Health and Population Unit

EMBRACING PARTICIPATION IN DEVELOPMENT:

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

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Acronym List

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

DEDICATION

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

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

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

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

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

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

Meera K. Shah

Sarah Degnan Kambou

Barbara Monahan

In Memoriam

CARE's Health and Population Unit
joins the editors
in dedicating the
Guidelines *to*

Jennifer Mukolwe

a senior field representative
tragically struck down
in the prime of life.
Throughout her professional life,
Jennifer sought to improve
the reproductive health status of African women;
she will be greatly missed.

Meet the CONTRIBUTING AUTHORS

MEERA KAUL SHAH

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

SARAH DEGNAN KAMBOU

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

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

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

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

JIM RUGH

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

FOREWORD

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

IN SUMMARY

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

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

CARE's Experience with Participatory Approaches

CHAPTER 1

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

Sarah Degnan Kambou

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

THE NEED FOR A DEFINITION OF TERMS

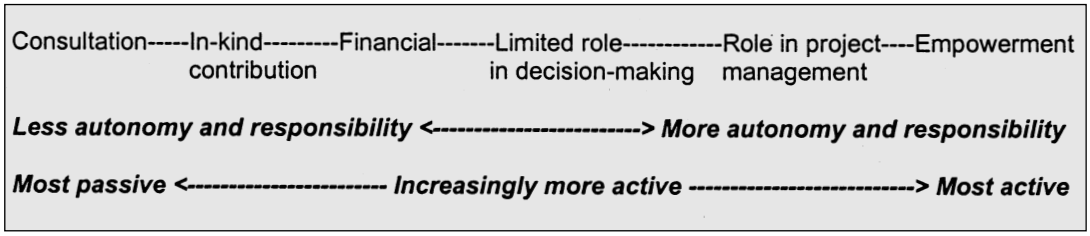
At regional and international meetings, CARE staff speak with conviction about their experiences incorporating participation into their projects; their enthusiasm and pride in their contributions to community development are heartwarming. Usually for lack of time, terms and methodologies have not always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

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

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

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

FIGURE 1.1 THE PARTICIPATION SPECTRUM



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

QUESTIONS FOR REFLECTION

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

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

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

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

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

FIELD WISDOM: POLITICAL REALITIES AS FACED BY CARE ZAMBIA

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

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

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

COMMON CAUSES OF FAILURE

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

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

FIELD WISDOM FROM CARE PERU

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

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

FIELD WISDOM FROM CARE RWANDA

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

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

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

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

FIELD-WISDOM FROM CARE SOMALIA

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

EXPLORING OUR OWN ATTITUDES TOWARDS PARTICIPATION

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

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

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

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

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

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

WORKING WITH DONORS

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

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

DON'T BE CAUGHT SAYING:

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

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

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

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

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

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

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

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

CHALLENGES TO PARTICIPATORY DEVELOPMENT

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

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

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

CHAPTER 2

PARTICIPATION AND SPECIAL POPULATIONS

Barbara Monahan

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

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

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

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

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

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

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

CARE BANGLADESH

PARTICIPATORY RURAL APPRAISAL IN THE WOMEN'S DEVELOPMENT PROJECT

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

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

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

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

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

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

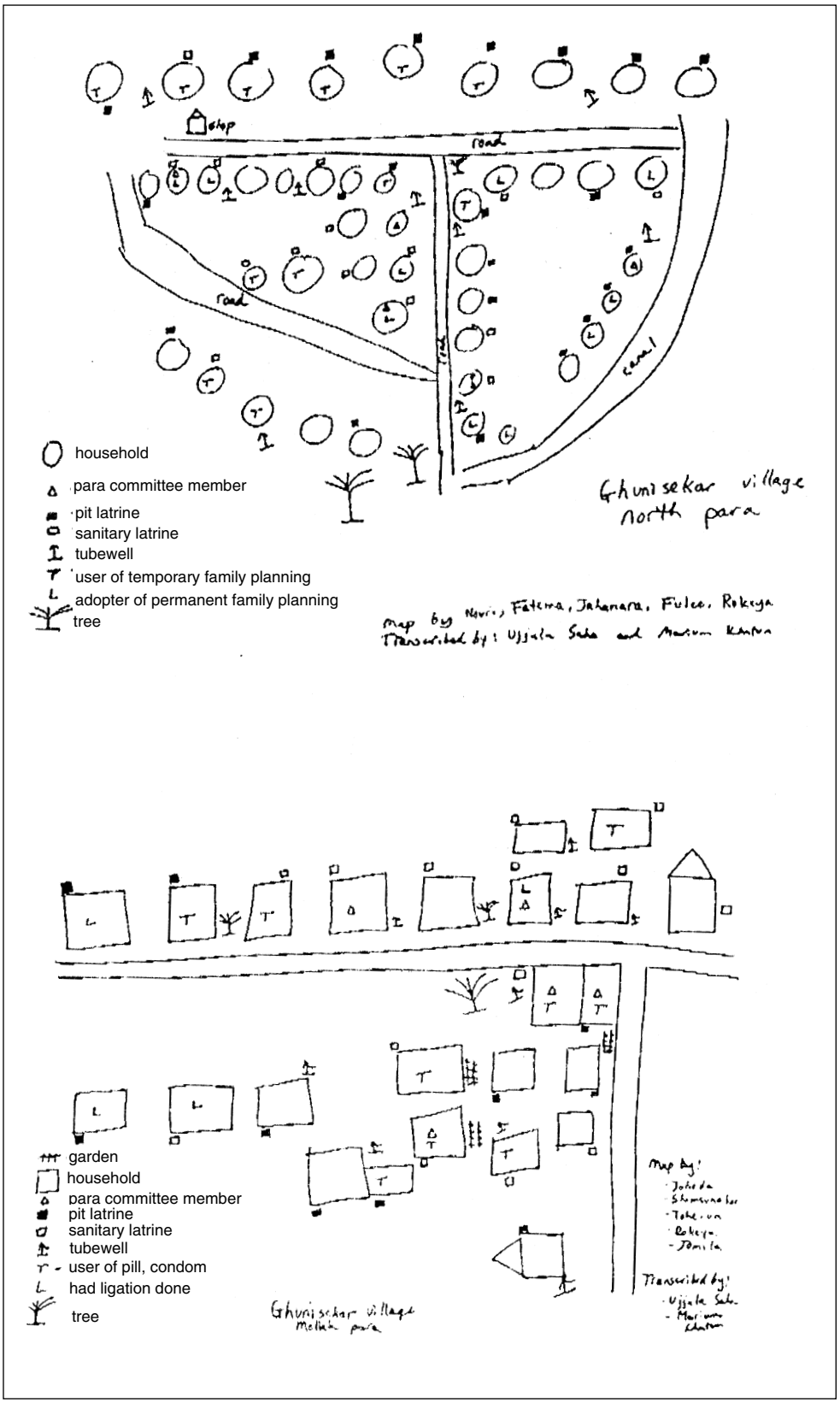
The second component supported the formation of neighborhood-based savings and loan groups enabling participants to start up income generating activities and gain access to small amounts of credit when necessary. The project worked in each village for four years, and it was explicit at the outset that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

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

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

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

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



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

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

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

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

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

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

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

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

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

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

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

CARE MADAGASCAR

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

Eléonore Seumo *and the CARE Madagascar Team*

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

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

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

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

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

STRENGTHS OF THE PARTICIPATORY ACTION RESEARCH APPROACH

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

Collecting relevant information efficiently

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

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

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

Creating a learning role for the development worker

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

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

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

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

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

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

Promotes community empowerment

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

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

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

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

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

WEAKNESSES OF THE APPROACH

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

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

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

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

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

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

LESSONS LEARNED

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

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

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

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

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

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

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

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

CARE TOGO

PARTICIPATORY APPROACHES TO ASSESS NEEDS

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

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

Lomé

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

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

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

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

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

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

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

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

Borgou Region, Benin

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

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

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

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

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

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

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

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

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

STRENGTHS

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

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

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

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

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

WEAKNESSES

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

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

Sometimes participatory approaches can slow down project implementation.

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

LESSONS LEARNED

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

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

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

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

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

CARE UGANDA

UGANDA FAMILY HEALTH PROJECT

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

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

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

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

Community development activities:

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

Reproductive health services activities:

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

District management activities:

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

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

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

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

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

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

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

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

STRENGTHS

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

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

WEAKNESSES

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

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

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

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

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

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

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

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

LESSONS LEARNED

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

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

CARE SOMALIA

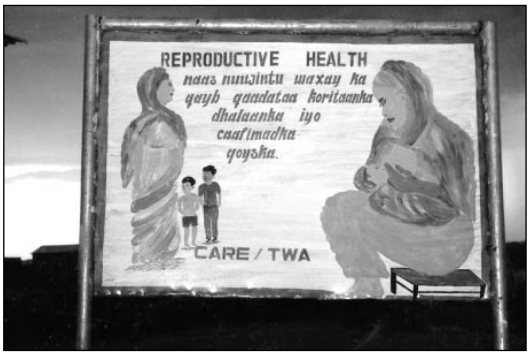
REPRODUCTIVE HEALTH AWARENESS AND ACTION PROJECT IN YIROWE (RHAAPY)

Barbara Monahan *on behalf of CARE Somalia*

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

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

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



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

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

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

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

A typical refugee home in the Yirowe displaced camp. Somaliland

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

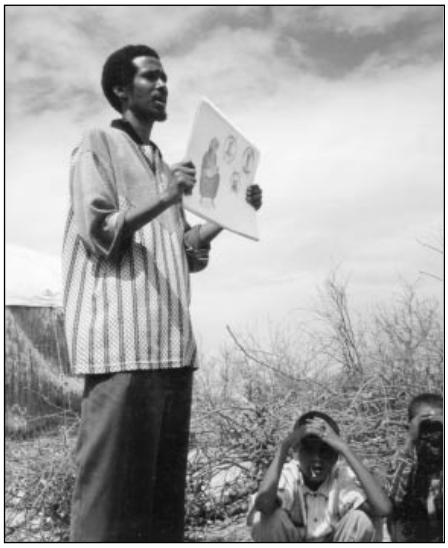
After completing the data collection and analysis of information from the mid-term review, findings were shared with the Yirowe community in a final presentation. Some of the strengths and weaknesses of the project and use of participatory methods are highlighted below.

STRENGTHS

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

WEAKNESSES

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



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

LESSONS LEARNED

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

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

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

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

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

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

CARE PERU

MULTISECTORAL POPULATION AND REPRODUCTIVE HEALTH PROJECT (MSPRH)

Extracted from an interview with Irma Ramos, CARE Peru

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

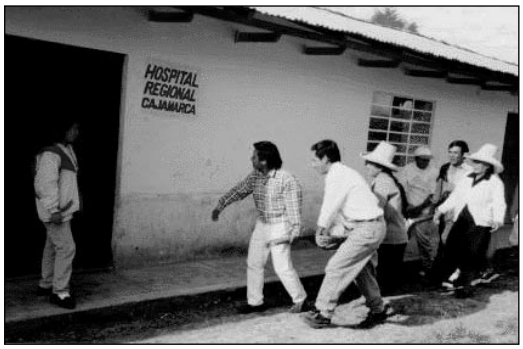
Main project activities include initiating a network of community-based distributors (CBD) to serve as health promoters in rural areas and linking these CBDs to the MOH. Once a CBD is trained, s/he is charged with providing RH information to the community, thereby permitting women and their partners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

The technical areas the project addresses include:

- Family planning
- Maternal health
- Adolescent health

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

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



Rural community members evacuate a woman experiencing an obstetric emergency.

STRENGTHS

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

WEAKNESSES

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

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

LESSONS LEARNED

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

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

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

CARE ZAMBIA

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

Tamara Fetters

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

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

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

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

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

SAMPLING AND METHODOLOGY

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

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

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

USING PLA METHODOLOGY

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

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

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

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

FEEDING BACK TO THE COMMUNITY

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

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

IN THE FIELD

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

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

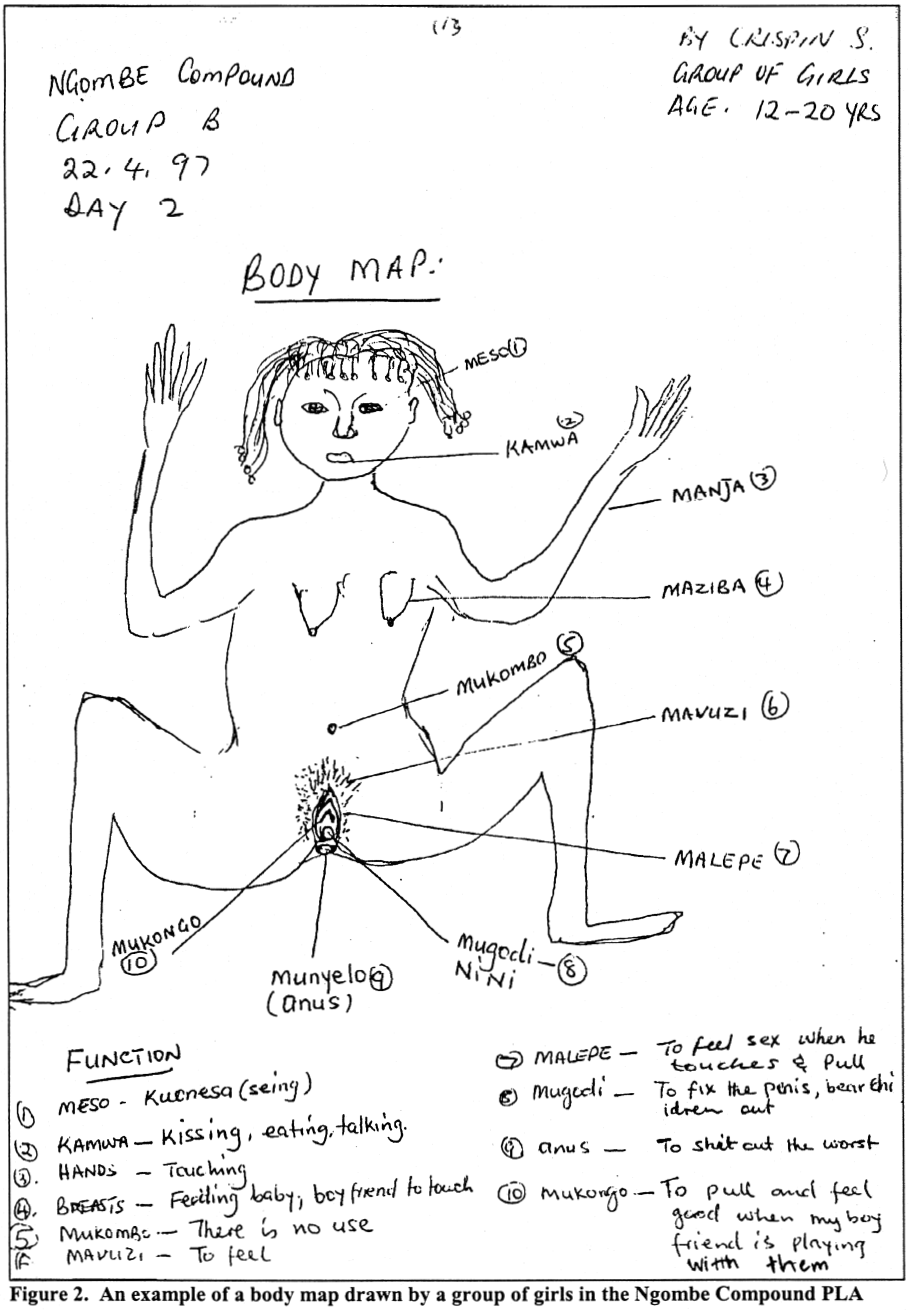


Figure 2. An example of a body map drawn by a group of girls in the Ngombe Compound PLA

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

PAIR-WISE RANKING OF ADOLESCENT CONCERNS

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

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

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

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

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

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

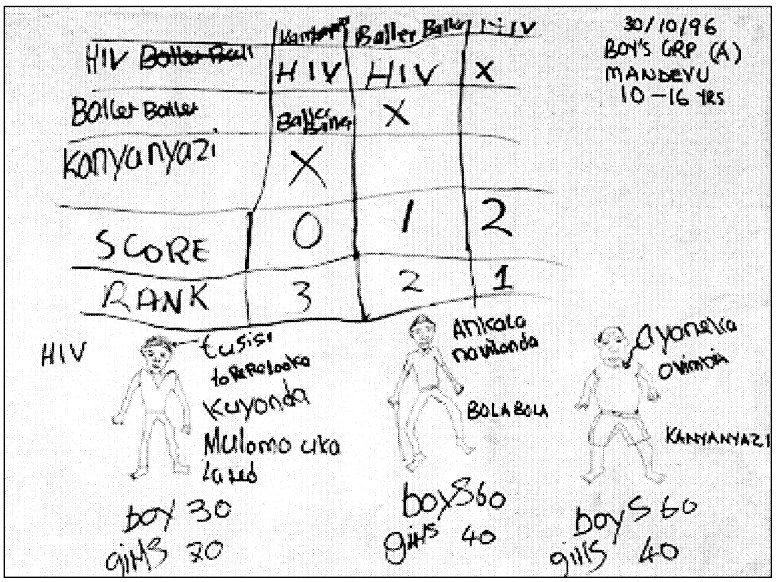
> Several groups of boys and girls narrated instances when a mother or grandmother would ask the girl to seek sex partners so that there is some money at home and they can have enough food to eat. However, it was mentioned that the girl would not be told directly to go and have sex but a mother could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

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

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

Recommendations to redress the trend:

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



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

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

CONCLUSIONS

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

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

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