, non-governmental organisations (NGOs), and government staff and officials to develop plans for improving women's health. While in almost all cases, the efforts have been considered successful and the resulting programmes indeed better than they would have been without the input of the various actors, we have been concerned that the resulting plans were not as good as they perhaps could have been. With that observation, we committed ourselves to providing planning groups with the information, background and process needed to develop sound programme plans. To ensure this, we took advantage of the combined experience and knowledge of the group, all available information plus that which could be gathered within a short period using participatory methods, as well as lessons learned elsewhere. This has led to the development of an approach we have named collaborative planning.

Elements of this process have been used successfully over the last 10 years to organise the following:

- rural water users in Central Tunisia to build and maintain community wells;
- the implementation of a national population policy through a grassroots grant fund in the Gambia;
- the development of a safe motherhood programme in Rwanda;
- the improvement of health services in rapidly growing urban neighbourhoods in Istanbul, Turkey; and,
- focusing and expansion of NGO efforts in women's health in Egypt.

This article will briefly describe the collaborative planning process using examples from our work in Beni Suef, a governorate[1] in Upper Egypt.

• Background

The Beni Suef initiative was designed to help Egyptian NGOs have the most impact possible in improving the reproductive health of Egyptian women. The first part of the strategy was to get NGOs working on priority issues in which significant impact was indeed possible. This involved identifying the most important health problems affecting women living in the governorate and specifically those women most in need. It also involved determining the things that local NGOs did well and the resources available to them. Any successful action that could be sustained would need to build on existing strengths and resources of local NGOs and a practical assessment of what NGOs could realistically be expected to do or not do. For example, even if more delivery services (birthing services) were a critical need in an area, it is unlikely that an NGO would be able to provide maternity services. It is likely, however, that an NGO could play an important advocacy role in obtaining more services for the local population, working with government to target those areas most in need or help local health officials make delivery services more acceptable to local women.

The second part of the strategy was to get NGOs working together. Ironically, one of the key strengths of NGOs, their ability to focus on specific issues and in a particular location is also often viewed as one of their key

[1] *Governorate* is an administrative unit, like a state or district.

weaknesses. Even very successful NGO efforts can have relatively small impact because of the limited geographical and programme scope. Collaborative planning encourages NGOs to combine resources and action to address area problems. Working together, NGOs can significantly expand both their programme and geographical reach. Finally, collaborative planning is designed to combine NGO action with government initiatives. By co-ordinating NGO efforts with government initiatives, the potential impact of their work can be multiplied.

Collaborative planning is a three-step process. A typical planning group would comprise local residents, local NGOs, area health staff and government authorities, who would then meet over a four to six-month period to go through the following steps with a series of workshops in the following areas.

- Preparing to Plan
- What do we know now?
- What else do we need to know in order to develop a sound programme?
- Gathering additional information
- The final workshop: analysing the information and making decisions

Key aspects of the process are discussed in the following section.

• Collecting the information needed for decision-making

During the initial workshop, the planning group reviews available studies and statistics in light of their own experiences. The team summarises what is known about the health of women in the area and the factors affecting it and then identifies what additional information is needed in order to make sound programme decisions to improve local women's health. The remaining questions are organised into a chart which shows the question next to how it will be answered. This chart forms the information collection plan for the second phase. What is collected flows directly from what the planning group has determined as essential during the first workshop The type of information collected depends on what the planning group has deemed to be the most important questions to answer, in order to develop good programme plans during the first workshop.

As collaborative planning is designed to bring about NGO action that uses all resources in the most effective way possible, information is gathered on resources as well as problems. The team considers existing resources within communities, strengths and on-going activities of NGOs working in the area, as well as the types and amounts of development funding available. Table 1 shows examples of resource information frameworks from the Beni Suef work.

A variety of information sources and collection methods

Participatory appraisal procedures are key to the collaborative planning process. During the information-gathering phase, the planning team learns more about local communities and their health needs using a range of participatory tools, such as community timelines, pile-sorting and ranking exercises, community transects, client-mapping plus other methods developed on-site. As well as adding significantly to what is known about women's health in the area, working together in the field builds respect and promotes strong ties among planning group members. Community members often take the lead at this point and are able to share their knowledge and experience.

Since participatory assessment methods generally provide only a certain type of information, the results are combined with other information sources, including health centre records, findings from traditional research studies, and national and regional statistics. In this way, the group is able to cross-check information from a variety of sources, including their own experience. This provides a broad and in-depth picture of the situation and enables the group to develop sound programme recommendations likely to work. Also, because participatory methods are carried out within the context of a programme planning process, community input and important qualitative information directly impact upon the programme outcome.

Table 1. Examples of resource information frameworks from the Beni Suef work

Programme Option 1 *Boy leaders' programme* • Local NGOs identify 3 to 4 boy leaders in each area. • Conduct problem-posing sessions with boy leaders within each district. • With boy leaders, develop and implement strategy to reach other boys in the district. • Coordinate with CEOSS (NGO)	**Programme Option 2** *Girl peer education programme* • Local NGOs organise girl groups in their areas. • Conduct problem-posing sessions with girl groups. • Support local follow-on activities. • Contact CEDPA (international NGO) to learn experiences.
Programme Option 3 *Community theatre programme* • YAPD (youth NGO) develop a series of community theatre pieces. • YAPD/BS co-ordinate with local NGOs to conduct these within communities. • Local NGOs hold follow-on discussions with community leaders. • Local NGOs identify and carry out actions recommended by local leaders	**Programme Option 4** *Parents' Groups* • Organise groups of parents that can eventually carry out joint action. • Conduct problem-posing sessions with parent groups. • Support parents' groups in follow-on action
Programme Option 5 *Sports for girls.*	

Group analysis and decision-making

An important aspect of the collaborative planning process is the emphasis on using, not just collecting, information. Workshop methods help the planning group easily consolidate, compare, and contrast information from a variety of sources while building on knowledge and experience of each group member. To facilitate group discussion and analysis, information is posted on flipcharts on the wall by topic clusters. In a corner of the room, for example, comments gathered from community men and women about delivery practices and preferences and the perspective of local TBAs (traditional birth attendants) is posted next to national statistics on maternal mortality, morbidity, the programme recommendations of a national maternal study, and an area map showing maternity facilities in the area and who is using them. Other clusters of information are posted in other parts of the room. The data is presented in a simple visual form that enables group members with little formal education as well as highly-trained managers and medical specialists to assess the situation at a glance and then, together, discuss implications for the programme. Throughout the process, the facilitator makes sure all group members have an opportunity to share their perspectives and pushes the group to compare and contrast all information. The facilitator challenges the group continually to explain and justify their decisions. In this way, programme decisions emerge from the interplay of the diverse backgrounds and experiences of planning group members supported by a rich array of programme information.

Lessons learned elsewhere

Starting from the first workshop, the group discusses strategies that have worked in other places and how the experiences can be applied to their own context. The Beni Suef group considered lessons learned in places as diverse as a community living in a landfill site on the outskirts of Cairo, rural villages from Central Africa and Indonesia, crowded urban neighbourhoods from Haiti, Bangladesh and the USA etc.. Brief summaries of relevant research studies are also shared with the group. These are introduced as evening reading with a brief discussion at the beginning of the following day.

BOX 1

PRIORITIES FOR NGO ACTION

There is much that can be done at the community level to improve the health of girls in Egypt today. Data reviewed during the collaborative planning process indicates that there is indeed a series of health problems that begin with the girl and continue as she becomes a teenager, a wife, a mother and at last, a grandmother. The data also shows that a girl's health is closely linked with other aspects of her life, such as her level of schooling, her position in the family and the future opportunities available to her which all affect her self-esteem and how she is viewed by others. By focusing attention on the health needs of a girl throughout her life cycle and by providing families and communities the necessary information and support to take appropriate action, Beni Suef NGOs can make an important contribution to improving girls' and subsequently, women's health. NGOs participating in the collaborative planning process identified this as a priority area for co-ordinated NGO action in Beni Suef.

Rather than just raising awareness, we suggest a more action-oriented approach that uses information and dialogue to encourage reflection and mobilise efforts within communities. The initiative could also be broadened to include women's health issues directly alongside those of young girls. Activities could include:

- community theatre, to approach issues affecting girls' health;
- discussion groups of young women and men to talk about their questions and concerns;
- problem-posing sessions with community men to identify ways to ensure better health for their daughters (and their sisters, wives and mothers);
- parent-teacher action groups to support school-based initiatives for girls; and,
- women's groups to provide advice and support to their daughters and to one another in reproductive health matters.

• Priorities for action

The process culminates in the identification of priorities for co-ordinated NGO action. Beni Suef NGOs identified three priorities:

- alerting communities to danger signs in pregnancy;
- getting reproductive health services to areas currently not served; and,
- raising awareness about the health of daughters.

The focus then moves to programme strategies, and we have found that an additional push for creativity and new approaches is often still needed. Following insightful analysis of the situation, groups often fall back to programme activities that they know, such as raising community awareness, providing information through health talks, etc. The continuing role of the facilitator in providing technical feedback and guidance at this point is illustrated in the summary of the selected priority action points and the options for action are used as a discussion starter in the NGOs programme discussions (see Box 1). The next step is organising collaborative action. Implementation planning is now underway in Beni Suef. One of the first tasks was to establish criteria for NGO participation in the joint programme. NGOs also outlined the desirable level of collaboration for each activity and the mechanisms to bring it about. In some cases, simply sharing information and feedback is adequate to ensure efforts are co-ordinated. In other cases, pooling resources is necessary to make the most of the collaborative partnership.

• Summary

At a minimum, the collaborative planning process results in less overlap and duplication of service; at its best, it captures the synergism possible through concerted action of NGOs on priority issues. Collaborative planning creates partnerships between and within communities, NGOs, and government, and builds commitment for action. It is effective in mobilising communities, NGOs and government for the improved well-being of women.

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NOTES

The collaborative planning team in Egypt were Elizabeth Bennour, Kamel Lolah, Ahlam El Alfy, Essam Adel Allam and Tandia Samir.

8

Participatory and learning action as a tool to explore adolescent sexual and reproductive health

Mary Simasiku, Gladys Nkama and Michelle Munro

Introduction

When CARE Zambia used participatory research techniques to explore issues around adolescent sexual and reproductive health (SRH) (Kaul Shah, Zambezi and Simasiku 1998), the findings that emerged were worrying.

- Adolescents reported early initiation of sexual relations.
- Despite this, their information about reproductive health was often incomplete and incorrect.
- Sex among young people typically involved some type of an exchange, for example, money, test answers or sweets.
- Sources of information were frequently unreliable ones.
- Young people seldom used clinic services because they found service providers to be unwelcoming.

Involving young people in the research was the first step in the design of appropriate adolescent reproductive health programmes in CARE supported Ministry of Health clinics and their catchment areas. This article discusses CARE's experiences.

The context

Zambia has high HIV prevalence with 19.9 percent of the population over 15 years of age estimated to be HIV positive. Among 15-19 year-old girls, infection rates are five times that of boys. Sexually transmitted infections (STIs) are also widespread, although their prevalence is not well documented. By the age of 20, one-third of Zambian girls will have initiated their childbearing careers and there is considerable unwanted teenage pregnancy. Despite the fact that service providers are mandated to provide SRH information and services to young people by the Zambia Family Planning in Reproductive Health Policy, service statistics showed that few adolescents sought reproductive health information or care from clinics. CARE embarked upon a sexual and reproductive health project because of these issues.

Involving youth through participatory research

CARE chose to adopt a participatory research approach as it was felt this would provide richer baseline information from the point of view of the young people that would then be fed into the project design. Thus adolescents, their communities and service providers were involved from the outset, not only as subjects but also as researchers.

Participatory methods help participants carry out their own analysis and appraise their own situation. The emphasis is on allowing people to feel free to identify and explore their concerns. Unlike most research, there are no predetermined questions. The process is left open ended and flexible in order to follow concerns and issues brought up during the research process. CARE chose a participatory methodology because:

- we had successfully used participation in other health and livelihood projects;
- adolescent reproductive health is a sensitive issue and we felt that we would be more likely to find out the truth if we worked with adolescents on their own terms;
- there was little qualitative data on adolescent sexual and reproductive health based on their own perceptions of their sexual behaviour; and,

- involving adolescents at this level would be a starting point for youth empowerment.

We used and adapted participatory tools to work with young people. Alongside 'standard' PRA tools, such as transect walks, social and body mapping, matrix ranking and scoring and Venn diagrams, the team used focus group discussions and in-depth interviews to understand young people's perspectives. Picture stories made up and illustrated by the adolescents gave further insights. By analysing the stories together, we were able to start to understand adolescent sexual behaviour, the types of sexual relations among the boys and girls and the consequences of these relationships.

One innovation that generated rich insights was the use of a participatory sex census. During group discussions it became clear that while boys spoke about their sexual behaviour and experiences freely, girls tended to be secretive about their experiences. So a secret ballot was used to explore issues such as the age of sexual initiation. The method uses slips of paper depending on the number of questions one has to ask. One question is asked at a time and the response is written on the slip of paper. The responses are kept anonymous so that participants feel comfortable writing honest answers. The slips are destroyed in front of the group. New slips of paper are then passed round for each question. The results were analysed with the young participants and then discussed. This method allowed us to generate qualitative information that was used for comparison with the results of other analyses, which were based on perceptions.

What did we find out?

Research findings indicated that adolescents have incomplete, inaccurate and distorted information on sex and reproduction (see Box 1). They mainly depended on unreliable sources of information such as friends, grandparent, elder siblings, traditional healers, science teachers, community-based organisations and pornographic video films. Very rarely were parents and clinics mentioned as sources of information. We found differences when working with boys and girls. Boys were more open when discussing their personal experiences. Girls, on the other hand, were shy to talk about sexual matters. They always answered questions in the 'third person'. It was also difficult to have discussions with girls very early in the morning or towards lunch, because they were busy with household chores, while the boys spent several hours with us.

The average age of sexual initiation found was 10 years for girls and 12 years for boys. Reasons for indulging in early sex ranged from the need for money (especially among girls), peer pressure, curiosity, for pleasure or fun to obtaining favours such as sweets or assistance with homework. The major impact of adolescent sexual activity upon these youths was the spread of sexually transmitted infections and teenage pregnancy, 75% of which had ended up in abortions. Many young people reported the use of unsafe abortion methods. This was exacerbated by the low use of contraceptives, especially condoms and the general lack of information about services.

Clinic utilisation among adolescents was found to be very low especially for sexual and reproductive health. Only about 30% of the boys with sexually transmitted infections reported that they would seek treatment at a clinic. The proportion of infected girls seeking treatment at the clinic was even lower. Reasons identified for this low utilisation were fear of clinicians' attitudes and lack of knowledge about the services available.

Next steps

Our participatory research led to CARE implementing adolescent sexual and reproductive health programmes in peri-urban compounds (shanty towns) of three cities, Lusaka, Ndola and Livingstone. We are continuing to work with and through adolescents and clinicians as a further step in the participatory research.

At clinic level, health workers are supported to provide youth friendly services, to form youth corners in clinics, to conduct outreach activities and to work towards improving the record keeping system.

BOX 1

QUOTES FROM YOUNG PEOPLE

'*Sometimes they only want to touch 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 school girls. They added *'When they ask us to have sex, we have to agree.' 'Because if a girl refuses, the boy will not help her with homework and may refuse to lend her a pencil when she wants one'.*

'*The Kasai or the Zairien sex workers have a more or less fixed rate for the services they provide. For the night they charge K4000 ($1.6), for half the day they charge K1,500 ($0.6) and for one round of sex you have to pay K1,000 ($0.4)'* - boys in Chawama compound

'*Rape is when an older man has sex with a much smaller girl and in the process tears her vagina .....the vagina tears because the man's penis is large'* - Definition of rape by a group of 9-15 year old school girls in Chawama

'What have you been doing so far?' Group of 13-17 year old boys discussing their sexual experiences when one 13 year old boy mentioned that he had not had sex up to this point.
'*Having sex with a condom on is like chewing a sweet with its wrapper on' On why there is low condom use among adolescents*

'If a boy has an STI, everyone comes to know about it. However, if a girl has an STI, it is not possible to tell for a long time. Boys have to be very careful otherwise the girls will give us all the diseases. I make sure she is clean every time I have sex with a girl.....before having sex with a girl, I put some cigarette ash in her vagina...if she has a disease it will hurt and she will scream'. A group of 13-17 year old boys in Chawama.

At the community level, the project has facilitated and supported groups of trained peer counsellors in community based adolescent health education activities. When the results of the research were disseminated to the community, young people suggested that one of the activities they would want to be included in this project was health education. They were then encouraged to form discussion groups, each of which had 10-15 members. They determined their own criteria for selecting group members. The same discussion groups were used to brainstorm the qualities of a good peer counsellor. Some of the qualities listed included being respected, responsible, accessible, of the same age group and not having many girl/boyfriends. Then the groups were asked to select one or two people from their group to be their leader and these were trained as peer counsellors. Peer counsellors also work in the youth friendly corners and act as a link between service providers and youths.

Things we might have done differently

We have learnt that it would have been good to develop strategies that help peer counsellors become economically active in order to reduce attrition rates. It would have also been good to focus on a small geographical area and stagger the training sessions for adequate follow up.

· Conclusion

Adolescent sexual behaviour has serious implications, demanding an extensive range of interventions. This requires adolescents themselves, the community, health workers and facilitating agencies to work continuously together in partnership. CARE has taken steps to address this in partnership with the Ministry of Health.

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9

Lessons from 'Auntie Stella': using PRA to promote reproductive health education in Zimbabwe's secondary schools

Barbara Kaim and Ratidzai Ndlovu

· Introduction

In early 1997 the Adolescent Reproductive Health Education Project (ARHEP), a project of a Zimbabwean non-profit organisation called the Training and Research Support Centre (TARSC), set out to find out what information, perceptions and concerns adolescents have about their reproductive health and their sources of information and support. Drawing on our collective experiences and understanding of participatory approaches, we aimed to prioritise the views of the adolescents themselves. We focused our research on four rural schools which, although a small sample of the 1500 secondary schools in the country, allowed a more in-depth review of the adolescents' views of their reproductive health. In the beginning, our research was open-ended, meaning that if we were to be true to the opinions of the youth in the schools, we could not predict the outcome of our findings nor what would follow.

The results of this initial research continue to have an impact, not only on the original pilot schools (expanded to a total of 12 schools to date), but also on the policy and strategies of the Ministry of Education, the Ministry of Health, a number of NGOs participating in our Reference Group, as well as having a ripple effect on groups working with out-of-school youth.

Much of this success can be attributed to our continued emphasis of listening to the views of the adolescents themselves, respecting their opinions, and drawing on their own experiences to analyse and act on their problems and priorities. Our early research showed unequivocally that, while teenagers are subject to strong social, economic and peer pressure in many areas, they lack sources of open, reliable support and information. For example, girls from one remote rural school show how community and government institutions, and even the Guidance and Counselling teachers who are mandated to provide AIDS education for 40 minutes per week, are not prominent (see Figure 1). Instead, adolescents repeatedly said that they were either getting information from family members (but not parents, who are conspicuously absent in the sexual education of their children), peers (although much of the information shared is superficial and inaccurate) and the media.

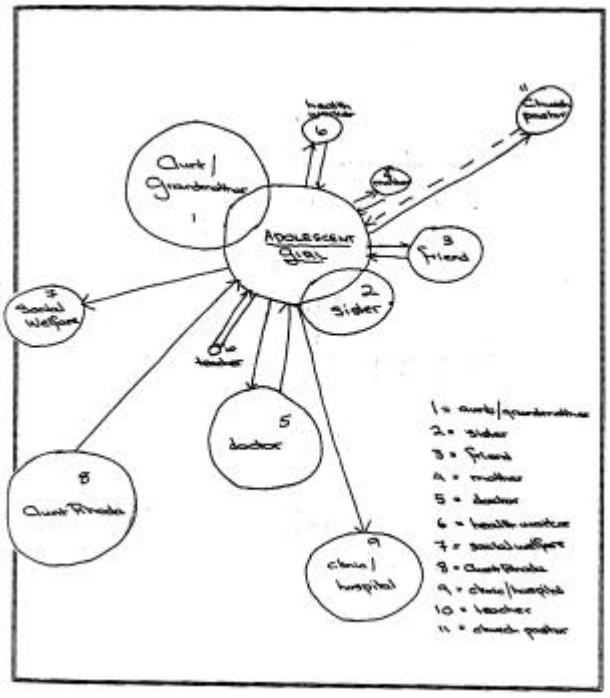

Figure 1. Sources of information and support – Chemhondoro girls

In exploring this last point further, teenage groups acknowledged that an alternative source of information came from magazine helpline letters, such as those written to 'Aunt Rhoda' and published monthly in a widely circulated magazine in Zimbabwe. None of the youth we worked with had written in to any of the magazine helplines, but they found the question and answer format and style of writing accessible and informative.

The creation of 'Auntie Stella'

The findings from this early participatory research led to the development of a reproductive health education pack called 'Auntie Stella', based on the stories, experiences and expressed needs of the adolescents themselves and using the question and answer format of helpline letters. It is a classroom-based activity pack for secondary school pupils aged 14 and above and has the following aims:

- to stimulate discussion among adolescents on key issues related to their reproductive health and to give reliable information about these issues;
- to create an activity and atmosphere where pupils are able to talk to each other freely and without inhibition;
- to fill a proven 'information gap' by providing advice in a non-authoritarian framework;
- to encourage pupils to express their own problems and questions, and to steer them towards suitable sources of information and help where relevant; and,
- to provide support and extra resources for already existing schools programmes developed by the Ministry of Education, Sport and Culture.

'Auntie Stella' consists of 33 questions and answer cards, the questions supposedly written by adolescents seeking information and/or advice on a variety of topics. The answer cards give Auntie Stella's reply. The topics covered include normal reproductive development, social and economic pressures to have sex, gender roles, forced sex, communication in relationships and with parents, depression, wanted and unwanted pregnancy, infertility, cervical cancer, HIV/AIDS and Sexually Transmitted Diseases (STDs).

Cards are discussed in small groups, which are usually of single-sex, with minimal intervention by the teacher. The cards can be used for approximately eight to ten 40-minute class periods. In the basic lessons, groups discuss the problem raised on the question cards, guided by the 'Talking Points' which follow each letter. Then they take the matching answer card and read and comment on what it says, using the 'Action Points' to focus on future action. In later lessons, pupils work, first in pairs to write answers to the letters, then write and discuss their own letters to 'Auntie Stella' before finally discussing specific letters, if they so choose, with pupils of the opposite sex.

The 'Auntie Stella' methodology is based on findings that adolescents are most at ease when talking to peers of the same sex but feel inhibited in full-class discussion and in discussions with pupils of the opposite sex, especially in the presence of the teacher. The pack includes a 'Teacher's Guide' which stresses that the teacher is a facilitator rather than a controller, and insists that pupils' discussions and writing are private.

Measuring the impact of 'Auntie Stella'

Since the production of 'Auntie Stella', TARSC and the Ministry of Education have been working closely in field, testing the pack in a number of schools in one region of Zimbabwe. One objective, in addition to exploring what local capacity is needed in order to implement a participatory reproductive health programme in the schools and how the experiences in the pilot schools can be made effective at national level, was to determine whether or not students gained new knowledge from 'Auntie Stella' and whether they put this knowledge into practice. From a methodological viewpoint, we were interested in designing an approach which gave the students in our pilot schools the opportunity to define their own indicators of change.

This was an ambitious task and, even at the outset, the ARHEP team was aware of its potential difficulties. We went about doing

this through a series of steps: in the early weeks of the students' exposure to 'Auntie Stella'. First, we asked them to describe which reproductive health behaviours they and their peers engage in, factors which influence their behaviour, and how they assess these behaviours (see Tables 1 and 2). We triangulated this information by interviewing teachers in the school. Later on in the programme, we returned to the schools and focused on those behaviours that the students' themselves had defined as 'bad'. For example, having sex, having 'sugar daddies' or 'sugar mommies', abortion (girls), smoking (boys) or *chiramu* (when an older man touches the girl's private parts). All of these activities were defined by the students as risky because they led to irresponsible behaviour with sometimes fatal outcomes.

We used the image of a river with one side representing the prevalence of that bad behaviour and the other where that behaviour no longer exists in their community. Then we asked the students what stepping stones (pieces of paper with specific actions written on them) they needed to cross from one side to the other. Crossing the river symbolised a change in attitude or behaviour; the stones were the students' indicators of change.

An initial interpretation of the stepping stones (indicators of change) defined by the students was interesting in itself. Students tended to focus on ways of *avoiding* risky behaviour. For boys who no longer wanted to pressurise girls into having sex, this meant avoiding having too many friends, not watching sexual movies or not walking in the bush with their girlfriends. For girls not to fall pregnant, they suggested they avoid nightclubs and having sex before marriage. Rather than being proactive and making suggestions about what they *can* do to change unwanted behaviour, they found it easier to identify what they should *not* do. They only peripherally mentioned the role that community institutions (such as family, friends, clinic, church etc.) could play in supporting their efforts to change a certain behaviour. Their strategies for trying to create a more positive reproductive health environment for themselves and their peers was often broad-sweeping (e.g. resist peer pressure), individualistic and lacking the necessary detail to be measurable.

Table 1. Behaviour influence matrix table for boys

	Peers	Biological instincts	Entertain-ment	Family	Culture	Economic pressure	Religion
Sex	8	9	7	3	2	3	2
Smoking	8	1	4	3	3	4	1
Alcohol	8	2	5	4	5	4	2
Masturbate	4	8	3	2	1	2	0
Girlfriends	9	8	8	4	3	1	4
TOTALS	**33**	**28**	**27**	**16**	**14**	**14**	**9**
RANK	**1**	**2**	**3**	**4**	**5**	**5**	**6**

Table 2. Behaviour influence matrix for girls

	Peers	Economic pressure	Entertain-ment	Family	Culture	Nature	Religion
Sex	8	7	8	2	4	8	2
Abortion	7	7	0	4	2	0	1
Marriage	6	7	2	7	5	3	7
Boyfriends	8	8	7	6	4	6	4
Masterbate	10	0	3	5	0	5	0
'Sugar dad'	9	7	0	5	4	2	3
Alcohol	6	3	7	2	5	0	1
TOTAL	**54**	**39**	**37**	**31**	**24**	**24**	**18**
RANK	**1**	**2**	**3**	**4**	**5**	**5**	**6**

- We returned to the schools once again a few months later to explore how students (and teachers) viewed the impact of 'Auntie Stella'. To our surprise, despite the students' prior over-generalised statements of how they could change their behaviours, they were very precise on the outcomes of their increased knowledge as a result of exposure to the 'Auntie Stella' pack. They cited evidence of:
- an increase in communication with parents, community members (e.g. some students had asked community elders about the traditional roots of *chiramu*) and with their peers;
- greater confidence and ability to make informed decisions and take initiative (e.g. to report seemingly harmless overtures by their in-laws so that they do not appear to be encouraging or inviting abusive behaviour); and,
- their increased ability to advise their peers on a range of reproductive health issues (e.g. telling their friends that they have rights over their own bodies; girls talking to their younger sisters about their first menstrual experience and telling them how to manage period pains).

While these focus group discussions also elicited a range of negative attitudes (where some boys still maintained that a girl means 'yes' when she says no'), there was a general feeling from boys, girls and teachers that the 'Auntie Stella' pack has had a positive impact on reproductive health behaviour.

· Lessons learnt from 'Auntie Stella' and the use of PRA

- Adolescents react positively to PRA. There was remarkable enthusiasm, participation and a general interest in the unfolding process. From the very beginning, boys were eager to talk. The girls were more reticent to start with, but opened up once they realised that this was a rare opportunity to share opinions and experiences. Clearly there is a need for more open and accessible channels of information and communication for adolescents.

- The concept of 'Auntie Stella', its format, the content of the letters and its methodology, arose directly out of the PRA research with the students and teachers in the original four schools. Initially, the ARHEP team was concerned that the pilot may be too small to represent the views of other teenagers in other schools. However, the first four schools and subsequent eight schools represented a good cross-section of the situations in which school-going adolescents find themselves. In all twelve schools, both students and teachers acknowledged that the letters reflected real problems faced by the students. This process emphasises the importance of designing educational materials only after serious dialogue with the end-users themselves.

- The project has shown that indicators of change do not have to be imposed from the outside but can evolve as part of the research design. This more qualitative approach to evaluating behaviour change does not preclude more quantitative measurements; it does, however, give voice to the participants themselves, who are ultimately the key players in the process.

- ARHEP's work reached a new phase with the signing of an agreement between TARSC and the Ministry of Education, Sport and Culture to work together in finding ways in which the Ministry can strengthen reproductive health education in the schools. Potentially, this relationship may have far-reaching consequences, including an impact on Ministry policy and/or distribution of the 'Auntie Stella' pack to a larger number of secondary schools in the country.

- The role of the ARHEP Reference Group, consisting of representatives from government, non-governmental and community groups involved in health, education and gender issues, deepened the work of this programme. Their input was invaluable during each phase of the project, in giving guidance and in exploring ways in which existing youth-oriented organisations can use ARHEP's findings.

- The role of the teacher, as defined in the 'Auntie Stella' pack, deepened the debate on how to implement a successful reproductive health education programme in the schools.

- One of the limitations of this research, was that the ARHEP team was confined to working within the school timetable. This often meant that not enough time was spent with the students in each school.

- Financial constraints limited the number of researchers who went out into the field. There was need for a larger multi-disciplinary team, including health personnel, so that at least two people could work with one group.

- There was a tendency for adolescents to exaggerate their stories. They were excessively critical of the adult community, especially their parents.

Where to from here?

Findings from ARHEP's field testing of 'Auntie Stella', reinforced by a positive external evaluation of the programme, supports the strategy of exploring ways in which 'Auntie Stella' can be distributed to schools in other regions in Zimbabwe. This will involve discussions with the Ministry of Education and other relevant players and, eventually, the devolution of responsibilities for the future of the pack onto larger national institutions.

At the same time, ARHEP plans to continue working with students from the initial pilot schools. Our intention is to involve them in a structured dialogue with health providers in their communities to explore ways in which the providers (clinics, village health workers, community-based distributors, traditional healers etc.) can better support adolescent reproductive health needs. The dialogue will follow specific areas of interaction between adolescents and services, for example, fertility regulation, prevention and management of STDs, etc., and will examine how information, service environments, type of service, professional/client interaction and other aspects can be improved to enhance access, use and effectiveness of services for adolescents.

· Conclusion

The use of PRA in this project has shown that learning is not just about adults teaching adolescents. Of great value is recognising that we, the adults, have a lot to gain from listening to adolescents as part of the process of sharing information with and giving support to young people. There is evidence that adolescents are sexually active and they need appropriate educational materials which meet their specific needs. The 'Auntie Stella' education pack has gone a long way in exploring strategies on how to meet some of these needs. It is hoped that, in the long term, the ARHEP programme will have some impact on education and health policies in government and non-governmental institutions, on methods of working with young people and, of course, on the behaviour patterns of the youth themselves.

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NOTES

The ARHEP reference group referred to in the text consists of representatives from government and civic organisations working in the fields health, education and gender. The group meets every three months to give input into the design and implementation of the programme and to encourage a closer interaction between the various programmes.

Inspiration for the activity where the image of a river was used, with one side representing prevalence of 'bad' behaviour and the other where that behaviour no longer existed, was inspired, in part, from 'Stepping Stones', the training package of HIV/AIDS by Alice Welbourn.

10

More talk, less sex: AIDS prevention through schools

Noerine Kaleeba, Joyce Kadowe, Daniel Kalinaki and Glen Williams

· Background

"Why is it that someone can at times have an erection even when he doesn't want it?"

"Is someone likely to get AIDS by kissing an infected person?"

"Can HIV be contracted after only one single sexual intercourse with an infected person?"

These are just a few of the frank questions about sex and HIV/AIDS which primary school pupils in Soroti District, Uganda are putting into their 'health letter boxes'. The health letter boxes are part of an innovative School Health and AIDS Prevention Programme, which has helped to dramatically reduce sexual activity among primary school pupils. The letters are read out to the children during morning assemblies and answered on the spot by specially trained teachers. As in many other countries, sex in Uganda has long been regarded as a taboo subject, which causes feelings of embarrassment or even shame when discussed in public. Yet this has not prevented large numbers of young Ugandans from becoming sexually active. A national survey in 1995 found that on average, girls became sexually active at the age of 16, and that 30% of girls had engaged in sexual intercourse by the age of 15[1]. In some parts of Uganda, up to 62% of boys and 38% of girls were involved in unprotected sex before completing primary school (Bagarukayo et al. 1993). This pattern of sexual activity was clearly exposing many young people in Uganda to a high risk of unplanned pregnancy, Sexually Transmitted Diseases (STDs) and HIV/AIDS.

In the early 1990s, the District of Soroti, in eastern Uganda, was struggling to emerge from several years of civil war. Many schools had been looted and damaged during fighting between dissidents and government forces and large numbers of children were attending classes in the open air. Although about 90% of children were reported to be starting primary school, (which has covers the range of 6–20 years of age) only 40-50% were actually completing the full seven-year course. Many children were in their late teens by the time they left primary school.

Health education, including AIDS prevention, was already part of the primary school curriculum in Uganda at this time. However, teachers generally lacked the training and the skills needed to talk explicitly about human reproduction and sexual health, and to encourage their pupils to discuss intimate sexual matters.

· Programme strategy

In 1993 the African Medical and Research Foundation (AMREF), together with the Soroti District Administration, started a School Health and AIDS Prevention Project in 95 primary schools, with an enrolment of about 120,000 children, in two rural counties and Soroti town. A baseline survey of primary school pupils aged 13-14 in the project area in 1994 found that 42.9% were sexually active. Boys were more likely than girls to be

[1] Statistics Department, *Demographic and Health Survey*, Ministry of Finance and Economic Planning, Entebbe, 1995.

sexually experienced: 61.2% of boys claimed to have had sex, compared with 23.6% of girls (Shuey et al., 1999).

The project aimed to encourage safer sexual behaviour, particularly abstinence, amongst primary school pupils, through a three-pronged operational strategy:

- improved access to information about healthy sexual behaviour and decision-making;
- improved adolescent-to-adolescent interaction regarding information and decision-making relating to AIDS, sexuality and health; and,
- improved quality of the existing district education system in the implementation of the school health curriculum and in counselling/advice-giving to school pupils.

Beyond embarrassment

The new approach was not without risks. Objections were to be expected from traditionally minded parents, as well as cultural and religious leaders. The project made meticulous preparations, therefore, to minimise the likelihood of misunderstandings, social tensions and outright opposition. A District level Steering Committee was appointed to oversee the activities of the project. This consisted of officials from the Departments of Education and Health, local government personnel, religious leaders, representatives of parents, youth and women's affairs, and staff from AMREF-Uganda. Headmasters and local leaders (politicians, government officials, religious and local opinion leaders) were sensitised about the aims of the project through a series of one-day workshops. The project also organised meetings to discuss health and sex education with local parents, community leaders and teachers at each school and in each administrative zone. Teachers were also thoroughly prepared: Senior Women Teachers (SWTs), Senior Men Teachers (SMTs)[2] and Science teachers attended four-day health education training courses to improve their knowledge and health education skills. Looking towards the longer-term future, the project helped local teacher training colleges to introduce school health, AIDS prevention and Child-to-Child health learning techniques into their training courses.

When the project entered primary schools, teachers initially encountered some reluctance on the part of pupils to discuss sexual matters and AIDS in a frank and open manner in the classroom. However, these inhibitions were soon overcome, and pupils responded positively to the more open approach (i.e. being frank and specific) to teaching about human reproduction, sexual health and AIDS.

Perhaps even more influential were the weekly 'guidance and counselling' sessions run by the SWTs and SMTs for pupils in years five, six and seven (aged between 11-14, but pupils can often be older). These sessions, often held in small groups sitting under a tree, gave pupils the chance to interact with one another informally, with guidance and support from teachers whenever necessary. They took the form of teacher facilitated group discussions, with the use of drawings and posters to support them. Particularly useful to the guidance and counselling sessions were copies of the newspapers *Young Talk* and *Straight Talk* supplied free to schools by the Straight Talk Foundation[3]. These provided accurate, factual information about sex, human reproduction and HIV/AIDS, and also stimulated discussions amongst pupils, and between pupils and teachers. Many pupils also wrote to one or other of these

[2] Senior Women and Men Teachers are experienced teachers designated by schools to give guidance and counselling to pupils, alongside their normal teaching duties.

[3] The Straight Talk Foundation is an organisation whose aims are: to increase understanding of adolescence, sexuality and reproductive health; and to promote safer sex, life skills and child/adolescent rights. It publishes two monthly newspapers – Young Talk and Straight Talk, which reach over 1 million young adolescents and youth, mainly through primary and secondary schools.

newspapers to seek advice or express their opinions.

Pupils began using 'health letter boxes' at school to ask questions about HIV/AIDS, STDs and other intimate matters related to sexual and reproductive health. In addition, pupils went to teachers for individual counselling, advice or practical help. *"Girls come to me,"* says Christine Oluka, Deputy Head of Soroti Demonstration School, *"for advice about their relationships with their boyfriends, or to complain about a boy who is pestering them. They also ask about their periods. Sometimes they get their period at school but they haven't brought a sanitary towel, so we can help them deal with that."*

In every school involved in the project, groups of pupils also started extra-curricula school health clubs, whose members came together to share knowledge and experiences, and to support one another in following a healthy lifestyle. They also composed songs, staged skits and plays, and wrote poems and essays about HIV/AIDS, pregnancy and other health-related issues. The condom issue had to be handled very carefully, since many parents feared that teaching young people about condoms would encourage them to become sexually active. Most teachers confined themselves, therefore, to providing information about the condom, without showing samples or demonstrating how it should be used. Some teachers, however, brought condoms to school and demonstrated, albeit discreetly, their use to senior pupils, especially to those who are already sexually active[4].

Increase in abstinence

In 1996, after the project had been fully operational for two years, a follow-up survey was made of the sexual behaviour of a sample of pupils in year seven of primary school in the project area. An identical survey was also carried out in a 'control' group of schools in a neighbouring county, where the project was not operating. The survey found that, in the schools involved in the project, the percentage of pupils claiming to be sexually active had fallen dramatically: from 42.9% to 11.1%. Boys were still more likely than girls to be sexually active: 15.8% compared with 6.4%. By contrast, no significant changes in sexual behaviour were recorded among pupils in the 'control' group of schools (Shuey et al., 1999).

The survey also explored the reasons for this 74% decline in reported sexual activity among young people. It concluded that the main reason was greater social interaction between pupils and teachers, and among pupils themselves. This high degree of social interaction was not accidental, but was carefully fostered by the project. It was effectively reinforced by the thrice-yearly visits paid to schools by officials from the District Education Service to monitor activities and provide supportive supervision to teachers.

The channels of communication that have been opened up between the project and local families and communities have also contributed to the success of the project. Community leaders and parents were sensitised about the aims and activities of the project, and also offered the opportunity to express their views at local meetings. These efforts have helped local parents and community leaders understand and accept the aims and strategies of the project. While some parents have complained that the project has led to their children experimenting with condoms, most would probably agree with Salome Abuko, a small kiosk owner and mother of two primary school children in Soroti town, who says:

"*It's good that the children are being taught about AIDS and sex at school. The teachers aren't spoiling them but are*

[4] AMREF also sells condoms and contraceptive pills to the general public. However, this project is separate from the School Health and AIDS Prevention Project.

helping to save their lives. In fact they are helping us to do our jobs of teaching our children".

· Feedback from project participants

The following section provides some feedback from a selection of the project's participants, both students and teachers alike, in which they share some benefits, outcomes and learnings that have been a direct result of the project thus far.

Jesca Harriet Acao: class 7 pupil

Fourteen year-old Jesca is in class 7 at Katine Tiriri Primary School, about 20 kilometres north of Soroti.

"The greatest worry in my life is AIDS. It has killed four of my sisters and brothers. My surviving sisters at home tell me how I could get AIDS and they advise me to behave myself so that I can stay safe. We talk about AIDS in our free time here at school, and we also read the Young Talk newspaper which comes to the school. I also borrow Straight Talk from the teachers. I also listen to 'Capital Doctor' on Capital Radio on Tuesdays, and I have learned a lot about AIDS from that. We have learned about AIDS in class - how we can get it, prevention, taking care of yourself, and teaching other people back home in the village so they do not get it also.

"My parents feel happy that I am learning about AIDS and sex at school, because whatever they teach us here I pass on to them. They tell me I will have a better life in future because of what we are learning at school.

Joseph Julius Omio: science teacher

Joseph is a Science teacher at Katine Tirere Primary School. He was trained by the AMREF School Health and AIDS Prevention Project:

"As a teacher, I am now much more open with my pupils. I don't hide any facts when I am teaching about sex or AIDS in the classroom. In the past, I could feel uneasy when talking about such things. But now, even if my own child is in the class, I talk quite openly. The children sometimes have problems being open. At first they are shy and afraid to use the language to describe sexual matters. I just encourage them not to be afraid and to speak out. We also talk about AIDS at school functions, like Parents' Day and Open Day, where the pupils sing songs depicting AIDS and other social problems.

"Not everyone agrees with what we are doing. Some parents bounce the problem back to us, and say we are trying to teach their children irrelevant things, and causing them to be interested in sex at too early an age. But the Project recently ran a peer group seminar on AIDS and sexual issues for school pupils, and afterwards some of the pupils went and explained it all to their parents. I also talk to people in my community about AIDS. The death rate from AIDS seems to be decreasing, but the problem is that the people at the grassroots, who don't have radio or television, still lack information. But we shouldn't try to hide anything about AIDS. The problem is already with us so we cannot hide from it".

Grace Ebunyo: senior woman teacher

As the Senior Woman Teacher at Soroti Demonstration Primary School, Grace is responsible for the weekly guidance and counselling sessions for pupils in the top three classes of the school. She is 39 years old, married, with five children. Her life has been deeply marked by the HIV epidemic.

"AIDS has affected me a lot. In 1995 I lost my brother, who was teaching in Teso College - he had just finished his university degree. I also lost my other brother just after his training, and my

sister died when she was in her last year in teacher training college. I spent a lot of money helping my brothers and sister get a good education, but they all died so young! I'm really worried about my own children. Whenever I lose a close relative to AIDS, I take them there to see, and I even tell them the cause of death, but still I'm worried for their sake. As a teacher, I'm worried about my pupils. Today's children learn many bad things from TV and from one another".

Grace is strongly in favour of teaching about sex, human reproduction and AIDS in primary schools:

"AIDS is covered in the school curriculum, but only from Primary 5 to 7. But with UPE[5], we are now getting big boys and girls, even 15 year-olds, in Primary 1. So the curriculum should cover AIDS right from P1.

"We try to emphasise abstinence from sex as the best method of AIDS prevention, but children cannot easily avoid temptation. We have to tell children about condoms. I even show condoms to the big ones. My brother is a doctor and he has condoms in his clinic, so I can easily get them. The parents are generally very positive about the teaching of AIDS prevention in school. Many have lost their children to AIDS, so they support of what the school is trying to do.

"People in the community are much better informed about AIDS, and they are much more supportive towards people with AIDS. In the past they were afraid to touch the sick, or even to carry the body of someone who had died of AIDS to be buried. But now they know that touching someone with AIDS is not risky, so they nurse and care for the sick. And they no longer waste time analysing how someone got AIDS, which was the case in the past.
"There are some school children who share their knowledge of HIV and AIDS with their parents. I have a friend who divorced her husband 16 years back. They were planning to reconcile but her daughter, who was in Primary 6 at the time, said 'Mum, you've been away from each other for such a long time. We are not sure whether father is free from HIV/AIDS.' My friend thought seriously about what her daughter said, and in the end she declined his proposal."

Caroline Imalingat: class 7 pupil

Fifteen year-old Caroline is in class 7, her final year at Soroti Demonstration Primary School. When her teacher first started talking about sex in class, she was uncomfortable:

"I used to feel so embarrassed when the teacher was talking about sexual matters in class. I felt that such things were not supposed to be talked about in class like that. Now I don't feel embarrassed at all, because I know that such things are important and should be discussed. But some of my fellow pupils still say it's bad to discuss such things openly. I also discuss sexual matters with the Senior Woman Teacher, and with my mother, and they advise me about what to do. I think sex is very dangerous because you can get diseases which cannot be treated. It can also cause you to get married early because you become pregnant. Some parents can even chase you from home. Sex is only good when you have finished your studies and got a job and want to have children.

"I have learned about AIDS here at school, and through reading. I read Young Talk and Straight Talk at school. My friends and I, we talk about AIDS during lessons and in our free time. We have agreed to stay safe so that we do not get infected, because AIDS cannot be cured. I tell my parents what I am learning about AIDS at school. They are happy about it. They say that the teachers are helping them.
"I have good friends who are boys. I think it is possible to be a close friend with a

[5] Universal Primary Education – a government programme which began in 1998 and which aims to enable each family to have four children educated to complete primary school.

boy without playing sex. I do not have a boyfriend and have never had one. A boy can make you neglect your studies because you are thinking about him all the time".

· Expansion and sustainability

In late 1998 the project expanded to cover all 213 primary schools in Soroti District and 154 schools in the neighbouring District of Katakwi - a total of 367 schools with a total enrolment of 192,000 children.

The project employs only one full-time health educator, who is scheduled to leave the project in March 2000. The prospects for the longer-term sustainability of the benefits of the project, however, are good. Firstly, the project is based on the existing health education curriculum. It is implemented on a day-to-day basis by local teachers and officials from the Soroti District Education Department, and pays no allowances to staff outside of normal government policy (i.e. for travel expenses and to cover the costs of attendance at workshops etc.).

Moreover, the social interaction approach adopted by the project has been incorporated into the curriculum of the two teacher training colleges, which supply most new teachers for the two local Districts covered by the project. There is every prospect, therefore, that the new approach will become institutionalised, and that future generations of primary school pupils will also be equipped with the knowledge and skills they need to postpone sexual activity until they are physically, socially and emotionally mature

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NOTES

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11

Experiences of using a participatory approach in Cambodia: Exposing the needs of sex and good women

Julie Forder

• Introduction

Over the last eighteen months, CARE International in Cambodia, the Cambodian Health Education Development, Reproductive Health Association of Cambodia and Women Development Association have been using participatory tools for sexual health assessment with young garment workers[1]. With additional funding and technical support from FOCUS on Young Adults, the project team adapted and applied participatory methods and tools used by CARE Zambia in their work on adolescent sexual health (Kaul Shah et al. 1999). The process, which is still continuing, has enabled project staff, in conjunction with factory management and local communities, to gain more in depth knowledge with the target population about thoughts and practices regarding sexual health. It has also helped strengthen their participatory facilitation skills, along with many other transferable skills, while undertaking participatory research design, implementation, report writing, presentation and action planning with factory workers and managers. This article reflects on some of the lessons that we have learned through this experience.

[1] Factory workers committed their free time, owners and managers gave their approval to their involvement in the process.

Background

The sexual health needs assessment aimed to identify the sexual health needs of young people undertaking garment work. It was designed so as to learn with these young people about a number of aspects of their lives. These included their general concerns, their knowledge of anatomy and physiology of men and women and their relationships and sexual practices. 77 young people aged 15-23 were involved in the research, of which 75% were female, broadly reflecting the balance of the workforce in the garment factories of Phnom Penh, the Cambodian capital.

• Opening doors

The project arose out of a joint Asia initiative of the United Nations Population Fund and the European Commission. Consultation meetings within Cambodia between the government and NGO staff identified young people as a group that had many unmet sexual health needs. From CARE's previous experience of working with employees of three garment factories, a need for sexual health promotion was identified. Therefore CARE sought to continue opening more factory doors and decided to expand and adapt their experiences, not only targeting factory workers, but also factory management and health staff in an attempt to institutionalise improved factory health services.

Authorisation for this project's work was sought from a number of relevant ministries.

Access to the factories was attempted through the Garment Manufacturers Association of Cambodia (GMAC) and eventually gained through door to door visits. Forty-eight factories were visited in Phnom Penh. Thirty-two agreed to be interviewed. All expressed interest and reported that a project such as this was important, yet whilst our project was seen as 'a good idea' and requests were made by many for medicine, medical personnel and for treatment of Sexually Transmitted Infections (STIs) and gynaecological problems, it was not perceived as needed. Seven out of those factories who expressed a strong interest were selected as project sites. The selection was based upon interest and co-operation, having more than 500 employees and a greater proportion of workers who were female and predominately single.

The seven factories selected originally had, for one reason or another, 'closed their doors' to the project. Some had gone out of business, others had simply 'changed their minds' and thus, none of the original seven were included in the participatory research. A further seven had to be contacted and access re-negotiated. Out of the seven factories selected as project sites, all managers and a total of 1,200 young workers were interviewed. From these seven, three were selected for participatory research. This was based on timing, funds, but most significantly, co-operation and agreement from the factory management. The findings of the research will be channelled into upgrading clinical skills and services in five of the seven factories – the ones which after one year still wanted help from CARE.

Once the factory management had conveyed the discussions about the project to their relevant owners, permission was received to work with CARE. The researchers and management conferred and sought agreement for the days and times when access would cause least disruption to the factory schedule. Factory health staff, a staff representative or a section supervisor were approached through the manager and asked for help in selecting groups of women and men between 15 and 24 years old. The young workers were then eventually approached directly and told about the research. The final selection was controlled by the young workers who self-selected themselves with approval from the supervisor or head of section. The approval was usually dependent on the work commitments and orders that had to be fulfilled. The participatory research was planned for weekends to avoid conflict with work.

Adopting a participatory approach to sexual health in Cambodia

Essential components of participatory research in the area of sexual health are trust, mutual respect and the ability to facilitate open discussions about sexual health matters. In a country recovering from its recent traumatic past, where a whole society learned to distrust their neighbour and children learned to spy on their parents, trust is a precious commodity.

Cambodian society is strongly hierarchical and patriarchal. Powerful social norms govern the sexual attitudes of men and women. Hierarchical power relationships and perceived loyalty were important to survival in the brutal Khmer Rouge regime, and continue to be an important feature in Cambodian society today. The powerful exist by the existence of the weak and vulnerable. And, in terms of this sexual health project, as in most patriarchal societies, women are the more vulnerable group.

The fate of a woman is in the hands of her parents choosing the 'good' man and in the hands of the man being knowledgeable and caring. A traditional proverb 'men are gold, women are cloth' does not refer to the fact that women are useful, versatile and essential, but to the belief that women are irredeemably stained by sexual activity while men can be washed clean. After puberty women find themselves in a difficult position. They have the task to make themselves sexually attractive yet at the same time, be on guard against a fallen reputation. The city presents women with many additional dangers: fears of trickery, deception and violence, of rape and of being drugged, caught and sold into the sex

industry. For young female factory workers, the environment they live in is one in which there are relatively few places to be safe from the attention of men.

Men are perceived to be the ones initiating sexual contact and of having sex with sex workers soon after puberty. It is not uncommon for men, both single and married, to talk openly about visiting brothels where they can pay women for sex. It is commonly assumed that the married woman will remain monogamous to her husband and the virginal woman will defend her 'good' reputation. This is a feat harder than it seems in a garment factory, as all those working in the factory can lose their reputation if one colleague is deemed to have done something 'bad.' 'Bad', (in Khmer the closest translation is the word 'broken', as in a broken machine) is a word most often used to describe women who sell sex. Its use is a little like 'slag' or 'slut' in English, a term with an elastic definition that makes it difficult to defend. Thus, with the exception of the heterosexual male and married woman, people outside this social norm face substantial barriers that prevent access to sexual health and educational services.

Learning participatory methods

Learning a new method of working and new active participatory tools placed the research team in an extremely vulnerable position. There was a strong chance that the activity would not be 'right' the first time. Moreover, it will not be 'right' in front of colleagues. Given Cambodia's recent traumatic past, this vulnerable position may have negative associations and in a society where status is of crucial importance, I assumed that it would be an additionally demanding experience to become a student and a novice again. Yet, as I write I am astonished at how eager the research team has embraced new ideas and how keenly they have explored new participatory techniques. As confidence has grown, a willingness to try new ideas, to act flexibly and to take the initiative has flourished. Before long, the research team was very impressed at the creativity and skills of the young people with whom they were meeting.

Some teething problems cannot be denied. How many books describing participatory approaches say it is difficult for the researcher 'to hand over the chalk?' This proved to be an extreme understatement. The research team raised certain questions around this issue: 'What if the participants do it wrong? The participants need us to help them!'. As a result, the command 'leave the group' became a frequent refrain – a non-participatory solution to a problem undermining participation. This was directed at the research team who required sensitive questioning by advisors in the evenings after the participatory research to facilitate a process of self-analysis and reflective practice prior to developing improved communication skills.

'The best laid plans of mice and women'

All negotiations with the factory management for the participatory research were, and indeed, still are, extremely flexible, and dates, times and access were established, verbal approval given, letters written and authorisation gained. However, there were sometimes problems, such as the arrival of a manager from China for example, which meant that the work of the factory had to take priority and the research team was told to come back the following week.

"No. No PLA today. Today the big boss has come from China and we have a rush order, so please come back next week! The additional note takers can go home; the helpers to arrange the food need to send it back; the drivers can have the day off; the pens, pencils, paper back to the office; postpone the translators; cancel the house rented for the day; cancel the room booked for synthesis reporting. Make a new plan, keep all the money for another rainy day!"

It was important to have a schedule for the participatory research to enable a degree of panning and co-ordination. This schedule however, had to be responsive and flexible to

the needs of a given situation and to the daily routines of all involved.

The majority of the research itinerary went according to plan. This involved three days working with groups from each factory. There were four groups per factory, each with seven participants. Three of these were all female and one was all male. The participatory activities took place in a house close to, but outside, the factory gates. Inside the factory it was impossible to establish any privacy or a relaxed trusting atmosphere. One exception to this was where the research team and the participants were talking about their lives in an office next door to an angry boss. This seemed to limit the discussion somewhat.

The schedule for the research was three full days, starting with discussions on working, living conditions and general concerns. Day two examined general health concerns, women's and men's health concerns, knowledge about men's and women's bodies, contraception and conception. Leaflets about infections of the genito-urinary tract were handed out, along with payment for attending[2]. By day three, the conversations were about sex, relationships and their own personal sexual history. At the end of day three the participants were asked for their evaluation and they received referral slips to a local NGO clinic for a free medical examination. In general the participants reported many favourable comments about the activities; only one man did not like drawing naked bodies. Tools used included mapping, transect walks, listing and ranking, matrix design, Venn diagram, seaonality analysis, thought bubbles, causality analysis, role play, sex census and body mapping (see Figure 1).

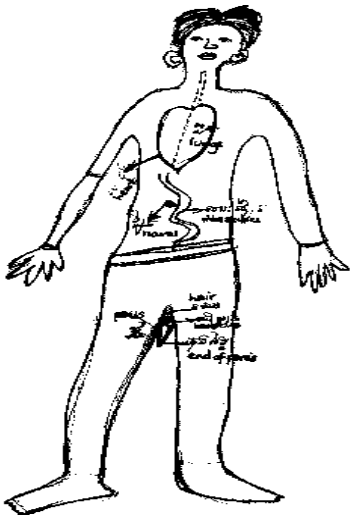

Figure 1. Drawing of male reproductive organs by young men, Factory Y, 5th April 1999

A closed way of opening up

We ran into a problem at the first experience of using participatory methods with a group of young single women. Although the female researchers initially expressed confidence in their ability to talk about sex openly, after all they were midwives, they found themselves unable to ask 'good' women about possible 'bad' behaviour. The tool agreed upon to learn about young women's actual behaviour was adapted for use in Cambodia from CARE Zambia - the Closed Paper method[3].

After discussion with the research team, I stepped in and asked the participants if the researchers could ask them personal questions. The participants agreed without hesitation, but the researchers still remained uncomfortable. In halting Khmer I asked about the young women's sexual relationships. When the scrap bits of paper came in with symbols that represented the replies, the researcher charged with noting down the answers found it difficult to remain quiet and not share the answers with us all.

[2] There were many debates about payments. In this instance, the young workers were missing the opportunity to work overtime. And, as the research shows, they have barely enough money to cover their living expenses. It was decided to respect their time and work with money, as indeed all the researchers were being paid.

[3] The closed paper tool is a method whereby the participants are asked some personal questions and they place a symbol on to a piece of paper in reply. The replies remain anonymous, so a major disadvantage to this method is that there is no discussion.

Her eyes lit up. She went from sitting on the floor to sitting on her feet. The participants remained calm and apparently unperturbed by our flapping.

By the end of this session, the method yielded little in the way of direct information, but it somehow facilitated trust. Many questions poured out from the participants; questions the young women had previously felt unable to ask anyone for fear of gaining a 'bad woman' label. In the following three months of fieldwork, it seems that though this is still a sensitive subject, questions about sex in a personal situation as opposed to a medical setting of midwife and patient can now be asked and responses acknowledged in a supportive style.

Other methods

Methods of body mapping involved drawing around another member of the group and this resulted in much laughter. Role-play turned into team role-play. Often the participants were too shy to speak, but in teams with one person nominated as a spokesperson, other members of their team could whisper questions to ask or suggest replies to make. All were shy but equally, all members participated and enjoyed this approach. At times, hilarity from one group caused a disturbance to another in the adjoining room. Role-play, as with all the methods, was selected to offer the research team and future health providers an insight into the thinking, attitudes and behaviour of the young target population. It was hoped that this would help to identify areas for potential health promotion activities and to enable the young people to practice negotiation through conversation. Often the role-plays resulted in agreement for blood screening or agreement for condom use without a great deal of negotiation (see Box 1). The researchers helped with ideas for a scenario; it is hoped in future participatory activities that the project staff will be more able to empower the participants to take this control and the initiative.

BOX 1
SCRIPT FROM A ROLE PLAY – MEN

Husband wants to use a condom what does he say to his wife?

Moderator:	Who is a volunteer to be a wife? Who is a brave man?
Participant:	I am looking I am not brave!
Moderator:	I like to have the volunteer so that you can explore your own words, can you play as a wife?

Lots of negotiation with the participants before the role-play started

Husband	Now we have 2 children, I am also busy with my job and our life is not so good, I like you to use birth spacing so that you have no problems. I will use a condom what is your idea?
Wife	Up to your decision dear!
Moderator	Any more ideas?
Husband	Don't you think my idea is strange
Wife	Strange or not, this is your business. You may have a bed with other women.
Husband	If you don't mind so I decide to use a condom, I think I shall use, what do you think?
Wife	Up to the man
Husband	Now can we have fuck?
Participant	Don't you think your husband has an infection?
Participant	Do you have infection that's why you want to use the condom?
Participant	Do you have another woman that's why you worry about infection?
Husband	I don't have infection but I want to space the birth. If we have many children it will cause problem to our job. If you have a job with one company and you take leave for delivery your salary will be cut down from $100 to $50 so our life will get down a little.

Cartoon drawings were used to represent relationships and events in a person's life. Drawing was enjoyed and in some groups everyone sat around the paper and added to the story of a girl/boy relationship. The story flowed in a circle with the chatter. Animated discussions took root over how to draw specific parts of the picture, for example, how should the hair of a young woman be drawn; in bunches? Parted? Parted to which side? What colour should the hands be drawn? etc. The drawing had to be *'sa-at'*, a word translated as beautiful, but also meaning clean and smart. The participants were clearly concerned about drawing the picture wrong.

Reports documenting the experiences of such participatory research are very important, but they are difficult to plan correctly. Should they be written on a daily basis? Should they synthesise the research of all the separate research groups? Which language should they be prepared in? At which point should they be translated? Should the final reports be easy to read but include an in depth analysis of young people's complex interpretation of the world around them? What about process reports of how and why and what happened with the use of participatory tools for sexual health with garment workers?

We planned time for reporting but this was too short. Redrawing the visual outputs, reflecting on experiences and translating to English after each session left little room for anything else. Translation was necessary to give appropriate aid with areas that required further probing. Fortunately further funding from FOCUS and CARE allowed us to recruit a consultant who was fluent in Khmer language and skilled in analysis. With support, the research staff analysed and produced their first report. In order to share our experiences of using participatory approaches and to provide a tool which would help with further capacity building, the final report was written in English.

Findings from the process

The project has succeeded in introducing a participatory concept to the project staff. Difficult as it is to measure success, project staff have clearly improved their facilitation skills and gained confidence as advocates for young people. The main concern and pressure throughout has been that of time: time to spend additional project funds was too short as was time for the Cambodian staff to fully understand and adapt a participatory approach before applying it to research. There was also not enough time to analyse the piles of information collected during the study, yet the staff did it and did it well.

A lesson learnt was that the tools needed to be more specific and more time was needed for flexibility. This would enable questions to be asked about what a specific group thought about contraception, what that group's mothers thought; what were the advantages and disadvantages of different methods of contraception rather than just ranking them. The research team had little exposure to experiences of probing; initially activities resembled a question and answer session. Thus while advantages and disadvantages of contraceptives may have been discussed amongst the participants with more experienced facilitation, it was not found to be the case in our first experiences of using participation in research.

Additionally, as it was a needs assessment, bounded by time and resources, specificity of tools would have been more timely and beneficial. Finally, working with 12 groups and using a range of tools, the researchers were able to cross reference and triangulate information learnt. However, due to the flexibility of the researchers approach to a subject, this was a challenging feat at times.

• Future and sustainability

The three factories involved in the participatory research were all invited to send representatives from the management, health staff and factory workers to a presentation with CARE and its local partners. Each factory sent at least two representatives who entered into discussions on the research findings and suggestions for future action. The project staff then visited the factory manager several more times to agree on an action and continued access for CARE and its partners.

At every stage of the process factory management has been and will continue to be actively involved as much as their many work pressures will allow. The factory workers remain interested and enthusiastic to commit whatever time they have free to participatory health activities. In terms of long term sustainability, the future is by no means certain. It is extremely dependent on the growth of the nascent garment industry, the growth and stability of the national and regional economy and the whim of the factory management. The aim is to try and make a demonstrable difference to the smooth running of the factory that would inspire some of the managers and owners to institutionalise improved health services. Managers are supportive with our involvement, one factory manager was proud to a show a potential European garment buyer their renovated health clinic.

Needs identified during the process of the research have resulted in all the factory health staff receiving additional training in STI management and contraceptives, as have the local NGO counterparts. Five factory clinics were renovated and will be intensively supported for six months whereupon the support will be reviewed. Participatory health activities over 2 months per factory with six groups of 15 workers each (4 groups of women and 2 groups of men) will hopefully offer factual information, challenge rumours and lead to a supportive environment for change.

A participatory approach to research is only a beginning of a process. As the project continues, we have time to further develop facilitation and probing skills. Furthermore, we have more time to put into question many of the cultural beliefs that the Cambodian staff continue to accept unquestioningly. Only by coming to terms with the effects of their own cultural beliefs can staff enable the factory workers to gain an insight into the social constructs of gender that perpetuate many a risky relationship. It is believed that components are in place for change. The female workers are in a unique position compared to their grandmothers and mothers; they have the opportunity for independent paid employment, the opportunity for independent living, and an opportunity, however rudimentary, to question social constructs that hinder informed choice. The process of change is beginning.

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NOTES

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12

Participatory learning and action requires good facilitators - who aren't always around

Andrew Hobbs and Mary Simasiku

· 'Good enough' participatory learning

We believe strongly in the value of new participatory research methods as a way of stimulating high-quality learning of facts and skills, and awareness of new attitudes to improve people's sexual health. Such methods would include mapping, ranking and scoring, 'problem trees', transect walks, time-lines, daily and seasonal schedules, pie-charts, flow charts and Venn diagrams. However, many of these methods require good facilitation, which is not always available.

But if we could put the skills and experience of a good facilitator down on paper (in a book) in an easy-to-understand way, then many more people would be able to facilitate participatory activities. This was our approach to the problem. We accept that a lower level of facilitation skills may reduce the quality of the learning that takes place, but the big advantage is that it greatly increases the quantity of learning. All that is needed is a group, a literate person with the confidence to speak in front of the group, and the book. The quality of learning will be higher if the facilitator has had some training, but even without training, it will be 'good enough'.

The request: a sexual health training pack for use with non-literate young people

This request came from a US NGO, Project Concern International (Zambia). They had part-funded a book of 50 participatory learning activities on sexual health for young people, produced by a Zambian NGO, the Family Health Trust. The book, 'Happy, Healthy & Safe', was targeted at school-going children and youth from ten years upwards. What made it unique was that it was designed to be used by young facilitators rather than adults, with easy-to-follow instructions (scripts, almost) requiring minimal training or facilitation skills. This approach allowed facilitators as young as 12 to lead groups of their peers in activities such as role-play, games and discussions, after an hour's preparation with an adult (older teenagers and trained peer educators needed no coaching at all).

Project Concern saw the need for a similar peer trainer's book that could be used with out-of-school youth possessing little or no literacy. At the same time, the Lusaka Interfaith HIV/AIDS Networking Group, who were working with Project Concern, identified the need for educational materials suitable for religious youth.

So in May 1998, Andrew Hobbs, one of the authors of 'Happy, Healthy & Safe', was contracted for two months to produce a training resource suitable for low-literacy groups of youth attached to religious organisations.

· Participatory research, the ideal approach (or so we thought)

The use of participatory research and the related tools seemed ideal: a participatory, empowering philosophy, a body of techniques that required no literacy, and a track record of use in sexual health promotion. 'Stepping Stones' is the obvious example, with its mix of drama and 'new' participatory methods, as well as participatory needs assessments of

sexual and reproductive health by CARE Zambia.

But even such approaches as these required too high a level of facilitation skills for the group with whom we were working. The plan was to gather a team of young people who led youth groups at their places of worship and train them in participatory research techniques. Then, together, we would develop and trial a sequence of learning activities and write them down in an easy-to-use trainer's manual.

Andrew Hobbs recruited three other facilitators: Mary Simasiku from CARE, an experienced practitioner of participatory methods; Richard Mambwe, a talented young writer and researcher, and Holo Hachonda, knowledgeable in HIV prevention training with religious youth groups.

The young people themselves comprised three young women and seven young men (two Muslim, eight Christian) aged 18-23, who were recruited mainly from youth groups linked to the Interfaith network. Exceptionally talented and committed, they worked on the programme one or two days a week for expenses only, even during the World Cup!

We began with three days of non-residential training. The aims of this induction were to enable participants to:

- explain the basic facts of sexual health;
- challenge attitudes and beliefs that can lead to poor sexual health;
- explain what their religion teaches about relationships, sex, health and self-esteem;
- agree the topics to be included in the learning pack;
- facilitate participatory activities;
- conduct basic research using participatory techniques; and,
- pre-test and evaluate participatory learning activities.

The first half of the programme concentrated on information about sexual health, plus religious attitudes to sexual health and HIV (including a gender awareness session from a Zambian nun who runs a women's refuge). The second half looked at different ways of raising these issues and preventing HIV with religious youth groups, looking at the use of participatory methods in particular.

Mary Simasiku introduced a range of methods including problem trees (flow charts), unfinished drama sketches, picture codes, mapping, seasonal and daily calendars, Venn diagrams, ranking and scoring.

The induction programme was somewhat over-ambitious, but succeeded in setting a friendly, informal and tolerant atmosphere and establishing the basis of participatory research.

Together we decided the topics to be covered in the manual:

- values;
- recognising risk;
- communication skills;
- positive and negative peer pressure;
- sexual relationships;
- biological facts, where to get help;
- how to talk to parents; and,
- how to live positively with HIV.

After the induction, participants were asked to go back to their youth groups and conduct a simple piece of participatory research, using techniques such as mapping, problem trees and focus groups. This allowed them to practise the techniques and provided information about the target group of the learning pack. They returned the following week with maps, diagrams and discussion notes which confirmed the group's choice of topics for inclusion in the manual and the suitability of participatory methods.

How we wrote the book: a cycle of action and reflection

We met for each Thursday every week for the next seven weeks. Richard and Andrew would draft instructions for two to three participatory activities, sometimes drawing on their own experience and sometimes adapting learning activities from other books. The young people used the instructions to lead us all in the activity, then we reviewed the activity and instructions, and developed their facilitation skills through coaching. We tried to make the Thursdays fun for the participants.

Before the following Thursday, the young people went back to their own youth groups and facilitated the same activities. When we met again, each person reported how last week's activity had gone at their church or mosque and suggested improvements, before moving on to the current week's activities.
During the time between Thursdays, Richard and Andrew researched and wrote the background biology and theology for each activity, and Andrew re-drafted previous instructions. Twice during this period we met religious leaders from the Interfaith group and went through drafts together. Their response was encouraging. These review meetings probably helped to allay the leaders' fears and build their confidence in what the young people were producing, to the extent that they approved material which presented condoms in a positive light, which was previously unheard of in religious approaches to sexual health promotion.

As the Thursdays hurtled by, something peculiar started to happen. Instead of the young people using activities devised by Richard and Andrew, they began to devise their own. For example, on how to talk to parents about boyfriends and girlfriends, they came up with two possibilities, which we reviewed together before choosing the best. This was a two-minute unfinished sketch of a mother outraged by her daughter asking a question about pregnancy. There were suggested discussion questions, a role-play to practice broaching difficult subjects with parents, and a final discussion. It was as good as anything in a modern training manual.

The team also became able and confident facilitators. They contributed to the background information, helped to brief an illustrator, planned and starred in the book's photographs, and chose the title ('Treasuring The Gift: How to handle God's gift of sex'). During the last session we discussed how the book could be disseminated - they were impatient to get out there and show other young people their book.

Three months after the Interfaith group gave the go-ahead, they were presented with a 142-page photocopiable draft, containing 18 learning sessions supported by 47 pages of background information. The book's message was that the religious 'Plan A' of 'no sex without marriage' can be good for sexual health, but we also need a 'Plan B' of harm minimisation.

The book's methodology: drama, rather than mapping, diagramming, ranking, scoring or calendars

Together we devised and adapted more than 30 participatory learning sessions. The 18 that we selected to go in the book are overwhelmingly drama-based, in which groups are asked to watch unfinished, open-ended drama sketches, to devise sketches themselves, or to role-play difficult situations. The drama stimulated discussion, and the role-playing allowed practice of skills (see Figure 1). The 18 sessions were combinations of 21 drama-based activities and 18 non-drama activities.

The non-drama activities include short bursts of teaching (e.g. about HIV infection and prevention, sexually transmitted diseases and religious teachings), problem trees, brainstorming, games, drawing, a picture code, quizzes, hot-seating and a ranking exercise. In hot-seating, one person takes on a role, sits in the hot-seat and is questioned by the rest of the group. They improvise their answers, based on their idea for the character, so gradually, through the questions and answers, a picture of the character and their behaviour are built up.

We had not planned it this way. The drama and role-playing won out because drama is very popular in Zambia as a pastime, as an educational method and as entertainment. Therefore the young facilitators were more confident with drama than with other methods, and needed less coaching in how to facilitate it. But unfamiliarity was not the only reason for using fewer 'new' participatory methods, such as problem trees and ranking and scoring. Our final product had to be a book that could be used by facilitators with little or no training in participatory methods, in meetings where no more than two hours would be devoted to the activities, and that seemed to rule out all but the simplest methods. Let us say that the essence of participatory research is to let the group's concerns set the agenda, with the facilitator suggesting the most appropriate tool for the task in hand. If the group needs to

listen to its quieter voices, there are suitable activities; if it needs to become aware of the varying needs and beliefs within the group, again there are tools, and so on with observation, analysis, decision-making and planning.

In this situation, a facilitator needs to have the confidence to 'go with the flow', without knowing what he or she might be called upon to do in an hour's time. The facilitator needs experience of a wide repertoire of activities, the creativity to invent some new ones, the judgement to choose the right activity at the right moment, plus all the usual group facilitation skills. None of this comes quickly or easily. By the end of the two months, our team of young facilitators were capable of such facilitation, but by then we had run out of time, because we had run out of money.

The strength of the approach of 'Treasuring The Gift' is that a facilitator only has to read the instructions aloud, and things happen. The book is very easy to use, the instructions are simple and a young person with only a few days' training can use it successfully. Indeed, during pre-testing, some young people who were not part of the programme and had had no training at all, used the book to lead groups. The strength of good participatory facilitation, its creative, improvisational quality, can't be written down, and we needed something that could be written down.

Figure 1. Three of the 'Treasuring the Gift' development team – Richard Mambwe, Mizzeck Banda and Albert Canteen, in a role play about negative peer pressure [Photo: A. Hobbs]

· Conclusion

We could have approached our challenge in other ways, and there are no short cuts to success. Our solution was a compromise. There is a danger that entrusting facilitation to young people with a low level of skill and experience can do more harm than good. We hope that evaluation will assess this risk, but the pre-testing that was part of the book's development showed no sign of any harm.

We have written this article as the opening of a conversation. We would like to hear what others think about the following questions.

- How important is good facilitation for good participatory research?
- Can we put good facilitation down on paper without killing it?
- What can we do about the shortage of good facilitators?
- What experiences are there of unskilled facilitation doing more harm than good?
- What are young people's experiences of facilitating participatory research?

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Moving beyond the 'KAP GAP': A community based reproductive health programme in Eastern Province, Zambia

Gill Gordon and Florence Phiri

• The problem

Over and over again, we read that populations have a high level of knowledge of contraception and AIDS but this does not necessarily translate into safer sexual practice. We know that information alone is rarely enough to bring about a sustained change in behaviour and we must address the underlying determinants of behaviour by creating more supportive and enabling environments. Gender relations, socio-economic power, support and self-esteem are key components of these environments. Often the response to this so-called 'KAP[1]-GAP' is a recommendation for more research to inform more targeted, persuasive messages, disseminated through social marketing or campaigns.

Until recently, family planning programmes have largely reached married women in their child-bearing years and sexual health programmes have reached men with sexually transmitted infections (STI). With the AIDS epidemic, condom use may now be reported as being for contraception *or* STI/HIV prevention. Adolescents have been at best provided with Family Life Education at school and/or local puberty instruction on how women and, occasionally men, are expected to behave. Older people rarely have access to sexual and reproductive health (SRH) services that meet their specific needs. Often there are separate service delivery points or days for each SRH service. Other SRH needs such as sexual violence and abuse, abortion and emergency contraception, sexual information and problems are often only provided through private practitioners, if at all.

This fragmentation of services, education and user groups has made it more difficult to achieve behaviour change and therefore improvements in SRH. Many men are concerned about the effect of hormonal contraceptives on the body and suspicious of their partner's motives for using them. There is also a tendency for men not to tell their partners when they have an infection and it is widely felt that condoms are associated with disease and improper sex. Many family planning providers see condoms as a backup method for married women before the pill or contraceptive injection kicks in and tend not to promote them for prevention of infection.

This article describes a more holistic SRH health project in the Eastern Province of Zambia. It focuses on participatory approaches used, gender issues, male involvement and the integration of SRH issues at community and clinic levels. The article aims to demonstrate the opportunities and challenges faced by a government programme that uses participatory approaches in its everyday work to achieve the vision committed to at the International Conference on Population and Development held in Cairo in 1994.

The community based distribution (CBD) project

In CBD programmes, men and women are selected by the community to be trained as family planning workers. Until recently, these programmes have aimed to motivate people to plan their families and have distributed

[1] KAP stands for Knowledge, Attitude, Practice; and refers to the idea that if people have knowledge and positive attitudes, they will change their behaviour.

condoms, spermicides and pills to people in their neighbourhood. The Zambia CBD project began in Eastern Province in 1994 and is being implemented by the Planned Parenthood Association of Zambia (PPAZ) and the Ministry of Health of the Government of Zambia with technical assistance provided by Options Consultancy Services and funding from the UK Department for International Development (DfID). The project has trained 220 men and women to work as CBD agents in six districts.

As a process project, the team has had the resources and flexibility to test out innovative approaches. These focus on ways to actively involve all community members in project design, implementation, monitoring and evaluation, to integrate SRH issues, to address the underlying determinants of behaviour and to foster NGO, CSO and government collaboration. Participatory activities include participatory research; 'Stepping Stones'[2] activities; interactive use of visual and performing arts; non-directive counselling and regular sharing sessions on progress between all community, NGO and government stakeholders.

The CBD agents

CBD agents are men and women between 24 and 55 years old, mainly farmers with around seven years of schooling. They live in their own villages and serve a catchment area of around ten kilometres radius. They are provided with a small financial allowance, bicycles, contraceptives and locally produced brochures, flipcharts and booklets[3]. They receive a four-week training which includes interpersonal communication skills, counselling, group work and participatory skills, producing simple drawings and role-play or songs as discussion starters and some Stepping Stones activities. Emphasis is placed on attitudes and behaviour, particularly in relation to gender, age and sexuality. Content includes contraceptives, condoms, STI, HIV/AIDS, abortion and emergency contraception, sexuality, managing logistics and planning their work. During the training, the CBD agents explore their own ideas and values in relation to SRH in the same way that they will later assist the communities. They work in separate sex and age groups and then share their ideas in plenary.

Participatory group work

Rural Health Centre staff supervise the CBD agents and support them in community work. They begin by explaining the project to the chief and headmen. A full community meeting is then organised where the work of the CBD agents is explained and people are invited to meet the CBD agent in six peer groups to discuss their needs and how they might like to work with the CBD agents. Peer groups comprise adolescent boys and girls, young men and women, and mature men and women. At the first meetings, the CBD agents facilitate participatory activities aimed at identifying the groups' idea of good SRH and priority problems; analysing the causes and consequences of these problems, looking at what they have tried, the achievements and challenges associated with the problems, and what actions they wish to take. The groups then hold in-depth discussions on priority problems using pictures, role-play, song and information sharing.

Work in separate peer groups is a key principle of the process. This gives people privacy and safety to explore their own values and feelings about their sexual lives without domination, sexual overtones or cultural expectations of age or gendered behaviour. The importance of this principle was reflected in Ghana when peer motivators began a group discussion with men and women on what helped sex to be pleasurable. The men launched into an excited sharing of the importance of physical beauty and female compliance with their desires and why women were so ready to have sex after minimal persuasion. The women were silent and angry. When it was suggested that the men and women go into separate groups and meet after some private discussion, the women

[2] Stepping Stones, written by Alice Welbourn, is a guide for a series of learning sessions on SRH, communications and relationship skills. It used participatory drama and drawing and is designed to be used with peer groups in communities.

[3] CBD Booklets on related issues can be downloaded from Options' website: www.options.co.uk. :

unanimously agreed that their partners' refusal to allow them to use contraception and fear of pregnancy was their major barrier to pleasure. When the groups met again, the women explained this to the men and a helpful discussion followed.

Counselling

Non-directive counselling is very important in sexual health programmes. It provides an opportunity for clients to explore their situation, to talk openly about their feelings and needs, to be listened to with empathy and confidentiality and to find ways of meeting their needs. The CBD agents provide counselling to men and women of all ages, separately or together on request. Many clients seek counselling following the peer group meetings. Male agents counsel women as well as men and visa-versa. Men rarely have an opportunity to discuss these issues. In Zambia, staff and communities reported that having time to express their anxieties about contraception and relationships was key to their acceptance of this service. Men with few resources have voiced fears that contraceptives will enable their partners to form relationships with richer or more virile men and leave them. As a result of the counselling and group work, there have been noticeable changes. Some men have stopped taking their wives' pills with them when they travel to prevent them from having affairs and instead are supporting them to take their pills correctly.

CBD agents were sometimes accused of having affairs because they counselled clients and provided contraceptives in a private place without their partners if they wished. This was most likely to happen with male agents and female clients. However, women have also accused the agents of providing condoms to partners and encouraging them to have affairs. As a way of tackling this problem, CBD agents have encouraged people in regular relationships to attend joint counselling together, whilst respecting the client's right to individual, confidential counselling.

Experiences of participatory group work

In the first participatory activity, people worked in separate peer groups and then came together to present their diagrams and findings at an open public meeting. This is normal practice in participatory research and the team did not perceive any risks with it. The young people used this opportunity to accuse the older people of failing to give them sex education and adequate support materially and pressuring young people to have sex with them. Women also expressed their dislike for some of the local customs relating to sexuality. These customs were supposed to be kept secret outside initiation teachings and not be discussed in public or between men and women. Initially the facilitators felt that the experience had been positive because usually submissive people were able to express their needs and feelings in front of those with decision-making power. However, CBD agents later discovered that there had been some negative repercussions in homes after the discussions, and also that some participants felt they had been misled in being asked to share their ideas with those from different generations and the opposite sex when confidentiality had been agreed.

Following this experience, the community leaders asked the CBD agents to meet with people in separate peer groups, without directly sharing their discussions in public meetings. They suggested that the CBD agents should act as mediators or negotiators between groups. They would share ideas from one peer group to another where relevant through role-play, stories or pictures, which would trigger discussion. The groups could then discuss any problems without feeling accused by a community or family member. This would prevent direct confrontations which older men and women found humiliating and responded to defensively.

For example, in Zambia, women complained that some men did not allow them to use contraceptives or refuse sex and this made it impossible to space births. The CBD agents created a set of picture cards, which they used to tell a story about a man who threw away his wife's pills and beat her. They asked the

men's group whether this situation occurred in their community, what were the good and bad points about it, why a man might behave this way and what the consequences might be. They were then invited to re-tell the story in a more positive way according to their perceptions of the situation. This was followed by a discussion on what would help men and women to talk about and agree on sexual decision-making.

This process has worked well but it does not actively encourage communication on sexual matters between the sexes or generations. However, in a participatory evaluation, people reported that men and women were talking more openly about sexuality because they had learnt to talk in peer groups and had greater understanding of the perceptions of others. Teachers, parents and grandparents reported that they now understood that adolescents are having sex in spite of traditional teachings and that they need condoms to protect themselves.

The CBD agents in some communities were trained to use an adapted 'Stepping Stones' process. This process provides several sessions with activities aimed at building trust, confidence and comfort with talking about sexual issues and preparation of drama in separate peer groups before presentation to the other groups. People develop role-plays for analysis in their own discussions and then adapt them for presentation to older or younger people and to the opposite sex. In this process men and women have been able to meet together and discuss in a frank way sensitive issues like condom use among married couples. For example, in one group, women said that they did not mind using condoms, but the men should wash first because they tend to be very dirty from working on the farm. They pointed out how dirty the condom had become when one of the men demonstrated its use.

· The impact of the CBD project

In a participatory evaluation of the Zambia CBD project, the top three positive changes reported by both men and women in equal numbers were good child spacing and its associated benefits, fewer STDs and happier sexual relationships. This indicates that there has been some integration of the components of SRH in the perception of the community. Negative changes reported by fewer groups were the side effects of hormonal contraceptives, poor condom disposal and more sexual activity outside marriage because of reducing the fear of a negative outcome. A few groups mentioned more marital conflict because women were making autonomous decisions about contraception. Men comprised of between 40-60% of the clients and people appreciated that peer group discussions were held in separate peer groups.

The most difficult group to reach was adolescents, mainly because of disapproval from older people. They did not attend meetings and asked for contraceptives to be supplied on the roadside at night. Older men and women also thought that the programme was not relevant to them as people past childbearing.

This was partly because the CBD project had initially been introduced as a family planning project which distributed contraceptives. Those who were not expected to be sexually active did not see its relevance. This highlighted the importance of introducing the project as an integrated SRH intervention that helped people to identify their own needs and design activities to meet them, rather than to vigorously promote the use of contraception to all.

The CBD agents themselves felt that the project had brought many positive changes in their lives and also some negative ones. The men felt than they had become more 'caring and kind' rather than 'brutal and rough' as they were before'. Some said that their relationships with their wives had improved and they no longer had girlfriends as well. Some women said that they were better able to assert themselves and some had made good marriages as a result of the project. Both men and women reported that they were now able to talk about sexuality with groups and individuals and help people with a range of SRH problems. The difficulties of being a CBD agent included the hostility of some parents, partners and religious leaders towards their work and a lack of respect at times because they deal with sexuality.

- **Lessons learned from training staff to use participatory techniques and 'Stepping Stones'**

Working with groups

Facilitating participatory activities in sexuality and gender is a new skill for many health and development workers and they need an opportunity to explore their own values and feelings through participatory processes before they can facilitate others to do the same in a non-judgemental way.

In single sex and age group discussions, people have a degree of common understanding of their situation and shared values. However, this should not be overstated. There is a danger that group closeness encourages people to affirm norms and build consensus rather than express perhaps minority views and harsh realities. For example, a person who is attracted by people of the same sex may find it difficult to even introduce the notion of same sex activity and may receive a very negative response.

Gender and generational issues

Men tend to find it more difficult to talk about personal feelings and experience than women and this can have a major impact on the process. Many women will readily share their vision of a happy sexual life and their experiences of problems such as male abuse and unwanted or unsatisfying sex. Men tend to distance themselves from their personal experiences and feelings by talking about men from a different age group or context. In Stepping Stones training, women performed a role-play showing a day in their own lives as women based on collective experience, whilst men performed a role-play about a behaviour pattern in culturally distinct farmers in a remote rural area.

On the other hand, some men and women seem able to capture the situations, body language and behaviour of the opposite sex perfectly in role-play. Some male CBD agents in Zambia acted the part of women in oppressive or distressing situations so realistically that it brought tears to the eyes of the audience. This appears to show an ability to understand the opposite sex, although this does not necessarily reflect a desire for change.

In one training, men felt that their drawings were too explicit or 'rude' to be shared with women. Members of the young male CBD agents group in the Zambia CBD project used their own slang and showed explicit scenes in a role-play and were reprimanded and asked to apologise by the older men.

Facilitation becomes more difficult when men and women come together to share their ideas. If women's presentations are based on their own lives and men's are not, women can feel aggrieved that they have 'bared their souls' and made themselves vulnerable whilst the men displaced their own concerns on to other groups. Men can tend to feel defensive when women present pictures of 'men behaving badly' and they react by generating an intellectual debate on the validity of the women's perceptions. Situations such as these are difficult for facilitators to handle and people who have personally experienced distressing situations may feel very upset.

A large group of men and women of different ages meeting together can exacerbate the problem because only the most vocal tend to speak and the whole ambience is one of challenge and 'a battle of the sexes' rather than listening and empathy. Arguing with women about sexual matters can be an arousing game for some men and they can use it to maintain control over women, especially young women. In Zambia discussions between generations were also confrontational in some cases, with older people eager to maintain the traditional culture and young people wanting to 'modernise'.

Some solutions to these difficulties

Conflict between groups is not in itself a bad thing; it is a normal part of life. Suppressing conflict limits growth and often has negative repercussions. We can use conflict constructively to build understanding and move things forward in a positive way. However, this requires training and practise in conflict management.

An important principle of all SRH work is that people are not pressured or manipulated to disclose personal experiences or feelings unless they are ready. If peer groups have different degrees of willingness to share personal feelings, it is not helpful to make those who are less willing feel inadequate. They need time, encouragement and supportive facilitation.

In a training with participants from South Asia, we found it helpful to divide the whole group into smaller groups of men and women, perhaps four or six. People in the small groups are asked to take it in turns to talk about their ideas for five minutes while the others actively listen and empathise. After each person has finished, the group members feedback the most important thing they have understood. When everyone has spoken, people identify the similarities and differences in their perceptions and how they can work together to improve things. This practice in expressing ideas with and listening to the opposite sex in an unthreatening way resulted in a significant increase in discussions between men and women.

When peer groups include two or three generations, this method could help adolescents and parents or older relatives to talk together more easily, with groups deciding who should sit together (in Zambia in-laws are forbidden to discuss sexual matters together.)

· Conclusions

The integration of the different components of SRH makes programmes relevant to all community groups. Men and women, boys and girls, need opportunities to work in separate peer groups in a private space to identify their own priorities and actions.

Sharing of needs, feelings and suggestions for improving their sexual lives between peer groups can accomplish a number of goals, depending on how it is organised. Programme workers can act as mediators between groups to share ideas in a non-threatening way. Small group sharing between men and women, young and old allows people to practise talking together about sensitive topics and develop mutual understanding. Public presentations from peer groups can act as a powerful advocacy tool for change at community level and result in dramatic change. For example, in an evaluation of Stepping Stones in Uganda, the older men's group put on a drama about a local man who demanded sexual favours in return for employment and requested him to stop this behaviour. He was publicly shamed and it was reported that he had since ceased harassing women. Drama by adolescent girls about harassment by sugar daddies had the same effect. (ActionAid, Redd Barna, Kahcae, Aegy 1998) 'The teeth that are close together can bite the meat': a participatory review of Stepping Stones in two communities in Uganda. SSTAP, ActionAid. London, UK).

Men and women, young and old may respond differently to participatory work in SRH in context specific ways. It is essential to continually review and adapt the process as it goes along in order to find the most helpful approaches for all those involved.

Facilitation skills are play an essential role for safely and successfully using participatory processes in SRH. They take time and practice to acquire. Programmes should aim to design participatory processes that match the level of skill of the majority of facilitators in order not to undermine facilitators and put everyone at risk.

Opportunities for individual, couple or family counselling are crucial in SRH because many personal issues and feelings will not, rightly, be discussed in a group situation.

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14

Gambian experiences with Stepping Stones: 1996-99

Matthew Shaw and Michelle Jawo

• Introduction

The Gambia is an Islamic, Anglophone country situated in the middle of Senegal in West Africa. Its population is about 1.1 million, spread along the banks of the River Gambia. The main economic activity is subsistence agriculture (groundnuts, millet, livestock) and fishing. HIV prevalence is quite low at about 2% of the population and as yet no-one has publicly declared themselves to be HIV positive. Therefore many people are doubtful that HIV really exists. Moreover, many men are suspicious of Family Planning (including condoms) and this view is strongly supported by some Muslim clerics who believe it to be against the Koran. For economic reasons, men like to have many children, if they live in a rural area. In one area, the total fertility rate for men is 12.0 compared with 6.8 for women; men achieve this impressive fertility through polygamy (Hill and Ratcliffe, 1998-9). The practice of male and female circumcision is widely practised, as in other North African countries. For women, this usually consists of a type 2 circumcision, where the clitoris, clitoral hood and labia minora are removed without closure of the vagina.

What is Stepping Stones ?

The 'Stepping Stones Gambia' project is a collaboration between five organisations; The Gambian Department of State for Health, ActionAid - The Gambia (AATG), Gambian Family Planning Association (GFPA), Medical Research Council (MRC) - UK and the World Wide Evangelisation for Christ Mission (WEC). The partnership began in 1997 to adapt, implement and evaluate the original Stepping Stones workshop programme (Welbourn 1995). This is a manual describing a series of participatory exercises designed to facilitate HIV prevention by encouraging a gender analysis of sex and its context. The workshops then move into assertiveness training, encouraging participants to be assertive about their feelings and dialogue with their partners, focusing on communication and relationship skills. It was originally designed for use in Sub-Saharan Africa, although has since been adapted and used in many different countries across the world. It operates around a workshop structure, with separate peer age and gender groups.

As outlined in the beginning of the Stepping Stones manual, the traditional ABC HIV prevention message (Abstain, Be faithful, use Condoms) is impractical. Abstinence is undesirable to most people, except in certain situations, such as after childbirth, and when not abstaining, condom use is unacceptable. It is unacceptable within marriage because of its contraceptive effect and generally, because it carries the message that one partner suspects the other of infidelity. When husbands have to support several wives, they may not have enough money to support them and their children adequately; providing an incentive for wives to seek help elsewhere.

Stepping Stones Gambia started because it was felt that the programme could help villagers develop more sensitive solutions to the problems of HIV prevention. One reason we have found the programme effective is that participants meet in age-sex peer groups: usually young men, young women, old men, old women. In the Gambia, (as in many African countries) this is the only forum in which sexual matters can be discussed relatively freely. Most villages are organised in these groups anyway and these are known as *kafos*.

The workshops last for about 10 one-day sessions. Within this period, the *kafos* meet twice to perform 'frozen pictures' or tableaux to each other. The way the workshops are arranged encourages assertiveness between groups of people. Peer group members can have sensitive conversations within their group, but can select what messages they give to other groups. This culminates in the final community workshop where each peer group makes a 'special request' to the whole assembled village, participants and non-participants alike.

Adaptation

Following discussions, the workshop programme of this original Stepping Stones programme was adapted in a number of ways and a Gambian Stepping Stones manual will be published shortly. Although very similar to the mother manual there are some changes. Certain exercises, such as those involving alcohol, were omitted, because the Gambia is an Islamic country, with very little alcohol. It was decided not to use video because electrification is rare in rural villages and very few organisations have portable screening facilities.

Entry into the village was a big problem. We often found men suspicious that this was a secret birth control programme, so we presented it as an infertility prevention package. Sexually transmitted infection is the biggest cause of infertility, and the way to prevent infertility is the same as to prevent HIV. This infertility approach proved to be very popular and we included exercises on 'questions and answers on sexually transmitted infections' and the causes of infertility as well as advice on how to conceive, drawing from the South African adaptation of the same training manual (Jewkes and Cornwall 1995). Most villagers did not know about the fertile period in a woman's menstrual cycle, even though delay in conceiving can often cause problems.

Many communities often guess well what development workers want to hear and play along because they think this will improve potential benefits. So we started the programme with a blind matrix scoring exercise on health priorities. Facilitators used the fact that they represented a coalition of organisations to prevent people guessing their area of interest. We did this to try and assess how close the villagers' agenda was to ours. Sexual health problems tended to fall in the top 5, usually sexually transmitted infections, sexual weakness or HIV. In the last case, HIV, villagers felt they were ignorant about something they had gathered was an important issue.

Sometimes the men were concerned that when we took the women away for their separate meeting we might inject them with Depo-Provera[1]. So it was important for the participants to know that every group did exactly the same exercises. The one exercise in the original manual where women do a slightly different activity was modified.

We also added body mapping of sexual 'turn-ons' and 'turn-offs'. This was to enable discussion of the difficult subject of female circumcision and orgasm. However female circumcision was not an urgent priority for the villagers, although there were other problems to do with the sex act itself. Exercise 'M' from the original manual (about will-making) was not included in our first adaptation because in the Gambia, the extended family has a responsibility to care for the bereaved. However we are now planning to include a modified version to try and have an impact on gender inequality in inheritance, which can contribute to poverty and financial dependence on sexual partners.

The basic structure of the workshop programme remains similar to that of the original Stepping Stones programme. An additional inter-peer group meeting was added so that the groups meet three times before having the final community meeting. More recently we have altered the exercise preparing for the final community workshop. Next time we will ask peer groups to produce a Group Action Plan based on 3 changes that they would like to see. They are then asked to select one of these changes to be presented as a 'special request' to the community. This means that the 'special request' is not necessarily the *most* important change that

[1]A contraceptive.

each peer group would like to see, but may be the one which is *hardest* to achieve without the support of the rest of the community. Also, we found that preparation for the post workshop review has been weak. Yet this is most important for sustainability as it may lead to continued community mobilisation.

Timing of the programme.

Programme timing was very important. The Gambia has three rainy months every year, when all villagers are preoccupied with planting. The original manual suggested spreading the workshop over 9 weeks. Although the dry season would be the obvious time to run the programme, a PRA exercise suggested that many people migrated to the urban areas during this period. Therefore the pilot study took place in the harvest season as a compromise. Thus we could only work one day a week on the farmers' day off. This was the second time the GFPA teams had run the programme, and (although they felt pressed for time), they managed to cover all twenty six sessions in 10 days. We would recommend 14 days as the ideal length of time required.

Pilot evaluation

The MRC ran a pilot evaluation of the programme in the GFPA areas. This included a fieldwork report (process evaluation), interviews, focus groups and a KAP (Knowledge, Attitude, Practice) survey[2]. We also planned a participatory evaluation although unfortunately, because of some confusion, the peer groups did not set their own targets for the changes they would like to see. The facilitators were asked to record the output of the workshops each week. However they tended to write down absolutely everything that happened. This made them less effective as facilitators, and made it very difficult to produce a field report at the end. The second time round, the exercises where it was important to record things, were clearly identified. When the Gambian Stepping Stones manual is produced it will include preprinted reporting forms for photocopying, designed to make a report readable when put together.

The pilot villages were small hamlets with populations of 158 and 250. About half the population over 17 participated in each community. More women participated because of the population structure of the villages. Shortly after it began, MRC field workers interviewed 140 people (participants and non-participants) chosen at random from the two villages involved in the programme, and two control communities. The questionnaire included knowledge questions about the transmission and prevention of sexually transmitted infections and HIV, as well as questions about attitude. We also tried using 'secret ballots'. We believe this technique was invented by a local anti-circumcision NGO (BAFROW). Ballot forms were give to each member of the peer group. When the facilitator read out the question participants had to mark a triangle for yes, a circle for no or nothing for 'don't know'. At the end of the session participants, folded their ballot sheet and put it in a hat. The ballots were therefore anonymous but the peer groups were known, enabling us to analyse the responses by age, and sex (see Box 1).

BOX 1

SOME EXAMPLE OF QUESTIONS USED IN THE SECRET BALLOT

- Have you talked to your partner about sexually transmitted infections in the last year?
- Are you responsible for any children under 16?
- If so, have you discussed the bad side of sexual relationships with these children in the last year?
- Can a man or woman be infected with a sexually transmitted infection but not have any symptoms?
- Can a man have a discharge from his penis without having sex?
- If someone has a sexually transmitted infection which is treated and cured, is it OK to resume sex with their partner?
- Is a woman most fertile on the day after her menses?
- Can sexually transmitted infection make a woman barren?

[2] A KAP survey is a formal questionnaire, based on a fairly rigid model, which tends to focus on health education.

• Results

Six weeks after the programme finished, we returned and conducted 50 key informant interviews, seven focus groups and repeated the KAP survey (140 interviews) and secret ballot. We will repeat these shortly, when a year has passed since the original intervention. Comparison of the 'before and after' results showed that intervention villages had gained a good understanding of the issues.

The KAP survey showed a significant increase in knowledge about sexually transmitted infections after Stepping Stones for women. However this is biased by the fact that young women are proportionally the largest participating group. When further analysed by age, the old women *kafos* usually gained least, maybe because many of them are no longer sexually active and the issues are less personally relevant. Men showed a strong trend in improved knowledge, but because they knew more in the first place, these changes were not significant. In most cases improvements could be seen when participants and non-participants from the Stepping Stones communities were included, even though workshop participants tended to keep their new knowledge to themselves rather than go out and share it. We did not set our expectations very high; e.g. knowing at least one way in which HIV can be transmitted earned a point. However at baseline, only half the women could answer this question. Next we will examine the men's responses using more stringent criteria.

In particular we found a much greater awareness of the risk of sexual activity in general and an appreciation by men of the importance of supporting their wives financially. The KAP survey supported the interviews in these results. For example 11/28 (39%) of women considered themselves to be at risk from HIV before the programme compared with 35/43 (81%) after the programme. Women in polygamous marriages were 9.7 times more likely to consider themselves at risk. These quotes are taken from recorded interviews.

"I have changed very much because I used to play about. I would sometimes leave my wives for a week . But when I joined the programme I stopped that. (in-depth interview - young man).

"We the women have also reduced irresponsible sexual behaviours and unnecessarily travelling ….…. to be able to meet our needs" (focus group discussion - young woman).

The survey showed about half the respondents had ever had sex outside of marriage.

- Participants who had been involved in the condom familiarisation exercise were much more comfortable about using condoms. It was remarkable that the issues to do with sexual activity could be discussed openly in the whole village, which greatly impressed our government colleagues.
- Several key informants told us that wife beating had stopped completely in the Stepping Stones communities. This was because of improved dialogue between husbands and wives and also, through peer pressure. Many men were now too ashamed to be seen beating their wives, having agreed that wife beating was wrong at the final community meeting.

Most of the role-plays produced during the programme included wife beating in one way or another.

Drawbacks

Unfortunately the secret ballot was not successful; participants did not understand that a 'no' response could be correct and all it showed was that participating in Stepping Stones makes you more likely to vote 'yes'. We realised this because we got strongly positive responses to all questions, no matter whether they contained very negative or positive statements. This contradicted information collected using different techniques. However we will continue to develop this technique because we feel it could potentially be an appropriate monitoring tool to include in the manual. We also feel that an anonymous monitoring tool is important given the sensitivity surrounding change in sexual behaviour. In future, we will emphasise that a

'no' response can be correct and structure the groups more like focus groups, thereby restricting their size and probably keeping the membership of these groups the same from one occasion to the next .

Collecting information about behaviour has been our most difficult challenge. Before running the programme, we identified all the official condom distributors in the area and asked them to monitor the number of condoms they distributed to members of participating communities. However we found that very few participants got condoms from these sources, most of them using their own (limited) informal channels. These channels were almost impossible to identify before the programme, so we had no baseline data. Following the programme, each peer group chose to identify a distributor. These distributors refer clients to each other but keep the details of the people they supply confident. Although we supply the condoms at the moment, the distributors are variable in keeping records for us. We use a pictographic form, but the distributors often lose or forget to complete them. However although the demand for condoms from one individual is not the same as condom use, (people may take condoms to sell), demand does seem quite high and is probably higher than before the programme. In one village (population 250) 600 condoms have been given out in 12 months.

"Now if some men ask women for sex the women will ask them if they have a condom and if he says no then she will refuse." (in-depth interview- young man).

"According to my observations there are changes of behaviour, attitude and awareness, especially [with] the youths towards safer sex, with an increase in use and demand of condoms to avoid infections." (in-depth interview - young man non-participant).

Operational issues

Running the programme gave us several problems in terms of logistics and human resources. Firstly, it was difficult to find enough women staff to be facilitators. Secondly, between 1996 and 1998, the programme was not completed six times in ActionAid areas. This was due to logistical reasons and from lack of enthusiasm from the communities.

Because they are posted evenly across their development areas, it proved difficult for the ActionAid community development workers to come together in one community at one time. It was a challenge for co-ordination and required extra fuel, (some staff having to travel up to 70 kilometres to attend the workshops). This was made worse because we failed to sensitise the middle managers at ActionAid, who therefore did not prioritise the programme in their action plans. Since these activities were budgeted at the national, rather than the area level, they were not included in the area work plan. Therefore area managers received no credit or incentive for programme completion. In all the pilot areas, the programme was disrupted by routine facilitator movements, or other trainings. This prevented consistent attendance in the Stepping Stones villages - which lost momentum.

In the GFPA area, community facilitators were employed. They managed to complete the workshop programme three times with substantial logistical support from the MRC and financial support from ActionAid. Initially they were salaried but this is unsustainable because of the intermittent and seasonal nature of the workload, and since our donors do not pay salaries. Transport was a problem: even though the Gambia is a small country, many villages have no public transport at all. Therefore the facilitators depended on MRC vehicles to get to the workshops, incurring a considerable fuel bill. Now facilitators are paid for three days per workshop, (one day's travel to the village and one day's return).

• Conclusions and future plans

In summary, we have found the following.

- The programme is popular and the infertility prevention approach is acceptable
- Changes were shown in the following areas; risk awareness, dialogue with

partners and peers, attitude to condoms and a reduction in wife beating.
- Young women are the main benefactors because they are less knowledgeable at the beginning
- Old women are less likely to gain knowledge or discuss in the community
- Secret ballots need further development.

Currently we are examining how to expand the programme sustainably, using some small UNDP funding.

We will pursue 4 strategies.

1. Stepping Stones as part of integrated rural development.
Following an EDF[3] programme, all government extension workers are now organised into Multi-Disciplinary Facilitation Teams, (MDFTs), co-ordinated from the Department of Community Development. These teams combine all the extension workers from different government departments by locality, and have been involved in participatory needs assessments of all the communities in their areas. In a bottom-up planning process, these needs assessments are combined to make (electoral) ward development plans, which will become the agenda for the new area councils due to be elected next year in local government reforms. Sexually transmitted infections are already a high priority in the first plan to be collated. This matches our own initial matrix scoring.

These MDFTs have now been joined by the NGO sector, including ActionAid and GFPA. Next year the MDFTs will expand to new areas. We hope to integrate Stepping Stones fully into this process, so that, should reproductive health problems be identified, the programme will be offered.

2. Freelance facilitators
The problem with a lack of women staff remains. Therefore the 'employment' of dedicated community facilitators will continue. Although they are paid essentially on a per diem basis, their terms and conditions have been modified to include a monthly 'retention fee' given if their earnings fall below a certain point, along with a savings scheme. This is because many facilitators had difficulty explaining their irregular employment to their families, who had heightened expectations of the amount of support they should give to the household. We hope these arrangements will attract more skilled women back into the workforce, and that as the popularity of the programme increases they will be increasingly contracted as trainers by outside agencies.

3. Non literate facilitators?
We would like to explore the possibility of a 'talking book', in which the instructions for the exercises are recorded on audio cassette in local languages so that facilitators do not need to be able to read. Another possibility is to make closer links with the ActionAid REFLECT[4] adult literacy programme. There are many similarities between the two manuals and the material in Stepping Stones could be a good base for the adult literacy exercises.

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15

A new approach to evaluating a peer education programme for sex workers

Kate Butcher, Sumi Baral, Krishna Bista and Rajendra Adhikary

• Introduction

Two years ago, a peer education programme was developed in Nepal to equip urban sex workers with the skills to help their fellow workers practise safer sex, to update their own knowledge on risks from unsafe sex and to provide a forum for sex workers to discuss imaginative approaches to safer sex beyond the condom. Initially 18 sex workers, all women, attended and this number has increased as the programme has developed. The women are keen to become peer educators because they are interested to learn about health issues and enjoy increased status among their peers because they give out condoms and assist other sex workers in the use of local services for sexually transmitted diseases.

While some of the sex workers who attended were able to read and write, the majority were illiterate or semi-literate. In the spirit of good participation, the workshop was adapted accordingly, using picture codes, symbols and stories to promote communication. However, one problem remained. How could we evaluate the success of the programme with regard to the desired objective of reducing risky sexual behaviour? Furthermore, how could the women evaluate their success as peer educators? Diaries were out of the question because of limited literacy, and besides, if discovered, they could be incriminating for women whose occupation was a secret from their loved ones. Verbal accounts were likely to be inaccurate and forgotten and women could not be expected to report to the programme on a daily or even weekly basis.

Mala

As a result, we developed an innovative and attractive alternative: the 'Mala' system. 'Mala' means necklace and is a popular accessory for all women. We decided to provide each participant with a set of different coloured beads, and during the workshop, and, in consultation with the group, allocated different colours to different activities relating to their role as peer educators as well as their own sexual practice. The activity relating to each colour is listed below.

- Red; asked a client to use a condom and he agreed.
- Green; accompanied a girl to the clinic.
- White; asked a client to use condoms and he refused.
- Yellow; gave a fellow worker condoms.
- Black; avoided intercourse, had safer sex.
- Blue; had sex without a condom.

The idea was that after each activity, women would thread the appropriate colour on to their mala. Each month the situation would be reviewed.

At the monthly review meetings, project outreach workers sit with the peer educators individually and look at their necklaces checking that the colours represent the agreed activities. Since the sex workers/peer educators themselves allocate the colours and activities, this has not proved too difficult. Results and queries are noted in the record book and subsequently discussed with all the peer educators together.

Figure 1. Diagram of a 'Mala'

• Impact

The Mala is a unique self-assessment tool which has helped women to monitor both their own activities as commercial sex workers as well as their role as peer educators. Because it is highly visual, patterns and trends are easy to identify. There has, for example been a marked increase in condom use among the peer educators and their peer sex workers over the monitoring period. However there are usually several blue beads where women have sex with regular clients and/or boyfriends and do not wish to use condoms. Non penetrative sex initially never occurred, although in the last 6 months it has appeared in two women's necklaces.

Monitoring of the system has been increased in the last 6 months and it has become clear that, with regular support and supervision, the Mala system can be an effective, attractive and enjoyable way of evaluating an otherwise difficult field of work. Not only can sex workers measure their own success and activities, but they also have an attractive accessory at the end which can be understood by no-one, other than their fellow peer educators and project supervisors.

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NOTES

This article was first published in *PLA Notes* 33 October 1998 as an extract. It is being included again with this special issue on Sexual and Reproductive Health as it offers an effective way of evaluating a sensitive area of work and it is hoped that those who may have missed this item previously will be able to learn from the authors' experiences.

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Introducing participatory methods to HIV prevention workers in the Southwest United States

Kim Batchelor

Introduction

In recent years, the demographics of the HIV epidemic in the United States have changed. What was once a disease that largely affected white gay men now disproportionately affects the poor, people of colour, the young, and women. Sexually transmitted diseases have historically had most impact on these same populations. Because of this, and the fact that prevention efforts have often centred around knowledge-sharing alone, participatory learning and action (PLA) methodologies offer an opportunity to make HIV prevention a more innovative, effective, and collaborative effort.

The philosophy behind participatory research was presented in workshops for HIV prevention workers in Dallas, Texas and for health educators taking on HIV as a new issue in New Mexico and Arizona. The latter training occurred in the Pojoaque Pueblo in New Mexico. Many of the prevention workers who participated in the trainings were indigenous to the populations they work with. In both workshops, careful attention was paid to the collaborative nature of participatory research, and both began with Edstrom and Nowrojee's 'Steps of Unlearning[1]'. The workshops incorporated several activities, including mapping exercises, Chapati diagrams, causal flow diagrams and problem solving techniques.

Mapping the body

Participants engaged in body mapping in both sites, illuminating several issues around the use of this method. In one site, when participants were asked to divide into gender-specific groups, one transgendered person, born biologically male but living as a female, did not know in which group she should participate. She was given the option to choose and chose to participate with the females, mapping the male body. This situation illustrates how important it is to consider transgendered/transsexual individuals when doing gender-specific exercises and groupings.

Participants in Dallas mapped erogenous zones; those in New Mexico mapped organs associated with the birth process and those affected by sexually transmitted diseases. For participants in both workshops, desire and sensuality came into play during the mapping exercise, expressed by both the female and male participants. The women mapped males with broad shoulders and chests and flat stomachs. Men mapped the 'ideal' woman with large breasts and lips, and (in one case) blonde hair. The exercise in one site was made interesting by the fact that the group of males mapping women was largely made up of gay men. The map of the female produced by this group replicated some of the same idealised female attributes as might usually be seen in an all-straight male group.

Following the body mapping activity, the women processed what they saw that the men had drawn and the men discussed what women had mapped, eliciting strong emotions on both sides that called for good mediation skills. The exercise illustrated the persistence of stereotypical body images, such as large breasts and penises, for example. The groups then discussed body image as a barrier, especially for females, in the prevention of transmission of Sexually Transmitted Diseases (STDs)/HIV and how this exercise could be

[1] Eldstrom, J. and Nowrojee, S.,(1997) *Visit to Sri Lanka: Report on a PRA workshop for sexual health needs assessment*, International HIV/AIDS Alliance, London, UK.

used to address this barrier directly. In New Mexico, participants saw how various health issues might be analysed through the use of body mapping, including cancer and 'appropriate and inappropriate touch' for children.

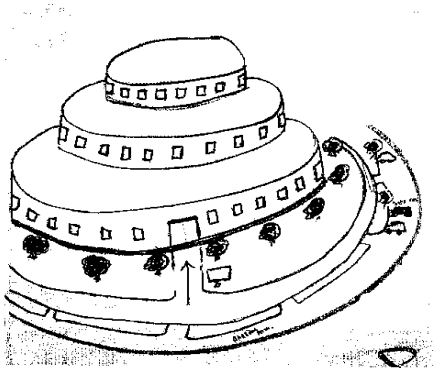

Figure 1. Facilities mapping exercise: Pojoaque Pueblo, New Mexico, United States

Facilities mapping

Participants from both sites participated in 'facilities mapping,' a technique used in the workplace that is also known as 'hazards' and 'social' mapping. For this activity, in small groups, one individual acts as the 'describer' of a facility, such as a health clinic. Others in the group act as different types of 'mappers.' First, the general mapper sketches a general design of the facility as the describer dictates. After rooms, corridors and waiting areas are all drawn, the general mapper uses arrows to describe the usual 'flow' through the facility. The social mapper uses red and green stickers to identify where 'leaders' are (red dots) and where people gather (green dots). The final mapper uses a green marker to indicate 'safe' areas and a red marker to indicate 'hazardous' areas, however those terms are defined by the describer.

Process dynamics

The describer being different from the mappers allowed the participants to understand what it's like to cede control and taught them to be specific in their instruction. For mappers, it encouraged listening skills. A note-taker in each group also described what s/he observed during the activity. Feedback from the two sites revolved around how the activity can illustrate barriers within organisations and can identify the perceptions of both staff and clients of the agency in terms of what's the same, what's different etc.

At the Pojoaque training, a group of five individuals from various American Indian tribes pondered the exercise for a time before asking if they could map something they would like to see, rather than what already exists. They mapped a building where all services could be centralised, a building of three levels constructed as a round structure (see Figure 1). The round structure was important, according to the group's reporter, so that 'you won't get boxed into a corner.' The significance and preference of the shape of the circle versus the square came up at various times during this training. The group also saw the centre of the second level as a place to carry out rituals, and then discussed the possibility of creating a jogging track on the bottom around the outside of the structure to encourage physical activity. Although I had thought of the activity as a way to describe what already exists, the creativity expressed by this group also raised the issue of using mapping potentially to describe 'desire': what can be as well as what is.

• Lessons learnt

These two trainings illustrated that participatory research holds promise as an innovative way to elicit information and develop and evaluate programmes, especially in the health field. In the Dallas workshop, a caution emerged in that fascination with PRA tools may result in superficial use of them without true collaboration with affected communities. Some participants wanted to use the visual techniques as interventions alone. Given those cautions, my initial experience with training on participatory methods for HIV prevention and other health workers gives some hope that this community collaboration can occur. Strategies to continue to inform and motivate front-line health workers are necessary if the approach is to take root.

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17

Mapping the effects of vasectomy

Ann Sturley

· Introduction

In a rural district of Nepal, as part of a year-long study of reasons for non-use of contraceptives, group sessions were held with men who had undergone vasectomy[1]. Hand-drawn outlines of a man's body were used to focus the men's discussion about their experiences. A main result of this exercise was the finding that men believe that vasectomy involves severing a vital channel, causing problems wherever this channel goes in the body. This article describes the process of using body mapping to explore the men's experiences of vasectomy. It illustrates just one example of how participatory techniques may contribute to deepening our understanding of the issues involved in the acceptance of contraception, clearly an urgent matter in countries such as Nepal.

Background

Many local Nepalese beliefs about the side effects of contraception do not coincide with the biomedical view. Instead, contraception, sexuality and reproduction are all viewed in the context of the social, cultural, and religious belief system. I sought to find the extent to which non-use of contraception is due to the incongruence between what people are told about contraceptives by health professionals and what they themselves experience or believe. Semi-structured interviews were held with medical practitioners, past or present contraceptive users and all adult members of a sample of families. A survey was carried out with 215 married women of reproductive age (15-49) and their husbands, 165 men[2]. The final activity was an exchange of information with the community to correct misinformation about locally available contraceptives and HIV, to ask directly what the villagers thought about some preliminary findings and to allay any remaining fears and misconceptions about the research. This article explores one aspect of the research, men's post-vasectomy experiences.

· Men's experiences with vasectomy

Focus group discussions with sterilised men were convened in each of the nine wards of one village of Myagdi District in Western Nepal. Each focus group began with an apology for talking about such a private topic, "*for we* (my assistant and I) *are like your sisters and daughters and should not mention such things, but we really want to understand your own, true experiences with vasectomy*[3]". Immediately after this, we unrolled a hand-drawn outline of a male body. We asked the men to describe their operation, giving each a different-colored marker pen to show the location of their incision (see Figure 1). Each

[1] The study took place in Myagdi District, Western Nepal, from May 1996 to April 1997. Myagdi was chosen because the 1991 Fertility, Family Planning and Health Survey showed respondents had a high level of knowledge about contraceptives and where they could be obtained, and yet reported average contraception use. The research sites were two villages and one section of the Myagdi District Centre.

[2] There were fewer male than female respondents because many men in this district work abroad, following a long-standing tradition of joining the British and Indian Gurkha regiments. Now men are more likely to work as unskilled labourers in the Middle East or Europe, the U.S. or Japan.

[3] I would have preferred to have had equally skilled male and female assistants, but this was not possible. We did have a local male assistant to help with the focus groups, but he did not have facilitator skills. My research assistant, Hema Pun handled the situation with impressive tact and persistence.

man in turn was asked to relate what he had experienced during the 'operation'. The men were encouraged to focus on the drawing, lessening the embarrassment of discussing this topic with two women. Then each was asked whether he had experienced any effects since the vasectomy. Finally, the groups were asked about other effects mentioned elsewhere in South Asia or by those previously interviewed for this study. We then asked about Sexually Transmitted Diseases (STDs)/HIV. Finally, we showed samples of all the contraceptive methods available in Nepal, including a diagram of how male and female sterilisations are performed and explained in detail about HIV using a flip chart produced by Save the Children/US. At the end of each session we provided refreshments, then walked home and translated and transcribed the tapes. The next day we began the process again. Each group was scheduled to begin early in the morning, but we often waited several hours for the farmers to finish their morning chores. Once we began, the process lasted from three to five hours.

Figure 1. Post-vasectomy effects explained with body mapping

After a few minutes of embarrassment, the men spoke openly about the operation and about the effects they felt it had had on their body and their lives, some commenting that this was the first time anyone had taken an interest in their post-vasectomy experiences. As they spoke, they indicated the connections they perceived between their current condition and 'cutting the *nasa*[4]'. The following quotes from the focus group discussions illustrate some of the issues that concerned the men.

"First they put on anaesthetic. There are many nasa*, but they cut the* nasa *the seed goes in, with a blade. Pulled the 2 ends together and tied them. Gave me medicine for pain, also for healing. I could walk then, but after 3 days my balls swelled. I got fever, and my seed came out on its own. It was impossible to work for 1 week. Blood came out from the incision. I had to be carried to town. The doctor checked me, gave me tablets and capsules. Told me to eat meat, strength-giving foods, for 15-20 days. I got well but still now the inside of my left leg is sore when I go downhill, and I get backaches. I think the* nasa *goes to the left leg, that's why it's weak. When there's much rain or sun, I get this. For the last 2 years I've had this. Backache too".*

"If I have to do hard work like with a hammer or axe, my sitting bones get sore, first the left side then the right side. When I have no hard work and get good food and rest, this doesn't happen. My eyes are weak. I think it's the nasa. *I can see at a distance, not close up. My balls swelled for a while, until the incision healed, but nothing else happened there where they cut".*

"Slowly my eyes are getting weaker and weaker. The operation did it, by cutting down there. The nasa *goes to the eyes. I get colours in front of my eyes. My seed can't go out; instead it goes to my eyes. The place where they cut is fine but the nasa is confused, it's not in the right place. For this reason the operation affected my eyes. Also this is why I'm weak. I get effects on the left side -- sometimes to the underside of my foot, and sometimes to the top of my head. This is how I got sick.* (Drew a line up the left side to left shoulder, then left eye). *" Because of this, my blood is insufficient, my eyes are getting weaker and weaker. My caste are supposed to bow down and touch the feet of those of high*

[4] *Nasa* is a Nepali word that approximates the English 'vessel', in that it is used for blood vessels, lymph ducts, nerves, the vas deferens and possibly the channels of acupuncture. Whenever *nasa* was mentioned, we prompted the men to draw the *nasa* on the outline of the man's body.

caste. My eyes are so weak I've even touched the feet of Damai" (lower caste than his).

"Before the operation, all my seed would come out. After cutting the main seed nasa*, now the seed goes in the small branch* nasa*. Because of this my wife has bad effects. When we had sex, seed used to go out forcefully, now it takes a long time. Because of this my wife is affected, because of less seed".*

"My seed used to be thick, but after cutting the nasa *it's thin. When going to my wife's 'house,' I get sick - backache. It causes more sickness to the man, less to the woman. Because the* nasa *was cut. Sex used to make my wife warm, feel well. Now it's thin, doesn't make her feel good. The doctor can't do anything for her, she just gets weaker".*

"For me sex is not much different but it is very different for my wife. When our wives talk together they say the wives of men who were operated on are thin. They say that women get sick after having sex with these men. In the evenings we talk, husband to wife, and wonder if this is what makes us weak. Probably it's due to the operation that she's weak, because her face looks sickly. She was fine before".

"Women with very hot bodies need sex a lot and get thin (after their husbands undergo vasectomy). Cold bodied women don't need much sex and get fatter".

"It's a big sin. To stop children who would have been born, to make one's wife thin, to make your own body thin. One man had two sons, then had the operation. Both sons died, and he then had no heirs".

"Uncastrated goats must be offered to the gods, not castrated goats. We are like castrated goats. It is sinful for us to do puja *(make religious offerings)".*

The main effects described by these men are as was reported in the previous South Asian studies of experiences with contraceptives in South India and Sri Lanka (Nichter 1989a, 1989b) and Bangladesh (Maloney et al. 1981). No such study had been conducted in Nepal. These effects may be grouped into seven main patterns.

- Generalised weakness mentioned as a result of every contraceptive method, but for different reasons. A lack of staying-power, such as needing food immediately when hungry, needing warmth immediately when cold, mostly post-vasectomy, was a new twist found in Myagdi.
- Sexual problems such as impotence, lack of 'force' of ejaculation, increased or decreased sexual desire.
- Other physical symptoms, from eye weakness to leg pains.
- The wife getting thin, weak, and sick because she no longer receives the man's seed as nourishment, with condom use as well as after vasectomy.
- Religious offerings not working because the man (or woman) offering them is no longer whole.
- The sinfulness of not allowing children that god would have given to be born; this in turn causing existing children to die and other misfortunes.
- Hot and cold body types reacting differently to the different methods.

What had not been evident in the previous studies, however, was the importance of the *nasa* that is cut during the vasectomy. The use of body mapping clearly showed how and why the vasectomy caused these effects. The similarity between charts of the energy channels used in Chinese acupuncture and these men's drawings is striking. Is this mere coincidence?

Aside from the context of different belief systems, the side effects experienced in rural Nepal may differ from those described in the West at least in part because of sending inexperienced doctors, who are eager to volunteer because of the monetary compensation, to perform vasectomies in mobile 'camps'. Though some vasectomy failures may be explained by men not using condoms for the requisite number of ejaculations (to assure there are no sperm left), we met couples with two or more children born post-vasectomy. Staff at one vasectomy camp told stories of inadequately trained doctors they had seen cutting a blood vessel or nerve rather than the vas, or making a several-inch incision because they could not locate the vas. Villagers who have heard of one or two

such cases are less likely to undergo the vasectomy themselves.

· Lessons learnt

Using this graphic tool has several advantages. The group can see a visual image while they are discussing, making clear where and what is being described. They are less embarrassed than if they have only each others' and our faces to look at, especially as in this case where women were interviewing men on such a sensitive topic. The researchers also have a visual record of the event in the drawings.

The meaning of anatomical terms varies from person to person, especially in a country with so many languages and dialects. This exercise makes evident what is meant, and also circumvents an attempt to seek a one-to-one correspondence between anatomical terms in two languages. This became clear in another exercise, when we asked for anatomical words from head to toe while pointing to prepared posters (a fully dressed boy, then medical charts of bones, muscles, and internal organs), supplemented on occasion with freshly butchered water buffalo organs. If we had merely used a list of English words, for example, we would not have discovered *tegeltuk*, meaning the space at the back of the knee joint, for which there is no corresponding word in English.

We did experience some difficulties with the mapping exercise, however. The villagers were illiterate, and thus their lines were not necessarily where they wanted them to be; drawing is not practised as an art here. There was a reluctance to draw on top of anyone else's line. This was especially evident with the women's groups, when we asked them to draw the uterus, they drew circles, each one next to the last. The lines, therefore, aren't to be taken as precise descriptions of the location of the *nasa*. Because the outlines stopped at the top of the legs, the men were less likely to draw the *nasa* going to the legs. An outline of the entire body could work better, but it needs to be large enough to show the location of the incisions.

A danger with this, as with any group process, is learning from others in the group. Here we saw the men 'learning' from others in the group that their vasectomy caused sexual problems and impaired vision. Our nodding or remaining silent may have been perceived as agreement. For this reason we felt it essential to discuss contraceptives and STD/HIV at the end of each session, and to return to the villages after the survey and discuss the research findings and misconceptions.

· Conclusion

In conclusion, this paper has shown how the use of body mapping tools allowed us to transcend the limits of biomedical concepts and vocabulary in exploring men's experiences with vasectomy. Hopefully this example will lead others to experiment with similar techniques.

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Evaluating sexual health services in the UK: adapting participatory appraisal tools with young people and service providers

Martin Westerby and Tilly Sellers

· Introduction

In 1997 Trent Regional Executive of the UK National Health Service funded a project called 'Evaluating Sexual Health Services: a Community Approach'. This project was based in the South Humber Health Authority area in Northern England. This is a largely rural area, but with two large towns, which has a history of relatively high local rates of teenage pregnancy and where sexually transmitted infections continue to be a real threat to young people's sexual health. The project worked with health service providers and young people to evaluate local sexual health services and built on several years experience gained whilst developing participatory appraisal tools and techniques with young people in order to learn about sexual health issues from their perspective.

Young people in the South Humber region defined a sexual health service as 'somewhere that young people can go for information or advice about sexual health or where they can get contraception'. This wide definition meant that informal services, such as youth centres and outreach projects, were included in the evaluation, along with more formal services such as government family planning clinics. After finding out what young people meant by sexual health services, the project worked with them to find out what they thought would make 'successful' sexual health services. Consistently prioritised were criteria under the headings of confidentiality, privacy, positive staff attitudes, locations that young people could easily get to, opening hours which were suitable for young people, a good mix of services and no cost for users.

Having found out what young people thought was important for a sexual health service to work for them, the project offered participatory evaluation training to service providers who wanted to work with young people to evaluate their own services. Initially, some service providers were sceptical that a participatory approach would work. However, all hoped that by building a working and trusting relationship with young people, and by using indicators developed by them, this type of evaluation would have a positive impact on their services.

20 service providers undertook training in participatory appraisal and evaluation from 13 individual services. Seven of these participants were from GP practices, three were youth workers, four were community support team members, two were nurses, two were managers, one worked for a voluntary agency and one was a member of the local library service.

Altogether, over 300 young men and women between the ages of 13 and 21 years, in either mixed or single sex groups, gave their thoughts and ideas about local sexual health services. Approximately 150 of these were accessed in local senior schools, 50 in colleges and 50 in youth centres. A further 50 young people were accessed by the trained service providers as part of their normal jobs, including a number who were in local authority care. As the evaluations continue and develop independent of the project, this total continues to grow steadily.

A whole range of participatory tools were used during training and subsequent evaluations. Tool adaptation and creation, along with non-rigid use of tools was very much emphasised

throughout the whole process. Four of these tools are highlighted below. The first three are examples of young people and workers adapting tools to suit a particular situation. The last one is a traditional tool which a group of young people used to illustrate something important, and which had an outcome not expected by the facilitator.

A timeline/trendline

One of the service providers who had been trained in participatory evaluation by the project worked at a rural youth centre. She had seen that numbers of young people using the centre were steadily dropping. This was a concern because the youth centre was one of a very limited number of places that local young people could go for sexual health information or just to talk about issues in confidence.

Initial discussion with some local young people seemed to suggest that the attendance at the centre had decreased primarily because of intimidation caused by increasing violence and aggression amongst some of the members. The youth worker used a time/trendline (see Figure 1) to explore the level of conflict and aggression at the centre and to see whether there was any link between this and the other activities.

It is noticeable that the line indicating conflict and aggression reaches its highest points during peaks of other physical and social activity. An example of this can be seen during the initial scramble for equipment; whilst sports are taking place; because of unresolved disputes at the end of the evening. Some of the conflict taking place at the same time as other social interaction was thought to have carried over from school, or to be drug/alcohol related.

The youth worker was able to act on this information, using further solutions suggested by young people to reduce the potential for conflict, aggression and violence at the centre. This improved the environment so that young people felt safe enough to return and use it as a resource to improve their sexual health.

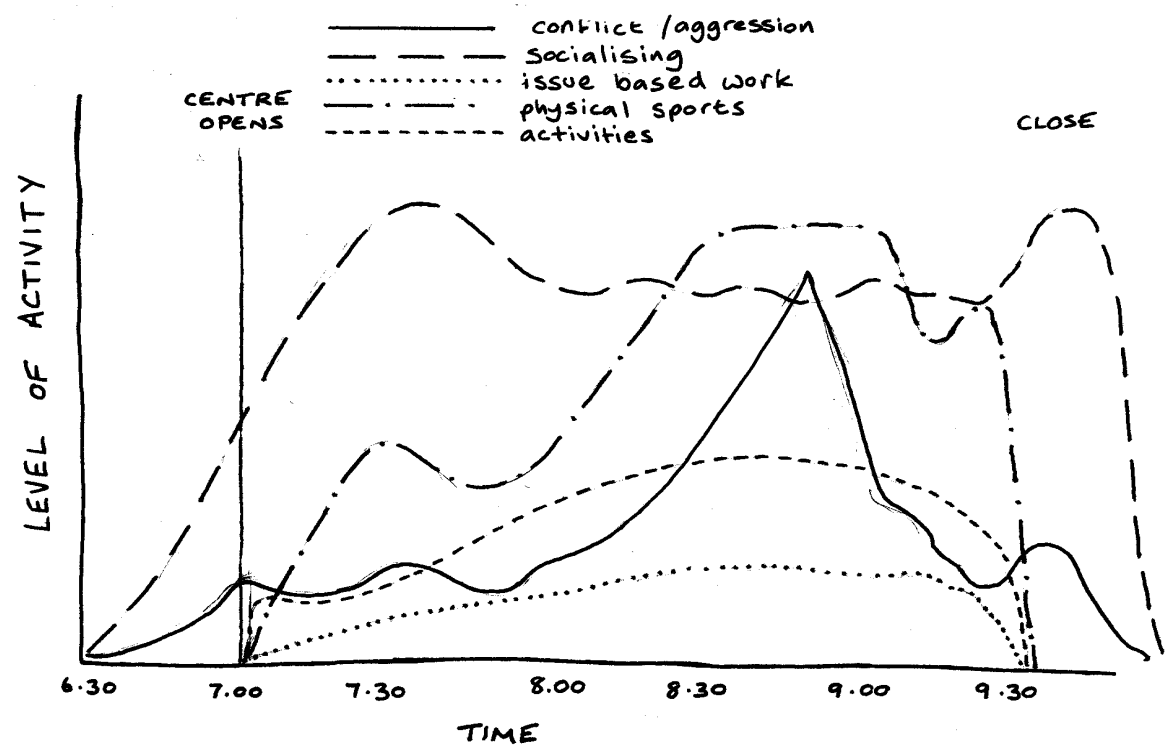

Figure 1. Time/trendline exploring levels of conflict and agression

A barriers wall

Working in a school, a group of young people came up with this visual method of highlighting and addressing barriers to accessing existing sexual health services (See Figure 2). They made a 'wall', using a large sheet of paper and different sized self-adhesive cards for 'bricks'. The cards could be moved, replaced or enlarged several times during discussion. Each brick then represented one specific barrier to using a local service, in this case a government clinic which they felt was particularly inaccessible. Types of barriers included: being embarrassed or scared; not having the skills/information to use a service; not knowing what to expect when using a service; lack of privacy or confidentiality; and not knowing that the service exists.

The group of young people talked about the visual tool they had created. They said that separate walls could be built for different services. The higher the wall, the more the barriers. Large barriers could be represented by more than one brick, or a larger brick. Therefore it is important to have different sized adhesive cards to use as bricks! They demonstrated how the bricks can be taken out of the wall as solutions are found. For example, as a solution for not knowing what to expect when visiting a service, the young people suggested that visits could be arranged by the school, or that service providers could come and talk to young people, either at school or in youth centres. They also suggested that where young people are embarrassed or afraid to use a service, service providers should encourage them to bring their friends with them for moral support.

Using this tool, young people can literally 'knock the wall down' or knock holes in it, perhaps leaving only the barriers which they feel are not significant enough to prevent the service being used. It was recognised that this tool could also be used to monitor how young people feel about a particular sexual health service as changes are made in response to the evaluation.

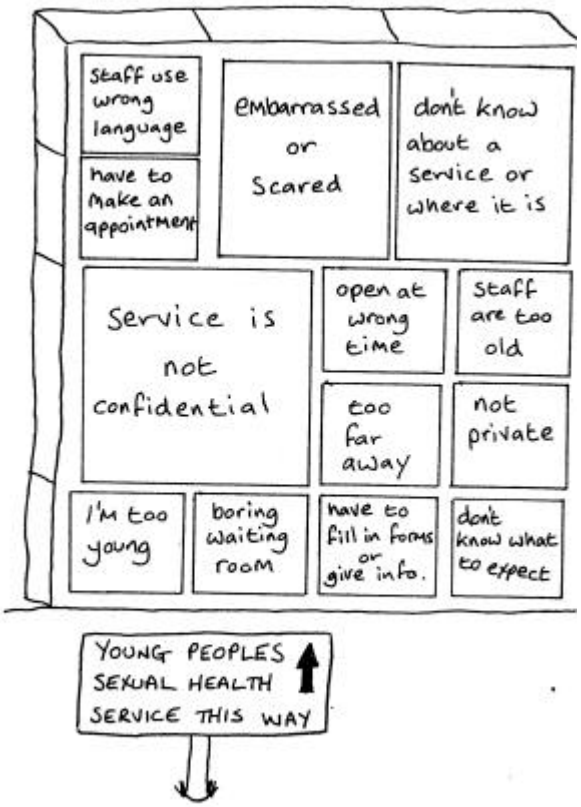

Figure 2. A barriers wall

A time-clock

Young people used this tool to show the times during the day when they would be able to use a sexual health service. It was produced by a group of young people during a youth club session who were asked to find a way to show when services for young people should be open and available for use. No further instructions were given, and the facilitator left the group to come up with something of their own.

After discussion, the group drew a round clock face, marked on the hours and split the clock into 12 segments. In this example they chose to look at the twelve hours between 8:00 am and 8:00pm on a school day (see Figure 3). Later they drew another time clock which indicated when young people would be free at weekends.

In each specific segment they wrote and drew what they do during this period of time,

sticking a 'tick' in any segment when they felt that young people would be able to use a service. They then went on to give more details, verbally, about why they could use the services at these times. For example, the young people suggested that they could only use services in their spare time, or when they could easily justify to parents where they were. This explains why they said that one ideal time to use a service would be during the period between leaving school and arriving home in time for their evening meal.

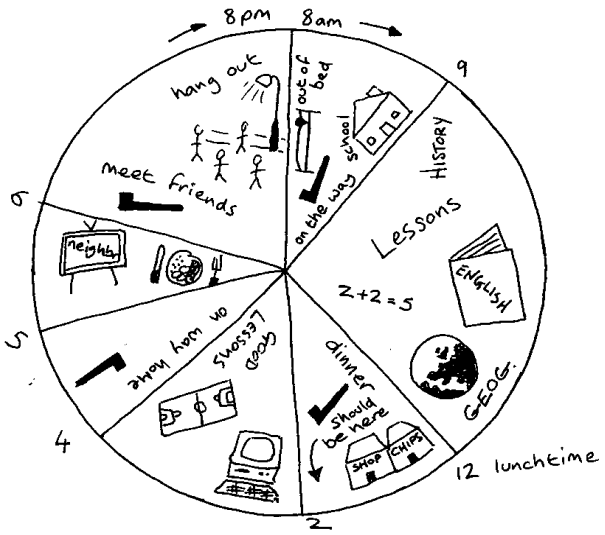

Figure 3. Time clock showing the times young people would be available to use a sexual health service

Pairwise ranking

In this last example, a small group of students, visited at a local college, had used a number of participatory tools to come up with a list of criteria for 'successful' sexual health services. The facilitator wanted them to use pairwise ranking to discuss which of their five general criteria (good staff, confidentiality, privacy and discretion, appropriate opening times and good location) were most important.

As can be seen from the illustration (see Figure 4), the group found that it was too simplistic to complete the exercise as the facilitator had planned, because several of the criteria are related and inter-dependant. For example, one of the young people said, 'How can we choose between good staff and confidentiality? One of the qualities of good staff is that they are confidential!' Similarly, another said that it was not possible for them to distinguish which was the most important between good opening times and location because, 'It's no good a service being open at the right time if it's a long way away.' And, 'It could be right next door, but that's no good either, if it's only open when we're at school.'

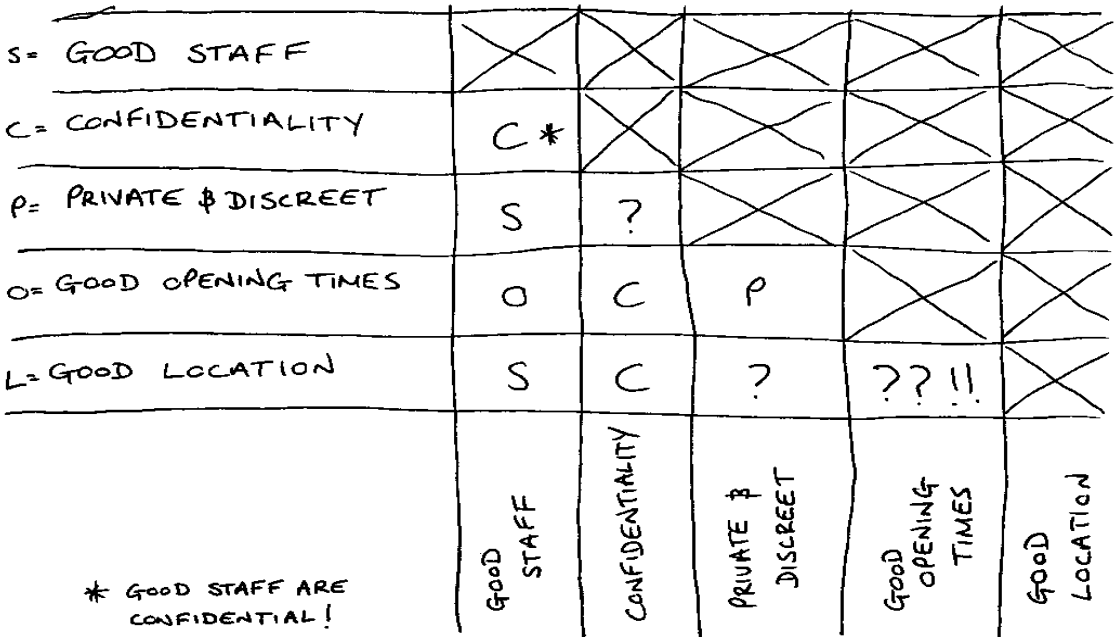

Figure 4. Pairwise ranking of criteria for 'successful' sexual health services

Here, pairwise ranking provided a valuable learning experience for the facilitator who had assumed that barriers would be discrete and have no relation to one another. The fact that the simplistic ranking 'did not work' showed that solutions to single barriers would rarely be sufficient to make a service work well for young people. Instead, the group showed that, when planning and developing sexual health services aimed at young people, all their important criteria need to be given equal consideration.

· Conclusion

Valuable insight into what young people want from different sexual health services, how and when they would use services has been gained from the 'Evaluating Sexual Health Services: a Community Approach' project. Moreover, service providers involved have been enthused by a model that some initially found threatening. Some partnerships between service providers and young people have become solid enough for the provider to explain some of their own constraints to providing a young people friendly service. For example, a GP practice nurse was able to use the evaluation sessions which she had with a group of her young service users to explain that the 'no appointments' or 'drop-in' service could not operate every day. Once the young people realised that this system caused a greatly increased demand on the time of the doctor and nurses, and the subsequent cost implications, they understood why the system only operated on Mondays and Thursdays.

Perhaps the most important lesson learnt during this project with regard to using participatory tools, is not just that they are very powerful, but also that they are very flexible. If they are to be successfully used to enable young people to better understand their situations and plan for change, practitioners should be comfortable enough to use them in a way which is not too rigid or prescriptive. The examples here show the value of this principle, in these different and individual situations.

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‘Safely through the night’ A review of behaviour change in the context of HIV/AIDS

Ann Smith and John Howson

· Introduction

‘Safely through the Night’ is a review prepared for the Department for International Development (DFID), UK, by CAFOD[1] and four of its partner organisations in 1998. The review was undertaken to look at:

- communities’ and organisations’[2] understanding of behaviour change in the context of HIV/AIDS; and,
- programme approaches and how/whether these impacted on communities’ behaviour-related concerns.

The title is amended from a Chi Bemba proverb from Zambia, *“Uwankwesha ubushiku, bamutasha nga bwacha”* meaning ‘you only thank the one who guides you safely through the night once it is day time again’. A participant in one of the review workshops cited this proverb to illustrate the difficulties inherent in exploring HIV-related issues within communities. In particular, participatory and experientially based approaches can often raise difficult issues that, at first glance, only seem to complicate matters further. It is only after we have ‘journeyed through the night’, with all its shadows, that we can appreciate the effectiveness of the process.

[1] CAFOD, The Catholic Fund for Overseas Development, is the Development Agency of the Catholic Church of England and Wales

[2] CAFOD and its partner organisations

Four CAFOD partner organisations, Lilongwe Diocesan AIDS Programme, Malawi; Lubancho House, Hwange, Zimbabwe; Mwanza Diocesan AIDS Programme Tanzania and St. Theresa’s Ibenga, Zambia took part in a field-based review with CAFOD staff. Organisations participated in a preparatory workshop where questions for the review were formulated and participatory techniques for exploring these questions were designed and practised. The fieldwork findings were shared at a second workshop and in written reports. Both workshops were facilitated by Francis Chirunga, Intermediate Technology Development Group, Zimbabwe, and Alice Welbourn, Consultant to CAFOD for the review.

The fieldwork was conducted by each organisation among one community where they work and within their own organisation, between March and May 1998. Review participants were divided by age and gender into four groups; Young Women, Young Men, Older Women and Community Leaders (deemed to coincide, in participating communities, with older men). CAFOD staff also conducted parts of the fieldwork with colleagues in London.

Questions covered by the fieldwork concerned:

- the relevance of the organisation’s programme to the community’s main problems;
- how communities perceived the programme’s process of working;

- the outputs/outcomes of the programme's work in these communities; and
- possible future directions for the community and the programme.

The questions were intentionally constructed so as to be broader than the specific objectives of the review. In this way it was hoped that any reflections on behaviour change would emerge from communities' lived reality rather than as a response that could have been skewed had the review taken a more direct approach focusing specifically on HIV-related behaviour change.

· Field work methodology and main findings

Relevance

Participating communities and organisations considered the main problems facing their community and how/whether these are being met by the organisation's programme or by others. Sunburst diagrams, pairwise ranking and bar charts were used to identify the main problems and support received. The sunburst diagram produced by young women from Malawi illustrates some of the problems identified by communities (see Figure 1). Collating the findings into an issues matrix indicated the problems identified by each and the differences that can occur between communities' and organisations' perceptions, as seen in Table 1.

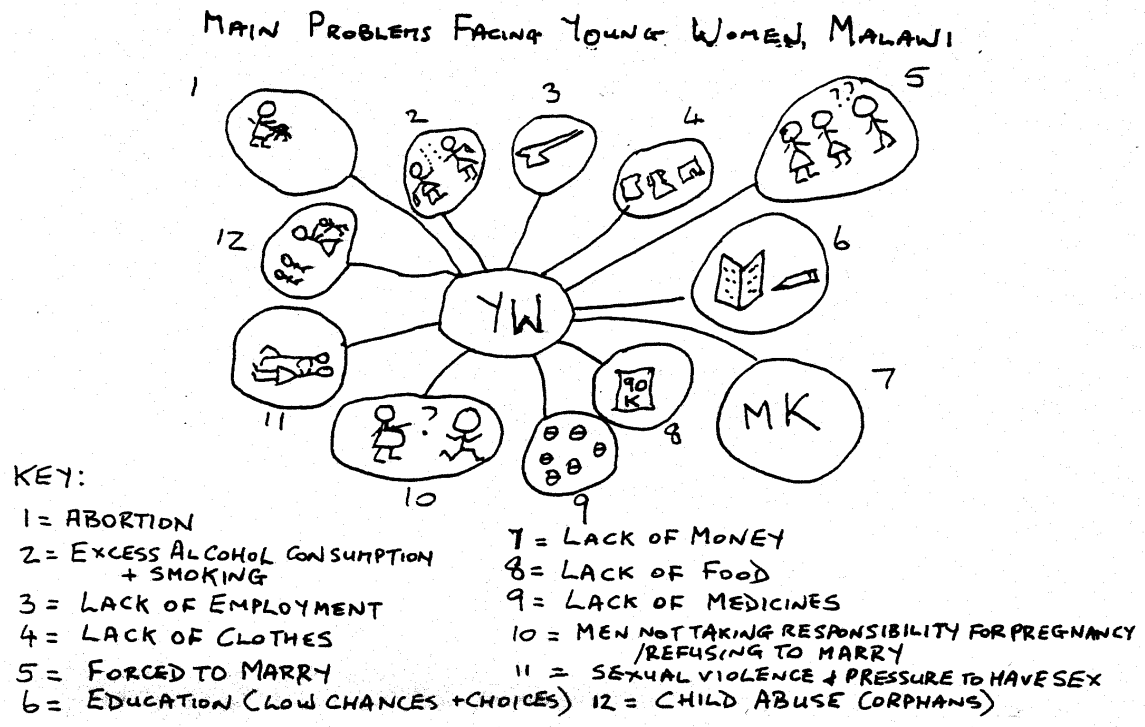

Figure 1. Sunburst diagram showing main problems facing young women respondents, Malawi

Table 1. The main problems faced and the extent to which felt needs are being met, Malawi

	YW	YM	Org
Lack of employment	✓ x	✓ x	
Sexual violence and pressure to have sex	✓ x	✓ x	
Lack of counselling and advice from parents	✓	✓ x	✓
Excessive drinking and smoking/drugs	✓	✓ x	
Transport			✓ x
Inequality oppression from dominant young men success is based on privilege and connection rather than on merit		✓ x	
Men are not taking responsibility for pregnancies/refusing to marry	✓	✓	
Need of money	✓ x		✓ x
Young girls have less opportunity/access to education due to cultural expectations and burden of domestic chores	✓ x		
Lack/shortage of HIV/AIDS and 'Why Wait?' education materials			✓ x
Condoms not the solution			✓
Condoms – we need them		✓	

Key
The ✓ indicates that this problem was drawn on the bar chart as a main concern of the peer group. The x beside it indicates that the peer group felt this concern was getting less than 40% support from any or all different sources.
YW = Young Women. YM = Young Men

Despite the high HIV prevalence in all fieldwork locations, communities did not identify this as a main problem. The Zimbabwe team reported that one meeting started several hours late because community members were trying to get rid of elephants that were damaging their crops. The chief's comments were instructive; *"You come to us with your AIDS programme while we have a bigger problem of elephants destroying our fields. Why don't you ask the national parks to kill the elephants?"*

Process

Using sunburst diagrams and *sadsa* or pie charts, participants reflected on how they perceived the activities of the programme and which they considered most important. Time lines illustrated who within their community got involved, when and why.

Young men and young women were concerned about sexual health issues. Both groups were also anxious to access education and skills-building programmes, young men for reasons of self-esteem, young women for financial independence. Only women (young and old) were involved in home care and orphan care programmes, illustrating the potential danger of these adding further to women's already heavy burden of care (and of excluding men where programmes focused solely on care initiatives). Older men (community leaders) subscribed only to activities that increased their political standing within the community. There was no acknowledgement of the relevance of HIV/AIDS to their personal behaviour. AIDS education was scored highly by young people of both sexes but not by older people, raising the question as to whether the old were being overlooked. Behaviour change activities also concentrated on youth groups

and left out older people who are the decision-makers over the young.

In their gender- and age- specific groups participants used seasonal calendars to identify:

- the volume and types of work undertaken by each in the different seasons;
- times of financial solvency and periods of heavy expenditure;
- occasions of community festivities/peak social events; and,
- their feelings of contentment or unhappiness plus tension points in different seasons

The calendars identified the differing workloads of women and men. They indicated the best and worst periods for programme activities with each group and also how sexual activity/vulnerability varied according to season (and times of community festivities) and according to the amount of free time and funds available, and therefore how programmes should target their activities accordingly.

Seasonal calendars (see Figure 2) also illustrated the domestic tensions caused by alcohol consumption, quarrels over finances and, most often, quarrels over sex (demanded by men and refused by exhausted women). The older women's group from Zambia told how in many instances, when they are tired and refuse sex, their husbands make them sleep under the bed. Sexual violence, highlighted as a problem only by women (older and younger) was not considered thus by men. Physical violence also featured, identified as a grievance by women and a right by men. Younger men from Zimbabwe affirmed their rights to beat their wives if they found them sleeping, exhausted, in the fields.

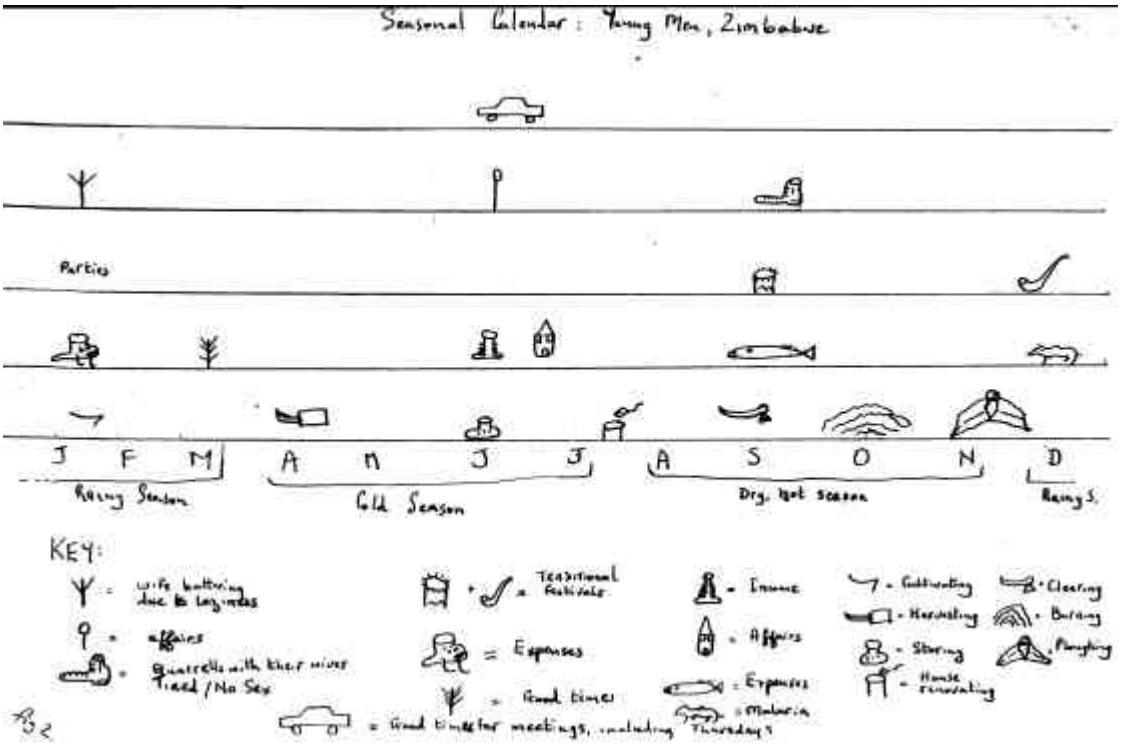

Figure 2. Seasonal calendar: Young Men, Zimbabwe

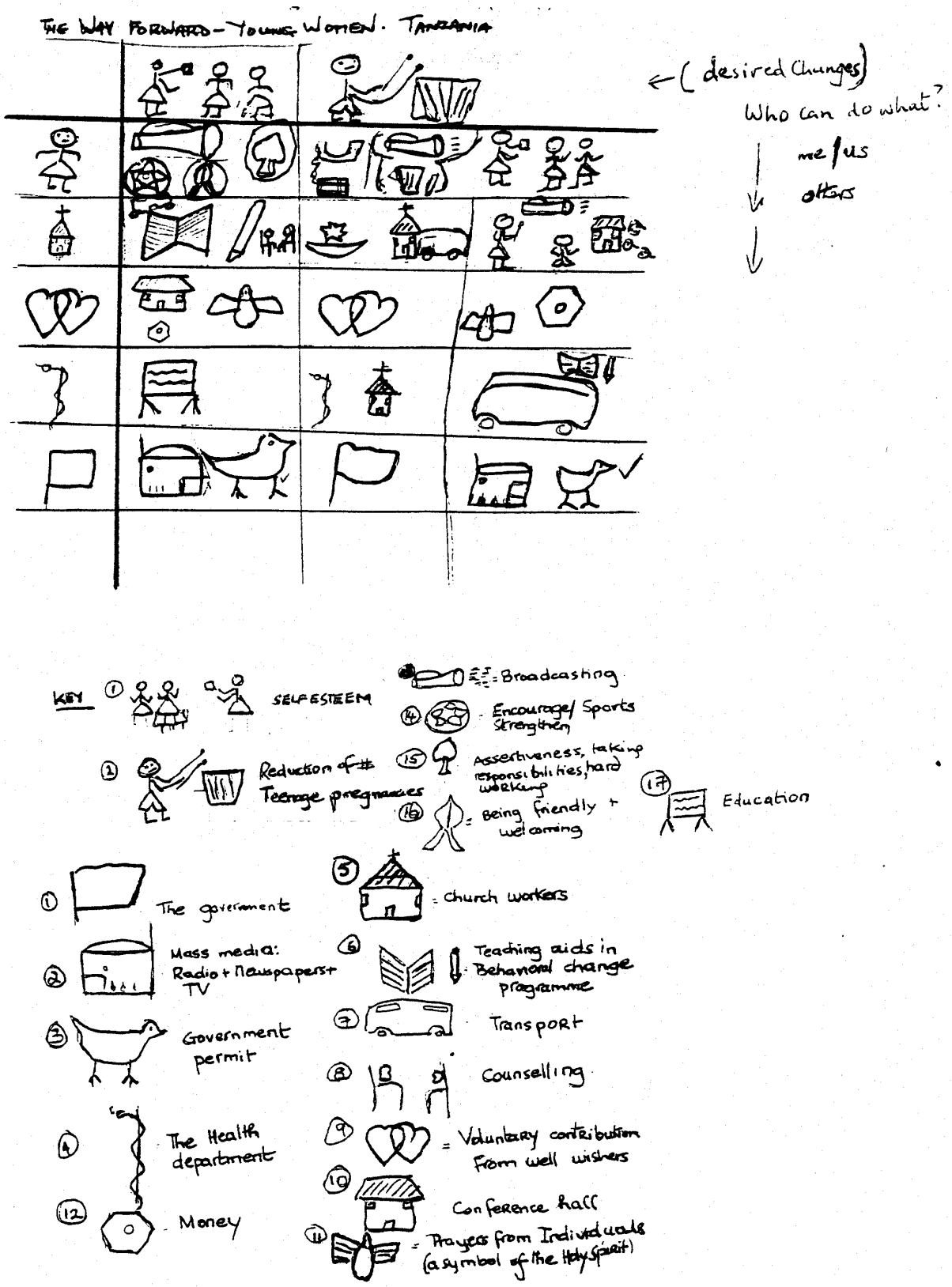

Figure 3. The way forward. Young Women. Tanzania

Outputs and outcomes

Using split sunburst diagrams and freeze work (also known as frozen role-plays or tableaux), communities identified positive and negative behaviour changes attributable to programme activities. Communities perceived behaviour change to concern more than personal sexual behaviour. It was also to do with achieving reduced stigma and discrimination against those infected/affected by HIV/AIDS and an increased willingness to acknowledge and care for people with, and children orphaned by, AIDS. Change was also evident through an increased sharing e.g. couples sharing information on sexual matters and fathers more able to talk about sex with their children. People also discovered how they misinterpreted each other's expectations. For example, in Zambia, married women said that men imposed dry sex on them whereas the men said it was the women who wanted it. When the two groups got together they realised that this practice was something inherited from the elders. The men are willing to have wet sex now.

Negative changes identified included, in some instances, greater dependence on service providers with people less likely to provide care themselves, greater distrust between young men and young women, heightened fear resulting from increased knowledge of HIV/AIDS and parents suspicious of programme activities with young people (because they were left out of the planning). Through freeze work communities also identified how they might strengthen the positive changes and minimise the negative aspects for the future.

The way forward

Community participants used a 'significant changes' diagram to identify priority changes for the future (see Figure 3). The illustration for young women in Tanzania shows the desired changes in the top row. In the row immediately beneath they identify what they themselves can do to achieve this. Subsequent rows identify what someone else can do to make this happen.

· Lessons learnt and recommendations

1. Participants' understanding of behaviour change in the context of HIV/AIDS

- HIV-related behaviour change is not just a matter of personal sexual behaviour. It is also concerned with reducing discrimination against and providing support for those infected or affected by HIV/AIDS.
- Changes in personal sexual behaviour are inextricably linked to an increased level of caring, sharing and learning among individuals and within a community.
- Personal behaviour patterns are not a matter of autonomous individual choice but are determined by a host of social, cultural, economic and gender-related factors and by major seasonal influences.

2. Programme approaches more likely to impact on communities' behaviour-related issues

- Communities' felt needs must be the starting point of any work. Behaviour change and HIV-related programmes will only be effective in as much as they are also concerned with communities' 'elephant problems'.
- Programmes must ensure all sectors of communities are active players at every stage, thus strengthening their sense of ownership and relevance and minimising risks of dependency. Equally, people with HIV or AIDS must also be active players, as appropriate, in planning and implementing programmes and in decision-making processes.
- Programmes need to take a holistic approach to addressing the complexity of traditional, cultural, economic and legal issues affecting behaviour. A narrow focus on HIV education and provision of care is unlikely to impact on behaviour longer term. Also, while Information, Education and Communication (IEC) activities are important in providing a basic understanding of HIV and its prevention, IEC alone is rarely effective in producing sustained behaviour change.
- HIV programmes must be set in the context of wider sexual health, teenage

pregnancies, Sexually Transmitted Infections (STI), infertility, sexual violence and other problems that are an integral part of people's lives.

- Any work on behaviour change needs to examine the roles of women and men, the relationships between them and the factors that determine the power/powerlessness of each.
- The review highlighted the connections between widespread gender-based domestic violence, (including sexual violence, physical violence and psychological abuse), and vulnerability to HIV and the need for programmes to address this as a central part of their work.
- It is essential to define what agenda or philosophy is informing programmes addressing behaviour change and whether this is congruent with the above points.
- Communities cannot be regarded as a single homogenous mass. No single set of authority figures can be considered to represent the situations of all community members. Similarly, no one programme activity will engage all community members or respond to their needs. The review stressed the importance of working with separate peer groups, based on gender and age, and perhaps on other locally relevant criteria such as HIV status, socio-economic well-being, religious affiliation etc. Integral to such a process is the step of also bringing the peer groups together regularly to enable intra-communal learning and sharing. Otherwise the result may be increased suspicion and misunderstanding between the groups.
- Programmes need to recognise the influence of the 'seasonality factor' on behaviour, to identify the specific seasonal commitments and pressures affecting the different peer groups and respond accordingly.

· Comments on the participatory process

The participatory nature of the review brought out considerations that were totally unanticipated by programme staff. Similarly the different age and gender groups discovered aspects of each others' concerns unknown until then and which may never have emerged in mixed groups or through less participatory processes.

Communities found the participatory process empowering. They welcomed the experience of actively contributing to the review and feeling a distinct sense of ownership for future directions of their programme.

The process was also empowering for programme staff. It identified community concerns not uncovered in a more 'top down' approach. It also identified organisational difficulties or shortfalls, some of which were being addressed immediately. The review highlighted organisational and political problems that adversely affected the Malawi programme and made it impossible for its staff to complete the review with all sectors of the selected community. This programme has since undertaken a major evaluation prompted largely by the experience of this participatory review. In Zimbabwe, the education department revised its mode of programming as a result of the benefits highlighted by a participatory process and the recommendations that emerged. In Zambia the programme immediately set about decentralising its service from the immediate catchment area of the hospital base and establishing a wider network of teams servicing further-lying rural areas. The Tanzanian participants report that work undertaken with other programmes in their support network is increasingly adopting a participatory approach. Within CAFOD, the HIV-related training and programme support work draws more firmly on participatory processes and takes the programme-related recommendations of the review as its yardstick for appraising funding proposals and reflecting with partner organisations on issues regarding behaviour change.

By looking at communities' general concerns the process avoided a narrow focus on behaviour change divorced from wider issues and influences. At the same time it afforded an opportunity to explore the impact on behaviour of these wider issues. It also allowed organisations to review the relevance of their programmes to communities' identified concerns.

Although participatory processes are widely used in community-based development work, they have only slowly been applied to HIV-related issues. Perhaps the very fact that HIV/AIDS is a taboo subject in all our cultures or that it inevitably touches on intimate issues of personal and community behaviour, has discouraged development workers experienced in participatory research techniques from applying these approaches to HIV/AIDS. Yet the group-specific, experientially-based and informal nature of this review enabled a degree of unbiased sharing on sensitive issues that might not have occurred with a more academically rigorous 'top-down' approach. Experiences described here, along with publications such as Stepping Stones[3] and Confronting AIDS Together[4], illustrate how participatory processes are eminently well suited to communities' exploration of HIV-related behaviour issues and demonstrate the advantages of participatory research techniques in drawing on people's lived experience to examine sensitive issues.

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Staff of CAFOD's International Division who collaborated in planning the review and preparing the report for DFID.

[3] Stepping Stones; A training package on HIV/AIDS, gender, communication and relationship skills. (Part of Strategies for Hope Series). Welbourn, Alice. ActionAid, London, England, 1995

[4] Confronting AIDS Together. Skjelmerud, Anne & Tusibira, Christopher. DIS/Centre for Partnership in Development, Oslo, Norway, 1997

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Learning to relearn givens

Jill Lewis

· The project

Living for Tomorrow is a three-year action/research pilot project at The Nordic Institute for Women's Studies and Gender Research (NIKK). It is working for HIV prevention with a key focus on gender issues affecting sexual beliefs and behaviour. It is actively engaged with people from countries belonging to the former Soviet Union, with its core action collaboration in Estonia, an active 'satellite' link to Lithuania and involvement from St. Petersburg in Russia.

The main efforts of the project are:

- to develop ways of working on sexual risk information and behaviour that radically centre the questioning of gender norms and traditions;
- to help people learn to use inter-active/participatory learning methods;
- to mobilise involvement of young people in HIV prevention, since it is the agency of young people themselves that will most effectively stem the epidemic;
- to develop commitment to inclusion and collaboration across differences: whether those be ethnic, national, religious, age, educational or sexual; and,
- to link research on gender and educational strategy to actual HIV prevention education

· Focus on gender

The project approaches HIV by exploring how gendered sexual behaviour, shaped by cultural and social norms, lean people towards risk sexual behaviour. The 'Living for Tomorrow' project argues that beliefs about how men and women 'are assumed to be 'naturally'' or are expected to behave 'as men or as women' form a very important part of what normalises unsafe sexual behaviour that spreads Sexually Transmitted Diseases (STDs) and HIV. Gender is seen as a social and cultural system that has institutionalised problematic inequality between men and women. If the dominant gender system in a culture normalises forms of passivity, complicity, dependence or disempowerment for women, and normalises forms of control, exploitation, access to power or force for men, that very gender system itself needs to be changed in order to support safer behaviour that depends on more democratic sexual relations. Drawing on recent gender and feminist research, and the most challenging of international debates on gender and AIDS, the project explores how a gender-focused approach could work for people in contexts where the discussions of 'gender' have not had wide circulation.

The participatory work aimed to allow participants to explore assumptions that shape masculinity and femininity in their daily lives. The work needed to be constructed in ways that made sense to people locally. The vision also was to root the initiative in Estonian contexts, develop local involvement, resource it with international data, analysis and debate and provide capacity building. From this we hoped to develop a 'core group' who would then continue to design and run workshops with young people to initiate mini-projects on the gender and sexuality theme with them. The project would document its vision, gender focus, methods and the implementation issues it faced to enable possibilities of transferability to other parts of the region, and to encourage stronger gender focus in sexual health education.

Setting things in motion

Core collaboration was established with The AIDS Prevention Centre, Tallinn (the capital

of Estonia) and its director, Nelli Kalikova. Preliminary meetings with people engaged in different dimensions of Women's Studies/Gender Research and sex education in Estonia helped identify how people understood and talked about gender and how the post-Soviet and new national independence contexts influenced the ways people thought about men and women. They began to establish a web of possible links between new Gender Studies work in Estonia, ongoing Nordic and international gender research, international data and debates on HIV prevention/education methods, and the people actually engaged in sex education/HIV prevention initiatives.

Stephen Clift[1] became consultant to the project. It was important for the gender-focused work to centre collaboration of a man and a woman in the active implementation of the work with participants. Women are often over-represented in sex education. To tackle the issues at stake in the spread of HIV, men's active participation is needed.

Recruitment of participants for the core group was slightly nerve-wracking. We needed people who showed signs of curiosity and excitement at exploring and creating new approaches, not people who constituted themselves as knowing experts and authorities on HIV. Also financial difficulties, poverty, low wages and limited possibilities in transitional Estonia, meant that it was complex, yet crucial, to find people really interested in working on *this* project, and not just on *any* project where there might be Western funding and links with the West. We also wanted people from diverse backgrounds, to create possibilities for new exchanges. 31 people joined the Capacity Building workshop, from which we would draw the core group; most from Estonia, 4 from Lithuania and 2 from St. Petersburg. Participants ranged from Women's Studies/social work/psychology students, AIDS Centre workers, teachers, gender studies researchers or lecturers, people whose lives were directly affected by HIV, people with medical backgrounds, youth workers etc.. The attempt was made to include men (though not as many as hoped for) and to have a diversity of people from both Russian and Estonian backgrounds, reflecting the population profile of Estonia today. Five or six people would then be needed from the Capacity Building group to commit themselves to take the project into its next stage of work with teenagers.

[1] Centre for Health Education and Research at Christ Church University College, Canterbury, England.

Capacity building

Capacity building work aimed to open up what we called 'critical literacy' about gender issues, in dialogue with sexual health/safety concerns and information about HIV and AIDS.

The concept 'gender' was new for most participants. In Estonia 'emancipation of women' or 'equality for men and women' have echoes in ideological impositions of a totalitarian Soviet past, a Soviet-stereotyped Western feminist hysteria or uninteresting Nordic neutering. Participatory processes are very foreign in post-Soviet contexts, where education had been disciplined and hierarchical, delivering expert knowledge to compliant students. An Estonian saying is that 'children may talk when chickens pee' (which means never). We hoped participants could experience the *feelings* of interactive learning and the energy it releases. Stephen and I also wanted to make evident the *processes* of running the capacity building, and model flexible collaboration involving good listening and support, criticism and humour.

The capacity building sessions ran over 6 days over 2 weekend workshops. We made a particular effort to link the 'importing' of the gender focus, unfamiliar to most Estonians, to real issues and conditions in daily life in Estonia; to find ways to let people themselves identify and discuss gender-related issues. We juxtaposed open-ended, interactive sessions, with input from Estonian research and international discussions, shifting methods and reflecting on how sessions were structured as we went along. We wanted people to access gender issues and interactive learning methods by experiencing them for themselves in the workshop, and to begin to reflect critically on the implications of these identified experiences. We also wanted people to be challenged and energised and for some of

them to be inspired to work further with the project. Each individual session had specific written evaluation feedback, and longer evaluation comments were sought at the end. Each day was organised under a thematic heading (see Table 1).

Table 1. Organisation of the workshops

Weekend Workshop 1	
Day 1: Setting the stage for collaborative work	• Welcome by Nordic Information Office, Tallinn • Ice breakers. Introductions: facilitators & participants • HIV/AIDS situation in Estonia & regionally • Project concerns, aims & possibilities • Where are we starting from? (1) • Taking stock of what is known (2) • The gendered scenario of sexual risk (3)
Day 2: So what's all this about gender?	• Why gender matters (4) • Current imaging of gender in Estonia (5) • Gender issues in Estonia today (6) • Gender assumptions in Estonian media (7) • Stories young people see (8)
Day 3: Where gender really matters: men, women, bodies, beliefs and behaviours	• The Male in Our Heads? (9) • So what happens ? What people say and tell.(10) • The gendering of sexual behaviour (11)
Weekend Workshop 2	
Day 4: Not just words and ideas: but a gendered, embodied self	• Reconnections & feedback from week • Working with young people: interactive strategies (12) • Embodiments of gender I (drama methods) (13) • Making a difference: what is known about changing behaviour (14) • Life in Estonia with HIV and AIDS (15)
Day 5: ' Doing IT': young people and sex	• From theory into practice: taking sex seriously (participatory method sample activities) (16) • Lessons learned (17) • Embodiments of gender II: loosening the borders from inside out (drama methods) (18) • Gendered sex and young people (19) • Embodiments of gender III: staging power (drama methods) (20)
Day 6: So where do we go from here?	Action agenda for Living for Tomorrow 1999: next stages of the project, processes of co-ordination; resourcing ideas; practical signposts -where to go next Concrete plans Winding up, taking stock: concerns, reflections, what people are taking away, and commitment to ongoing work Evaluation time Saying farewell

· The first workshop weekend

The opening welcome set the initiative within Nordic governmental priorities. The session on HIV/AIDS by the director of the Tallinn AIDS Prevention Centre anchored the project within national concerns with local support. The first workshop was on feedback collected in advance from participants about differences in problems and expectations young men and women face in Estonia today. This brought personal visions of gender into discussion, through small group debate and larger group discussions. It began reflection on the wider social and sexual implications that the problems identified raised (e.g. men and risk taking; women and fear).

The next workshop was based on findings by Estonian researchers about sexual knowledge and behaviour of Estonian youth (2). Instead of presenting the findings, we designed a questionnaire asking people, in pairs, to think what findings they would expect concerning boys and girls. These were then discussed in a group of everyone together in relation to the actual findings of the research where the discrepancies between participants' expectations and the findings were considered. Finally we watched an explicit but careful Danish sex education video made for young people, some key extracts from the film 'Kids[2]' (3) and discussed informally 'cultural framings' (i.e. images of sexual behaviour that circulate through education and the media) of images of sexual behaviour and information.

The next day began by placing concerns of the project within international research and debate on sexual health and the AIDS epidemic (4). Then a 'doing' workshop session followed which was based on magazines and newspapers obtained from that morning's newspaper kiosks (5). In small groups, participants took this material, which included subjects ranging from sports, porn, food and teenage magazines to home decoration etc., from Estonia, Russia and other countries, and made separate collages of images of men and images of women. These were then mounted on a wall for 'men' and one for 'women' and participants guided a partner round the images, explaining to them what a man is and what a woman is, based *only* on the images. A huge amount of humour and argument and surprise was generated from this.

Two 'formal' presentations from Estonian Women's/Gender Studies lecturers, followed. It was important, given the general unfamiliarity, and indeed, some scepticism, concerning the use of participatory practices, to include formal, more familiar formats as well. This generated discussion of different responses and receptiveness to these sessions in contrast to other interactive ones. The talks highlighted how differences between men and women are historical, social and political. The first brought into discussion recent findings on how the situation was changing since the collapse of the Soviet Union (6). A general belief that 'men and women are equal in Estonia' co-existing with the sentiment 'we are now free not to be the distorted 'working' women of soviet ideology, but real, free, feminine women' was set alongside new data on the impoverishment of women, lower pay, the increased tensions in domestic life and generated very intense discussions of information and personal experience.

A talk by an Estonian journalist/researcher analysed how women are represented in 'political' coverage in a popular Estonian newspaper (7): how men's authority and influence is stabilised in how their activities are reported, while women in politics are trivialised. An evening session (8) showed the video *Dreamworlds II* which critically examines how sexuality is exploited in MTV rock videos to normalise men's and women's sexuality within certain assumptions of violence and abuse. The discussion and beers, with people, all sitting round on the floor in a close cluster, lasted long into the evening. The shift from Soviet censorship to free-flow Western media and its commercial usage of sexuality was discussed in relation to youth culture and sex in Estonia today.

A workshop session, inspired by findings of the Women Risk AIDS Project research (9), had small groups agreeing or disagreeing

[2] *Kids* is powerful film from the US, filmed from the perspective of inner city teenagers, which focuses on the type of boy-girl behaviour that leads to the spread of HIV.

about women's and men's sexual behaviours. Statements had to be allocated to true, false or unsure categories, such as:

- 'Women's priorities in sex are to please men';
- 'Women have difficulty telling men about their sexual desires' etc.

Participants circulated amongst the groups in order to see how groups had allocated the statements, and people explained why and how they had taken decisions, and also, where disagreements lay. Huge discussion was generated by this, both between and within men and women. A relaxed meeting, with very active discussion followed with an Estonian director who had produced a play from 'sexual biographies' collected by researchers in Estonia and taken the production into discussion with audiences (10). Gender issues were featuring more and more in the participants' discussion. A lecture, and question/answer/comment session ended the first 3-day session (11). It brought into critical focus the gendered sexuality issues that sexual health interventions need to address, incorporating issues raised during the first 3 days.

People were asked to keep notes and cuttings about conversations or issues observed during the process that related to our discussions and bring them to the following weekend session. Care was taken in the warm-up and 'saying goodbye' processes to strengthen connections within the group.

· The second workshop

A week later, after starting proceedings with group activities to set adrenaline going again, and reporting back on the week's observations, we set up activities modelled on participatory learning work from Health Wise[3]. We used 'problem letters' written to a youth publication by young people in Estonia to set up a concentric circle carousel, where participants seated in the inner ring presented problems to those rotating in the outer circle and listened to their 'constructive advice' (12) concerning how to resolve the issues identified in the problem letters. Then there was discussion about the diversity of available advice, the complexity of dealing with specific problems in specific lives and the difficulties faced in communicating effectively.

There were three drama workshops focused on gender and sexuality run by two actors from the Split Britches Company[4] (13, 18, and 20). Their own productions focus with humour, critical insight and generosity on the tensions of masculinity and femininity. They drew on forum theatre methods, and got participants moving, miming, acting embodiments of noises and power, gesturing large and small, throwing imaginary body parts into the circle etc. People in pairs made safer sex slogans and produced, with their bodies, an image for them, which was photographed with an instant camera and mounted onto a wall display. Objects from pockets formed a basis for recounting half-memory/half fiction stories of love, sex or romance, told in the first person, then passed on and retold in conjunction with the object. The circulated, altered stories were told to the full group, who then picked ones where gender and power were at stake and staged the story with members of the group. The final act was to change the body language of one person in the story to see what different story could then be read from its embodiment.

We discussed how research on sex education shows only limited behaviour change, when people are just told what to do. We considered how evaluation and research could help inform more effective engagement with young people's awareness and behaviour change and how actual education is crucial (14). Evenings of informal discussion with people living with HIV and AIDS provided the participants more private time spent in small groups with no large group feedback (15).

We sampled ways of conducting gender-focused warm-up/icebreaker exercises (16), and circulated examples of exercises that could be adapted for workshops. We discussed preparing and facilitating participatory methods in the next workshop, telling people

[3] Cohen, J. and Wilson, P. *Taking sex seriously: practical sex education activities for young people,* Health Wise, Mersey Regional Health Authority, Liverpool, UK.

[4] A feminist theatre company whose performances challenge gender norms and which teaches about drama and gender

how we prepared sessions and how we processed what has happened together, providing critical feedback, identify what the theories behind the practice were etc.(17). People reflected on their own responses to the experiences of the participatory workshops. They discussed their feelings of ambivalence, their feelings of being 'enabled' and empowered, as well as their moments of resistance at certain points during the workshop sessions, in the context of their other 'non-participatory' educational experiences.

The final day focused, by way of small group discussions, on taking forward an action agenda for the project, looking at what the next stages might look like. 11 people volunteered to join the 'Core Group' that would be central in carrying the project forward in Tallinn.

Next steps

Following the capacity building, the Core Group met regularly, independently and through e-mail dialogue with NIKK project co-ordinator and designed and organised eight days of workshops, held at weekends over 2 months at the National Library, for a group of 25 Estonian and Russian 15-16 year olds. The teenagers, recruited from Estonian and Russian schools in Tallinn, were contracted into the project, and were given certificates recording their participation. All parents were informed about the project and were given opportunities to learn more about its work. The Ministry of Education and School Principals gave support for time off from school for some of the youth workshops. Some young people conducted video-interviewing projects on attitudes to sex and gender; some of them are now finalising a 84 page booklet called 'How To Bridge The Gaps Between Us?' on gender and sexual relations and safer sex, including a ten page 'vocabulary' in Estonian, Russian and English, of words relating to sex and gender. In August 1999, the majority of the Core Group established themselves as an NGO and drew up 3-year action plans in order to take their work further across Estonia, for which they are now trying to seek funding. Activities to date have included presentations at various national and international fora and dissemination of materials through articles and on the world wide web.

· Conclusion

HIV and AIDS is partly an epidemic of poverty and social vulnerability, where resources for education and health are too limited, where despair about changes and survival permeates peoples lives, but it is also an epidemic moving along very nerves of life and diverse interpersonal relationships in negative ways. The focus on critical literacy about gender and power in people's lives and the often problematic terms of men and women's sexual relations, along with the engagement with collaborative learning and education processes, appears to have opened up an interest and energy in people to acknowledge the problems and become an active part of creating some part of the solution. There is now an urgent need for the multiplication of energies to engage in the participatory and gender-focused work of more effective prevention processes, in every country in the world, in the face of the relentless spread of HIV and its dire human consequences.

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For further information about the project see: www.nikk.uio.no/Instituttet/Verksamhet/LfT/LfTE.html

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Putting breast cancer on the map

Helen Lynn, Diana Ward, Cathy Nugent, Laura Potts, Liz Skan and Nicola Conway

· Background

'Putting Breast Cancer on the Map' grew out of the work the Women's Environmental Network (WEN) has done on polluting chemicals in the UK over the last ten years. The project developed out of a need identified by women to participate in positive action to bring about change in the minds of the government and medical establishments, as well as society at large, about the way in which breast cancer is viewed, treated and politicised in the UK.

The primary basis for this research has been the rising incidence of breast cancer in the UK, where the estimated lifetime risk for all women is now 1 in 11. Levels of incidence have increased every year this century[1]. The disease was comparatively rare 200 years ago but today it is the commonest cause of female cancer death and the top overall cause of death for women aged under 50[2]. In world terms, breast cancer incidence has increased by 33% between 1987 and 1997 (Lancet 1997). But of equal significance in terms of the design and focus of this research is the growing concern that the contributing cause of the disease may lie in the state of the physical environment we inhabit (Read 1995; Steingraber 1997).

Research carried out in Israel (Westin and Richter 1990) and studies of Long Island, USA (cited in Read, 1995; Steingraber 1998), Cape Cod, USA (Silent Spring Institute) and Lincolnshire, UK (Watterson 1998; Rattanamongkolgul et al., 1998; Dispatch 1994) have highlighted the necessity to consider the state of our lived environment to be a significant risk factor for breast cancer. Research into genetic and heritable determinants of breast cancer has proliferated since the discovery of the marker genes BRCA1 and BRCA2[3] in 1994, despite the fact that inherited breast cancer accounts for only 8-10% of all cases (Kelsey and Bernstein 1996).

In 1995 WEN submitted a petition called the National Action Plan for Breast Cancer to the Department of Health. The 80,000 signatures on the petition highlighted the need for better care and treatment of women with breast cancer. The petition particularly called for more emphasis on prevention to stop the epidemic of breast cancer for present and future generations. Petitions are an intrinsic part of campaigning and a useful tool in terms of developing networks, raising awareness and getting the issue 'out there'. However during the lifetime of the petition, it became clear that there was a distinct lack of places to refer women to when they contacted WEN with concerns about possible links between breast cancer and their environment. Women wanted to do more to publicise the breast cancer issue than sign their name to a piece of paper. They wanted to be active in campaigning at both a local and a national level to raise awareness about breast cancer and the urgent need for prevention. This need for participation developed into the project network that we continue to play a part in to this day.

WEN identified the need for a focal point for reporting and collecting women's concerns about their health and environment. A project was devised around a means of collecting this

[1] Breast Cancer Campaign (BCC) 1997; Cancer Research Campaign, (CRC) 6.2, 1996; Zeneca 1998.
[2] BCC 1997. CRC, 1997, 1996.

[3] BRCA1/BRCA2 are human mutated genes that indicate a predisposition to breast cancer, with a 75-85% lifetime risk for people carrying these genes to develop the disease.

information via a questionnaire and a map drawing exercise. Project workshops were organised to facilitate the mapping process and as a method of engaging and supporting women to express these concerns about breast cancer and the environment in a group setting. In 1997 we submitted a successful bid to the National Lottery Charities Board who granted us £135,000 for a two-year project.

· Project design

The project focused on new ways of collecting information in a participatory, non-threatening and empowering way, using the network that had already begun to form. Traditional epidemiological methods of research do not usually involve the individuals or communities affected by a particular pollution source other than as study subjects and are characterised by a top-down approach. This effectively excludes local communities from participating in processes by which knowledge about health and the environment is collected. Involvement in policy or decisions reached and input into plans for change or improvement is therefore limited. There is little or no room for personal experience and concerns to be voiced by community members. A different method of collecting information was needed in order to involve women and their communities directly in the study by asking them to be their own experts. We contacted women's studies programmes for information on women's research methods. This proved useful in terms of reaffirming the value of qualitative research methods as a means of collecting women's perceptions. One of the most useful packs of information utilised was one on Participatory Appraisal from the Institute of Development Studies (IDS) at the University of Sussex. It illustrates how participatory mapping methods have been used to explore issues as diverse as women's time usage, land usage, sexual health and body image.

The project asked participants to be the researchers, as they already possessed all the skills, knowledge, experience, enthusiasm and local knowledge necessary to compile maps. They also had a vested interest in themselves, their communities and their environments to do this and this was what was missing with traditional methods of research. As one woman wrote:

"I am very concerned that breast cancer seems to be quite prevalent where I live but I can't really say or put my finger on any one thing, there seems to be so many and it becomes bewildering at times".

By involving women actively in the research process, the project sought to build on women's concerns and reach out to women all over the country to make the kinds of connections that might help identify avenues for change.

Mapping

The idea of drawing maps came from the women who were involved in collecting signatures for the petition. They were concerned about high incidence of breast cancer and what they perceived as 'clusters' either in their work or living environment. Although a number of academic and independent studies have investigated certain identified clusters, few definitive answers have been found. The definition of a cluster, as stated by the National Cancer Institute, is the occurrence of a greater than expected number of cases of a particular disease within a group of people, a geographic area, or a period of time.

Yet most clusters are initially identified by concerned residents who may live in what they define as a high incidence area or cluster. When investigated however invariably their concerns are dismissed but they are still left to worry that certain elements of their environment were overlooked. For example in the West Midlands, research around a particular landfill yielded no significant increase in ill health or breast cancer incidence. The local women knew this was because the area under study was governed by two different health authorities so the 'cluster' became half its actually size under each authority.

Maps have been used throughout history as a means of giving visual representation when discussing issues of importance, giving directions and locating landmarks. They are a very easy way of conveying information about how we relate to our environment and people tend to relate to them more easily than the

spoken word. Anyone can draw a map, you do not have to be literate or even speak a common language. They are also a good and safe way for people to convey different aspects of their lives that they may not readily admit to in words.

The background research began by looking for other examples of maps drawn by other individuals and communities. There were some very good examples of Parish maps from organisations such as Common Ground[4] and examples from America where people were reclaiming maps as a means of identifying their bio-regions. There was also some interesting work being undertaken by some trade unions and labour activists looking at risk mapping of work environments as a useful means of indicating health risks in the work place. However these offered very little guidance in terms of women mapping health effects.

Compiling maps seemed to be an ideal way of collecting information that reflected past and present experiences of possible environmental pollution. The idea of map drawing was difficult to get across to participants in theory which made the workshops an intrinsic and crucial part of the project. The idea was that maps needed to come from the participants themselves and they needed to be individual. Purposefully no specific example was given in the project information pack as it was felt that participants might 'copy' the example and so the ideas would not come from them but be dictated by WEN. Maps were a way in which women could identify these 'clusters' while maintaining confidentiality about themselves and other individuals locally. They also served as a way for women to recall things that had happened in the past and think through possible connections, as the following comments show:

"The mapping exercise was quite useful because it made me think of incidents nearby that had happened in the past. "

"With hindsight I remember 42 years ago complaining of the smell of ICI[5] when I lived at Norton on Tees (near Stockport). Air pollution was appalling in Billingham where my husband worked. My next four children were born, 2 months, 1 month, 6 weeks and 1 month premature - I developed breast cancer 31 years ago".

"When we first moved to the countryside I used to lose my voice when they sprayed the crops. All the family suffered from a feeling of grittiness in the eyes, some light headedness, headaches, tightness in the chest etc., when crops were sprayed".

Questionnaire

It was not enough to get visual representation from individuals about their experience. We needed to collect more personal written information in a questionnaire format. The project design was therefore two pronged with the more visual representation on the maps being submitted along with the written documentation in the questionnaires.

"After filling in this section [of the questionnaire] *I have suddenly become aware of the possible harm from the materials I used (in and around home) when unemployed. Previously I had not been concerned about them and thought the proximity of the Sellafield and Chernobyl cloud the likely causes (or contributory factor) of my ill health. It has made me even more concerned about the future health of my children (both still at university) especially my daughter."*

Information pack design

One of Wen's primary aims is to inform people about issues which link environment and health particularly in relation to women. We reviewed the health requests WEN had received, particularly those connected with breast cancer, in the last few years. Common threads emerged and these were used as a basis for the type of information which went into the pack. As one woman commented:

[4] Common Ground is an organisation working with communities on Parish maps and helps to encourage people to value their own surroundings.

[5] Imperial Chemicals Industries – one of the world's largest coatings, speciality chemicals and materials companies.

"Your information pack gives some interesting and useful sources of further information, for example details of pollution incidents from nearby factories and if I had more time that is something I would like to pursue".

Distribution and publicity

The information pack needed to be publicised all over the UK. The best way to do this was through our existing network and local individuals. A mail-out to organisations and individuals was completed with a letter, a sample article, and a poster, asking them to publicise the pack and the project via their network, organisation, newsletter, minutes of meetings, local women's centre, library etc. This was followed up with a phone call to elicit support, strengthen bonds and discuss ideas about promotion and possible workshops. The requests came flooding in. Individual areas were not targeted at this stage, only existing networks.

One of our best allies for promotion of this project has been the Public Sector Trade Union, UNISON[6]. This is largely due to the fact that Unison was campaigning for Lindane, a pesticide linked to breast cancer, to be banned and the fact that they have a very large female membership. The project was promoted by the National Women's Committee in 1998 thus adding to its publicity among Unison's members. Several other national women's organisations such as the Women's Institute, and the Women's National Commission. the Inner Wheel[7], and Breast Cancer Care were instrumental in publicising the project amongst their members on a national scale.

A press release was distributed to all the national papers, radio stations, regional media, magazines and publications from other NGOs and organisations. Media coverage was good with the biggest response coming from an article in The Guardian. One women's magazine proved to be invaluable in getting the word out there. Utilising local media was an obvious way of promoting a local campaign. Participants were supported in contacting their local media as a means of raising awareness locally and facilitating the formation of a network. While it may be quite difficult to attract the attention of the national media to a particular issue, it is easier to tackle the local media for coverage of a particular local event or campaign. This was an essential part of the press strategy for promoting the project locally.

Workshop publicity

Workshops were devised around the pack. A list of aims and objectives was compiled and the workshop developed to cover each of the aims and fulfil each of the objectives. The areas in which we held workshops basically chose themselves within about a month or two of distributing the pack, as participants rang with questions or to ask us if we would do a workshop locally. Particular regions were chosen according to criteria such as: local demand for workshop, written requests for information packs, local key contact, availability of venue, willingness for different groups to be involved etc..

Once areas were identified, at least one local person was sought to organise a venue, do some publicity and to speak to the media about local environmental issues. This local 'key' contact was supported by the resources of the WEN office and by the project's staff to provide a point of contact for the developing network. Issues of confidentiality were observed by checking with people as to whether it was acceptable to pass on their details to the key person. Letters were sent out to anyone in the area who had sent for a pack and then any organisation local to the workshop. This was done about two to three weeks before the workshop date and in some cases a full month. WEN members were also mailed. A large number of workshops were facilitated by Unison through their Regional Women's Officers who co-ordinated the event and publicity.

The key person was asked which day and time was best and the timing of the workshops were varied in order to discover if any one time was better than another. This didn't prove the case. All local press were faxed and then phoned and asked to publicise the workshop and the project using the local contact as a source of more information. Participants who had

[6] UNISON – Public sector trade union with over 1.4 million members in the UK.

[7] One of the largest women's organisations in the world.

returned a questionnaire or request were contacted with details of workshop. On the evaluation sheet at the back of the questionnaire, participants were asked if they wished to be more involved in the project and in what way. This was used to assess if people wished to become a local contact point or work on the project with as little or as much participation as they could give.

Workshops

The workshops began with a pilot session, which was planned for members of the steering group of the project, the WEN Board and local women we had identified as having expressed particular interest in being involved. The feedback from this workshop was incorporated and used to modify proceedings in preparation for the next workshop. After the initial two to three workshops, the format was changed around dramatically, as it was found there was not enough time at the end of workshops to do justice to the map drawing exercise. It soon became clear that although current concerns and exposures were relevant, so too were participants past experiences going back to birth, given that contaminants and health problems may arise from as far back as twenty years or more. In some cases, pre birth exposures could have led to breast cancer or other health effects evident today. Participants were encouraged to map their life from the cradle to present day.

The geographical area covered by the workshops was extensive. We had workshops in England, Scotland and Wales but not Ireland. We were unable to cover a few areas where we had been invited, such as the Isle of Man. In some places, we were helped by volunteers, who became workshop facilitators. The attendance at our workshops varied greatly. A poor attendance in Bristol could have been because it was held on Bonfire Night (but the only time available to the women who organised the event in Bristol). We know some of the women involved in setting up workshops, and for some it was the first time they had organised anything like this, were disappointed with the turn-out. We had some discussion about what might hold people back from coming. Not being ready to talk about the issues may have been a major factor. On the other hand, we saw from the evaluation forms that many participants heard about the project from a wide range of sources including women's magazines, local press, local authority meetings, friends, through their union, through specialist journals etc. This indicates the project had an appeal to a very wide range of people and therefore attendance was not necessarily linked to content.

Attendance was certainly related to the amount of work that went into the organisation and one telling example is the Leeds workshop: 30 women attended after the local council had sent out around 1,000 invitations. Attendance was also linked to special conditions: in Boston, Lincolnshire, a good coverage in the local press brought in 20 people over the course of 4 hours. There is, of course, a great local concern about breast cancer in Lincolnshire, which has a higher than average incidence rate. When we went to more remote places, such as Launceston in Cornwall and Wales, the women who came were very gratified that a national organisation had made the effort to travel there.

Although we would liked to have done more workshops and to have met more women, we did get a wide cross-section of women attending the workshops, women with breast cancer, environmental activists, trade unionists, women from women's groups and health workers. For example in Cardiff, staff from the Cancer Registry attended the workshop leading to a good discussion among women who had experience of breast cancer and the group. In Hull a current and an ex-employee of the Ministry for Agriculture Fisheries and Food (MAFF) contributed alongside breast care nurses and activists from Friends of the Earth (FOE). We met our objective of getting together people looking at different parts of the breast cancer jigsaw and have started to form a unique network in England and Wales.

Observations by workshop participants

Positive comments indicated that the workshop was interesting, thoughtful and that it had raised awareness. Participants also stated that the mapping had been made easier through their involvement in the workshop. Criticism related to the complexity of issues. For example one person felt there had been a

lack of prior information; a few felt they had not had long enough to absorb the information; others wanted different kinds of information e.g. breast cancer information. On the other hand, some participants felt more information would have been overwhelming.

Specific suggestions were made for improvements in the workshops and future inclusions in our work:

- ensuring disabled access was *always* available;
- providing more positive advice on protecting our breasts and what we can do as individuals. For example breast-feeding was mentioned, as women need to know this has a protective effect for women who have babies at a young age;
- providing more information about breast cancer itself and about the environment;
- information about breast cancer in men and perhaps more targeting of men;
- scientific information more accessible; and,
- more focus on action and follow-up.

From the analysis of the workshops we can conclude that the most successful part was the content as people felt this to be thought provoking and informative. The most disappointing part of the workshop was the length; people felt they wanted more time. This was particularly true when the workshop had to be reduced to two hours due to constraints of time or availability of venue. From the comments we saw that some people wanted the time to discuss further action and follow up.

Observations and reflections of the facilitators

The time when we were organising, presenting and following-up on the workshops was a very intensive one for the team. At times we got quite fed up with the limitations of a privatised 'public' transport system especially when travelling to some of the more remote locations. Yet this was an exciting and very important experience. There was a positive two-way interaction between ourselves and the participants in the workshops, improving *our* understanding of many issues; we gathered information that we were able to feed *back* into the workshops.

The central focus on interactive mapping in the workshops was a powerful tool for drawing out both historical and/or environmental information. We were able to create group pictures of local concerns, where participants were able to spark off each other's ideas and recollections. Using 'fun' tools like fuzzy felts and bright coloured pens helped to demystify the whole mapping process. The environmental factors identified in the workshops were echoed in the respondents' maps. Flip charts were used to generate discussion about local sources of pollution and this information was used to compile a 'fuzzy felt' map of the locality to illustrate how participants could began to imagine their maps.

This information creates an interesting picture: pesticide use was highlighted universally, even though many women did not live in a rural area. Traffic pollution was a common worry. Heavy industry, in these de-industrialised times was not a large factor. The new commonly perceived industrial hazards seemed to be computing and photocopying. We also got some information which was relevant to the location, for example radon in Kettering or the dye works in Leicester. Through the mapping exercise, we created personal and individual histories which participants were able to share with each other. Sometimes we were able to experience the landscape we visited before jumping back on the train to London.

The free-ranging discussion and mapping in the workshop allowed us to broach, if not address in depth, various political issues such as the interaction between poor social and economic conditions and a poor environment. In some instances (e.g. in North Wales) we also talked about the difficulties of getting council and health authorities to even *listen* to our concerns. Most importantly we felt that we had given women who had breast cancer the chance to ask the question 'why me?' and to explore some of the possible answers. This was therapeutic but far more importantly it was empowering with a big 'E'.

· Next steps

The bringing together of the various strands of the process produced a dynamic and 'living' picture of breast cancer incidence in the UK and possible factors which affected it. When the completed maps and questionnaires were returned to WEN, each one was given a unique reference number. The information from the questionnaire was entered onto a database at the office and analysed. In order to get the maps onto the computer a picture was taken of each one using a scanner and this allowed it to be viewed on the screen and used in the report. With the co-operation of The London School of Hygiene and Tropical Medicine, a Geographic Information System (GIS) was set up to pinpoint and locate participants and local sources of environmental pollution identified. The idea was to link each questionnaire with the geographical point on the map which represents where participants had lived or are currently living.

From an analysis of the first 545 questionnaires received, 320 maps and contributions from 26 workshops, the project participants identified a large number of breast cancer clusters and a significant number of 'hotspots' for breast cancer. The term 'cluster' was defined as 3 or more cases of breast cancer occurrence in the same location, e.g. street or place of work, in the same time period. In addition, participants were very concerned about the high incidence of breast cancer in the UK, and the increase in health problems which have been linked to environmental pollutants such as asthma and hay fever. This was expressed especially in connection with air pollution from traffic and industry.

As a result of this project WEN has put forward a number of recommendations calling on the Government to commit a large part of annual health spending to a comprehensive programme for primary prevention of breast cancer. WEN also calls for a further analysis of Health Authority data on breast cancer incidence and prevalence by locality. We want prevention of breast cancer to be very high on the agenda.

WEN recommends making women and children's health the prime indicator of the state of the environment and acknowledging women's experience and knowledge about issues to do with their health. This could be utilised as a valid and valuable resource base from which to initiate official research programmes.

Including women as active participants in shaping this project 'Putting breast cancer on the map' has raised awareness, empowered and affirmed women's own knowledge. Women all over the UK have mobilised themselves to take forward the issue of breast cancer and environmental pollution. They are beginning to ask more questions, feel the strength of the network and develop the scope of the project beyond breast cancer to the larger issues of environmental impacts on both our health and that of future generations.

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NOTES

The above extract is from the *Putting Breast Cancer on the Map* Report. For a copy of the project report (priced £16 including post and packaging), the information pack (send an A4 sae with 66p stamp) or the Project Executive Summary (send an A4 sae with 39p stamp), please contact: Health Project, Women's Environmental Network (WEN), P.O. Box 30626, London, E1 1TZ, UK. Tel: +44 (0) 20 7481 9004; Fax: +44 (0) 20 7481 9144. Website: www.gn.apc.org/wen.

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22

Preference ranking: a cautionary tale from Papua New Guinea

William J. Fielding and Janet Riley, with a response from Robert Chambers

Feedback is a forum for discussion in *PLA Notes*. It features articles which raise common concerns or challenges in fieldwork or training, together with a response from another practitioner of participatory approaches. Letters and articles are welcomed for this section, as are your comments on any of the issues raised by ***Feedback***.

• Introduction

Preference ranking is commonly used in participatory research to *understand* local people's preferences and priorities. These can include characteristics, aspects of a new farming method or more general development needs. Ordered lists are an important result of preference ranking, which can be used to guide researchers' future investigations or plan policies.

However, some problematical aspects of ranking and their interpretation have already been raised in *PLA Notes* (See Fielding, Riley & Oyejola, *PLA Notes* 33, October 1998). This article raised the importance of having a sufficient number of respondents in the study before differences in the ranked order of a list of items can be reliably identified. In the current article we discuss some ways in which ranking techniques can be misleading and limiting, and suggest some solutions. One method used to obtain a priority ranking of a list of items is to ask respondents to put each item in rank order; the numbers associated with the ranks are then added across all respondents and the totals are used to obtain an overall ranking from the group.

An example

Consider the following example. Four farmers are asked to rank five characters of a tree species using the numbers 1,2,3,4 and 5 to indicate worst to best respectively. In practice, farmers may be given counters to allocate to the items being ranked. Suppose the following ranks were obtained (see Table 1). The 'TOTAL' column, containing the sum of the numbers associated with the characters, can be used to give the overall preferences of the four farmers. In this exercise the farmers felt that the tree species was most useful as a building material.

Table 1. Example of a preference ranking method

Character	Farmer 1	Farmer 2	Farmer 3	Farmer 4	TOTAL
Fodder	1	2	2	3	8
Thatching	2	3	3	2	10
Straw	3	4	4	1	12
Fire wood	4	5	1	4	14
Building	5	1	5	5	16

An example using two methods of obtaining preferences

In the example above where five characters were ranked, farmers were asked to allocate the numbers 1,2,3,4 and 5 to each character. This system allows each respondent 15 'votes' to be allocated, but only in a specified way. Another method of obtaining preferences is scoring. Here there is a fixed total number of 'votes' or counters which respondents can allocate as they wish. The literature contains many examples of both ranking and scoring methods. But can the choice of method have an effect on the final ranks and hence conclusions? Does it matter which method is chosen?

In a recent biometry training session in Papua New Guinea, 13 researchers were asked to indicate the relative importance of five problems which were thought to be constraining agricultural production in the country. They were asked to do this using two different methods, so that the two methods could be compared:

- *System 1 (ranking):* they ranked the problems in order of importance using a simple 1, 2, 3, 4, 5 ranking system (as described above).

- *System 2 (scoring)*: they were asked to score the same five problems by allocating a total score of 25 'votes' between each of the five problems. Thus if a respondent considered all problems to be equally important, a score of 5 would be given to each; if only one problem is considered important this could be given 25 votes and the remaining problems no votes (see Table 2).

The total scores obtained from the researchers using Systems 1 and 2 are given in Table 2. It can be seen that although there is general agreement between the two ranking methods, different total rank orders are obtained. For example, using System 1, it seems that 'lack of suitable varieties' was regarded as the most important constraint. However, looking at the results from System 2, it appears that 'weed problems' are the greatest constraint. Thus it seems that the two methods have produced different results from the same group of people, to the same questions under the same conditions!

Statistical analysis was carried out to see if these rank orders were equivalent and, if not, which one was correct. The analysis revealed that there were statistically significant differences between the five totals. Using the same statistical technique for the corresponding 13 datasets in System 2, significant differences were also revealed between the five System 2 totals.

Thus, the statistical analysis indicates the differences in the scores are large enough for us to say that some problems really are more important than others. However, when multiple comparisons are calculated between the total scores within each system separately, the results indicate that there are different significant groupings in the two different total rank orderings and thus the order of the lists is not equivalent. If there were similar significantly different groupings in the two datasets, the two systems could be assumed to have generated equivalent results. The same would apply if no significant groupings were found in both datasets. Thus the statistical analysis indicates that the two methods have produced a different set of preferences, either or none of which may be correct.

Clearly we would not like our conclusions to be dependent upon the method used to collect the preferences. In the above example, the two methods produced different results from the same group of people, to the same questions under the same conditions. This is a worrying observation and it would require triangulation of the results (checking the results using data from other sources, if they exist) to verify which ordering is correct.

Table 2. Results from two preference methods

Problem	System 1 Only ranks 1 to 5 allowed	System 2 Scoring with a total of 25 'votes'
Weed problems	43	86
Pests and disease problem	43	73
Lack of suitable varieties	47	64
Poor market price	30	53
Lack of markets	32	49

Two preference methods discussed

System 1 is rigid and does not allow respondents to express their views in as much detail as System 2. An exercise which allows 15 votes to be split at will between 5 items and so allows for ties, is a system 2-type method. However, use of only 15 votes reduces the range of preferences which can be expressed**.** For this reason, the second ranking method may be preferred. However, the second method can be more confusing for participants; some of the researchers in this experiment failed to allocate exactly 25 votes. If they had been given exactly 25 counters and told to apportion all of them between the five problems, this would have overcome the problem. As a result of these demonstrated differences, it is reasonable to ask what properties a 'good' ranking/scoring method should have? We feel that an appropriate method should:

- allow each item to be equally preferred (i.e. given the same score);
- allow extreme preferences; and,
- be simple to administer/explain.

Ranking (System 1) always fails the first two properties listed above, whilst scoring (System 2) always allows equal ranking of the items. Scoring is also easy to administer/explain if the number of items being compared is small (six or less). If the number of items to be scored is exceptionally large (more than six), we suggest that for practical reasons five times as many counters as items are allocated between the items. So if there are eight items, 40 (5 times 8) counters are given to each person. Scoring also allows the possibility of greater differentiation between items which then makes it easier for the researcher to focus on items with similar scores and those which are extremely different to the next ranked item.

Because, as we have seen, the method chosen can influence the results, the interpretation of the scores must be made with caution. Simply applying statistical tests is not a solution because different tests can give different results (Riley & Fielding, 1998). Probably the best solution is for researchers to collect data from as many respondents as possible and look at groupings within the total rankings and investigate how each grouping differs from the next grouping down the ranked list. Then triangulation of results with other sources should be done whenever possible, in order to assess the validity of the study.

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Feedback… Feedback… Feedback…

- **Preference ranking: a response from Robert Chambers**

Fielding and Riley have illustrated the point made by Maxwell and Bart in *PLA Notes 22* (February 1995) that adding up numbers in ranking is statistically illegitimate and can mislead. One reason is that ranking does not show the size of interval. In this context, as they say, scoring methods are better. It is useful that they have also given a clear example of different results from adding up.

Two sets of comments seem pertinent. The first set is within the numbers paradigm. The second set is beyond it.
Within the numbers paradigm, the weaknesses of ranking compared with scoring have been explained in the article.

It is useful to go further and recognise that there are many different methods of scoring and estimating with matrices and that these have varied strengths and weaknesses. They can also be conducted with individuals or with groups. Those with statistical backgrounds may tend to prefer individuals to generate commensurable numbers. Some of the more commonly used methods (following and qualifying Maxwell and Bart 1995) include the following.

- *Scoring each box out of the same total.* This is the most common method. Each box is scored out of, say, 5 or 10 (16 has been used in Bangladesh for rice varieties). Boxes can be left blank.

- *Restricted scoring by column or row*. This allows the same fixed number of units to be distributed in each column or row.

- *Free scoring*. Allowing any number of counters to be placed in any box.

- *Voting systems*. Each person has a fixed number of counters and places these as votes. This is often preferred by people in the North, but is weak because late voters have more influence, having seen how earlier votes have gone.

- *Restricted overall scoring*. A fixed number of counters, often 100, are distributed between the boxes as scores.

- *Restricted overall estimating*. A fixed number of counters, often 100, are distributed between the boxes as estimates.

This is not the place for a detailed analysis but, in my judgement, the first, third and sixth points are the strongest.

- Scoring each box out of the same total is easily understood by participants, who usually quickly take over the process and argue freely. It is easy to inspect, interpret and discuss. It allows fine judgements and compromises.

- Free scoring overcomes problems of weighting. It allows an individual item to be heavily scored for a key characteristic in a way which is not as easy with any other method.

- Matrix estimating is a powerful method for estimating and allows adding up. If a total of 100 units are used, rows and columns can be added up to give percentages, for example of the relative importance of different crops in different agro-ecological zones. Beyond the numbers paradigm, there are several key points. Some of these are illustrated in Drinkwater's fascinating and revealing account of matrix scoring in Zambia (see *RRA Notes* 17, March 1993 pp. 24-28) 'Sorting fact from opinion: the use of a direct matrix to evaluate finger millet varieties':

- *Learning process.* Much of the value of matrix scoring is the process of analysis. Hearing the arguments, watching the interactions, sensing the power relations between individuals, and especially seeing how scores are debated and changed, can reveal more about the complexities, subtleties and variance in the realities and judgements than the scores themselves.

- *Whose analysis? Whose learning?* Farmer and other analysts themselves learn much from the process. As Drinkwater shows, they learn from one another. At the end of a good process they have a different understanding from the beginning.

- *Whose reality is expressed?* In any group certain individuals may dominate. Observing and interpreting interactions, and understanding the interests and views of dominant and subordinate individuals within a group deserves attention.

- *Empowerment*. Well facilitated, matrix scoring, like many other PRA-type methods, empowers the 'lowers' who carry them out. In some of my recent field experience in Eritrea, it was after matrix estimating that the village leader changed from *"whatever the government says is best"* to *"now you can see why your land policy will not work"*.

A valuable part of the process is often the discussion which follows, using the matrix as a visible agenda from which items can be picked out. This can be a wonderful experience of learning, often about topics one did not know to ask about.

Thus it is often the non-numerical aspects which matter. As practitioners, we need to exercise care to keep the reductionism of numbers and statistics in their place as useful tools, applied where appropriate to illuminate and enlighten, but not allowed to divert us from process and learning. For the realities which are analysed and shared are often complex, diverse and dynamic and are mediated through judgements and interactions. It is through facilitating good judgement and interactions that we can find ways of doing better.

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• Authors' reply

We are grateful to Dr. Chambers for his comments and we just like to add a few of our own. As Dr. Chambers points out, the discussion process involved in any scoring/ranking method may be more informative than the numbers which are collected. Therefore, the exercise is useful in the *understanding* aspect of participatory studies, which is one of its key features. This is something not necessarily reflected in the data.

However, it is increasingly difficult to escape the 'numbers paradigm' and, as decision makers look for justification for their choices, numbers are an obvious support to them. Therefore, the researcher must, however reluctantly, be able to assess the limitations of the conclusions associated with a data set, so that a reliable interpretation is put on the data. In this context, statistical methods can be useful.

As Maxwell & Frankenberger (1995) write: 'It is important to recognise that both quantitative and qualitative techniques are tools that play a useful and complementary role in improving our understanding' and that 'sampling considerations also apply to qualitative information'. What this real example shows is that the interpretation on a set of preferences depends upon the method of data collection and the method of analysis. Therefore, any interpretation of this type of data probably should not be made solely via statistical analysis. Thus we conclude that there is a need for checking results from other studies.

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23

Tips for trainers: Analysing personal dilemmas

Randini Wanduragala

· Introduction

This is a way in which staff of an agency can be helped to link some of the root causes and possible needs of a situation to the particular dilemmas of individuals in communities with whom they are working. This exercise is suitable for groups with a maximum of 20 participants, although a smaller group is preferable. The group can be either mixed or single-sex.

Time required: 30 minutes

· Preparation

Find a quote from a local magazine, a radio programme or book and type it up on the middle of a sheet of paper. It is best to have one copy of this sheet of paper for each participant. The more local the quote the better, since it will help staff to focus better on local needs. If you have time, it would also be good to have the same quote printed large on one piece of flip-chart paper for a second stage of the exercise. You will need pens, prepared sheets of paper, prepared flip-chart sheet, post-it stickers/blank cards, marker pens

· Method

- Distribute one sheet of paper with the quote to each participant, then ask them to read the quote quietly to themselves and to think about it for a minute or two.
- Next, encourage participants to split into groups of two or three. These can be mixed groups of men and women or single-sex groups; it's up to you, which you think will work better. They should start to think together about the wider issues which relate to the dilemmas facing the individual in the quote, such as poverty, environmental degradation, healthcare needs etc. It might help for you just to give two or three suggestions like this, just to start them off. Ask them to write *brief* key words for these issues around the edge of the paper, in a circle around the quote.
- Once everyone has written down some key issues for themselves, ask them to draw lines to link specific parts of the quote with the key issues that they have written down. You could give an example, suggesting that they link part of the quote you have chosen with, for example, health care needs, to help them understand what you are asking.
- Give each pair a few more minutes to do this. Each pair should now have a page criss-crossed with lines, joining the original quote to the keywords that they have added.
- Now ask all the participants what this exercise has taught them about this subject and encourage some open discussion.
- Then, if you have time, compare everyone's analysis, since some pairs may have thought of different key words. For this, it would be best to have your quote printed largely in the centre of a piece of flip-chart paper. Ask each pair quickly to write their key words on post-it stickers or cards and to stick them around the outer part of this flip-chart. Next you can ask two volunteers to group the key words, according to their subject. For instance, all the key words to do with poverty can go in the top left corner; all those to do with belief systems can go in the top right corner, and so on (see Figure 1).

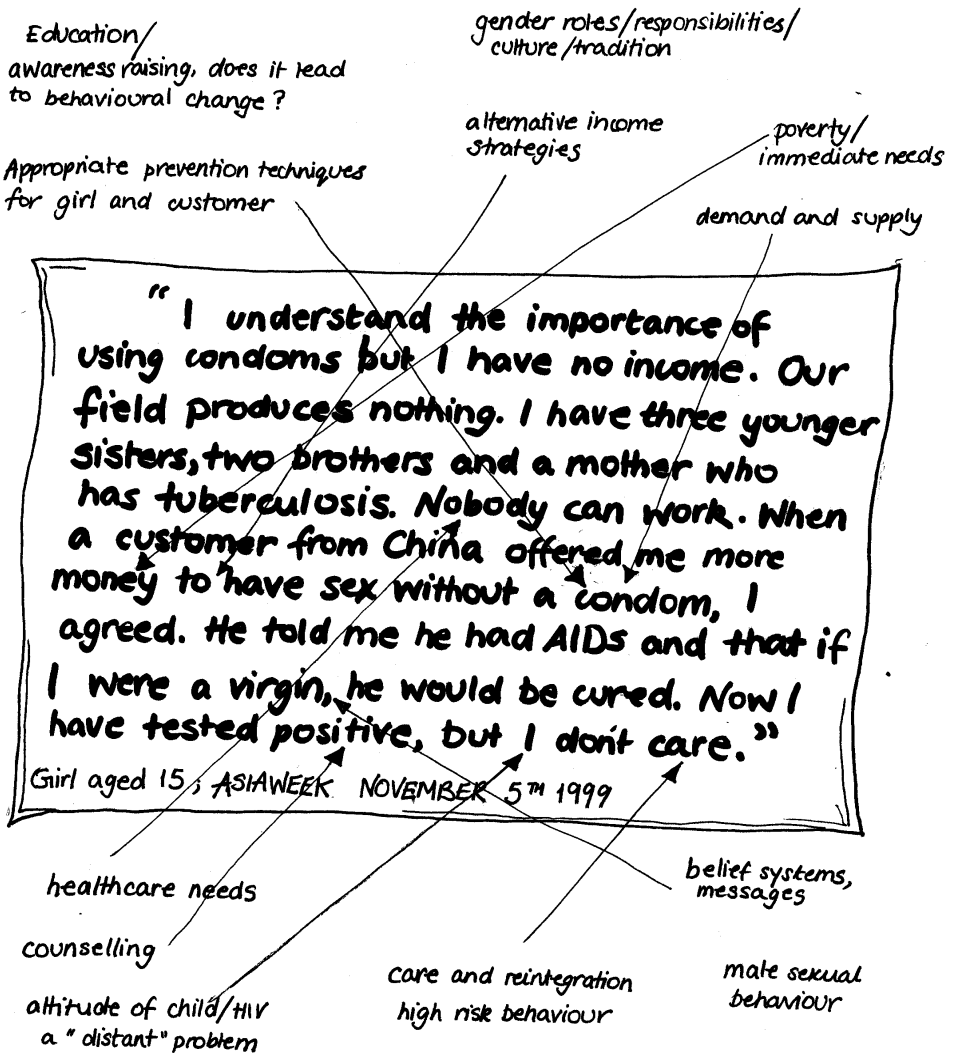

Figure 1. Sheet linking quotes to wider issues as identified by participants

- When this has been done, ask participants to gather around the flip-chart and see if there are any key words written up which some participants may have not included in their own analysis, or which they may disagree with.

One likely contentious key word may be to do with gender issues, for instance. In this case, ask the participants who included it to explain their reasons for doing so. Ask those who didn't to explain their reasons for excluding it. More discussion is likely to follow. Try to make sure it doesn't collapse into an argument though!

Conclusion

This exercise should help staff members to link a theoretical understanding of the issues involved in HIV to the personal dilemmas of individuals in the communities with whom they are working. This can help them to use their theoretical knowledge to address practical issues; it can also help them to recognise that HIV is far more than "just" a health problem.

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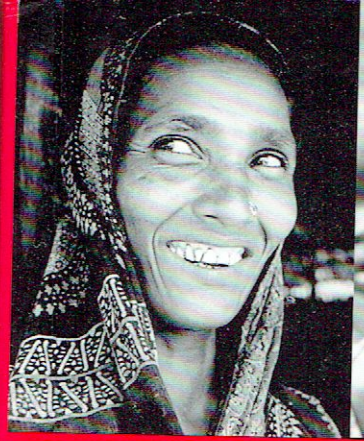
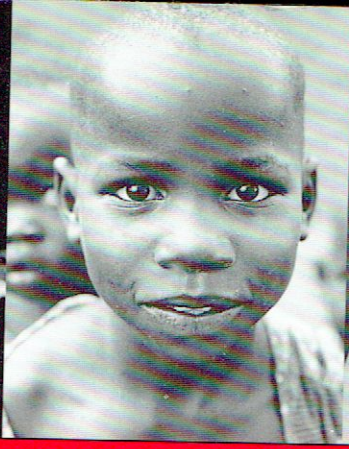

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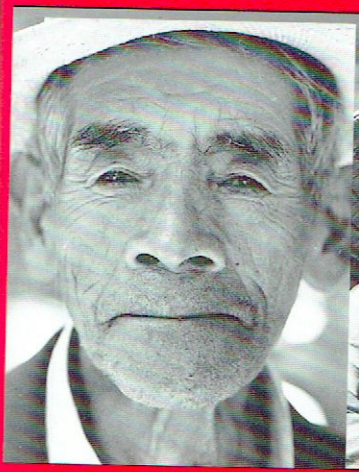

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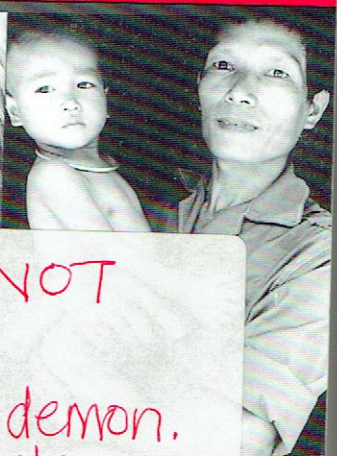

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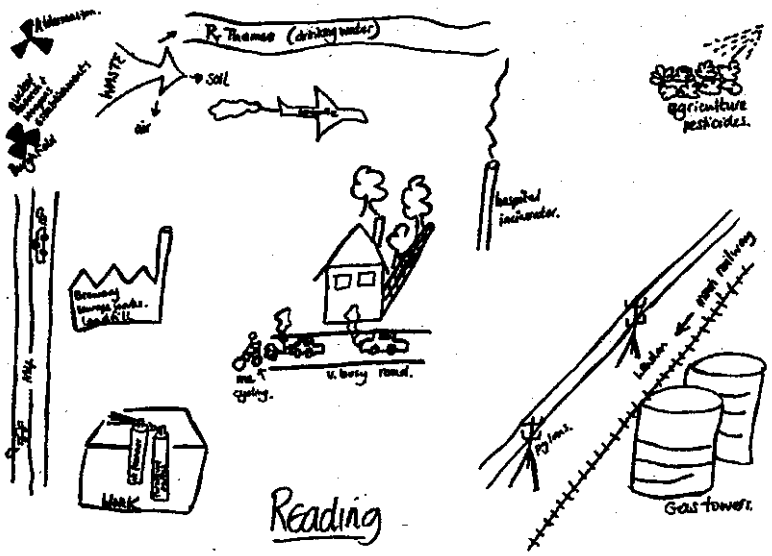


Figure 3.1 Mapping environmental risks: an example

> When we first moved to the countryside I used to lose my voice when they sprayed the crops. All the family suffered from a feeling of grittiness in the eyes, some light-headedness, headaches, tightness in the chest, etc., when crops were sprayed.

Sharing Our Knowledge: Complementary Strategies

Visual representations offered important insights into women's experiences. To draw out further connections, however, we needed more information. To obtain this, we asked women to fill in a written questionnaire to accompany their maps. This in itself served to provoke reflection among women on the possible risks they had been exposed to, as one participant commented:

> After filling in this section [the questionnaire] I have suddenly become aware of the possible harm from the materials I used [in and around home] when unemployed. Previously I had not been concerned about them and thought the proximity of the Sellafield and Chernobyl cloud the likely causes (or contributory factor) of my ill health. It has made me even more concerned about the future health of my children (both still at university), especially my daughter.

"Putting Breast Cancer on the Map" by Helen Lynn & Diana Ward in Cornwall & Welbourn eds 2002

"Using Visual Techniques to Initiate Discussions on
By Ann Sutherland and Felicia Sakala in Cornwall &

Figure 6.2 An uncle threatens to kill his niece with a knife if she refuses his demands

When participants were asked to draw their perceptions of violence against women, the Evaluation Team were surprised by the poignant and vivid images that were produced, as well as the wide range of images and themes that emerged. This occurred across literacy levels. Some of the artists' descriptions of their drawings follow:

- 'A pregnant woman who already has too many children.'
- 'An uncle threatens to kill his niece with a knife if she refuses his demands' (Figure 6.2).
- 'A man beating his wife because he is seeing another girl' (Figure 6.3).
- 'Preaching the rib story of creation to suppress women.'
- 'Women not getting promotion even though they are more serious than their male counterparts.'

The documentary film was particularly effective in capturing the attention of forty-six schoolboys who were part of the study. The topic was met with much amusement when it was first introduced to the group of thirteen- to seventeen-year-olds. However, they all watched the film intently, and were anxious afterwards to discuss their perceptions of the advantages that males have over females, and the results of this inequity. They were adamant that the film should be shown more widely to educate both sexes about violence and its effects on women and the family.

In each case the visual activities were followed by in-depth discussions. Generally, the facilitators started the conversation by asking if

Gender Violence in Zambia"
Welbourn eds 2002

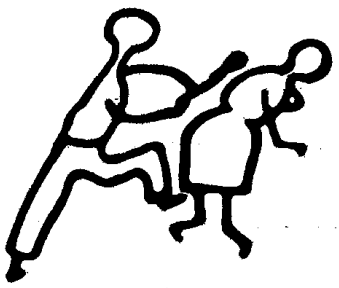


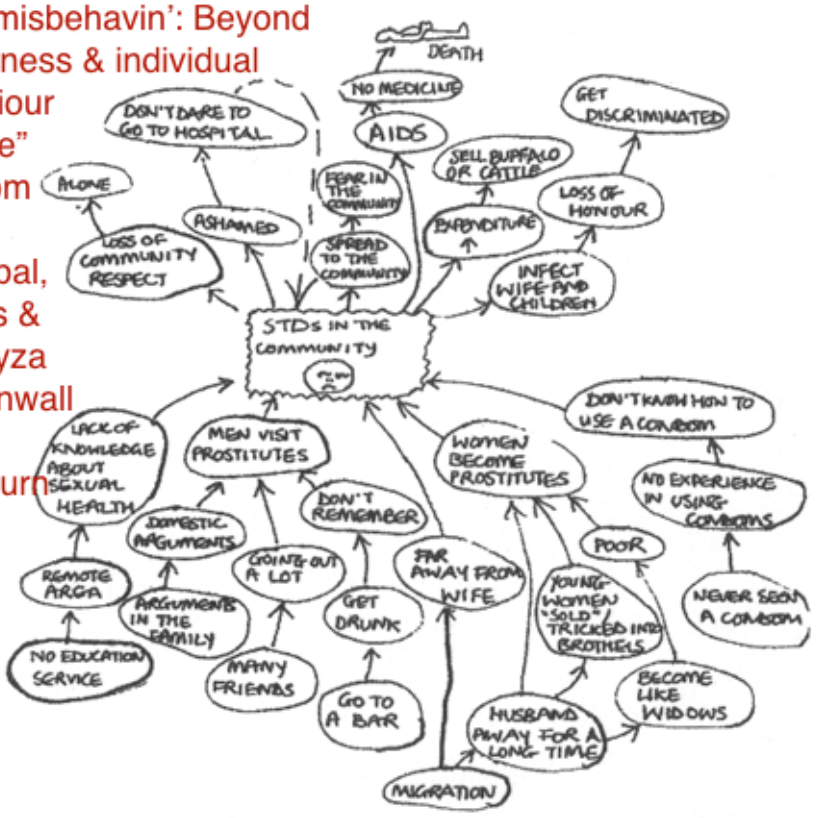
Figure 6.3
A man beating his wife because he is seeing another girl

the type of violence that had just been depicted actually happened in that specific community. This question was invariably answered by a chorus of affirmative responses. From that point on, the discussions became quite animated. Whenever there was sufficient time available (in approximately half of the sessions), participants were encouraged to explore the causes of gender violence, and its impact on women. Their answers were recorded on a web chart,[2] a useful tool for issue analysis.

There was remarkable consistency in the way the diverse groups of people involved in the study understood violence against women, and in the way they thought it should be addressed. The primary themes that emerged were grave concern about the prevalence of gender violence and its effect on families, the ways culture and tradition were used to justify violent acts, increasing poverty, and women not doing enough to support one another. Attention was also focused on the role of institutions – such as the police, government agencies, the legal and health system, and religion – in perpetuating women's subordination. The imperative of breaking the silence about violence perpetrated against women and girls was constantly raised. It was notable that all participants, from tribal chiefs to police officers, felt that society must indeed address these issues.

At each discussion the facilitators ensured that time was reserved for talking about ways in which individuals, the group and the YWCA could take action. These suggestions shaped many of the recommendations in the evaluation report that was produced. The facilitators wrapped up each discussion by asking participants to

"Ain't misbehavin': Beyond Awareness & individual behaviour change" Edstrom with Cristobal, Sellers & de Soyza in Cornwall & Welbourn eds 2002



Causal flow chart exploring causes and effects of a major sexual health problem or need in a local community. Hum Touch and Sok Mayong, BFD, Banteay Meanchey, Cambodia. November 1996. International HIV/AIDS Alliance.

Table 9.2 Comparison of good changes reported by respondents in two villages

Good changes	Village 1	Village 2
Happy marriages	Y	Y
Dialogue between couples	Y	Y
Less quarrelling	Y	Y
Husband accepts a wife's refusal to have sex	Y	Y
More understanding and respect in the home	Y	Y
Husbands buying presents for wife and children		Y
Husbands helping wives with difficult jobs at household level		Y
Husbands granting permission for wives to visit relatives	Y	Y
Shopping money is provided by husband	Y	Y
Co-operation and mutual understanding women/men	Y	Y
Sustained good health	Y	Y
Acquired communication skills from the programme	Y	Y
Wife-beating has reduced	Y	Y
More trust and confidence between couples and the community	Y	Y
Awareness of sexually transmitted infection	Y	Y
Talking to children about sex		Y
Fewer sex partners	Y	
Wives stay with husbands during breastfeeding[3]		Y
Safer sex even outside marriage	Y	Y

Key: Y = positive response.

tions and negotiate condom use, increased use of condoms as protection. Several key informants told us that wife-beating had stopped completely in the Stepping Stones communities, because of improved dialogue between husbands and wives, and through peer pressure. Many men were now too ashamed to be seen beating their wives, having agreed at the final community meeting that wife-beating was wrong. Here are some quotations from both the participatory analysis and MRC evaluation illustrating these themes.

"Before we were sleeping but now we are awake": the Stepping Stones workshop Programme in the Gambia" by Matthew Shaw in Cornwall & Welbourn eds 2002

Table 10.1 Main problems faced and the extent to which felt needs are being met, Malawi

	Young women	Young men	Organiz-ation
Lack of employment	• x	• x	
Sexual violence and pressure to have sex	• x	• x	
Lack of counselling and advice from parents	•	• x	•
Excessive drinking and smoking/drugs	•	• x	
Transport			• x
Inequality: oppression from dominant young men (success is based on privilege and connection rather than on merit)		• x	
Men are not taking responsibility for pregnancies/refusing to marry	•	•	
Need of money	• x		• x
Young girls have less opportunity/access to education due to cultural expectations and burden of domestic chores	• x		
Lack/shortage of HIV/AIDS and 'Why Wait?' education materials			• x
Condoms not the solution			•
Condoms – we need them		•	

Key • indicates that this problem was a main concern of the peer group; x indicates that the peer group felt that this concern was getting less than 40 per cent support from any or all different sources.

charts to describe graphically the magnitude relative to each other of the problems emerging in the pairwise ranking. A second bar was drawn for each problem to indicate how much support communities considered was available for each problem and from whom. This exercise pinpoints a sometimes considerable mismatch between the magnitude of the problem and the support communities perceive to be available. It also reveals situations where communities felt that organizations were not at all involved even though the organization was in fact investing considerable effort which was either being credited to other groups or not acknowledged at all.

"Safely through the night: A review of behaviour change in the context of HIV/AIDS in Africa" by Ann Smith and John Howson in Cornwall & Welbourn eds 2002

"Engaging women: learning about safe motherhood in a Myanmar slum" by Frances McConville in Cornwall & Welbourn eds 2002

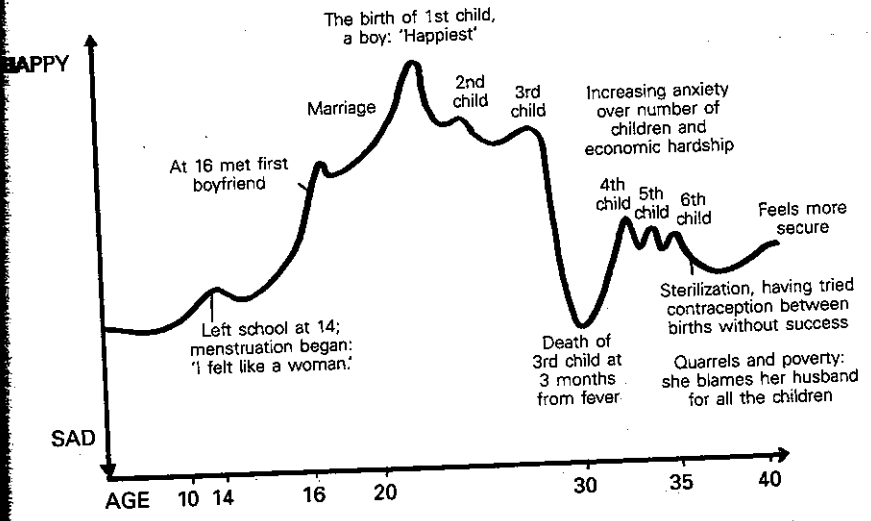


Figure 22.1 Sexuality Life Line: Ma Khin Aye (aged forty-six)

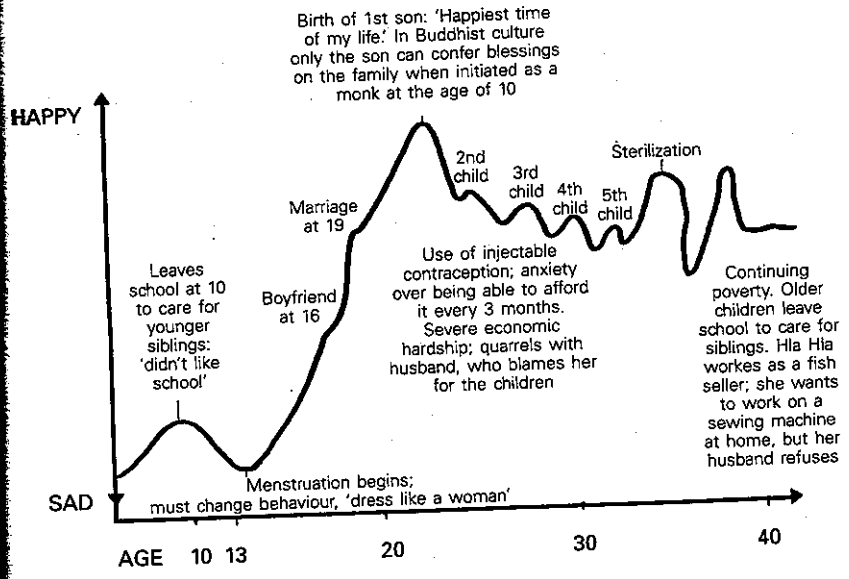


Figure 22.2 Sexuality Life Line: Hla Hla (aged thirty-seven)

‘Man Hunt Intimacy: Man Clean Bathroom’: Women, Sexual Pleasure, Gender Violence and HIV

Alice Welbourn

1 Introduction

‘The more men participated in the care of children, housework and daily conversation ... the more the wife increased her level of satisfaction and sexual intimacy.’ A recent light-hearted article in the *International Herald Tribune* finished with these supposedly surprising findings, based on a survey of 21,000 Americans conducted by the US Bureau of Labor Statistics (McNeil 2004). But what this US news report did not spell out was how men’s contribution – or lack of it – to household tasks and expenditure and the daily burden of running a home is also closely linked not only to sexual intimacy and pleasure, but also to sexual dissatisfaction, gender violence and HIV. Women around the world have known for many years what this survey has now established as ‘fact’ in the USA. But as usual, women’s stories from elsewhere in the world have gone unnoticed.

2 Sex, work and money

In Northern Sierra Leone in 1991, I conducted a seasonal calendar exercise separately with men and with women in one community (Welbourn 1991). Both groups explained clearly how, during the ‘hungry season’ – the lean months when the grain store is empty, when it is wet and cold, when there is heavy work to be done (mainly by the women), such as weeding the fields, and before the new crop has been harvested – everyone finds life miserable and quarrels erupt, men beat their wives, people have to ‘eat credit’ and children go hungry. The women described how heavy work ‘brings the sickness’. This story has been repeated many times elsewhere: in Ghana for instance, a similar drawing exercise revealed how patterns of men and women having extramarital affairs, and the incidence of increased sexually transmitted infections (STIs) and pregnancy coincided, in the respondents’ views, with times of famine and cold, heavy workload, money shortage and quarrels in the home.[1]

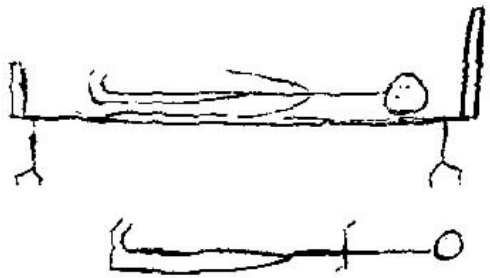
In rural Uganda too, women described to me in 1991 how tough they found it living with their husbands without any support for all their household tasks or expenditure: but they said that they could not contemplate leaving their husbands because they would fear for what would happen to their children if they were left in the home without a mother. In Zambia also, in 1997, another study reports: ‘the domestic tensions caused by alcohol consumption, quarrels over finances and, most often, quarrels over sex (demanded by men and refused by exhausted women … *“when we are tired and refuse to have sex with our husbands, we are asked to sleep on the floor”*)’ (Smith and Howson 2002: 147) (Figure 1).

This same study reported that:

> Sexual violence, highlighted as a problem only by women (older and younger), was not considered in the same way by men. Physical violence also featured, particularly within the domestic context, identified as a grievance by women and as a right by men. Younger men from Zimbabwe reported that they felt it was appropriate to beat their wives if they found them sleeping in the fields, because they believed the women were lazy. (Smith and Howson 2002: 147).

Such stories are universal, as the survey from the USA illustrates, and women in all parts of the world connect with them. They reflect common experiences with men’s behaviour in most societies of the world, thanks to the way in which most men in these societies are expected to conform to certain

Figure 1 'When we are tired and refuse to have sex with our husbands, we are asked to sleep on the floor, under the bed' (Older women's group, Zambia)



'male norms'.[2] Sadly many of us know only too well that hot on the heels of these quarrels, physical violence and their consequences come vulnerability to STIs and HIV, as men seek comfort by having sex with other women who may have less justification for arguing with them, and as their wives also turn to other men for sex in order to buy school clothes for their children or food for the daily meal. In many parts of the world, women are brought up by older female relatives to expect to need to have sex with men other than their husbands to make ends meet and, as long as it is not totally obvious, men often turn a blind eye to this, since they are doing the same thing themselves with other women. Work, money, sex and violence are inextricably interrelated and women believe otherwise at their peril.

3 Breaking the cycle

The situations described above show how vulnerable women are to contracting HIV. But is HIV inevitable? It is clear that girls' education and the prospect of independent income through getting that education is *the* important thing which can break the cycle of women's dependency.[3] Good sex education for boys and girls too, as well as laws which ensure equitable property, inheritance and child custody rights for women are clearly also important factors. But for women who are already past school age, is there no means of breaking out of this cycle of economic dependency and physical, sexual and psychological violence once it has begun? Fortunately there are some community-based programmes that have managed to break through this negative vicious cycle.

Once people understand these links, and how much everyone *suffers* because of them – men as well as women and children – they can then start to do something about them. A recent initiative by an NGO in Southern Africa that has male staff members who work a long way from home was a training programme for the staff. The male staff realised that they only send a proportion of their salaries home each month, since they expect their wives to make ends meet by having sex with other men in their absence. They resolved in future to send more money home and to see if their NGO could support their wives and children to live closer to them.[4] In another recent workshop in Latin America, an exercise explored the meaning of the word 'love' and what the participants expect from their partners when they use that word, compared with what their partners get from them in return (PLAN International *et al.* 2005).[5] One honest young male participant, a youth worker, announced after this exercise that it had helped him to re-evaluate his own relationship in the light of the discussion, and had made him realise that he demanded more of his partner in many respects than he gave.

In the same workshop, a female group of doctors, sex workers, HIV-positive women and NGO staff worked together around an outline drawing of a woman's body on the ground, discussing and sharing together what gave them pleasure and what turned them off when having sex. The same women went on to role play and share different scenarios from their own or from friends' lives. These included a woman having to cope with sexual harassment from her male boss at work and trying to decide whether she could afford to leave that job or not; another woman being expected to stay at home and look after the children all the time outside work hours; and a sex worker having to negotiate carefully with a pimp so that he would not beat her for not having brought him enough money from her earnings. Workshops such as these which facilitate participants to share and compare their experiences in a non-judgemental, caring and very practical way enable people to recognise these linkages in their lives, become less judgemental and more understanding of others' life experiences, and start to be open to possibilities for change.

Workshops elsewhere have taken these ideas even further. In the Gambia, for instance, men have learnt the importance of the female orgasm and the G-spot and now recognise that the 'wham, bang thank you ma'am' approach to sex leaves women emotionally and sexually unsatisfied (Shaw 1998).

They have also learnt that physical violence is wrong and that it has far-reaching physical and emotional effects, not just on the woman but on the children, the men themselves, and in the wider community. Condom use has also been introduced to protect against infertility. In the Gambia (and Uganda and elsewhere) community participants in separate peer groups have learnt how a condom works and practised putting it on a banana.

4 Learning for change

Participants in these workshops have been able to take home new knowledge about how their bodies work as well as those of their partners; they have been able to explore different ways of giving each other and asking for pleasure in their sex lives, safe in the knowledge that they will not be accused of having had an affair in order to learn such things, because everyone knows that these are issues which *all* the workshop participants are addressing and learning about together. They have learnt that condom use in sex is not only possible but can also become a part of sexual foreplay, that non-penetrative sex can be as pleasurable as penetrative sex, that having sex safe in the knowledge that you will not get pregnant or catch – or transmit – an STI can actually enable a woman to enjoy sex much more than she had before. In addition the women now know that having sex with a man who is ready to help her with household tasks and expenditure, discuss issues and share decisions with her, and develop a relationship based on mutual respect, is not only far more pleasurable for the woman, but also makes life much easier and happier for the man and the whole family. These and other revelations through such workshops have been reported widely in many countries. This shows then, that the cycle of violence *can* and *has* been reversed in these communities.

Such workshops and exercises are not always easy: people who have been sexually abused as children, or who have been raped, or who are stuck in abusive relationships, or who have to sell their bodies for sex, often find that strong painful memories and emotions are raised to the surface. Even something as simple as encouraging people to remember a good time in their childhood, or asking them what they look for in someone they love can raise deep emotions. So such workshops have to be well run by trained facilitators with caution and care. Like any strong medicine, there can be unwelcome side-effects, so the workshop exercises must be handled with respect.

5 Sexuality matters

What about HIV-positive women in all this? HIV-positive women – and men and transgendered people – have the right to happy, healthy and safer sex in their lives just as much as anyone else. We also have the right to have children, if we want to, and when we want to. We are all of us sexual beings, no matter who we are. (Almost) none of us would be here if it hadn't been for our parents having sex. Our sexuality is a central part of all our lives, along with our physical and psychological make-up. As Hanne Risør of the Danish Family Planning Association (FPA) pointed out many years ago to her patients in her regular general practice surgery, we do ourselves a lot of damage if we deny that our sexuality exists. For those of us who maybe had no opportunity to learn about the far-reaching importance of good sex in our lives before our diagnosis, such workshops can also give us the opportunity and skills to reclaim our own bodies from the clutches of an HIV diagnosis; to learn about what gives us pleasure and to develop a closer, more loving, mutually respectful and satisfying relationship with those with whom we choose to have sex, in the knowledge that they are likely to realise through these workshops that respect for us means that *their* lives become more meaningful too.

'Man hunt intimacy: man clean bathroom'. Now there's a thought.

Notes

1 Gill Gordon, with IPPF and Ghana FPA, 1991.
2 Important work by l'Associacion des Hombres contra la Violencia (AHV) in Nicaragua suggests that men's violence against women is a response to a fear that they may otherwise be regarded as gay by their peers, i.e. that male violence against women is a response to society-wide homophobia. The AHV works against both homophobia and gender violence across Nicaragua and beyond; see www.healthcomms.org/learn/learn01.html
3 However, caution also needs to be taken here, because schools can often be very dangerous places for girls, who can find themselves sexually exploited by teachers, older pupils, soldiers barracked nearby, etc.
4 Susan Amoaten pers. comm. See also Oglethorpe and Gelman (2004).
5 'Paso a Paso' inaugural workshop for Latin America (*Paso a Paso* is the Spanish translation of Stepping Stones, www.steppingstonesfeedback.org).

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Creating a Vision Tree – a participatory process for Strategic Planning and development of a workplan

DESCRIPTION OF THE PROCESS

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September 2011

Salamander Trust
TRANSFORMING THE WAY WE THINK ABOUT HIV

CREATING A VISION TREE: a participatory exercise in collective strategic planning

INTRODUCTION

Here is a description of an exercise, which I have used with groups on many occasions over recent years, in order to support them to develop their own vision for the future and how to reach it. I find such "visioning" exercises far more creative, uplifting and therefore empowering for a group than "needs assessment" exercises. The latter, by their very nature, tend to encourage participants to dwell on their problems and promote a sense of helplessness and depression. Instead, visioning exercises enable creative thoughts of opportunity and possibility to flow, together with ideas for possible innovative actions.

There is strong evidence from the cognitive science disciplines to support the link between active and successful use of positive language and enhanced psycho-social outcomes. There is also a growing body of biological evidence indicating that use of positive language increases the oxytocins in our brain and makes us feel happy, whereas use of negative language increases the cortisol levels, which make us feel sad.[1]

Such visioning exercises enable a group to feel that they are in control, in terms of creating their own strategic plans for a better future, based on their ideas of what that future might look like. Especially in contexts where group members have felt traumatised by an event, such as an HIV diagnosis, it is especially important to support them to feel that they are "in the driving seat". This can help individuals to build their sense of self-esteem. The combination of the use of positive language[2] and the creation of a dream for the future[3] serve to support the members of the group, individually and collectively, to start to feel empowered.

The exercise also offers a much more simple, accessible means of strategic planning than more conventional methods, which demand relatively high levels of literacy. This exercise, using the metaphor of a tree, its branches, the overall canopy, trunk and surroundings, is accessible to all, irrespective of whether or not they can read and write. It is also a metaphor which is almost universally understood, in terms of creative growth and what is required in terms of inputs to make the growth happen.

[1] Heinrichs M., Baumgartner T., Kirschbaum C and Ehlert U, (2003). Social support and oxytocin interact to suppress cortisol and subjective response to psychosocial stress *Biological Psychiatry*, 54, 1389-1398; Uvänas-Morberg, K. (1998). Oxytocin may mediate the benefits of positive social interaction and emotions. *Psychoneuroendocrinology*, 23, 819-835.

[2] Dilmitis S., et al, (2012). Language, identity and HIV: why do we keep talking about the responsible and responsive use of language? Language matters *Journal of the International AIDS Society* 15, Supplement 2.

[3] McAdam, E. and Mirza, K. A. H. (2009), Drugs, hopes and dreams: appreciative inquiry with marginalized young people using drugs and alcohol. Journal of Family Therapy, 31: 175–193

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NB throughout the exercise, it is important that the facilitator offers much praise, encouragement and support for participants' contributions. This is not a competition. Instead it is designed as a collaborative, mutually supportive exercise.

PART ONE – before the Workshop

WISHES FOR THE FUTURE

NB please read through this whole exercise before you begin, to gain a good overall understanding of how it works. The exercise may well take a couple of days to complete. Encourage participants to stand back regularly to pause and appreciate their progress.

In the first stage of this process, participants write (or draw) their ideas for what changes they want to see on post-it stickers. **Before the exercise day**[4], it would be good for you, the facilitator, to send the participants an introductory letter (or meet with them a few days beforehand), asking each of them to think about their lives and to write (or draw) a list of 5 things which they would like to see changed in a perfect world in, say, 5 years' time. Ask them each to bring her/his own list with them to the workshop.

PART TWO – at the Workshop – creating the tree

Materials required: flipchart paper; coloured marker pens; sticky tape; writing pens; rough writing paper; different coloured post-it stickers or coloured card; coloured sticky dots, if available, for colour-coding of post-its or cards; scissors (to cut up the card and sticky tape).

THE FRUIT

Now ask the participants at the workshop to write up (or draw) each of these ideas on a separate brightly coloured pink or yellow (not green) post-it (or card of different colours, if post-its are not available), encouraging them to add more post-its with more wishes if they would like.

As the participants write out (or draw) the post-its, stick together several sheets of flipchart paper to make a large tree to lie on the ground of the space where the meeting is taking place. The larger the better, so that you have space for many ideas. Ask one of the participants to draw the basic outline of a large tree (trunk and overall outline shape – but no other details yet - on the sheets. Then ask all the participants to stick their post-its on the branches of the tree. These will be the **fruit** of the tree.

[4] This exercise would of course need, at least, preliminary warm-up "ice breaker" exercises. For more information about how you might like to run a workshop, see here: http://www.shetoshe.org/about-she-programme/toolkit-introduction

The participants then all have time to read all the wishes (or explain them to one another if they are drawn), to comment on them, and to question and discuss any which they aren't quite clear about.

I'm amazed how similar all our wishes are. On the way here I was making up my wishes and I thought – oh no-one will have my wishes, I'm sure they are wanting something else from me, not this. But now I've seen that our wishes are all the same.

BRANCHES

Then ask the participants to group their wishes according to similarity of the issues which they had raised on the post-its, along separate branches of the tree. At least three branches may emerge – one for each issue, grouped by the participants according to their own wishes. For instance, one branch might be about housing wishes, another about access to food and water, a third about treatment – but it is important that the *participants* do the grouping and naming of these branches. Next the facilitator asks the participants to give a short name to each branch which would, in some way, summarise the post-its hanging on that branch. Please make sure here that the name for each branch is written in a *positive* way – eg "good housing", *not* "lack of housing". It is very important to keep ensuring that all the wording on the notes and the tree is positive. If participants write negative things, gently support and encourage them to turn the language round into a wish or dream, rather than leaving it negative. This may be hard for them at first, but encourage them that it becomes easier with practice.

Then ask the participants to take another look at each branch of the tree, to which the participants had earlier assigned a word or phrase. Divide the number of branches between participants, so there may be three or four participants working on each of the three or four branches, for example. With each branch, participants are asked to develop a statement of objective, starting with "To…..". The idea is to produce a statement which would be positive and which would reflect where the participants would like to *be,* or to *have* in the future. Ask participants to write these on rough exercise paper, not on the tree itself yet.

Once the participants have each had a go at their own statement, everyone looks together at each statement in turn, to see if there are ways in which the objective could be developed or improved. So for instance, one statement which reads "to struggle to get…." or "to overcome barriers to…" could be changed to read "to *have*…(something *positive)*....".

Once the participants are happy with all the objectives they have created (with your gentle guidance), ask them to write each one along the tip of its relevant branch on the tree. You may then want to start to introduce the idea of "strategic planning processes" and how each branch represents an "objective". Explain also how the post-its which they have stuck on the tree already – the fruit - will represent the

"outcomes" – which show the good things which will happen as you achieve each objective.

THE CANOPY

At this stage, you can also encourage participants to brainstorm an overall "vision statement", which can be written across the whole canopy of the tree, above all the leaves and branches. Again, this needs to be framed in positive language and something which somehow links all the branches/objectives together. Reassure participants that if they are unused to these terms, they need not worry. We will all be creating the tree together and it's their tree that is important, not these technical terms. Alternatively, you can leave out the technical language until later – you are the best judge of when this will work best.

THE TREE TRUNK

Explain how you will then next ask participants to brainstorm on strategies – on ways in which the participants feel each of their objectives in turn could be achieved. These strategies would be written on post-its of a different colour (or light brown card) and stuck on the trunk of the tree.

You are going to look at ***each objective in turn***. Ask participants to decide which objective (branch) they would like to look at first.

Then place some fresh flipchart paper over the trunk of the tree and at the top of it write: "Strategies for Objective 1: "To…….".

The trunk will soon be covered with a mass of stickers as more and more ideas flood out. Once the ideas have stopped flowing, encourage participants to distinguish between strategy ideas and activity ideas. For instance, "media campaign" would be a strategy. "Influence policy makers" would be a strategy. "Write letters to our parliamentarians" would be an activity.

Then take the post-its with *strategy* ideas first and group all these post-its into 4 or 5 key strategies. Ask participants to give each strategy an overall name, just as you did with the branches above. Remember to make the strategy title a positive one.

Then you can make bands across the trunk, one representing each strategy. Ask participants to write the title of each strategy clearly in its band across the tree. Leave good space in each band because you will next look at its activities.

Then put aside the post-its with the strategy ideas on them, just leaving the title of each strategy on the tree. Don't throw them away though! You may want to refer back to them later, to ensure you have included them all.

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STRATEGIES FOR OBJECTIVE 1: To……. (TREE TRUNK WITH STRATEGIES MARKED IN BANDS ACROSS IT)		
	Strategy Five: …… Strategy Four:……. Strategy Three: …… Strategy Two: *eg media campaign* Strategy One: *eg influence policy makers*	

Next, look at the post-its which are *activities*. Ask participants to work together to allocate each of them to the relevant strategy. Some activities may apply to more than one strategy, so would need to be written once for each strategy. For instance, "write letters…" could appear both on the "media campaign" strategy area of the tree and the "influence policy makers" strategy area of the tree.

Then once the trunk is covered with different bands about strategies for objective one, each with its related activities, you can ask the participants to look at *each* strategy in *turn*, to see *who* needs to be involved in implementing the activities in this particular strategy.

You can do this by marking different coloured dots or letters from marker pens on each activity post-it. For instance, on the "influence policy makers" strategy, you could have an activity post-it that says: "talk about our ideas with five others". This activity could be undertaken by: a) participants themselves; b) by neighbours; and c) by service providers in their community. So on this activity post-it, the participants could, for instance add a blue mark or a (U) for "us", a pink mark or an (N) for "our neighbours", an orange mark or (SP) for "service providers" and so on. Participants should choose what colour or letter they want to use for each group.

In this way, it is possible to start to build up a colour- or letter-coded picture of who might be involved in what activities and strategies across the tree trunk.

It may be that your participants want different groups of people to work on each strategy. For instance, you could ask three to four participants to focus on each strategy and its related activities, just as you did above with the branches. In this case, you could just have a list of all the activity post-its up on a wall for all to look at. Then each group can write out new activity post-its, based on which ones they want to include in the strategy they are working on. It is always a good idea, though, to enable all the participants to review all the activities for each strategy, so that there is general cross-fertilisation of ideas and a sense of shared ownership of the finished product.

Remember to encourage participants to go on adding new fruit (see above), strategies and/or activities, if they think of new ones, during the course of the

exercise. Something may occur to them later in the exercise, which they had not thought of earlier. This should be seen as an ongoing process. The ideas may well keep flowing. You need good time!

NB if participants seem to find it hard to think about what they can do themselves to make things better, it can also be really useful to run an appreciative inquiry exercise here[5], to bring out participants' own skills and strategies they have used in the past for coping with and overcoming difficult situations they have experienced in their own lives. Then participants can be encouraged to draw on these same skills and strategies and include them here.

NOW PLEASE GO BACK TO THE START OF THIS TREE TRUNK SECTION to repeat this strategies and activities exercise for Objective 2 and then for Objective 3. For each time, start with fresh flipchart paper to cover the trunk of the tree.

You are likely to find that you come up with similar strategies and activities for each objective. This is fine and normal. You may also think of extra ones though, for each objective. Once you have completed the exercise for each objective separately, you can ask all the participants to work together to check which strategies relate to more than one objective and which are unique to one objective. Again, you can use colour-coding or letter-coding to help you.

HOW WILL WE KNOW WE ARE ON TRACK?

Later on, you will also need to look at all the trunk in more detail, to create leaves, as outcome indicators, in order to know the tree is growing well and on course to bear fruit. So please remember never to throw anything away! The matrix exercise on pages 9-10 explains more and can be useful here.

First however, it is a good idea to look at the wider environment of the tree, as follows.

WHAT MAKES OUR TREE GROW?

No tree can grow on its own. It needs a supportive wider environment. For instance, is there enough sun, rain or manure for the tree to grow well (ie what inputs are needed)? What about the ground beneath the tree – is it good ground? What assumptions are we making about the quality of the ground that we are planting this tree in? Might there be problems in the ground such as earthquakes, animals digging holes, toxins, (which can stand for the wider political, social, legal or economic environment) over which we have no control, that can affect the growth of our tree? What *good* things do we need in the ground, the air, the rain, the sun to make our tree grow? These can be named by participants also and drawn onto the diagram in

[5] See McAdam and Mirza, op cit

pictures or words. Please remember to prompt participants to focus on positive language here also.

LOOKING AT THE WHOLE TREE

I found this session and the skills exercise really therapeutic – getting it all out of me from here (she pointed to the pit of her stomach)

Next, explain that you hope that the participants will view this picture organically, with their objectives changing over time, shedding less ripened or less sweet fruit and growing as a tree would grow, to develop even better or sweeter fruit in future. They can keep these diagrams as a key record and come back to them at regular intervals, to keep track of what they have achieved so far, what needs to be modified and what additional ideas they may have.

If possible, it is a good idea for you to keep track of each stage of the exercise with photographs, so you can record what information was shown where. It is important also to keep track of post-its or cards through colour, letter and/or number coding processes.

I think it's really important for other others to do these kinds of exercises for themselves, because it's so therapeutic and then they can come up with their own ideas for themselves

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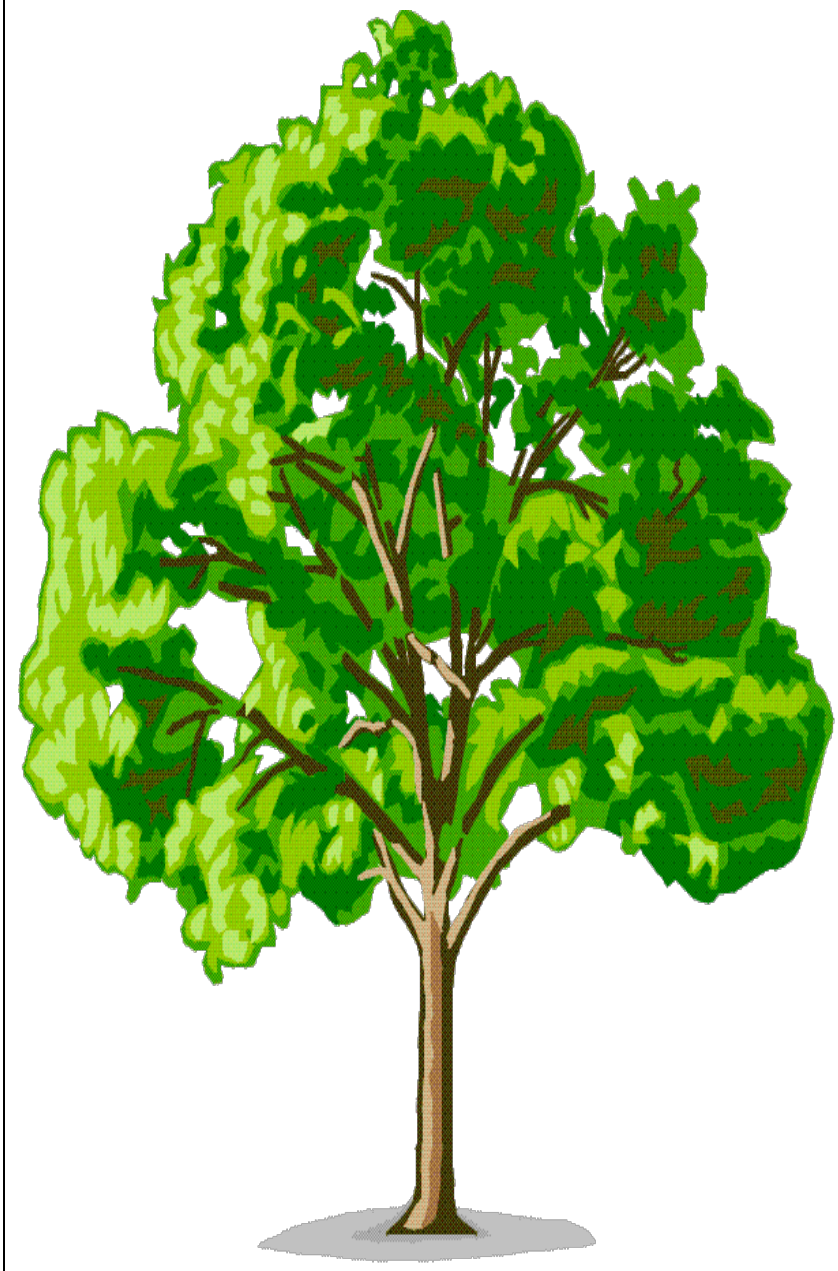
THE VISION TREE: what we want to see in our community in five years' time

KEY:	
Canopy: Vision, Aim, Goal **Main branches:** Objectives **Fruit:** Outcomes (**leaves:** Output indicators – after the matrix exercise) **Trunk:** **Different parts of tree trunk:** different strategies, with activities related to each strategy; exercise repeated for each objective in turn **Sun/rain/air/manure:** key inputs from us and others to make the tree grow strong and produce fruit, some of which we can eat, some to sell and some to collect seeds for future trees and our new forest **Ground beneath tree:** political/economic /legal/social factors beyond our direct or immediate control	

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SUGGESTED MATRIX TO ASSIST YOU. YOU CAN ADAPT THIS AS YOU SEE FIT. HOWEVER, it is suggested that you keep this matrix to *yourself* at first and just use the tree with participants. You can then fill this table in as you progress, on the basis of what the participants have produced on the tree. **EG: OVERALL VISION: To ensure that all women with HIV can feel safe, happy and supported in our community (Canopy statement)**				
What is the **issue/objective**: (eg picture of an issue) (Branch) **NB ONE PAGE FOR EACH BRANCH / OBJECTIVE**	**Objective One: To be well looked after in our health centres**			
Fruit on this branch: (outcomes)	**To have good health care**	**To be stable on treatment**	**To have two more babies free of HIV**	**To be free of TB**
Possible strategies relating to this objective?				
What **strategies** will help us reach this objective?	Strategy 1: eg	Strategy 2: eg	Strategy 3: eg	Strategy 4:
What can *we* do? (Activities)				
What can *our neighbours* do? (Activities)				
What can *our service providers* do?				
What can *our parliamentarians* do?				
What do we need?				
Available resources (eg sun/rain/air/ Manure)	Another picture – eg our own faces and voices, or, if women's group, faces and voices showing support of older and younger men, community leaders….			
Needed resources from outside our group or community (eg what is in the ground)	More pictures – eg support from religious leaders, health staff, to promote community-wide care			
How to obtain the resources we lack? (activities)	Eg community-wide meetings, workshops,			

	meetings with relig. Leaders, health staff etc to ask for their support etc.			
When to implement				
When changes expected by…				
HOW will we know… that we are on track??? (you can ask participants later to write post-its to represent "leaves", on branches which help them to know that activities are on track towards outcomes (as leaves appearing on a tree show that it is healthy and on track to produce fruit)				
Who to monitor the changes…				
Etc…..				

****

Extract from a letter from one participant, subsequently inviting others to join the group:

"I recently attended the Partner's weekend (for partners of men with haemophilia who have contracted HIV in the UK). I have to admit that initially I was not going to bother going as I did not see what I could contribute to an event like this. I don't know anything and have no experience about steering or pressure groups. However, it was a weekend away in a nice hotel with a leisure club and complementary therapies, so if nothing else it would be a nice break.

So you can imagine how surprised I was when the weekend turned out to be one of the best experiences as a partner of a person with haemophilia that I have ever had. I think that all of us who attended felt the same way and the following are just some of the words that were used to describe the experience.

Exhausting

therapeutic **Productive**

empowering FUN optimistic

Supportive **Powerful**

Exhilarating

I was even more surprised that by the end of the day on Saturday the group had identified clear objectives that would improve our lives. Not only had we done this but we had also developed strategies to actually achieve these objectives. I could not believe it. We were just three "ordinary" partners and I for one had no clue before we started about objectives or strategies or anything like that, but we had done it. By Sunday we were talking about presenting our findings to the different organisations and even to parliament.

The sessions created so much positive energy that clearly a "group" had begun to form and needed a name. One of the activities had involved us drawing a tree and using post-it notes to record our hopes, wants and wishes for the future and sticking them onto the branches of the tree as leaves (really fun, back to your childhood stuff!). As we all enjoyed and gained so much from this activity we wanted to continue the tree theme through to the name. The Oak being a good strong tree appeared to be a good choice, acorns etc, well you can see our train of thought, the name OAC was proposed standing for Organic Action of Carers….." (NB: the group is now called Organic Action for Change).

This vision tree exercise was also used in 2002 by ICW to produce its five-year strategic plan[6].

[6] http://www.icw.org/node/10

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http://www.jiasociety.org/index.php/jias/article/view/17990 | http://dx.doi.org/10.7448/IAS.15.4.17990

JIAS Journal of the International AIDS Society

Letter to the Editor

Language, identity and HIV: why do we keep talking about the responsible and responsive use of language? Language matters

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Abstract

Language matters. It impacts on how we think about ourselves, as individuals within our families and within society. As advocates and activists, we constantly use language as a tool to effect change. People living with HIV have been critical in shaping this language over the last 30 years and still play a central role in ensuring that new discourse in the HIV field does not stigmatize, but rather that it catalyzes empowerment for our community members. In this annotation, we seek to shift the language used in relation to ourselves, our medical condition, our bodies, our identities and the events we face, towards something more life-enhancing, self-affirming and positive in outlook.

Keywords: people living with HIV; women living with HIV; vertical transmission; MTCT; identity; terminology; language.

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Discussions

Language matters. It impacts on how we think about ourselves, as individuals within our families and within society. Our words are the tools we use to share our experiences and to create shared visions of the future. A simple shift in language can speak volumes not only about where we are but where we would like to be. When we make our language inclusive, we break down barriers and build new bridges for greater mutual respect and understanding.

As advocates and activists, we constantly use language as a tool to effect change. We think about how our words affect others, and we reflect on the words others use to learn what language is damaging and what language is constructive and enabling. We listen, and we act and we lobby others to do the same. Language can make all the difference towards achieving our goals.

People living with HIV have been crucial in shaping this language over the last 30 years and still play a central role in ensuring that new discourse in the HIV field does not stigmatize, but rather that it catalyzes empowerment for our community members. As a community of people living with HIV around the world, we represent diverse groups in constant change. Language is not static, and what is appropriate today, may not be in future years. As our understanding of HIV grows and the reality of living with HIV changes in response to improvements in treatment care and support, the language used to describe these realities must also change.

One big challenge, which we face with language as found in medical textbooks, is that it focuses on managing, avoiding or eradicating disease, rather than enhancing health. Therefore, whilst the WHO definition of health (''Health is a state of complete physical, mental and social well-being and not merely the absence of disease or infirmity.'' Preamble to the Constitution of the World Health Organization as adopted by the International Health Conference, New York; 1946 June 19–22) is essentially positive and life-enhancing in concept and tone, we are immediately and unfortunately faced with the language of medical textbooks, which is focused on ''ending disease'' (two negative words) rather than on ''promoting health'' (two positive words).

In this annotation therefore, we seek to advocate to shift the language used in relation to ourselves, our medical condition, our bodies, our identities and the events we face, towards something more life-enhancing, self-affirming and positive in outlook. Much of the wording we offer may still be perceived as negative in tone, so we still have a long way to go. Nonetheless, we offer these initial suggestions as some first steps to promote research,

discussion, reflection and action to harness the wealth of academic research of linguists, philosophers, psychiatrists and others to all of our own work in the arena of HIV. Below are some of the terms that we, as women and mothers living with HIV, would like to see challenged and changed as we continue a dialogue with key decision-makers, enabling us to have safe, planned pregnancies, healthy babies, and to stay alive and healthy ourselves.

Language that puts people first

People living with HIV *instead of* HIV-infected or HIV-positive person

When we use language that puts people first, we acknowledge ourselves and others as fellow human beings. For example, ''people living with HIV'' puts the individual first rather than ''infected people'', which puts the virus first. Similarly, when we say people who are, or have been in prison, or people who engage in sex work, or people who use drugs, we are making a distinction between ''being'' and ''doing''. It is important to acknowledge that those of us who have been, or are, in prison, or use drugs cannot be defined and reduced only to those experiences. By defining us as people first, we affirm and emphasize our shared humanity, and we acknowledge that our identities, just as the identities of all human beings, are nuanced, evolving, and layered. The Convention on the Rights of Persons with Disabilities takes this one step further, by specifically talking about ''persons'' as individual humans, rather than about ''people'' as a mass (http://www.un.org/disabilities/convention/conventionfull.shtml). The active use of verbs is also critical, as this further emphasizes the central role of the individual and avoids making a person passive in a situation, for example, people *living* with HIV as against people infected with HIV.

People living with HIV *instead of* PLHIV

Spelling out people living with HIV or women living with HIV is preferable to highlight that actual *persons* are being referred to rather than using an abbreviation. Using acronyms when referring to people can dull awareness of the person or people and adds to a sense of being labelled and the loss of our identity as human beings. Using the whole phrase puts people at the centre of the issue being outlined.

HIV or AIDS *instead of* HIV/AIDS

In our efforts to raise awareness of HIV and to change public perceptions, we encourage the use of the term that is most specific and appropriate in the context to avoid confusion between HIV (a virus) and AIDS (a clinical syndrome). Examples include ''people living with HIV'', ''HIV prevalence'', ''HIV prevention'', ''HIV testing and counselling'', ''HIV-related disease'', ''children orphaned by AIDS'', ''AIDS response'', ''national AIDS programme'' and ''AIDS service organization''. We appreciate that UNAIDS has already recognized the need for this kind of accuracy and specificity in its Terminology Guidelines (http://www.unaids.org/en/media/unaids/contentassets/documents/unaidspublication/2011/JC2118_terminology-guidelines_en.pdf).

Avoiding the use of the word ''infection'' and its derivatives

Unless ''infection'' is an essential word to use for understanding, people living with HIV prefer more neutral words, for example, ''One in seven people who acquire HIV globally do so perinatally, accounting for approximately 400,000 new children living with HIV annually''. This is because, in an English thesaurus, the word ''infection'' is associated with ''corrupt, dirty, tainted''. Alternative, more neutral words, such as ''acquire'' and ''transmit'' can usually be substituted without any change in meaning.

Comprehensive prevention of vertical transmission *instead of* MTCT

''Mother-to-child transmission'' (MTCT) is perceived to have an accusatory tone, blaming the mother for ''transmitting'' the virus to her child, which can have negative ramifications on the mother (e.g. criminalization, forced sterilization, physical and emotional abuse by family members). Focusing on the event, rather than the persons involved removes the onus, blame and guilt for transmission of HIV to the baby solely from the mother. This simple change in term from MTCT turns the focus away from women being ''vectors of transmission''. Women find comprehensive prevention of vertical transmission less accusatory and more conducive to male involvement; it also has the potential to increase access to services.

Stopping or ending vertical transmission *instead of* elimination

The term ''elimination'', in the context of vertical transmission, fails to recognize how HIV affects many aspects of people's lives and how it can form a part of their identity. Therefore, the term ''elimination'' can be perceived as threatening to one's existence and, if taken out of context and without qualifying terms, can evoke fear and be disempowering for people living with HIV. For example, it may be misunderstood to mean eliminating women living with HIV or infants living with HIV in order to eliminate ''mother-to child'' transmission. For those who do not support the sexual, reproductive, and human rights of women living with HIV, the term may justify the use of any means to achieve ''elimination,'' including the criminalization of all HIV exposure or transmission (see, for example, The Global Criminalisation Scan and the website of The Global Commission on HIV and the Law, and also those individual cases where women living with HIV have been prosecuted for not preventing vertical transmission, or have been penalised by the criminal justice system for being pregnant), mandatory HIV testing, and coerced or forced sterilizations. Even if HIV transmission is averted in a child, that child will still have to grow up in a world with HIV and will still be impacted by the virus. Whilst HIV

may no longer be in the child's growing body, he or she will still have to deal with HIV, including threats to their identity.

Supportive and sensitive language is critical in our efforts to achieve our goals towards an HIV-free generation and support those who continue to care for an HIV-free generation but who continue to live with HIV. It can empower us and motivate us to take the step to access necessary services to stay alive, stay healthy and to ensure healthy lives for our children.

We invite all stakeholders in their daily work and life to further reflect on their choice of language in research, policy making and programming to ensure that terms are clear, not clouded by ambiguity, that they do not perpetuate or play into stereotypes, and do not hurt or marginalize the very people they seek to support.

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The authors declare that they have no competing interests.

Authors' contributions
All authors contributed equally to the writing, revisions, and approved the final version of the annotation.

How can rural seasonal food insecurity and environmental changes affect women's vulnerability to HIV?

Alice Welbourn & **Kate Seeley**, Salamander Trust

AIDS 2012
XIX INTERNATIONAL AIDS CONFERENCE JULY 22 - 27 WASHINGTON DC USA

Salamander Trust
TRANSFORMING THE WAY WE THINK ABOUT HIV

Background

Whilst recent research makes it clear that gender-based violence (GBV) can both increase women's vulnerability to HIV and worsen women's experience of their HIV, there has been scant research into the links between seasonal food insecurity and gender-based violence. With increased pressure on food security from environmental changes, this would appear to be an area overdue for further research.

Viewing food insecurity as a driving factor for increased GBV and consequentially increased vulnerability to HIV is likely to shed light on an as yet unexplored vector of transmission. It may provide insight into how organisations can work more effectively to reduce gender inequities within families and communities, to deliver better health outcomes for rural women, their children and partners. Overlooking this 'missing link' can potentially limit the capacity of policymakers and practitioners to devise effective programming.

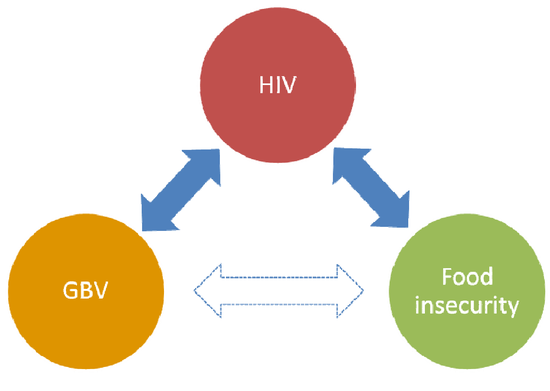

Fig 1. HIV, food insecurity and GBV should not be viewed in isolation, rather as a triad of factors interacting in complex ways within the context of gender inequality. Exploring these would yield important data on challenging violence within intimate relationships and reducing HIV.

The relationship between food insecurity and HIV

Studies have also highlighted the reciprocal relationship between food insecurity and HIV. Food insecurity, defined as existing 'when the availability of nutritionally adequate and safe foods or the ability to acquire acceptable food in socially acceptable ways is limited or uncertain' (Life Sciences Research Office, 1990) acts as an exacerbating factor for HIV vulnerability in environments where power relations between men and women are already unequal. Patel notes that hunger is not 'a deficit of calories but… a violation of a broader set of social, economic, and physical conditions' (2012).

Weiser et al. (2007) find an association between food insufficiency and inconsistent condom use, sex exchange and intergenerational sexual relationships. Transactional sex is a recurring theme for women whose access to food is limited. In relationships where the male partner travels regularly to find seasonal work, he may also engage in sexual activity with non-primary partners.

Moreover, poor nutrition at times of food scarcity has adverse consequences for those living with HIV. Anema et al. (2009) report that food insecurity is associated with reduced ART adherence, lower CD4 cell counts and ultimately poorer survival rates. For those taking antiretroviral medication, limited access to a nutritious diet also reduces the immediate efficacy of the drugs and exacerbates side effects.

In turn, those already affected by HIV are less likely to be able to sustain their farming commitments either as family members die or whilst caring for ill family members. This 'burden of care' (Gillespie, 2008) can lead to a reduction in productivity and removal of girls from school to undertake farming tasks. In some cultures, the death of a man will result in property being transferred away from his wife and children, leaving them with no means of food production or income.

"Women in this village explained that nowadays they have to return to field labour just a week after child birth for fear of being beaten by their husbands."

Courtesy of Beyond Profit

The relationship between GBV and HIV

Extensive international research has identified significant links between HIV and GBV. Women with a history of intimate partner violence are more likely to be living with or at risk of HIV (Jewkes et al., 2010). Moreover, several studies have found that women with HIV are more likely to experience intimate partner violence (IPV) than those without (Maman et al. 2002, Dunkle et al., 2004).

In particular, being in a violent relationship may cause a woman to engage in sexual practices that make her more vulnerable to HIV, including inconsistent condom use, transactional sex or excessive alcohol or other drug use (Hale & Vazquez, 2011, Engstrom et al. 2011). Violence can also negatively affect a woman's ability to access prevention, testing and treatment (Human Rights Watch, 2007), thereby worsening her experience of HIV.

The role of GBV within the context of food insecurity

While the evidence base elucidating the interaction between HIV and violence and between food insecurity and HIV is increasingly robust, research on the interaction between food insecurity and its psychosocial impacts within intimate relationships remains paltry. New data on gender-based violence and HIV suggests that violence is perpetrated in families at times of food scarcity. If food insecurity increases the likelihood of GBV, we suggest that, in communities vulnerable to HIV, this food insecurity may therefore render women more vulnerable to HIV than at times of abundance.

Participatory research conducted in East, West and Southern Africa in the early 1990s on the social and economic dimensions of poverty and ill-health, highlighted the seasonal nature of gender violence and its impact on the cycle of food production. Using the Rapid Rural Appraisal (RRA) technique, which aimed to identify specific health issues affecting people in rural areas and the relative value given to these problems by different groups (Welbourn, 1992; see also IIED website), this study showed how disharmony within couples is often a result of famine, heavy workload and lack of money during times of scarcity. Figure 2 shows two calendars drawn up by men and women in a village in Sierra Leone. Poverty, ill-health and worry feature highly for both groups and the men identify in their calendar how the heavy rains coincide with times of particular upheaval and disagreement within the family. Such upheaval may result in domestic violence, extramarital affairs and consequently an increased vulnerability to HIV.

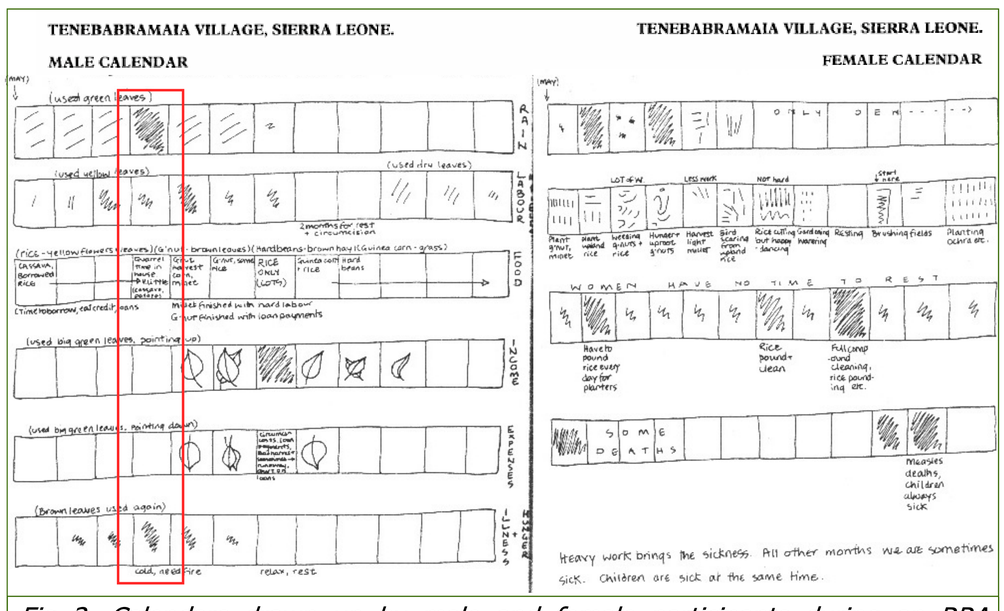

Fig 2. Calendars drawn up by male and female participants during an RRA exercise in a village in Sierra Leone, 1992. The highlighted section shows the heightened tensions within families during the period of heavy rain, low income and hunger.

Conclusions and recommendations

The research described above showed that seasonal variation in food security is linked closely to household arguments and physical violence. Renewed assessment of these findings in the context of the recognition of links between gender-based violence and vulnerability to HIV and of the effects of climate change on food security and malnutrition levels is likely to show significant associations between seasonal food insecurities and vulnerability to HIV. Observations from Rio +20 emphasise the importance of coordinating social development and sustainability (UN, 2012).

We propose that further research is required to investigate how these seasonal changes influence stress and behaviour in intimate relationships and how environmental change is likely to further affect women's vulnerability to HIV. In particular, an evaluative study assessing an intervention to address violence at times of scarcity would be beneficial in identifying techniques to counter new HIV transmissions and to challenge ongoing gender imbalances within families and communities.

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ANALYSIS : SEXUAL HEALTH

The Pillars and Possibilities of a Global Plan to Address HIV in Women and Their Children

by Alice Welbourn, Founding Director, Salamander Trust
June 9, 2013 - 11:10 pm

> The following article based on a presentation by Alice Welbourn at the Women Deliver Conference, which took place earlier this month in Kuala Lumpur, Malaysia.

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What has worked and what needs to be improved, to ensure that the HIV and sexual and reproductive health and rights of women and girls are adequately addressed? *(World aids day via Shutterstock)*

I was recently invited to take part in a panel discussion at the Women Deliver Conference in Kuala Lumpur, Malaysia, the theme of which was "More than mothers: upholding the sexual and reproductive health and rights of women in the Global Plan."

The plan in question is the "Global Plan Towards the Elimination of New HIV Infections in Children and Keeping their Mothers Alive," about which I have co-written before. Since maternal mortality among women living with HIV is still so very high, especially in sub-Saharan Africa, it is critical that we have a Global Plan which works for women as well as for their children.

According to UNAIDS, over 40 percent of maternal deaths in some hyper-endemic countries are attributable to AIDS-related illnesses. Despite these extraordinary figures, sessions on HIV and AIDS still play a rather minor role in this conferences, and this was reflected by a rather sparsely populated hall for this session, despite the presence of such great advocates for women's rights as politician and lawyer, Dame Carol Kidu of Papua New Guinea, UNAIDS Ambassador Crown Princess Mette-Marit of Norway, Sia Nyama Koroma, the First Lady of Sierra Leone (who is also an organic chemist and psychiatric nurse), and Helena Nangombe a dynamic young AIDS activist from Namibia, one of the Women Deliver 100 Young Leaders.

During the panel, Jan Beagle put this question to me: "Alice, we have seen significant progress through the Global Plan but we know we need to do more. Can you tell us what you consider has worked and what needs to be improved, to ensure that the HIV and sexual and reproductive health and rights of women and girls are adequately addressed?

This is what I replied:

What has worked is a scientific revolution. It is fantastic that the science is there now for anti-retroviral medication (ARVs) to support women with HIV to fulfill our sexual and reproductive rights, including the right to motherhood, if we wish. When I was diagnosed with HIV in 1992, when I was expecting a baby, it was feared that I might die, because ARVs didn't exist in those days and it was also feared that the baby would die. So I was advised to

Tell Iowa Gov. Terry Branstad to investigate why Plymouth County Courts want to return two special needs Native children to a home where Iowa Child Protective Services knows they're being abused.

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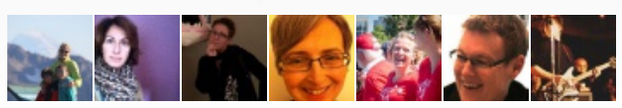

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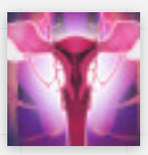


Nine Women Receive Uterus Transplants in Sweden, Raising Ethical Questions by Martha Kempner

In Texas' Rio Grande Valley, a Reproductive Health-Care Crisis Goes From Bad to Worse by Andrea Grimes

have an abortion. Many women of my generation with HIV had no children at all. So it is wonderful now to see younger women with HIV able to fulfill their dreams of motherhood, since with ARVs it is now possible to have 99 percent HIV-free births, even with a normal vaginal delivery. So this is a brilliant breakthrough and huge cause for celebration for us all.

In terms of what could be improved, I would like to focus on three areas today, namely language, care and support and safety.

Firstly, language matters. Just reflect – please read out the following words to yourself aloud: "blame, stigma, fear, prevention, violence, discrimination, sickness, death." How did that feel? We are learning from neuroscientists now that very negative language increases cortisol levels in our bodies, which in turn make us feel stressed. We are also learning from neuroscientists that if we use positive language this increases levels of oxytocin and serotonin in our bodies, which both make us feel happier and more positive in outlook. From this springs feelings and thoughts of hope, opportunities and possibilities, which we can harness to "think outside the box" and create new ways of addressing old challenges.

So what has this got to do with the Global Plan? Well the Global Plan is made up of four "prongs", about more of which below. I am afraid the very word "prongs" rather makes me squirm. It feels invasive, sharp, attacking, threatening, and reminds me of pitchforks and damnation, abortions gone wrong or impalement.

Presumably because they also preferred more positive language, Anandi Yuvaraj and Aditi Sharma, the authors of an inspiring report from India last year, presented the Global Plan using the idea of four pillars instead of four prongs. To me the word pillars immediately invites an image of something strong, uplifting, bigger than us all, building up the best in us all, in all our societies worldwide.

So how does this shift of language play out in practice? Well the Indian report authors shifted the whole language of the Global Plan as follows. Instead of Prong 1 (which covers "preventing HIV among women of reproductive age") the proposed "Pillar One: My Health." Rather than Prong 2 ("Meeting unmet Family Planning needs of women with HIV") they proposed "Pillar Two: My Choice." They replaced Prong 3 ("Preventing HIV transmission to Infants") with "Pillar Three: My Child." And instead of Prong 4 ("Treatment, care and support for women and families") they proposed Pillar Four: "My Life."

Can you hear the difference? If not, just read that last paragraph out loud to yourself. If you were a woman living with HIV, which would you rather hear?

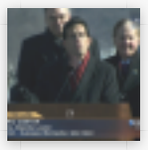
There is a complete about-turn shift from negative prongs, prevention and needs to positive, women-focused pillars and possibilities. Wow. And these possibilities are now open to us all.

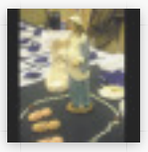
So how do we weave care and support and safety into all this?

Well as I have explained previously with other co-authors, there is no mention of the words "voluntary," confidential," or "informed consent" in the Global Plan, which has now been adopted by quite a few states around the world. Sadly, care, support and safety are hugely wanting, both from the Global Plan and from peri-natal services for women in general, as well as for women with HIV around the world. Yet these ingredients are also paramount in an effective response to infant and maternal mortality, with or without HIV.

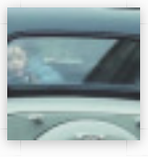
So to expand on Pillar One, instead of the existing language above, we could seek to ensure informed choice and access to condoms, needle exchange program and negotiation skills training for all women and girls, including girls born with HIV, who often feel very excluded by this "prevention" language.

The Establishment Clause: A Simpler Answer to the Contraception Question? by Imani Gandy

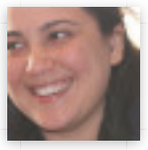

Eric Cantor Announces Anti-Choice House Vote at March for Life by Adele M. Stan

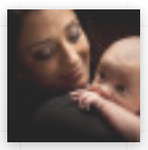

Fetal Rosaries, Our Lady of Fatima, and the Spanish Inquisition: Welcome to the 2014 March for Life by Adele M. Stan

How Not to Report on Sex Trafficking by Soraya Chemaly


'Philomena,' A Must-See Film About the Magdalene Laundries and Forced Adoptions by Karen Smith Rotabi

Get Angry: 41 Years After 'Roe,' Thousands of Women Are Dying From Unsafe Abortions by Lauren McKown


Munoz Medical Records Detail 'Distinctly Abnormal' Fetus by Andrea Grimes


'Roe v. Wade' Let Me Become a Mother by Sarah Erdreich

RH Wire

- Watch Sarah Silverman and Jesus Discuss Reproductive Rights ...
- Why Roe v. Wade still matters, 41 years later ‹ American Civil ...
- Are Home Health Care Workers About to Get Screwed by the Supreme Court?
- Roe v Wade Anniversary: Pro-Active Legislative Agendas | Civil ...
- Raising the Minimum is the Bare Minimum
- Taking Note: The First Amendment Protects Abortion Providers, Too
- Obama admin: Freedom from sexual assault a basic human right - MSNBC

We could describe Pillar Two as “access for all women and girls to dual protection (i.e. from unplanned pregnancy and from transmission of sexually transmitted infections, through, for instance, use of a condom and the contraceptive pill) that is judgment-free, youth- and women-centered.” In Asia now our colleagues tell us that many women with HIV are just being told by health staff to use condoms, since they shouldn’t be having sex anyway, in their view, and certainly shouldn’t be thinking of having children. Just imagine the power of a replacement “pillar” like this to counteract that message.

Pillar Three could be to “support all women with HIV in our deep commitments to keep our children HIV-free.” What a transformation that would be.

And Pillar Four could be “ensure care, support, love, respect, food, shelter and treatment (when we need it and not before) for all women with HIV and for our families. Louise Binder has written eloquently previously about our concerns regarding the “treatment as prevention” movement.

As an aside, there is also on-going and increasing concern out there about the “Option B+” roll-out, which puts all women in a country when pregnant on ARVs for life, whether they actually need them yet for themselves or not and whether they want them or are ready to start them or not. The “option” bit is only for each government to decide, there is no real option for women at all. It’s a bit of a post-code lottery writ large. We hear of some women throwing their package of ARVs away as soon as they have passed through the health centre gates en route home – for them the idea of being found with ARVs is too terrifying for them to contemplate and outweighs any possible good the medication might do.

I’m all in favor of options for women when they are real options, but not when they are just wrapping up lack of choice in something pretty. Policy makers and practitioners: please mind your language.

Finally, safety.

WHO tells us that gender-based violence (GBV) occurs during pregnancy worldwide – especially in circumstances where the pregnancy is unplanned. Add HIV into this mix and it is like throwing a match into dry grass. We have a potential conflagration of physical, sexual, and psychological violence. We know already that GBV increases women’s vulnerability to HIV. It is also clear that an HIV diagnosis can provoke or exacerbate GBV globally.

Therefore “safety, safety, safety” must be our mantra, at home, in the workplace, and in health care settings. It is vital to turn the tide on the “cascade effect” of women dropping away from health services during pregnancy or after child-birth, once they have been diagnosed, because of their fear of this diagnosis and their terror of what it will bring to themselves and their children. Safety, safety, safety is the mantra. Maybe then we could start to avoid the awful tragedy of so many women dying through AIDS-related issues connected to maternity. Then we could truly have a really powerful and effective Global Plan.

Like this story? Your $10 tax-deductible contribution helps support our research, reporting, and analysis.

Tagged: AIDS, Analysis, Faith and Ideology, Family, global, HIV, HIV and AIDS, international, Reproductive rights, Sexual Health, Sexual rights, Sexuality education, Sexually transmitted infections, Violence, Violence against women, Women Deliver, Women Deliver 2013

Arkansas Reproductive Rights Activists Gear Up for Rally

Should Some Teen Moms Be Exploited on Reality TV to Prevent Others From Having Babies?

New Research Suggests Middle Schoolers Who Sext Are More Likely To Be Sexually Active—But Please Don't Panic

Comments for this thread are now closed.

1 comment

0

Best · RH Reality Check · Share · Login

Bruno Benavides · 8 months ago

Alice, what I see behind your wonderful article is a firm defense of the role of individuals to make decisions that affect their lives and their love ones'. Many times, public health programs are built and implemented in the name of the people, but not necessarily with their consent and active participation. Example of these initiatives go from community outreach activities -where government officials make the altruistic decision of bringing services to the households, rather than waiting for clients at the health facility-, to laws that try to regulate the information that may shape consumer food choices. In all these cases the intention is very good, reasonable, and deserves admiration and support. However, there are unintended side effects that policy makers and officials are not taking into consideration. Every time that a health worker visits a house to deliver services, inadvertently s/he is making a decision on behalf of the person s/he is trying to serve. Even that small decision of bringing a baby to the health center to receive vaccines is now taken from the mother or caretaker and redirected to a health officer. Every time that the government intervenes to avoid that consumers receive bad food advertisement, the consumer gives up his/her right to make the decision of what to eat and what not to eat. Taking power from the people and transferring to governments is risky; governments are well known by their lack of effectiveness and efficiency; corruption is a global issue. Empowering government officers rather than citizens could allow to get figures in the short run, but any political or financial storm can easily turn them down. Sustained changes require empowered individuals, citizens. The modern public health challenges require empowered individuals who make daily decisions to protect and improve their health and quality of life; if government has a role, it should be to strengthen the individuals capacity to make appropriate decisions.

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ALSO ON RH REALITY CHECK

WHAT'S THIS?

Four Insurance Companies Accused of Widespread Sex Discrimination

24 comments • 7 days ago

colleen2 — The insurance industry so corrupt and venal that every state has an special elected position called an …

New Jersey Supreme Court Considers Whether Methadone Use During …

3 comments • 2 days ago

Stephanie Lastra — I am disgusted and angry to hear this. I was a heroin addict as a teenager and when I became pregnant …

Marital Status Doesn't Cause Poverty—Not Having Money Does

523 comments • 4 days ago

CJ99 — Notice he feels pity for deadbeats but not the famlies they abandon.

Buffer Zone Ordinance To Be Introduced in Madison, Wisconsin

160 comments • 8 days ago

fiona64 — Well, then, rock on. I'll look forward to seeing it. ::crickets:: Yeah, that's about what I thought.

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TAKING PART:

"A Brief Introduction to Advocacy"

Alice Welbourn PhD

27 October 2014

London

Salamander Trust

POSITIVELY UK

ADVOCACY agenda……

1 WHAT is ADVOCACY?
2 WHO are ADVOCATES
3 OUR VISIONS, VALUES and SKILLS
4 With WHOM (our partners)
5 WHEN (timeline of key events)
6 TO WHOM (key decision-makers; & others who influence them)
7 MAKE YOUR CASE
8 HOW: Choose your ACTIVITIES
9 Take stock and review PROGRESS – M&E
10 *Develop your ROADMAP……*

1. *WHAT IS Advocacy?*

Brainstorm.....

"ADVOCACY"

Dictionary definition (Oxford English Dictionary):

Public support for or recommendation of a particular cause or policy

From late Middle English: via Old French from medieval Latin *advocatia*, from *advocare* 'summon, call to one's aid' (see *advocate*).....

"ADVOCATE"

A person who publicly supports or recommends a particular cause or policy

GYCA: "Advocacy"

"Advocacy or policy advocacy: a strategy to influence policy-makers to make a policy change (e.g. create supportive policies, reform or remove harmful policies, or ensure the funding and implementation of supportive policies)."

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- **Advocacy** is a set of organised activities designed to influence the policies and actions of others to achieve **change**

- Advocacy must always be about getting a **change in actions** not just in understanding

From Womankind

- **Changing** the decision making processes

- **Empowering ourselves** to have the confidence skills and opportunities **to influence change**

From Womankind

Advocacy is about collective actiion!

Indian demo to change trade agreements which stop access to ARVs

Washington DC March, July 2012

"First they ignore you,
then they laugh at you,
then they fight you,

then you win"

Mahatma Gandhi

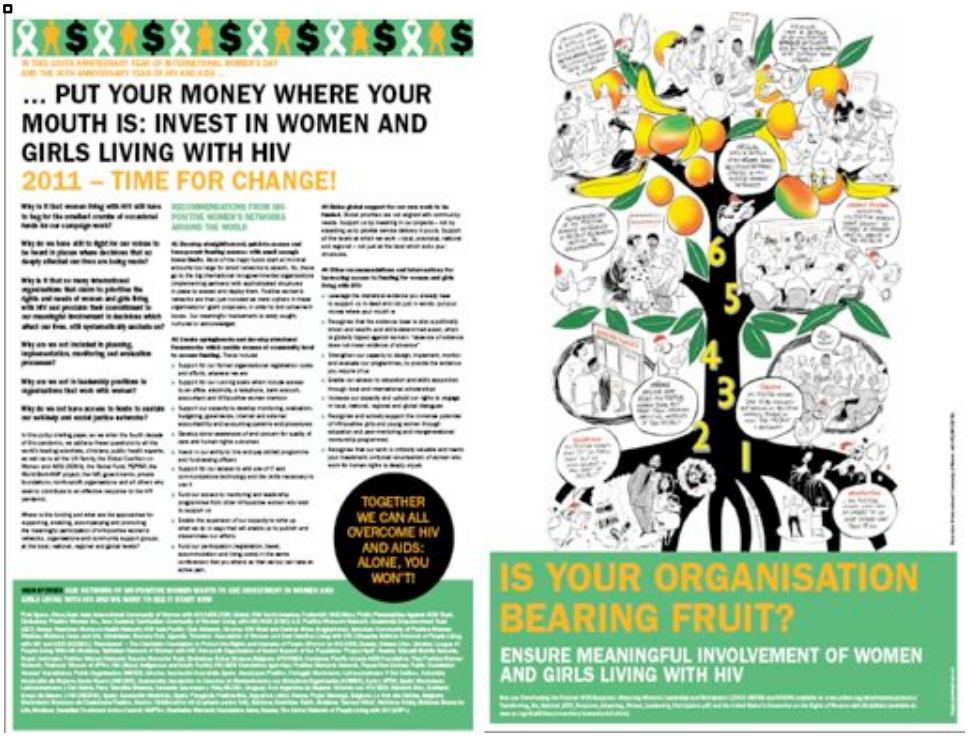
2. *WHO ARE Advocates?*

GIPA.....

MIWA.....

The personal is political.....

How does what ***you*** have learned from ***your*** HIV diagnosis, and living with HIV apply to being an activist and an advocate for the rights of people living with HIV?



Last year 60 networks of women with HIV from around the world together developed a policy brief calling for investment in our work, so we can:

All reach the parts that others *cannot* reach, like those fisherwomen. On the back of this policy brief, we also have a "participation tree" highlighting the benefits that true meaningful involvement of us in this work can bring to an effective global response to this pandemic.

So we have a special request to make to you all today…… please remember in your work also to support *us,* networks of women living with HIV, in *our* work.

So many women with HIV are doing so much to change global policies and practices on a voluntary basis with no funding or support like the widow's mite in the Bible.

Our networks don't have the support of big donors, philanthropists, gala dinners or even of global fund-raising teams. Yet our work has gone on being there, from the start of this crisis, and will go on reaching the parts that others, no matter how well intentioned, just can't reach. We know what the root challenges are – and what the solutions are – if only we had the support to be heard.

Using the French participation tree signed by women with HIV from francophone Africa to advocate for their rights with
Michel Sidibé, Executive Director, UNAIDS, September 2013

3. *Our VISIONS, VALUES & SKILLS*

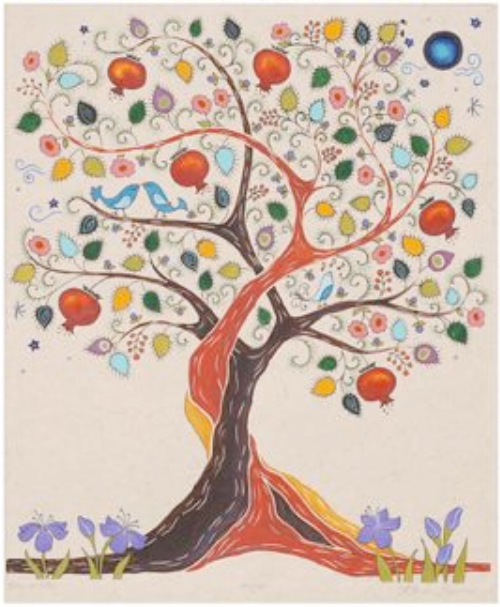
CANOPY: our positive statement for the future

FRUIT: What gifts we have to offer to support this tree

BRANCHES: Our hopes & dreams to achieve our statement

TRUNK: Our abilities & skills

ROOTS: Our values & the people who gave them to us



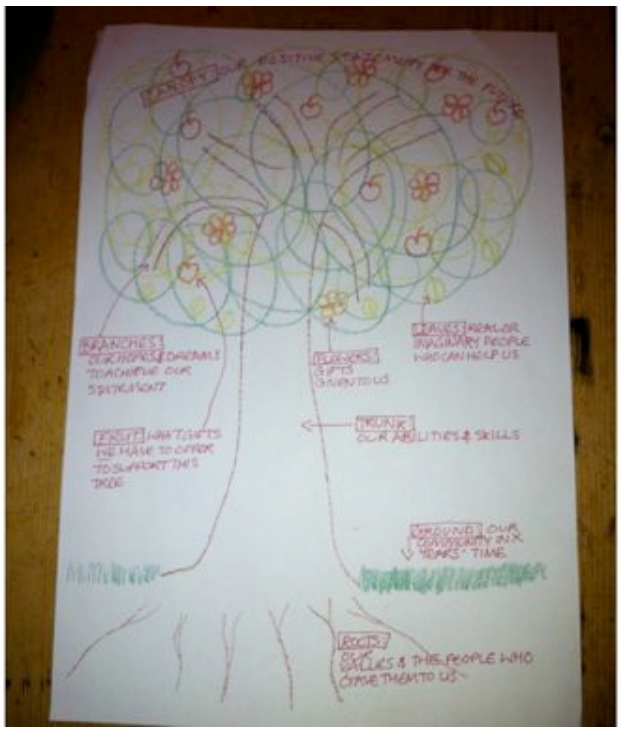
FLOWERS: Gifts given to us

LEAVES: Real or imaginary people who can help us

GROUND: Our community in X years' time

OUR VISION TREE

Salamander Trust



Salamander Trust

In 2 years at least 3 women attending the
health watch in various cities and be
members of patient & public involved in CCG
Gifts
EMPATHY
Passionate
Creative
Pro Active
Challenge
Presentation and public speaking
Networking
Organize
patience
mobilization
resilience
public speaking
dedication
Peer Support groups
Social services
Family

WISE-UP+

4. *WHO ARE our Partners?*

EXAMPLE PARTNER TRACKER

PARTNER *(name, organization, etc.)*	*AREA FOR COLLABORATION (e.g. political or media connections, technical expertise, resources or funding, connection to those affected by your issue)*	CONTACT INFORMATION *(phone, email, address, etc.)*	TRACKING COMMUNICATION *(notes on how our partnership is progressing, important things to take forward so that we can build the relationship, etc.)*
Hannah, Restless Development	Hannah could share tips on government advocacy. In exchange, we will share tips on working with key populations.	hannah@ restlessdevelopment.org	31st April: I introduced myself to Hannah via email. We are going to share ideas on potential partners on Skype next Tuesday. Hannah works Monday–Thursday.

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5. ***WHEN:*** *build your timeline*

- Identify key events for advocacy
- Plan your strategy to address these
- Don't overstretch yourself!

UN ESCAP
ECA/AU
KEY MESSAGES REFLECTED IN OUTCOME DOC.
EXPLICIT LINK TO POST-2015

6. *To Whom: key people to influence*

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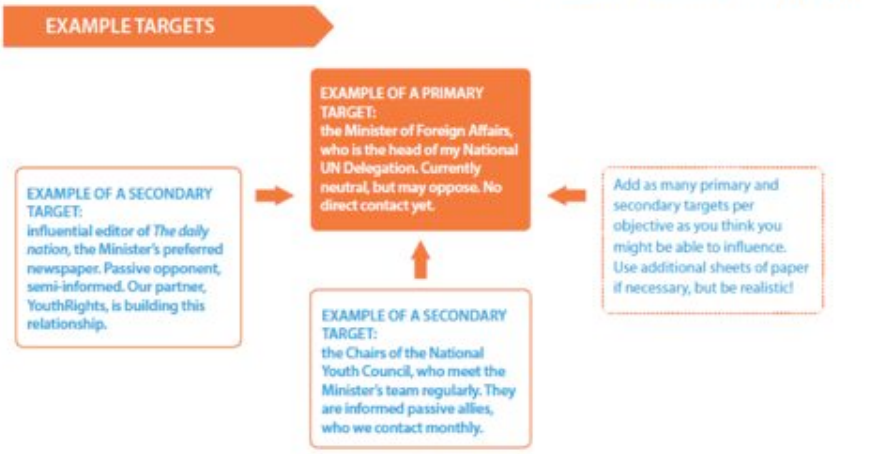
Primary & Secondary Audience.....

!!NB avoid militaristic language!!!



.....Use positive affirmative ***nurturing*** *language!!!*

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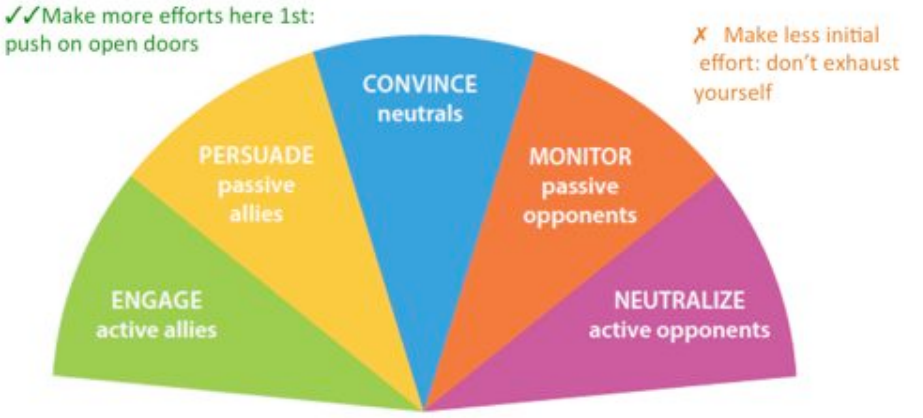
7. MAKE YOUR CASE….

1. Tell a ***personal*** story: connect your reality to lived experience
2. Build your ***technical*** argument: use facts and figures
3. Step into their shoes: ***they are human too***! Seek common ground and build on it
4. Lastly, ***tailor*** your approach and start to develop key messages (see Melanie Croce-Galis….)

Your audience spectrum....



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8. HOW: *CHOOSE your ACTIVITIES…..*

1. CONTEXT –
   - Legal / policy context
   - Public / media opinion
   - Advocacy efforts to date – by you; by others; successes / failures
   - Implications for YOU
2. OPTIONS –
   - Open door
   - Half-open door
   - Closed door
3. REVIEW –
   - Tactics and possibilities, in relation to your audience spectrum
4. DECIDE –
   - Which activities and with whom will work best for you?
5. $$$$$ -
   - Work out how much this will cost – is it doable within your budget?

Do your **CORD$** bind your advocacy strategy broom together well?

HOW can we advocate?

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9. *Monitor & Evaluate*

Make your process SMART and SPICED……

Sophia

SMART:

POSITIVELY UK

Specific

Measurable

Attainable

Realistic

Timebound …. *and*….

Sophia

.....SPICED:

POSITIVELY UK

Subjective - *personal* to *us* – what *we* want

Participatory – *developed* by us

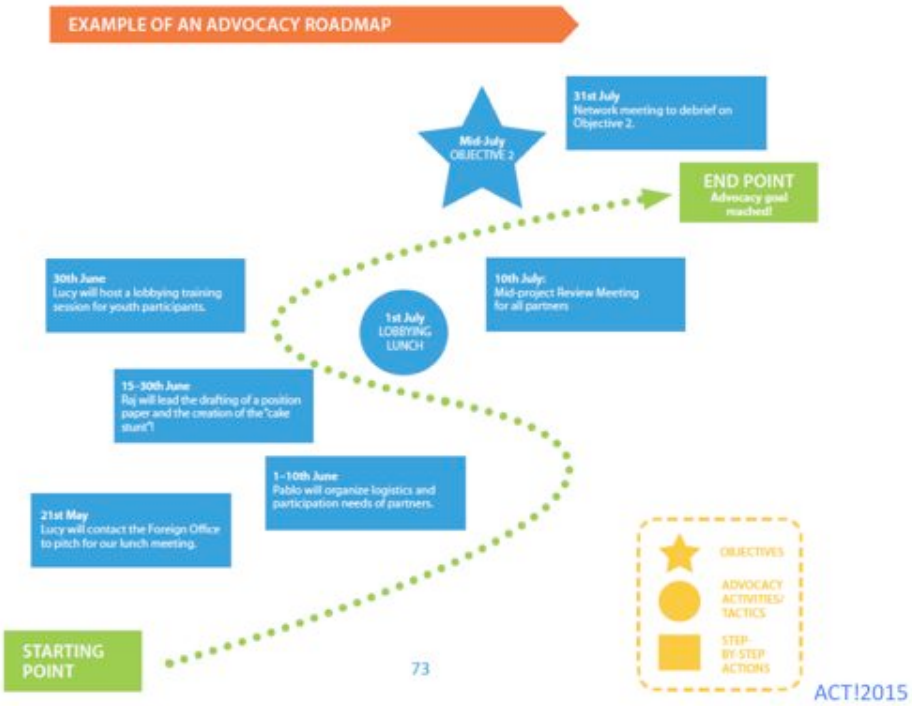
Interpretable – *understood* by us & others

Cross-checkable – can be verified

Evaluable – can be measured

Disaggregated – recognises our diversities

9. *Develop your own Roadmap….*


EXAMPLE OF AN ADVOCACY ROADMAP
31st July
Network meeting to debrief on Objective 2.
Mid-July
OBJECTIVE 2
END POINT
Advocacy goal reached!
30th June
Lucy will host a lobbying training session for youth participants.
10th July:
Mid-project Review Meeting for all partners
1st July
LOBBYING LUNCH
15-30th June
Raj will lead the drafting of a position paper and the creation of the "cake stunt"!
1-10th June
Pablo will organize logistics and participation needs of partners.
21st May
Lucy will contact the Foreign Office to pitch for our lunch meeting.
STARTING POINT
OBJECTIVES
ADVOCACY ACTIVITIES/ TACTICS
STEP BY STEP ACTIONS
73
ACT!2015

With thanks to: PLEASE CREDIT THEM IF YOU USE MATERIALS

ACT!2015 Advocacy Strategy Toolkit UNAIDS/PACT
Website: www.crowdoutaids.org
Prezi: http://prezi.com/huhylgalfyid

Sophia Forum WISE-UP+ workshop June 2014
www.sophiaforum.net
http://tinyurl.com/p522a77

Melanie Croce-Galis Artemis Consulting (for messaging)
www.whatworksforwomen.org

Womankind Toolkit:
http://www.womankind.org.uk/policy-and-resources/womens-rights-advocacy-toolkit/

Salamander Trust training materials (especially Vision Tree)
www.salamandertrust.net

And others!

This adaptation of the Stepping Stones programme is specifically designed to help facilitators run workshops within communities to improve communication and relationship skills, so as to promote peace and prosperity through reducing conflict and violence in Karamoja sub-region, Uganda.

It is also recommended for any community affected by small arms proliferation, sexual violence and conflict.

In this programme according to me, the most important aspect I learned is that conflict begins with one's self. I learnt that the way I think and what I tell others might spark off conflict, so I learned to behave and guide myself and also accept advice. Young man from Lorengedwat Sub-County in Nakapiripirit District, Karamoja, Uganda.

[The program] changed attitudes completely, [things are] totally different since the coming of Stepping Stones. It has brought cooperation within family members like mothers and fathers. The man used to be lying under the tree, today they share ideas together. If it's cultivating - they all go together; if it's looking for survival, they share together. Women Participants, Tufts Evaluation of Stepping Stones, 2014.

The original **Stepping Stones** manual was published in 1995. Now translated and adapted into at least 20 languages, it is used across sub-Saharan Africa, South and Southeast Asia, the Pacific, Latin America, the Caribbean and parts of Europe. The *Stepping Stones* package (a 240-page manual and a 70-minute optional video) is designed to help trainers and community groups organise a series of workshop sessions to help women and men explore their social, sexual and psychological needs; to analyse the communication blocks they face; and to practise different ways of addressing their relationships. The aim is to enable individuals, their peers and their communities to change their behaviour - individually and collectively - through the 'stepping stones' which the workshop sessions provide.

Stepping Stones Revisited: A film taking us on a journey back to the village of Buwenda in southwest Uganda, where the original *Stepping Stones* workshop was conducted, and the video was filmed, in 1994. We learn at first hand from participants in the original workshop what has changed in their lives since then.

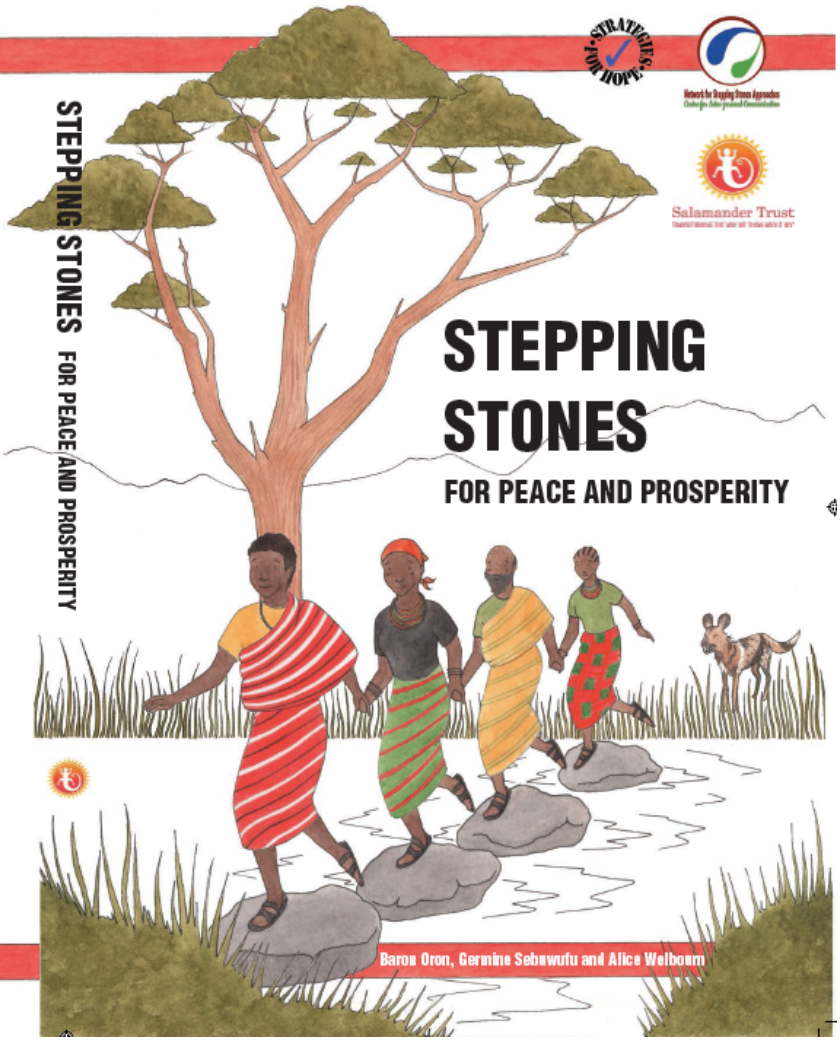
Stepping Stones PLUS: A supplement to the original workshop manual. It consists of additional exercises for existing sessions, and new sessions to follow the completion of the original workshop. These are designed to promote a whole-community response to the HIV epidemic through appropriate care and support, and the involvement of people living with HIV in all aspects of the programme. Stepping Stones PLUS incorporates a comprehensive approach to HIV and motherhood and the prevention of peri-natal transmission.

For further information on Stepping Stones materials, please contact the Salamander Trust: **www.salamandertrust.net**

Salamander Trust

ISBN: 978-1-905746-26-2

STEPPING STONES FOR PEACE AND PROSPERITY



STRATEGIES FOR HOPE

Network for Stepping Stones Approaches

Salamander Trust

STEPPING STONES

FOR PEACE AND PROSPERITY

Baron Oron, Germine Sebuwufu and Alice Welbourn

Exercise B.5: ABILITY SPOTTING[4]

Appreciative Inquiry and Ability Spotting - a strong exercise to make people feel GOOD about themselves and their abilities again.

Aim: To start to look at stories in our lives that reveal our strengths and abilities. This is a way of raising people's self-esteem. It also helps them to become aware of abilities they have but have not really appreciated they had. Once they realise them, these new abilities can be used as additional resources for them in their lives. They can help them to see they can solve issues in their lives with all these resources inside them.

Reminders: Put up the flip chart record of the values brought out from when we were looking at the Ground Rules in Session A. Remind them that, by living out our values - such as respect, thoughtfulness and care for others - we demonstrate a lot of the abilities and skills that we possess.

Instructions: Share with the participants that, in this exercise, they are going to "interview" one another, in order to help one another spot each other's abilities. Tell them that there will be different steps in the interview.

To help everyone remember the different steps in the interview, show them a flip chart with the steps drawn on it. Explain that you will do a demonstration interview first, so ask the participants to listen closely.

Here are some interview guiding questions, to write or draw on the flip chart, for all to see:

INTERVIEW GUIDING QUESTIONS FOR ABILITY SPOTTING:

* Say: "Tell me something you have done that made you feel really proud".
* Be curious - ask detailed questions about the episode, so you can see it as if a story was being told by a wonderful story-teller - or a story on the radio.
* Ask lots of questions - who, what, where, when, and how.
* Spot abilities in the story and write or draw them on paper squares.
* Ask about other times the participant has used this ability (for instance, thoughtfulness, kindness, cheering someone up…).

Please try to either draw (or write) a symbol for each ability on a new paper square.

When this exercise has finished, the participants will feed these paper squares onto a thread and tie them as a necklace around the person with these abilities.

Ask the participants to save this flip chart to bring to future sessions.

[4] Adapted from *NAMWEZA - Friends Intervention Programme*, by Elspeth McAdam, Alice Welbourn, Charles Steinberg, Kicki Oljemark and Keith McAdam, © 2011.

Demonstration interview: Now please interview one of the participants appreciatively about something s/he has done that made him/her proud. Spot abilities, draw each one on a separate paper square and give them to the person as soon as you have written them, so they are relevant and feel "true" to the person.

After you have spotted a few abilities, ask the group to shout out abilities when they see or hear them mentioned in someone's story. Then write or draw each of them on a separate small piece of paper and give it to the person being interviewed.

After a few minutes ask all the participants to group into threes and to start their own interviews amongst themselves, with one telling the story and the other two doing the interviewing and ability spotting, as explained below.

Here is a demonstration interview for you, conducted by Peter Simon, one of the facilitators in a workshop in Karamoja in 2013. **DO NOT READ THIS OUT.** It is just an example for you to see how this works.

"So one story that really inspired me so much was from a young woman who narrated a story of what she does in a day. She wakes up at 4: 00 a.m. and lights a fire in her house, and warms food for the kids. You know kids have morning food, before she goes for firewood. This time she was going for firewood in a far place, so she left at 5 a.m. when she had already warmed the food and told her husband "when the kids wake up you can do something". So she went and saw a big tree, and she cut the best firewood she had ever cut in her life, and she carried it, and people bought it from her on her way home, before she even reached the central selling place. She bought food for her family and also some waragi for the husband. Then she came home and they were happy.

So I told her to stop there…. So now I asked them, "what qualities do you see in this person?" They said "maybe work", so I said "hard work, she works hard, like that". So you just try to let them know, since they can't identify that easily to start with. But I went ahead and said, "don't you think this person is caring?" and they said "yes". So I again asked, "in what sense?" and they said "by warming the food for the kids, then working hard by cutting the tree, and then buying food for the family and also buying something for her husband." Then I asked "Don't you think she is respectful, loving, with many qualities?" …. and they all agreed that yes, this woman was a very hard-working person.

Everything you mention you relate it to that, like hard-working; you relate it to cutting firewood and bringing a bigger bunch. So you find that whenever someone brings a story, they could easily identify the abilities in that person. So you find that the person feels happy when the (others) mention something they have seen in him/her when he/she doesn't know that he/she has that ability."

Directions: Please explain that this is an exercise to help us to begin to look at stories in our lives, so that we become aware of our strengths. We are all living in many stories simultaneously. Some of our stories are happy, others are not so good, but if we can focus on the good parts of our lives and experiences, then many things can change. We begin to feel happier and more resourceful, and better about ourselves.

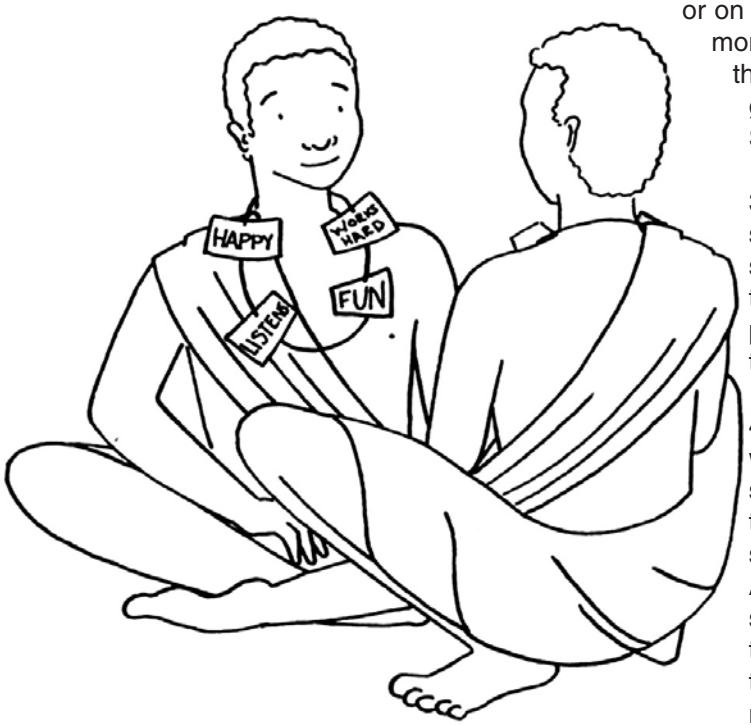
This exercise is done in threes. Encourage participants to work with different members of their peer group each time, so they all get to know and work well with one another.

Have each group of three decide who is to be the “interviewer”, who the “ability spotter” and who is the one being interviewed. Each person will take each position. Switch roles after about 6-7 minutes so everyone gets a turn.

The one who is the interviewer (the one asking the questions) asks:

1. *”Tell me a time when you have done something you are proud of, or that someone else would be proud you have done*.” Listen carefully to the answer and then…

2. Interview your partner in detail. Be curious (*ask questions that encourage details about who, what, where, when, how…*). Encourage her/him to expand the story so you can almost see it as if they were listening to a wonderful story from an orator or on the radio. Go into a lot of details of episodes, so that more and more abilities emerge. Make a few statements that will lead to more abilities emerging. *”*So you are very good at planning, where did you learn to plan so well?” So you have then two abilities - planning and learning.



3. As the person talks, the third person - the “ability spotter” - identifies abilities that the person telling the story has shown, and which are possible to notice through the story. What are the positive things this person did in this story? (For example, demonstrating thoughtfulness, kindness, quick thinking, generosity…)

4. As each participant *spots abilities*, ask her/him to write (or draw if s/he prefers) that ability on separate, small squares of paper, and to give these to the person telling their story, naming each ability in turn and where s/he saw it. Often you will find 6, 8, 10 or more abilities. Ask him/her to make a small hole in the corner of each square and then to string all the squares onto a thread to tie round their neck as an “abilities necklace”. Tie the thread in a bow so that it can be easily undone, so that more abilities can be added later!

Ability	**Example of symbols that can be used - encourage participants to think of their own**
Friendly	Hands greeting, smiley face
Peaceful	A dove
Loving	A heart
Hard-working	A hoe
Supportive, caring, sharing	A giving hand
Good at listening	An ear
Etc.	Etc.

5. Then ask the interviewing participant to ask her/his neighbour: ”Tell me about other times in your life when you have used these very same abilities.”

6. S/he can also ask: ”What abilities do you hope to develop or improve in this programme, what do you hope to get out of this programme?”

Next we will switch roles. The interviewer becomes the interviewee, the one who was the ability spotter becomes the interviewer, and the interviewee becomes the ability spotter.

After about 6 minutes, say “One more minute” to give people a chance to wind up, and then a minute or so later, announce “Okay, switch partners”. This process needs to be done twice so everyone gets a chance to be in all three roles.

Ensure that everyone has had the opportunity to be interviewed for 5-7 minutes.

Before moving on to the next exercise, tell the participants that they will be able to put more abilities on their “abilities necklaces” at each meeting and that it would be great if they can each bring their necklace with them to each session.

When everyone is ready, ask them, as a large group, to reflect on how the interview affected how they felt emotionally and physically, as well as their energy levels and their relationships.

Exercise B.6: CLOSING CIRCLE AND LOCAL SONG

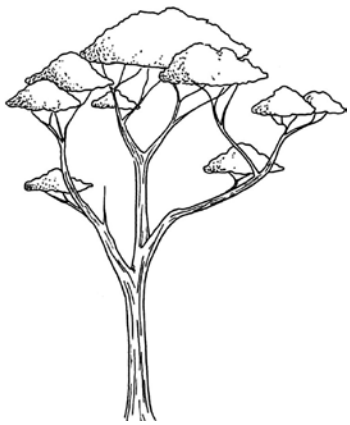
Aims: To finish the session on a happy note.

Description: The participants choose a well known happy song about the beauty of the landscape after the rains have arrived, or about the beauty of their livestock, to sing together. Encourage them to dance also if they want to.

Directions: 1. Sit in a circle together. Thank everyone again for coming to this session.

2. Ask each person to say one thing which they have learnt from this session and one thing they are looking forward to before the next session.

Acts of kindness: Explain to everyone that you would like them to think of one small act of kindness that they would like to say to, or do for, someone they *like and feel close to*, before the next session. It can be anything unexpected that the person would feel surprised and pleased by. They don’t have to tell us what it is - this is their own secret. Just ask them to think of it on the way home and to make sure they do it before the next session.



3. Arrange a mutually suitable time and place for the next session together. Ask everyone to remind one another again about it.

4. Breathing and Words of Comfort exercise. Please repeat this exercise from Session A, Exercise A.11, where full instructions are found on pages 35 - 36. NB: this is a very important part of the programme and should be included at the beginning and end of every peer group session.

5. Thank and congratulate everyone on completing this session. Remind everyone of their role as a guardian angel (see Exercise A.9, pages 33 - 34).

5. Then ask for four volunteers to stay behind to prepare a couple of short role plays for the next session.

Exercise G.2: OUR RIGHTS AS HUMAN BEINGS

Aims: To understand the meaning of the term ”rights” and the rights of us all as human beings.

Description: Sharing information on rights.

Materials needed: Flip chart diagram of “Our Human Rights” drawn beforehand (see page 96); A4 size copies of pictures i, ii, iii, iv and v (page 97) for participants to discuss in groups; and flip chart of “Nine Rights” (page 99).

Directions: 1. Ask participants to give their ideas on what a ”right” is and to give some examples of rights in their lives.

2. Explain, in your own words, the Universal Declaration of Human Rights, as outlined in the information box below and the diagram on page 96.

Information for facilitators to share - DO NOT READ OUT

Human rights are about respect for everyone, just as you have shown for one other in the tasks you have just achieved together. They are about having our needs met, staying safe and having a say in what happens in our lives. They are also about saying what we think and feel, and living life as we want to, as long as we act responsibly and respect the rights of others.

Human rights and the Universal Declaration on Human Rights

In 1948 all the governments in the world agreeed to sign a special agreement called the Universal Declaration on Human Rights. This describes the following main kinds of rights:

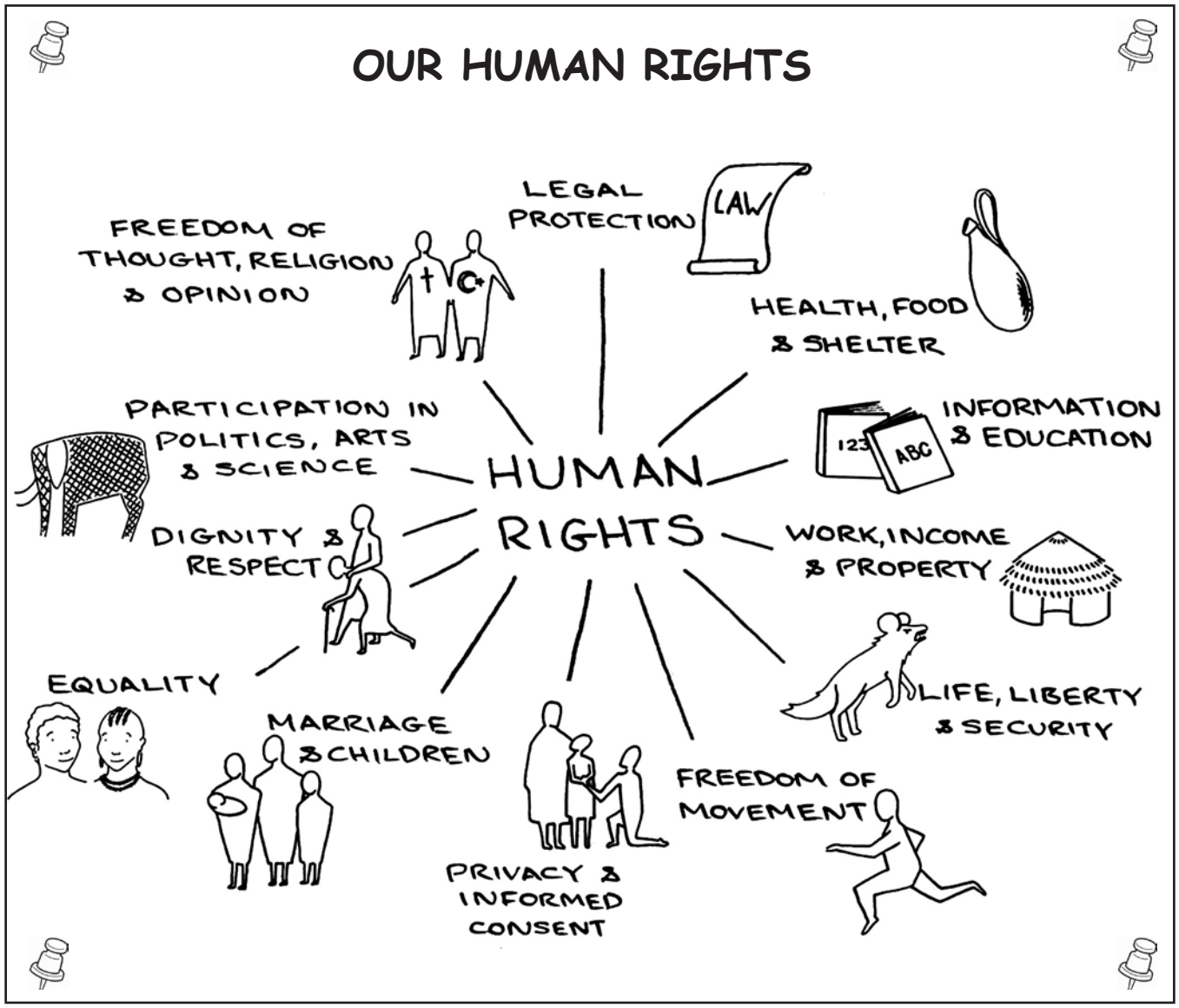
A. Rights to things all humans need, such as a home, food, health care, shelter, education and information, work and property.

B. Rights to be kept safe from harm, to move around safely, and to life.

C. Rights to take part in deciding how we live our lives and to be treated with dignity and equality by others. This includes the right to get married, have children and to take part in all decisions which affect our lives.

Under the Universal Declaration on Human Rights, the government has to make sure that all people in the country enjoy all their rights. This applies to all children as well as all young people and adults. As children grow up they can act and think for themselves more and more. Governments and adults should encourage children to do this and also keep them safe from harm.

Please draw the diagram below (on page 96) on a flip chart before the session, so that you can explain each circle to the participants. Draw a picture for the words in each circle, so that everyone can understand it. For instance a milk gourd for food, a book for education, a child for children and so on.



3. Next, work in small groups numbered i, ii, iii, iv and v. Show each group a photocopy of one of the five small drawings on page 97 (opposite). Ask each group to think of rights related to the drawing their group is looking at.
Each small group should ask themselves:

- What do we see happening in the picture? Check that they have understood the drawing correctly before they move on (see explanations for each drawing on page 97).
- What right is being supported or abused?
- Who has the power to abuse this right?
- Who has the power to uphold this right?
- Does everyone in our community have this right met?

Ask them to give examples first of this right *not* being met in their own lives or the lives of others in their community. Ask them then to give examples of this right being met in their own lives or in the lives of others in the community (for example, older and younger men and boys, older and younger women and girls).

i

ii

iii

iv

v

KEY TO THE FIVE DRAWINGS:

i: The right to education – a teacher welcoming all the children to school, male and female, rich and poor.

ii: The right to safety – a man or a woman hugging his or her daughter.

iii: The right to health – a young man being given health care even though he is poor.

iv: Ending child marriage – a girl being supported by her father not to marry an older man.

v: End to gender-based violence and safety and security instead - men stopping another man from hitting his wife.

4. Then ask everyone to come back to the full circle. Ask them to share with the full group all the negative and then the positive examples they have thought of.

5. Then ask each small group to create a role play showing a situation where one of these rights is *not* met.

6. Then ask each small group to present each role play in turn to the full group. After each role play, ask the group the following questions:

- How does each person in the role play *feel*?
- Why is the perpetrator acting in this way?
- If s/he does this to the other person, how does the other person feel?
- What will the other person do? What are this person's underlying hurts, needs and fears when they are treated like this?
- What are the likely consequences for the perpetrator? Will s/he get away with it? Will life always be simple for her/him?
- Does the perpetrator have any underlying hurts, needs, fears which need to be addressed somehow? (Remember the Termite Mound exercise: E4, page 78.)

7. Invite participants to come up and *change* the role play so that this right *is* met.

8. Then for each of the five role plays, backlight again. Imagine a time in the future when the "perpetrator" and "victim(s)" are like the two people in the Statues of Power exercise (F4, page 90) supporting one another to achieve *both* their goals. Ask them to role play this and then interview them, asking the following questions:

- What happened to let you resolve the problem?
- How did you achieve this?
- What happened before this?
- When and how did this happen?

Encourage all the participants to join in with "who, what, how, when, where, why" questions - and also with suggestions, to support them all in creating a ***positive*** story together.

9. Finish this exercise by asking participants to connect their role plays back to the flip chart about our human rights (page 96) that you were all looking at earlier.

Exercise G.3: ARE OUR RIGHTS BEING MET?

Aim: To understand where our rights are being met and not met.

Preparation: Prepare beforehand the nine rights in the box opposite, with their questions beneath them, on a flip chart or a board.

Directions: 1. Explain that in this exercise we are going to look at whether our rights are being met fully, partly or not at all. Read through the rights, with their questions, and explain them as needed.

NINE RIGHTS

1. **The right to food, water, fuelwood, shelter**
   - Does everyone in our community have these basic things? Who doesn't have them, and who does?

2. **The right to be healthy and use health care services**
   - Is the health clinic friendly and welcoming to us all?
   - Can we get all the health information and services that we need from the clinic?
   - Are the services provided by the clinic informative, voluntary and confidential?
   - Who in our community doesn't have access to health care?

3. **The right to education and information**
   - Do we get the education and information we need to help us make decisions about our lives?
   - Who is left out and why?

4. **The right to freedom from abuse and exploitation (being used for another's benefit)**
   - Are some of us afraid of others in our community?
   - Who is afraid of whom?
   - What are the causes of their fear?

5. **The right to work, income and property**
   - Are we able to find training so that we can have work, earn an income and own animals and other goods?
   - Are some in our community not able to do this? If so, why not?

6. **The right to be protected from harmful practices**
   - Are women and children in our community treated well or are some beaten and treated badly?
   - What are the causes of some being ill-treated or beaten?
   - Who is beating or ill-treating them?

7. **The right to be a part of important decisions that affect our lives**
   - Do we feel that family and friends listen to our feelings or opinions and take them into account when they make decisions about our lives? If not, why not?

8. **The right to say what we think (freedom of expression)**
   - Can we talk to other people about things that are important to us?
   - Do we have to keep some things secret? If so, what sorts of things, and why?

9. **The right to meet and talk with others (freedom of association)**
   - Can we meet with others to discuss matters that are important to us? If not, why not? How can we change things?

2. In small groups, invite participants to choose one of the nine rights. Alternatively, distribute them all amongst the members of the group.

3. Invite the participants, in their groups, to discuss ”their” right, by responding to the following questions:

- What does this right mean?
- Do we have this right?
- In what ways do we have this right, and what are the gaps?

4. Ask each group to make a poster to explain the right and the gaps.

5. Bring the groups together to present and discuss their posters.

Exercise G.4: WHO CAN SUPPORT US TO REALISE OUR RIGHTS?

Aim: To identify people, institutions and collective strengths to work towards realising our rights.

Description: Discussion in small groups followed by plenary sharing.

Directions: 1. Explain that we all need help and protection from one another, including government officials, family members, clan leaders, friends, neighbours, school teachers, faith leaders, police, army, mass media - and others - in order to live safe, healthy and happy lives. We especially need to support those who are less protected, including women and children, so that they too can get help and protection if they need it.

2. In this exercise we will look at some of the gaps in our rights and the reasons for these, and also identify ways that we could work together and get support to realise our rights more fully.

3. The chart opposite shows some examples of these problems and asks questions about how we can all support one another to solve them. Before doing the exercise, make a chart that shows the problems identified by the participants *in your community* in the previous exercise, and write suitable questions to find ways to solve them.

4. Go into four or eight groups. Each group will discuss one or two of the problems. Talk about what people can do to solve the problem and who can help.

5. After 10 minutes for each issue, invite all participants back to the full circle. Ask each small group to share the results of their discussions with the whole group.

6. For each problem, describe one idea for how we can all work together to improve this situation in our community.

7. Explain that we can discuss this with our friends and families. We can form groups and plan campaigns to speak about our feelings. We can bring into the

open problems like hunger, theft, school fees, few training opportunities, and lack of work opportunities. We can all support one another to overcome these human rights issues within our community.

Gap in rights	What we can all do to support one another and those less powerful than us in our community
1. We don't have access to training for work.	- Who can help us to gain access to training? - How could we plan together to share our skills, so that we can learn more from one another, so that we can all earn an income from our work?
2. It is hard to stay in school because of costs of books and uniform.	- How can we all support our children together to go to and stay in school? - Who will help us?
3. If we have a poor harvest, some of us have to go hungry and will get ill.	- How can we ensure that everyone in our community has enough to eat and does not stay hungry?
4. Some individuals treat others disrespectfully or angrily.	- How can we support one another to behave respectfully to one another and to avoid or minimise anger?
5. If children are afraid of what another child or an adult is doing to them, they don't know who to tell.	- How can we protect ourselves from this? - Who could we tell? What might happen? - What can we do if they don't believe us? - Who could support us?
6. Some boys have to leave school to herd cattle; some girls have to leave school to help at home.	- What can we do about this? - Who can help?
7. Some girls are forced to get married to older men.	- How can we stop this happening? - Who can help us?
8. Boys and girls are beaten by caregivers and teachers, so they feel hurt and afraid.	- How can we support people to use positive discipline instead of violent punishment? - Who can support the change?
9. Some women and children are beaten by others.	- How can we support these women and children not to be harmed like this? - How can we support those who harm them to stop beating them and to resolve their differences calmly and safely?
(Add in others here if you like.)	

Exercise N.2: MAPPING OUR SAFE COMMUNITY TOGETHER

Aim: Focus on the ideal and safe community.

Description: Fixing a Future Tree of Life and mapping a safe community.

Directions: 1. Start with fixing the Future Tree of Life of this peer group carefully, ideally to a wall where you are meeting, so that it can be clearly seen by everyone. Then ask

everyone what they thought of the Second Full Workshop Meeting. "What were our impressions of the Future Trees of Life presented by the other peer groups? Did they surprise us at all? Were we pleased or surprised by what we saw? What other ideas did we hear that we want to add to our own future tree? How did we think other peer groups responded to our own presentation?" Encourage a few minutes' discussion of these points.

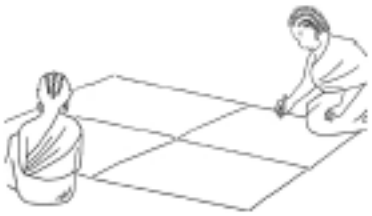
2. We are going to create together a Future Map of Peace. Explain that we all want safety and peace in our homes and around our communities. This exercise is going to help us imagine what this safety and peace will look like. We are going to create together a map which will help us to go on a journey round our community, thinking of all the places we would like to go and things we would like to do, but perhaps don't at present because of fears about safety. In this exercise we are going to dream our community - and all these other places - as places of *safety* in 5 years from now. Suggest that we start by brainstorming together all the places where we spend any time - or would like to spend time - in our community, either during daytime or at night. Invite some volunteers to keep a record of these places on a flip chart or on pieces of paper or card, by drawing a symbol for each place.

Here are some of the places which your peer group might already visit or would like to visit. Encourage them to think, first, of all the places which they themselves might visit. Then, perhaps in a different colour, list all the additional places which others in their community might want to visit. Perhaps suggest a few more places after they have finished their list.

EXAMPLES OF PLACES WE WANT TO BE SAFE IN OUR COMMUNITY

Home		*Bed*		*Roads*		*Tukuls*
	Fields (crops)		*Work-place*		*Kraal (animals)*	
Markets		*Shops*		*Police station*		*School*
	Firewood place		*Watering hole*		*Church*	
Mosque		*Place to collect wild veg & fruit*		*Football field*		*Netball field*
	Village centre		*Army camp*		*District offices*	
Wall		*Café*		*Health centre*		*Parade ground*
	Veterinary office		*Beer hall*		*Cinema*	

3. Now, once all the places everyone has thought of have been mentioned, invite the whole peer group to start to draw a map on the ground of their ideal community - maybe it is similar to their own community, maybe it is different in some ways. The idea is for them to create together a community in which they would like to be living, in five years time, in which they feel safe, happy, secure, peaceful and prosperous. Encourage them to be realistic! Hospitals or secondary schools won't come to our village! Just ask them together to construct a beautiful community with all the places they listed on it, using all the wonderful ideas that they have included in their Future Tree of Life.



4. Ask them to stick together more pieces of flip chart paper and lay it across the ground, or stick it onto a wall if the ground is too rough. Then invite ideas about where to put different items they have listed. Encourage the peer group also to think of places where they might go to work - and how they might reach there - by walking along safe paths, by bicycle taxi, or by bus if necessary. They could also think about where they might buy or grow food to eat; where they might collect firewood and water safely; where their stock could graze peacefully so they can access milk when they need it or sell an animal when they want to; where the children might go to school so that they can learn to read and write and understand more about human rights and the wider world around them; where older young people might go to learn a trade such as veterinary care or nursing or teaching, agriculture, forestry, leather working or sewing; where they might plant trees and flowers around their homes; and where there are informal gathering places around their community, for themselves to meet and talk and rest or hold meetings, or for their children to play in and feel safe. Think of the Tree of Life they created together last time and all the wonderful gifts and ideas which that now holds. How could these contribute to this peaceful community that you are now drawing? Just go on suggesting ideas as they start to draw, and encourage the participants to go on sharing their ideas and their stories for this future community as they draw it on the ground. Encourage everyone to be involved in the drawing - even if it is just drawing some flowers or trees around tukuls.

5. Once everyone has had a good 40 minutes or so drawing this new, vibrant and peaceful community together, explain that you would like to ask them at which four to six places, of all those they have drawn, they feel it is most important for them to have peace and safety *at all times*. Is it their beds? Their *tukuls*? The bush where they gather firewood and collect water? The fields where they grow crops? The roads? Or where else do they feel are the four to six most important places? Ask them why they have identified these places.What is it that makes them seem the most important to them?

6. Then explain that you would like to ask all the participants to divide again into four smaller groups. This time they should decide which group they want to join, on the basis of which four to six places they feel it is most important for them to feel safe and at peace at, at all times. You would like to ask them in each small group to:

- Identify the one place - or a maximum of two places - which they really want to focus on as places that need to be safe at all times (for example, beds and *tukul*; roads and markets; kraal, fields and bush etc.....).

- Develop a brief role play amongst them that shows someone like themselves, together with their partner, or children, or parents, or friends or peers in that place.

- The first part of the role-play needs to make clear where they are, and will show some sort of difficulty or conflict developing in that space between the different actors. This first part of the role-play should be only 4 minutes maximum!

- The second part of the role play will show how the actors have learnt new skills from this workshop which will enable them to wind back time and meet again there, in that same place, in peace and security and without any conflict developing, showing mutual respect and dignity at all times. They will be able to listen well to one another, show assertive body language, use "I" statements with one another, attend to one anothers' needs, do kind things for one another such as offering to help with tasks or chores, share or exchange produce with each other if needed..... Perhaps they could have developed a rapid response team to support one another when there is a risk of conflict developing or anger spilling over. Maybe they have introduced sanctions to respond to people who have behaved aggressively - and their relatives. Or maybe they could have introduced some of the exercises to friends and family or to school children. Or maybe they have encouraged participants to dream together how things could be peaceful and prosperous for everyone in future! This second part of the role play should *also* be only 4 minutes maximum!

- Explain that the third part of the work you would like each small group to do is to create a "we" statement which they can together state to the rest of the peer group. This "we" statement is just like an "I" statement, but coming from all the small group members together. This "we" statement should be 2 minutes maximum!

- Invite this group work to start. Participants can split into smaller peer groups alongside others who want to work on peace in the same place as they do. You could invite all who want to work on peace in the home to one corner; all who want to work on peace on roads and in market places to another corner; and so on.

- Say that you would like everyone to spend 30 minutes or so working together in their small groups, and we will then watch all their scenes together. Remind them that each small group will have only 10 minutes maximum for their two role-plays and their "we" statement.

- As the small groups work together, see how they are getting on. They may need more than 30 minutes. Encourage them to think of all the different characters involved and what they have heard from them in the two different workshop meetings - from their dreams in the first one and their Trees of Life in the second. Remind them that amazing dreams have come to life in the world, so even if right now they feel that some areas have conflicts which are impossible to unravel, reassure them that thinking about them and believing in them - *and then deciding to address them* - can start the journey to change.

- Ten minutes before you want to bring everyone back to the main circle, ask them to wind up their "before and after" role-plays and their "we" statements.

- Then ask everyone to move back to the main circle, taking a quick stretch on the way.

7. Now invite each of the small groups in turn to present their two role plays and then their "we" statement to the whole peer group.

- After each small group has presented, ask for any quick questions of clarification from the audience before offering a warm round of applause and then moving on to the next small group's performance.

8. After all the small groups have performed their two role plays and presented their "we" statement, ask all the participants:

- what *similarities* have they noticed across all the small groups' presentations?
- what *differences* have they noticed across all the presentations?
- were there any particular aspects of any of the presentations which another small group would like to *add* to their own presentation?
- were there any particular things which anyone felt they have *learnt* from all these presentations from their peer group today?

9. Explain that, with their permission, all the peer groups will be presenting all these "before and after" role plays, together with their Future Trees of Life and their maps of their safe community to the *whole community* in an open meeting, after the end of Session O. Ask them if this is acceptable to them all. Remind them not to feel nervous - this will be a great opportunity to share with the wider community all the amazing work that they have been doing in all these sessions.

10. Explain also that in Session O they will all have a chance to rehearse their role plays again and to work more on them. You would also like to ask all the small groups in *this* peer group to think together about how they can combine all their "we" statements into *one* "we" statement for the whole peer group, combining all the issues in their scenes. Ask them to start thinking about this and to bring their thoughts with them for session O.

11. Now say that we are going to talk about resilience and looking after ourselves together.

others. Just because someone has injured someone or drinks too much does not mean that they suddenly become inhumane or evil for the rest of their life. It is also important to support participants to understand that:

a) There is a difference between a person and their actions: their actions may not be respected but the person may still be fundamentally a good person who has done something unwise;

b) People can change their behaviour in future if they want to!

c) People can be supported by their peers to change their behaviour if they want to!

Exercise D.4: DREAMING OUR FUTURES AND "BACKLIGHTING"[8]

Aims: To imagine a positive future and start to create the future.

Description: Work in pairs.

Direction: 1. Explain to the participants: "We believe that our futures are influenced and determined by how we act now, in the present, and how we view ourselves and opportunities. It is, therefore, very helpful to get into the habit of dreaming or imagining our futures so that we make choices and do the things now, in the present, to realise and get the futures we want.

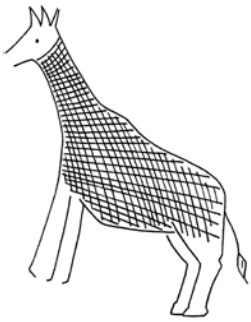
"In the last session we thought of a first step we could take to improve a relationship by one mark and we tried that out. In this session, we would like you to take an even bigger step.

"We would like you to dream your future 5 years from now and imagine you are living it now. While you are imagining this, you will be questioned from the future to the present about how you achieved this future. This is called "backlighting" - or working backwards through time. When you "backlight", you ask lots of questions that place someone in the future: Where are you living, what sort of house? What livestock do you have and how many? Do you have a garden? What are you growing - vegetables or anything else?"

2. Now ask the participants to imagine the livelihood or work they are doing, and how many years they have been doing this work. Then ask how they got this work, who they talked to about it, or what courses they went on to learn the skills to be able to do it. The details of the dream are what you need to be curious and questioning about, so you can get a clear idea of how the person got there.

This "backlighting" from a dreamed future is important as you always come from a position of success - having achieved your dream.

[8] Adapted from *Namweza - Friends Intervention Programme*, by Elspeth McAdam, Alice Welbourn, Charles Steinberg, Kicki Oljemark and Keith McAdam, © 2011.



3. Explain further that this exercise is like a rehearsal for living our futures, imagining them and planning what actions we need to take, to get to where we want to be in the future. Explain that the good thing about dreams (or visions for the future) is that we can change them if we do not like them and try different ones. It is often helpful to have at least five dreams so we can see possible alternatives to our future but all ones we want. If you are facing any difficult situation in your life, try dreaming a future in which you have got over that difficulty, and by "backlighting" you can begin to see the best ways of managing it.

Tell them that dreaming and imagining are creative processes that come from beyond our regular "thinking" minds. We are not talking about thinking and planning our futures, but rather letting our deeper wisdom and values emerge as a dream, a hope or an imagined future. And to let this dreaming happen, the first step is to relax and clear our minds, to slow or even stop thinking, and just listen to our deeper selves.

Ask them to work in pairs and to really question the details of each other's dream. Ask them to imagine that they are living a healthy life. Who are they living with, who is supporting them, what sort of life are they living, and what are they doing to earn their living? What are they doing during the day?

Ask them to talk as if they were 5 years older than now, and to just talk about how they dream their lives will be then... We suggest you allow 10 minutes for each person to dream and be interviewed about his or her dream.

NB: Some people fear that the dreams which participants produce will be completely unrealistic for them over 5 years. For instance, they may want to become an airline pilot or a heart surgeon. In this case, you could gently point out that this is quite possible but that they both involve rather more than 5 years of study. So instead you could encourage them to dream that they are on their way to achieving these dreams, and what will they have achieved in 5 years from now, in order to be on their way? It is really good to try to dream all kinds of things - for instance, at the start of the 20th century, few people imagined that there would be independence from colonial rule in Uganda, that a man would walk on the moon, that people could travel at 30 miles an hour, that South Africa would have majority rule, that the USA would ever have a Black President…. But all these have happened. Dreams can happen if enough of us want them to!

Exercise D.5: "I" STATEMENTS - USING ANGER AS AN INVITATION TO SORT OUT DIFFERENCES[9]

Aim: To introduce a different way of communication.

Description: To support participants in developing a new verbal communication skill.

Directions: 1. Ask participants if they noticed how they were feeling during the previous exercise. We hope people will say things like "curious", "energised", or "interested in new ideas and in different ways of thinking about things".

2. Then ask them how their *bodies* felt in the previous exercise. We hope they will say things like "relaxed", or "un-stressed" - these sorts of words. And what about their

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